IN THIS ISSUE:

- Kia ora to the new Censor-in-Chief
- 48th Annual Scientific Congress — the countdown begins!
- Increased Impact Factor for Clinical & Experimental Ophthalmology
- Role of the ophthalmologist in the management of dyslexia

Come and join us at the RANZCO 48th Annual Scientific Congress in Melbourne and explore the LANEWAYS OF MELBOURNE.
Cover picture: City Lights Art Project, Hosier Lane, Melbourne, Photographer Mark Chew

Eye2Eye is published by The Royal Australian and New Zealand College of Ophthalmologists as information for its members. The views expressed in the publication are those of the authors and not necessarily of the College. The inclusion of advertising in this publication does not constitute College endorsement of the products or services advertised.

Editor: Laura Sefaj  Design and layout: Francine Dutton
The Royal Australian and New Zealand College of Ophthalmologists A.C.N 000 644 404
94-98 Chalmers Street
Surry Hills NSW 2010 Australia
Ph: +61 2 9690 1001 Fax: +61 2 9690 1321
E-mail: eye2eye@ranzco.edu
Website: www.ranzco.edu

Contents

Message from the President 4
Censor-in-Chief’s Update 6
CEO’s Corner 14
Membership Spotlight 18
RANZCO 48th Annual Scientific Congress 28
Indigenous Eye Health 43
Policy and Advocacy Matters 46
International Development 52
RANZCO Museum 54
Feature Article
  Ophthalmology and Dyslexia 55
Branch Musings 58
Special Interest Groups 61
RANZCO Affiliates 64
Ophthal News 68
Ophthal Events 80
Scholarship Reports 81
RANZCO Office 83
Classifieds 86
Addressing the challenges in a changing medical environment

The tagline for the new College Strategic Plan reads, “RANZCO: The Leaders in Collaborative Eye Care”. For the sake of our patients and our discipline, ophthalmology must collaboratively engage with optometry and general practice. We intend to do this using RANZCO referral guidelines. Ophthalmologists are all well aware that the environment in which they practice is changing. Emerging medical diagnostic technologies, patient expectations and governmental fiscal constraints are impacting on our practising lives. RANZCO and its Fellows must adapt to the changing medical landscape. The Council and Board have evolved a bipartite approach to meet these challenges.

General practice is now in significant oversupply, with a greater density of GPs in regional areas than was the case in metropolitan Sydney and Melbourne 10 years ago. Increasing subspecialisation within general practice is fundamental to large, successful GP practices. RANZCO has had encouraging discussions with the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners, with a view to creating pathways for GPs to develop some ophthalmic skills. We believe medical graduate oversupply, GP subspecialisation and the recent approval of a Medicare Benefits Schedule item number for retinal photography by GPs mean that there will be interest.

The recently launched RANZCO referral guidelines project represents a proactive initiative to engage with all optometrists and general practitioners using RANZCO’s guidelines. The RANZCO referral program, both education and guidelines, are available to all optometrists and all general practitioners. We seek to promote the RANZCO guidelines; we are not endorsing any particular group or

“This is a historic proactive initiative by the College to enable us to lean forward towards our future.”

Dr Bradley Horsburgh
individual optometrist or general practitioner. We welcome clinical feedback from all ophthalmologists, all optometrists and all general practitioners who wish to participate. We have confirmed a collaboration with Specsavers to facilitate a clinical efficacy trial pilot program, enabling the collection of data to assess the impact of the RANZCO guidelines, both in terms of patient outcomes and healthcare costs. Clinical feedback from all participating optometrists and GPs will contribute to the research. The clinical efficacy trial will be specifically designed, such that it will not be dependent upon any particular referral platform or methodology. We have launched the RANZCO referral guidelines for glaucoma based upon the White/Goldberg paper (2014). Guidelines for diabetic retinopathy and age-related macular degeneration are currently under development and will be released as soon as they are completed. This is a historic proactive initiative by the College to enable us to lean forward towards our future. The RANZCO College Council meeting on July 23 provided me with the most satisfying moment of my presidency, when the Councillors voted unanimously in support of this motion: The Council strongly endorses the RANZCO Professional Code of Conduct with respect to appropriate billing practices. In particular, it is a breach of the Code to take advantage of the Medicare or private health funds reimbursement and it is a breach of the Code (and various laws) to use public resources (including Medicare) principally for your own financial gain. The Council strongly disagrees with the practice of utilization of uncapped Medicare Item Numbers to exploit the extended Medicare safety net.

The RANZCO College Council have telegraphed that they intend to maintain a watchful eye on Fellows’ professional behaviour and, if necessary, will take disciplinary action. The struggle to introduce the new RANZCO Constitution has been vindicated.

Dr Bradley Horsburgh President, RANZCO
In 2008 changes in leadership were all the rage. In November that year, Dr Mark Renehan took on the mantle of RANZCO Censor-in-Chief. Observing his performance in that role during the last few years, he seems to aspire to servant leadership, a term coined in an essay published way back in 1970. This type of leadership, it contends, “... begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead”. I asked Mark if that was how he saw himself.

“What’s great about leading QEC is the collaborative effort of the leaders of our profession in so many dimensions,” said Mark.

“There are the gifted teachers, the clinical innovators, the strategic thinkers — all working together to ensure the next generation of ophthalmologists get the education and development they deserve.

“There’s a lot of talk at the moment about the ‘social licence’. Our communities hold us in high regard. The medical profession lives up to its part of the bargain by excellence in practice and, importantly for us, in its role in propagating excellence in the next generation of doctors.

“The ‘reward’ for the extra hours of participation in QEC, or examinations or the training post inspectorate, is the satisfaction of giving back to a profession that’s given us all so much.”

When asked what the most significant changes in the Vocational Training Program had been since he became Censor-in-Chief, Mark was quick to share the accolades.

“I think the integration of the foundation assessments into a five-year training program has served the College well. Trainees now have a more cohesive introduction to training, letting them learn ‘the basics’ in the context of practice. The introduction, and recent revision, of the work-based assessment program has been a great innovation. The curriculum review was complex and wide-ranging,” replied Mark.
Reflecting on more ‘behind the scenes’ changes, Mark said, “The regional QECs are more active, and play a more important part in the operation of the training program nowadays. Their roles, and those of the Directors of Training and Term Supervisors, are key. Dealing with the stresses and joys of trainees on a day-to-day basis is challenge and reward rolled into one.

“We’ve made great improvements in governance, policy and process matters. These occur with little fanfare but make the day-to-day running of the training program much more sustainable. The credit for improvements in this area must go to Penny Gormly, in her role as the head of the Education team, who has supported me splendidly during my term. I couldn’t have imagined negotiating the recent AMC accreditation submission and visits without her.”

What lesson does Mark think is the most important for his successor, Dr Justin Mora? “That’s easy! There’s no need to feel you have to do it all by yourself. Surround yourself with good people. Your colleagues on QEC and the RANZCO Board have expressed their confidence in you, and you are supported by the professional staff of the College. Think “why not …” rather than “best not …”

“If you were to ask me what I’m most proud of, I’d have to say it’s the trainees. Every graduation ceremony, the fruits of our labours and theirs are there to celebrate.” Spoken like a true servant-leader.

Neridah Baker
Manager, Curriculum and Course Development, RANZCO

---

Kia ora to the new Censor-in-Chief
Dr Justin Mora

Q Tell us a little about your family and your professional life and how that influences your practice of medicine.

A Helga and I celebrated our 25th wedding anniversary in February but she always says that the more important time is how long we have been together which is 30 years next year. She has been at my side throughout my career and has backed all the various professional moves I have made including two years of fellowship training in the US, setting up in private practice, starting as a RACE examiner and then taking on the Chair role. When I brought up the possibility of putting my name forward to become Censor-in-Chief she was very aware of the time commitment required and of the potential stress it might create but she was 100% supportive. I am very fortunate to have her by my side and she would probably agree!

We have two girls, Genevieve (22) who has recently completed two years at the Lee Strasberg Film and Theatre Institute in Los Angeles and Juliet (17) who will finish high school at the end of 2017. They are good pals and lovely people. What more can a parent ask?

From a professional point of view, I trained in ophthalmology in Auckland before going to the States. We lived in San Francisco while I undertook the Shaffer University of California, San Francisco Glaucoma Fellowship and then went to Indianapolis for Gene Helveston’s Paediatric Ophthalmology and Strabismus Fellowship. They were two great years and really set me up for my career which inevitably includes looking after all the paediatric glaucoma in my part of New Zealand.

Since 1996 I have worked three sessions per week as a consultant at the Greenlane Clinical Centre in Auckland and the rest of my time is spent with my 12 colleagues in group private practice at Auckland Eye.

My public hospital commitment is about one third glaucoma and two thirds paediatrics and strabismus and I have the joy of training both registrars and paediatric fellows. I love to teach and I hope that by being enthusiastic about it I am instilling into our trainees an understanding of the importance of sharing what they learn.

My private practice is paediatrics, glaucoma, general and refractive. I took
on refractive surgery in 2002 with the support of my colleagues at Auckland Eye and, although it is only a part of my practice, I thoroughly enjoy it. We adopted SMILE last year and that has been exciting. We are lucky to be in a field where there is such constant innovation.

**Q** What drew you to membership of the Qualification and Education Committee (QEC) in the first place?

**A** I joined QEC when I became Chair of RACE in 2011. I know the exam processes well and I was a member of the recent curriculum review committee but over the last five years I have learned a great deal more about the other subcommittees including CPD, Training Post Accreditation, SIMG assessment and progression. I gained even more respect for what those groups do and for the selfless work done by all the QEC Chairs and Directors of Training.

It’s a big commitment to put your hand up for any of these roles and we are very fortunate to have so many people who care enough that they are prepared to do it.

**Q** How would you describe your leadership style?

**A** Collegial, I would like to think. I am honoured to have been selected for this role and I intend to drive any changes that I think are important and particularly those that will be required following the recent Australian Medical Council assessment.

But I will be very dependent on and will encourage the expertise of other people in the QEC team. For example, QEC had already planned on moving to continuous curriculum renewal and the Curriculum Committee Chair Cathy Green, with all her knowledge in this area, is the perfect person to make this happen. I don’t expect she will need much help from me but I will support her in any way I can.

Similarly, the institutional knowledge (no pun intended) of the Training Post Accreditation Committee and all the other subcommittees has to be respected and honoured. Again, I will help them and guide them if I think we need to alter the focus in any way but I’m not going to tell them how to do their jobs.

**Q** You are the first Censor-in-Chief from New Zealand. What benefits will that bring?

**A** For a start, when it comes to College functions there will be no more sheep jokes! And thanks cobbers for letting us have a turn.

Perhaps the perspective may be a little different. For example, one of the things the College has to work on is increasing the involvement of our Indigenous populations in our health programs and I think we are probably further ahead with that in New Zealand. There are, I think, just three ophthalmologists in New Zealand who acknowledge Maori ancestry in the Medical Council registry, of which I am one, so obviously we don’t have it all sorted yet. But my own medical school, Otago, is expecting next year to enrol a number of Maori students equivalent to the Maori proportion of the population (about 15%) and Indigenous rights in New Zealand are taken for granted in a way they aren’t quite yet in Australia.

Nevertheless, even though our health systems have some differences, the fundamentals are still the same.

Our ability to ensure the health, safety and well-being of all our trainees and of all our trainers must be a priority and we need to develop systems to ensure that this will work on both sides of the Tasman.

Both countries face shortages of general ophthalmologists willing and able to work in provincial centres. To address this, we need to ask questions about our selection processes and of course about our training priorities. One issue we will grapple with shortly is that of requiring a minimum number of certain procedures in order to obtain the Fellowship. For example, can we reasonably expect someone to work as a generalist in a provincial town if we have never taught him/her to do a good trabeculectomy? These are difficult questions but they need to be addressed.

**Q** What’s the biggest challenge that supervisors face?

**A** Supervisors are the unsung heroes of the College. Why would you volunteer to put yourself in the position of having to do all that extra work of monitoring trainees and providing constructive feedback? It’s done in your free time, it requires specific skills which we don’t necessarily learn in our undergraduate training and it opens you up to criticism at every level.

I am forever grateful that we have people who are prepared to take this on. I think a lot of it comes from a genuine love of teaching, a desire to pass knowledge on to the next generation and I think we are also blessed with such a degree of collegiality in RANZCO that people want to do their bit to help.

One thing we need to do better for supervisors is to provide more support when they first identify a trainee who is struggling. At the moment they are bearing too much of that responsibility and the College will become more involved in the assessment, the feedback and, if it is required, the remediation process.

We have a new position on QEC: Chair of the Mentorship program. I see this role leading to mentors taking a more active part in training. We owe it to our trainees to support their health and well-being as well as their accumulation of knowledge and skills, and the mentors are in a position to work separately and objectively to help supervisors with this.

**Q** You were most recently the Chair of RACE. What did you like best about being involved in College examinations? What advice would you give your successor?

**A** Dr Maria Moon will take over as Chair of RACE and, when I wrote to the examiners to tell them this, I expressed my belief that she has just the right mix of passion and compassion for the job. Maria has been a RACE examiner for 10 years so she knows the processes back to front. She is a committed educator and believes in the excellence that the training program and the exam
are trying to ensure. As trainers, and particularly as RACE examiners, we feel a duty to maintain high standards so the public can be certain that once people graduate as Fellows they will be safe and effective ophthalmologists.

Balanced against this is the memory we all have of going through the ophthalmology exams and how it completely dominated our lives and how terribly stressful it was. I still remember the sense of relief when I got through my Part Two, as it was in those days. And that is where the compassion comes in. It is an examiner’s duty to get the best out of a candidate and to do that we have to try to relax him/her as much as possible in what is a very challenging environment. When I have watched Maria run her OSCE stations I see how well she does this and I know that she will bring that skill to her new role as Chief Examiner. I am also confident she will enjoy the job. It’s a privilege to hold that position and to work with such a wonderfully committed group of people as the RACE examiners.

Q Paediatric ophthalmologists are a special breed. What, besides being allowed to play Lego with your patients, is so special about your sub-specialty?

A Funnily enough paediatric ophthalmology was the first subspecialty I crossed off my list of options when I was a junior registrar and with hindsight I know that was because I just didn’t feel confident dealing with children. I see that in my own trainees now and I encourage them to be patient and reassure them that the confidence will come and with that the enjoyment. Although when I think about it I don’t think I have convinced too many as, like many other centres, Auckland has over the last 20 years had very few trainees choose to specialise in paediatrics.

If you enjoy children, then paediatrics is fabulous. With few exceptions, children bring a certain joy into the room with them. We all know that job satisfaction is something ophthalmologists have in spades but there is a particular reward in helping little people and knowing that you are setting them up for a better life than they might have had otherwise. I have learned to enjoy the interactions with parents too; there is a real sense of satisfaction in helping them to understand what is going on and giving them the confidence that you are going to be able to support them through whatever happens.

I have also been around long enough that I have watched many of my children grow into wonderful young adults and I feel a real bond with them, which is pretty special.

Q You’ve been active in the College’s international development projects as a visiting lecturer and an external examiner. That’s a big commitment. What in particular about this RANZCO activity would you recommend to others?

A I am a relative newbie to this and I feel embarrassed to mention the paltry amount I have done compared with other College Fellows, including close friends of mine, who have made this an integral part of their careers from day one. I had thought about it for a long time but was reluctant to spend more time away from my family when the children were young and it became a bit of a ‘never got around to it’.

Then a few years ago I was offered the opportunity to get involved with Sight for All’s work up in Southeast Asia, training the first paediatric ophthalmologists for that part of the world. I have been to Cambodia and also to Laos on several occasions. I have also helped out with the exams and with teaching at the Pacific Eye Institute in Suva.

Without a doubt this has been one of the most satisfying things I have done in my career. It is so humbling to come face to face with the level of need that exists in other parts of the world and I am very grateful that I have a job that allows me to make a useful contribution to improving their situation. I admire and am very proud of colleagues like Dr James Muecke who runs Sight for All, all the RANZCO Fellows who contribute their time and expertise to service and training in international development projects and of the College itself for making a commitment to help establish robust training programs in these countries.

I would encourage anyone with the slightest interest to consider getting involved. It is so rewarding.

Q How do you ‘get away from it all’?

A Do you have hobbies or a creative passion?

Helga and I love to travel and we have always made it a priority even when the children were small. Before my oldest reached school age, I made a resolution to take at least a week off every school holidays and a minimum of three weeks over summer and I have never reneged on nor regretted that commitment. I think that spending a lot of time together on various adventures has made us closer as a family and it has certainly been sanity-saving for me to have regular time out with them. I would commend to anyone starting out on his/her career to ensure balance in your life and not to neglect family time.

Helga and I like to hike and have done some but not all of the great walks in New Zealand. We walked the West Highland Way in Scotland a couple of years ago which was fabulous and we have the Milford Track booked for next year.

I love skiing and scuba diving though I seem to find less time for those activities these days. I like to pencil-sketch but I’ll never show anyone my work as I’m hopeless.

It’s been interesting reflecting on these questions and one of the things that strikes me is that I regret none of the commitments I have made to College activities. From local QEC, to RACE, to overseas development, each of these roles has added something to my life, not just professionally, but also socially through all the wonderful people I have met along the way. I don’t believe this has been at the expense of my family life so I hope people don’t let that fear get in the way. If you have ever considered putting your name forward for a role, then I would encourage you to do so.
RANZCO Censors-in-Chief over the years

With the appointment of a new Censor-in-Chief earlier this year, RANZCO Honorary Fellow Ms Margaret Dunn will be taking us through the College’s Censors-in-Chief over the years. Starting with Dr Ken G. Howsam, Dr Peter Rogers and Professor Frank Billson, Ms Dunn provides an extensive overview of the careers and achievements of each Censor-in-Chief.

The RANZCO Censor-in-Chief is responsible for all aspects of post-graduate education; over-seeing the selection of trainees, the curriculum, post-accreditation training and examinations.

Before the Australian College of Ophthalmologists (ACO) was founded in 1969, ophthalmologists had either qualified with Fellowships from overseas or from the Royal Australasian College of Surgeons (RACS), or with Diplomas of Ophthalmology (DOs) in Australia. At that time there was no national training in ophthalmology and this resulted in fragmentation and discord. Although the Universities of Melbourne, Sydney and Queensland had all set up DOs with limited scope of training, they formed the academic base for the specialty, and provided experience in administration, teaching and examining which made possible the development of the College. The purpose of founding a College therefore, was to establish a national integrated vocational training program (VTP) in ophthalmology; to establish the management of examinations in the discipline; and to confer Fellowships.

Separate to the administrative aspects of the College, a nine-man Committee was established to deal with the qualification and education aspects as set out in the new Memorandum of Articles (MoA) which had been compiled by Drs Geoff Harley and Ken (‘KG’) Howsam. The MoA contained articles from the Ophthalmological Society of Australia (OSA), including the stated purpose of promoting the study of science and the practice of ophthalmology, with two additional keystone objectives:

i. to educate people in ophthalmology;
ii. to examine their competence in ophthalmology.

The nine-man Qualification and Education Committee (QEC) was made up of Dr Howsam (Chair); Professor Gerard Crock and Dr James Foster from Melbourne; Dr Daniel Hart from Brisbane; Drs Frank P Claffy, John Hornbrook, John Pockley and Peter Rogers from Sydney; and Dr Max Moore from Adelaide.

Dr Ken G. (‘KG’) Howsam

A qualified ophthalmologist as well as a medical administrator, Dr Howsam was eminently suited for the key position as first Chair of the QEC, and hence Censor-in-Chief, because he was the Medical Director of the Royal Victorian Eye and Ear Hospital (RVEEH) which was at that time the training centre in Victoria for aspiring ophthalmologists for the DO.

Dr Howsam had graduated MBBS in 1943 during World War II from the University of Melbourne and then worked as a junior resident medical officer (RMO) for three months at the Royal Melbourne Hospital. There he gained experience as an eye resident, and ear, nose and throat (ENT) resident. He sought enlistment in the Royal Australian Air Force (RAAF) but was deferred for six months to serve as a resident at the RVEEH. He then served in the RAAF as a general duties medical officer from October 1944 to March 1947. During this time he met George Thomson, a first-class medical administrator and surgeon, who had a marked influence on him. On discharge from the RAAF Dr Howsam was appointed as Resident Medical Superintendent at the RVEEH.

Dr Howsam was one of the early pioneers of ophthalmology in Australia. His liaison with Dr Ronald Lowe and Peter Howsam at the RVEEH was a cornerstone in the development of Australian ophthalmology. K.G., as Dr Howsam was known, had been elected to the Council of the OSA in 1958 when it was still a section of the British Medical Association at that time. He actively supported Australian involvement in the Asia-Pacific Academy of Ophthalmology and the holding of its second Congress in Melbourne in 1964.

He was sent overseas by the RVEEH on three occasions, in 1958, 1966 and 1972, to seek new knowledge which resulted in raising ophthalmology standards in Australia to an international level. He visited a large number of centres to investigate hospital design, administration and the relationship between universities and the state with respect to hospitals; and studied the training of RMOs and rotations between hospitals.

With the formation of the College in 1969, Dr Howsam and his team set about tackling the compilation of a syllabus and conditions for training. They began negotiations with post-graduate medical education bodies in the states regarding courses of training for examinations for entry to the College. The training programs and periods of training were agreed upon with RACS and the idea of a conjoint final examination between the ACO and RACS seemed to be a satisfactory way to achieve a national qualifying examination. Regulations were drawn up and the establishment of teachers...
and examiners to assess the qualification of candidates for admission to the College were inaugurated. It was agreed that entry to the College would be by examination as from 30 June 1971. Qualifications issuing from the College’s agreement with RACS came to be accepted by the Australian Commonwealth and state governments as accreditation for ophthalmologists and the university diplomas of ophthalmology were discontinued. With the institution of a uniform Australia-wide training program and appropriate examinations to set the hallmark of Australian ophthalmologists, the hotchpotch of available qualifications was brought under control.

In 1972 Dr Howsam stepped down as Chair of the QEC to focus on the development of the RVEEH. He was subsequently elected to the role of Vice-President of the College, then President, and Immediate Past President, over a span of three years from 1981 to 1983. After his term as Immediate Past President, K.G. took on the challenging and time-consuming role of Inspector of Training Posts and designed the optimal structure and function of all the Australian Training Posts, which served as their model for many years. The inspection and accreditation process ensures that the training posts are of the required standard and at the required level.

Dr Peter Rogers

In 1972 Dr Peter Rogers took over as Censor-in-Chief from Dr Howsam. Peter graduated MBBS from the University of Sydney with honours in 1946 and was RMO at Mater Misericordiae Hospital, Sydney from 1946 to 1947 before becoming ophthalmology registrar at St Vincent’s Hospital until 1949. He was awarded with a DO in Sydney in 1949 and became Honorary Medical Officer at both the Mater Misericordiae and St Vincent’s Hospitals in Sydney. After qualifying with his DO in 1949, Dr Rogers took an active role in the OSA from 1951 to 1960, and then again from 1965 to 1969. He was a Councillor with the OSA and performed the roles of Secretary and President during that time.

Dr Rogers was a founding member of the ACO in 1969 and made an enormous contribution to the promotion and development of the College at almost every level. From 1969 to 1978 he was a member of the QEC and, as Chair of that Committee from 1972, he was an ex-officio member of the ACO Council. Dr Rogers’ wisdom, tact and understanding made his years of service quite outstanding and he was in no small way responsible for much of the success of the educational activities of the College. At his first Council meeting, he reminded Councillors that the basic reasons behind the move to establish a College had been the question of qualifications and standards and, therefore, the success of the College would stand or fall on the success of the QEC and the support given to it by College members.

By 1977 the QEC reported that most of its original aims had been achieved: that the examination system was working well and that by 1978 any reciprocity with the universities’ DOs would cease. At that time ways for meaningful and fair assessment of performance during vocational training were being examined.

When the College became the Royal Australian College of Ophthalmologists (RACO) on 31 March 1978 after the Queen granted the College the right to use the prefix ‘Royal’ in May 1977, for its own guidance the Executive formed a special ad hoc committee under the chairmanship of Dr Theo Keldoulis to examine and report on what the long-term aims and objectives of the College should be. “The End of the Beginning” was how Dr Rogers summarised the first nine years of the QEC when he stepped down as Censor-in-Chief in 1978. He reported that the original QEC pursued the fundamental task of drawing up rules for its own conduct and it set up an examination system and training procedures. By that time the basic science examination relative to ophthalmology was
conducted by the RACO on its own behalf without the aid of the RACS.

Simultaneously, negotiations had been going on with the Education and Qualification Committee of the Ophthalmological Society of New Zealand (OSNZ), with a view to achieving regional standards throughout Australasia. Future participation and assistance to other countries was also part of this regional concept.

**Professor Frank Billson**

When Dr Rogers stepped down as Censor-in-Chief in 1978 he handed over to Professor Frank Billson. Already an active Fellow of the College when he was appointed as the Foundation Chair of Ophthalmology at Sydney University, Prof Billson proceeded to make a major contribution to the work and development of the College. As Chairman of the ophthalmological section of RACS and having served on the RACS Court of Examiners, Prof Billson formalised the RACO/RACS Conjoint Examinations with the RACS which were ultimately endorsed as the only mode of proceeding to Fellowship of either College. He also formalised RACO’s responsibility for examining in New Zealand by sharing written papers, sharing one or more examiners in vivas and strongly coordinating training programs with the OSNZ with reciprocity of training posts and interchange of trainees between the two countries.

Prof Billson was educated at the Melbourne Church of England Grammar School and graduated in medicine from the University of Melbourne in 1958. After working at the Alfred Hospital he travelled to England where he gained a Diploma in Ophthalmology in London in 1962. He was admitted as a Fellow of the Royal College of Surgeons Edinburgh in 1965; the Royal College of Surgeons London in 1966; the Royal College of Australasian Surgeons in 1966; and as a Member of the Australian College of Ophthalmologists in 1975. He became a Fellow of the American College of Surgeons in 1977; Fellow of the American Academy of Ophthalmology in 1978; and Fellow of the Royal Australian College of Ophthalmologists (FRACO).

Having served on the QEC and as Censor-in-Chief, Prof Billson also served on the Editorial Committee, the Council and as President. He served with distinction to raise the prominence of the College amongst its peers. His work in basic ophthalmological research and service to the underprivileged overseas, particularly in Bangladesh and more recently in East Timor, added to the College’s prestige and reputation.

In 1980 the QEC introduced the requirement to pass the Part I Basic Science exam for admission to the VTP and implementation of a common final examination with the OSNZ, paving the way for the later amalgamation of the two bodies. It was also confirmed that after 1981 reciprocity with UK Fellowships (ophthalmology) would be withdrawn by RACO and RACS. By 1981 the QEC was structured formally in three parts comprising Qualifications, Examinations, and Continuing Education.

*Ms Margaret Dunn*
*RANZCO Honorary Fellow*
The Council and Board have recently finalised a new Strategic Plan for 2017–2020, which is shown following this article.

I always have an eye on the future. That’s not to say that the past does not provide valuable lessons, but I think it’s far more important to consider what is ahead. This can make it difficult to run a membership organisation as most of the time you don’t get to decide what is going to happen. Members, regulators and government make decisions and we have to react. However, we can mitigate this by being prepared (maybe that’s the Scout in me coming out) and planning. Our new Strategic Plan is more detailed and proactive than the current one. It also, for the first time, gives RANZCO a Vision: To be recognised as a world leader in eye care education, training, and setting of policy and standards.

The Plan has five Strategic Priorities: Education, Training and Accreditation; Advocacy and Awareness; Member Engagement; Standards; and College Activities. Our core business remains education, both vocational training and professional development. We recently completed our Australian Medical Council (AMC) major accreditation review, in conjunction with the Medical Council of New Zealand. Although we are yet to receive the final feedback, I have seen the interim full report. The accreditation team had a lot of positive things to say about our training program, in particular noting the dedication of Fellows providing training and serving on committees. They also commended the high quality of the training. However, there are a number of areas where we will need to improve. Many of these are around broadening our interactions with other health care providers, particularly optometry, and patients and patient groups. Although these interactions occur in the daily environment in which most Fellows operate, we need to bring this back to a College level. This and numerous other improvements will be done as we
develop Business Plans to undertake the direction provided by the Strategic Plan.

In order to best meet the challenges of the future, and address the areas required by the AMC in order to remain accredited, I have decided to undertake a restructure of the Education department. After discussion with the Board I have created a new role of Deputy CEO and Head of Education. This person will be responsible for all educational activities (selection, vocational training, professional development) and work closely with our new Censor-in-Chief Dr Justin Mora to define our educational offerings. They will also have a key responsibility for integrating the numerous IT systems currently used by RANZCO to deliver education, and anticipate any IT developments required. The role brings together all the elements of our core business of education while looking towards the future of ophthalmic training. I expect, as part of the Strategic Plan, that RANZCO will remain The Leaders in Collaborative Eye Care through education of not only ophthalmologists but GPs, optometrists and other allied health. This creates challenges for us as a membership organisation, but also an opportunity to shape the future of eye care in the region and remain the organisation sought by government, other health providers and the public for advice.

Dr David Andrews
Chief Executive Officer, RANZCO

RANZCO Strategic Plan 2017-2020
THE LEADERS IN COLLABORATIVE EYE CARE

The Royal Australian and New Zealand College of Ophthalmologists has completed a review of its Strategic Plan 2013-2016 and established an updated approach to the coming four years that builds on the successes to date, yet more clearly articulates our vision, mission and strategic priorities.

We will use this plan to maintain our focus on:

<table>
<thead>
<tr>
<th>Best patient outcomes</th>
<th>Aiming to ensure equitable access to the highest quality eye health for all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and training</td>
<td>Providing contemporary education, training and continuing professional development</td>
</tr>
<tr>
<td>Evidence based decision making</td>
<td>Using research to underpin improvements in education, training and eye health care</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Working with others involved in the delivery of eye health care nationally and internationally</td>
</tr>
<tr>
<td>Collegiality</td>
<td>Supporting trainees and Fellows through all stages of their career</td>
</tr>
</tbody>
</table>

We are the leaders in collaborative eye care – focused on our commitment to:
- Working with others involved in the delivery of eye health care nationally and internationally, including working with government on policy development; and
- Providing best quality education, training and continuing professional development.

We have articulated our vision and defined our mission.

VISION:
To be recognised as a world leader in eye care education, training, and setting of policy and standards.

MISSION:
Improving eye healthcare through education, communication, collaboration and advocacy, nationally and internationally.
OUR STRATEGIC PRIORITIES
RANZCO will realise its vision and deliver on its mission by way of five strategic priorities, all underpinned by our commitment to ethics and achieved through collaboration.

<table>
<thead>
<tr>
<th>Education, Training &amp; Accreditation</th>
<th>Advocacy &amp; Awareness</th>
<th>Member Engagement</th>
<th>Standards</th>
<th>College Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate the highest quality practice of Ophthalmology through evidence based education, training and accreditation.</td>
<td>Lead the policy debate as the trusted, authoritative source of information and research; and promote Ophthalmology as a medical specialty, body of knowledge and career.</td>
<td>Represent, support and foster our members’ interests; and build engagement, ownership and collegiality among them.</td>
<td>Set, monitor and maintain standards for the provision of highest quality Ophthalmology practice in Australia and New Zealand.</td>
<td>Deliver superior service and value to our members, partners and stakeholders to ensure ongoing sustainability.</td>
</tr>
</tbody>
</table>

GLOSSARY OF TERMS
AMC: Australian Medical Council
AHPRA: Australian Health Practitioner Regulation Agency
CMC: Council of Medical Colleges (NZ)
CPMC: Committee of Presidents of Medical Colleges
GP: General Practitioner
MCNZ: Medical Council of New Zealand
ORIA: The Ophthalmic Research Institute of Australia
NGO: Non-Government Organisation

STRATEGIC PRIORITY 1
Education, Training & Accreditation

We will facilitate the highest quality practice of Ophthalmology through evidence based education, training and accreditation.

**Key Programs, Projects and Activities**
- Develop strategic and proactive responses to developments within the training network.
- Undertake a comprehensive Education and Training Review to ensure we are aligned to best practice in professional education, standards and resources.
- Consider adding additional education/training options to ensure adequate access to eye care for the whole community.
- Develop programs to meet government requirements around CPD and revalidation/recertification.
- Develop resources to meet Practice Accreditation standards.
- Develop programs that support Trainers and Trainees and meet the needs of our Members for education on the key issues of diversity, inclusion, bullying and harassment.
STRATEGIC PRIORITY 2
Advocacy and Awareness

We will lead the policy debate as the trusted, authoritative source of information and research; and promote Ophthalmology as a medical specialty, body of knowledge and career. We will endeavour to build capacity in the Asia-Pacific Region.

Key Programs, Projects and Activities
• Develop strategic and collaborative initiatives to address maldistribution and other workforce planning issues.
• Undertake national, state, territory and branch level advocacy on issues of importance to our members and the profession.
• Build and enhance key relationships (hospitals, GPs, Optometry Australia, NZ Association of Optometrists, and CPMC/CMC).
• Expand our effectiveness by working more collaboratively with GPs, optometrists, orthoptists, practice managers, nurses and vision scientists.
• Develop a public awareness strategy and campaign that is relevant and appropriate and delivers on the objectives of this plan.
• Develop a plan to deal with Indigenous/Maori/Pacific Islander eye health and access issues.
• Promote Ophthalmology in the Asia-Pacific region and advocate for the building of capacity in this area.

STRATEGIC PRIORITY 3
Member Engagement

We will represent, support and foster our members’ interests; and build engagement, ownership and collegiality among them.

Key Programs, Projects and Activities
• Ensure appropriate and ongoing development of innovative membership services and structures (including counselling and other support services).
• Grow and promote our Congress to be the leading medical eye care event in the region; and, support/develop other relevant events.
• Maintain our strong position of promoting research through working collaboratively with ORIA and the Human Resources Ethics Committee and supporting the CEO Journal.
• Work with the Eye Surgeons’ Foundation on areas of mutual interest which support RANZCO objectives, particularly in relation to international development and Indigenous eye health initiatives.

STRATEGIC PRIORITY 4
Standards

We will set, monitor and maintain standards for the provision of the highest quality Ophthalmology practice in Australia and New Zealand.

Key Programs, Projects and Activities
• Be proactive in developing clear clinical/standard positions and policies for eye health.
• Maintain AMC and MCNZ standards.
• Uphold AHPRA and MCNZ policies appropriate to Ophthalmology and service provision.
• Develop and articulate our position on clinical standards in order to provide the necessary leadership to the profession.
• Develop appropriate policies and processes for enhancing the skills of Fellows (including reviewing terms of reference for various existing committees).
• Support the work of the special interest groups in Australia and New Zealand.
• Monitor and maintain Member adherence to our Professional Standards and Code of Conduct.

STRATEGIC PRIORITY 5
College Activities

We will deliver superior service and value to our members, partners and stakeholders to ensure ongoing sustainability.

Key Programs, Projects and Activities
• Ensure our structure, human resources and processes are designed to effectively support our strategic direction and member needs.
• Ensure we have in place policies and programs to develop appropriate diversity, equity and inclusiveness in College activities and committees.
• Ensure we have policies and programs to educate and appropriately manage bullying, discrimination and sexual harassment.
• Consider appropriate areas to target for increasing membership numbers, and how they will be supported (GPs, nurses, orthoptists, and vision scientists).
• Develop integrated sub-strategies to address:
  • International – where we will focus our efforts on South East Asia and the Pacific. We will work on capacity building, supporting the enhancement of educational and professional standards, supporting/increasing the effectiveness of our partnerships and improving communication.
  • Diversity – where we will develop policies and an action plan to increase the diversity (including Indigenous/Maori/Pacific Islander) of ophthalmologists in Australia and New Zealand.
  • Relationships – where we will build and/or enhance strategic and collaborative relationships with key groups, societies, organisations, governments and NGOs interested and/or engaged in eye health and eye care.
• Ensure we have in place appropriate systems to identify and retain staff to support activities.
• Consider activities to support service delivery to Indigenous communities.
• Work closely with the Eye Surgeons’ Foundation to fund activities aligned with our Strategic Plan.
Membership Spotlight

Part-time Fellows — important changes that affect you!

Recency of Practice Registration Standard

Effective 1 October 2016, the Medical Board of Australia (MBA) has made significant changes to the number of practicing hours medical practitioners need to complete to remain registered.

To meet this registration standard, you must practise within your scope of practice at any time for a minimum total of:

- four weeks full-time equivalent in one year, which is a total of 152 hours, or
- 12 weeks full-time equivalent over three consecutive years, which is a total of 456 hours.

The Medical Board of Australia defines practice as “any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.”

Continuing Professional Development Registration Standard

Also effective 1 October 2016, the MBA has updated the CPD requirements for medical practitioners; RANZCO’s Australian Part-time Fellows need to be aware of these changes for the 2017 CPD year.

For all Part-time Fellows, as with all Full-time Fellows, CPD must include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning.

In practical application, this means all Fellows must complete 80 hours of CPD annually, which includes 30 hours in Clinical Expertise, Level 2. This can be achieved by undertaking one or more of the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Audit</td>
<td>30 points</td>
</tr>
<tr>
<td>Office Record Review</td>
<td>10 points per ORR</td>
</tr>
<tr>
<td>Peer Review Practice Visit</td>
<td>30 points as either a host or a visitor</td>
</tr>
<tr>
<td>Medico-Legal Report</td>
<td>10 points per report</td>
</tr>
<tr>
<td>Audit/Peer Review Meeting</td>
<td>1 point per hour for participating in a Peer Review Meeting</td>
</tr>
</tbody>
</table>

As the Medical Council New Zealand has similar CPD requirements, all Part-time Fellows will be affected by this change.

For further information regarding registration standards, please visit the Medical Board of Australia or the Medical Council of New Zealand websites. You can also contact the College at ranzco@ranzco.edu to discuss what these changes mean for you.
RANZCO Human Research Ethics Committee

The RANZCO Human Research Ethics Committee (HREC) has over the past twelve months seen a dramatic increase in the number of low and negligible risk applications. These can be assessed much more quickly than clinical trials and are often able to be discussed by Committee members through email correspondence out of session. Some of these applications have requested that the Committee consider approval under the National Mutual Acceptance (NMA) scheme.

The NMA is an interstate initiative that aims for a single ethical and scientific review of a submitted multi-centre human research study:

Researchers and sponsors proposing to conduct a human research project at Public Health Organisation (PHO) sites in more than one participating jurisdiction may submit the study to one Certified Reviewing Human Research Ethics Committee.

In cases such as this, the researcher would be able to submit just one application to the participating HREC. Presently there are four states that participate in NMA but there are structures in place that will enable other states to participate. Of course, there are some cases where jurisdictional restrictions prevent a researcher from using the NMA scheme such as projects requiring access to statewide data collections. Fellows at RANZCO often ask for ethical consideration relating to private practices and these would fall outside of the NMA scope. Nevertheless, there are moves to streamline the ethical review processes and the NMA is an example of one such successful initiative.

Dr Alex BL Hunyor

In the last issue of Eye2Eye we profiled RANZCO HREC member Dr Chris Basten. In this issue we are concentrating on one of the members of the Committee who is an ophthalmologist, Dr Alex BL Hunyor.

Dr Hunyor joined the Committee in July 2007 and has since been actively involved in decisions relating to new applications. Recently Dr Hunyor was able to write down his reflections on past and present experiences and expertise in relation to his Committee responsibilities.

“Having finished my ophthalmic training at Sydney Eye Hospital in 1969, with a year of retinal training under Dr Eddie Donaldson, I was fortunate to be one of the founding members of the Australian College of Ophthalmologists, now RANZCO.

“Appointed to the Visiting Medical Officers staff at Sydney Eye Hospital in 1970, I was involved with some of the registrars in a few clinical research projects, in times when there were no HRECs and one just checked with senior colleagues and went ahead with projects which may lead to improved clinical outcomes in conditions for patients whom we could not help significantly.

“The most important of these projects, with our first overseas retina Fellow (in 1992), was to establish a technique and analyse the possible benefits of intravitreal injection of triamcinolone for exudative AMD, which was at that time untreatable. We collaborated with the Professorial Department; Prof Mark Gillies and Dr Philip Penfold being the originators of the idea to try this.

“Fortunately, this was a controlled trial and showed that although nearly all patients initially returned with improved vision and beaming smiles, the effect was short-lived, significant elevations of intra-ocular pressure and worsening of cataract changes were common. However, after six months there was no significant benefit. The technique of safe intravitreal injections for antibiotics, steroids for other conditions, and subsequently for anti-VEGF and other agents became well established.

“Having established a private, comprehensive vitreo-retinal practice with Dr Donaldson in 1977, I was very happy, when approached to join the RANZCO HREC in 2007, to accept and have some input into the Committee’s deliberations, and to learn from other members of the Committee with special expertise in other areas important for ethical research project approvals. It has been a privilege to have had this opportunity.”

We anticipate interviewing another HREC member in the next edition of Eye2Eye.

Prof Mark Radford
Chair, RANZCO HREC
Surgical Instruments Quizzes

Last year the College initiated the first phase of several surgical quizzes on Moodle (http://moodle.ranzco.edu/login/index.php), which involved photographing and documenting various ophthalmology operating tools on their respective trays. Recently supervisors and clinical tutors were able to provide more detailed descriptions of instrument functionality and design including a description of their use in different situations. This knowledge has been distilled down into a description of the operations pertinent to the instruments on the tray. Distractors have been placed at various points in the quiz which will get trainees to think about the various aspects of the instrument and how it is used in the operation. Currently functional endoscopic sinus surgery and the eye bone tray have been completed and we are working on completing the other trays over the next few weeks.

If you would like to get involved in developing more e-resources for our Fellows and trainees, contact Adam Kiernan, Manager, E-Learning and Indigenous at akiernan@ranzco.edu.

Increased Impact Factor for Clinical and Experimental Ophthalmology

The Editorial team of the RANZCO journal, Clinical and Experimental Ophthalmology (CEO), is delighted to announce an increased 2015 Impact Factor (IF) of 2.55, and an associated move up the international ophthalmology journal rankings from 17th to 16th position.

The Thomson Reuters Institute for Scientific Information (ISI) publishes the annual Journal Citation Reports (JCR) to provide an evaluation of the world’s leading journals. By compiling articles’ cited references, the citation reports help to measure research influence and impact at the journal and category levels.

The recently released 2015 JCR include 56 journals in the field of ophthalmology, providing information on numbers of citations and IFs. The IF is the average number of times articles from the journal published in the past two years have been cited in the JCR year, and is arguably the most universally accepted quantitative tool used for grading journals.

The Editors, Professor Bob Casson, and Associate Professor Salmaan Al-Qureshi would like to thank the College Fellows for their contributions as Editorial Board members, authors and reviewers. The continuing increase in IF is not only a reflection of the hard work of the editorial team, but also an indication of the high standards of ophthalmic research being conducted by the RANZCO Fellows. Thank you for your support of the College journal.

Victoria Cartwright
Managing Editor, CEO
Since RANZCO Fellows Professor Robert Casson and Associate Professor Salmaan Al-Qureshi took on the roles as Co-Editors-in-Chief of *Clinical and Experimental Ophthalmology (CEO)* in 2010, they have contributed greatly to the success of the journal making it an influential publication which attracts high-quality scientific papers from around the world. With an Impact Factor of 2.55, CEO now ranks 16 among the top international ophthalmology journals.

Prof Casson and A/Prof Al-Qureshi went to the same medical school in Adelaide and then trained together as registrars in South Australia. Whilst in their third year of training and having just passed their Fellowship exam, they shared the job as the senior registrars at the Royal Adelaide Hospital. Prof Casson did his fourth year of general ophthalmic training at the Oxford Eye Hospital and a Glaucoma Fellowship at the same hospital in 2000. He stayed on in Oxford to do a PhD in the adjacent Nuffield Laboratory of Ophthalmology, finally returning to Adelaide in 2004. Prof Casson is Head of the Discipline of Ophthalmology and Visual Science at Adelaide University. A/Prof Al-Qureshi did a Cornea and Anterior Segment Reconstruction Fellowship in Leeds and a Medical Retina Fellowship at Moorfields Eye Hospital. He is a Principal Associate of Eye Surgery Associates, and Medical Retina Specialist. He is also Associate Professor of Ophthalmology at the Centre for Eye Research Australia at the University of Melbourne.

Eye2Eye Editor Laura Sefaj spoke to Prof Casson and A/Prof Al-Qureshi to learn more about their backgrounds, the motivation and determination behind their work, and their life outside of ophthalmology.

**Prof Robert Casson**

*Q* Can you tell us a little bit about yourself, what was it like growing up in Adelaide?

*A* I was a very ordinary and happy generation X child. I was born and raised in Adelaide, and my dad owned the drive-in-theatre in Clare. I lived adjacent the River Torrens when it was still totally natural and wild. I spent a lot of time riding around the neighbourhood with friends, building rafts and treehouses and stupidly climbing up storm drains. I went to the local government primary and high schools, played football very averagely, and tried (mostly unsuccessfully) to meet girls at Blue Light Discos.

*Q* How did you become interested in medicine and in ophthalmology?

*A* No one from my family had ever been to university but my parents were very supportive of a university education. I have loved science for as long as I can remember, with a particular interest in physics and space science. But I was also fascinated by medicine and was influenced by the BBC show ‘Your Life in Their Hands’. It must have appealed to some narcissistic regions and during the summer holidays after high school I swapped my first choice of Electronic Engineering at Adelaide University to Medicine.

After an introduction to ophthalmology in medical school, I was pretty much hooked. In fact, if ophthalmology were not a specialty, I’m not sure I would still be a doctor. Ophthalmology held great appeal because of the fascinating basic science surrounding vision; the diagnostic challenges; the cool microsurgery; and the scope for high-tech, first-world research and the ability to impact on the developing world.

*Q* How did you become involved with CEO?

*A* I was a CEO Glaucoma Section Editor when Prof Charles McGhee was the Editor-in-Chief. When Charles stepped down, I ducked for cover but wasn’t quick enough.
Q What are some of your tasks and responsibilities as Co-Editor-in-Chief of CEO?

A Salmaan and I triage the large number of submissions that we receive. We split the submissions approximately evenly between us, but Salmaan does most of the work liaising with the publishers and handling technical issues. At conferences, I hustle for good papers and badger various people to write review papers for the journal.

Q What are some of the challenges you and A/Prof Al-Qureshi face as the journal’s Editors-in-Chief?

A We are aiming to increase the journal Impact Factor and to do this in an honest manner. The scientific journal world is heavily ‘gamed’ but we try to stay on the straight and narrow. The percentage of disgruntled authors is surprisingly small, but they can be a challenge to handle.

Q What is it like working with A/Prof Al-Qureshi?

A Salmaan is brilliant to work with. He is a friend and I always admire his no nonsense style. If he thinks something is rubbish he isn’t afraid to say so.

Q What are some of your roles outside of the College?

A I’m a consultant at the Royal Adelaide Hospital and work in private practice. I’m the Head of Discipline of Ophthalmology at the University of Adelaide and Vice Chairman of Sight for All. Research time involves a lot of admin, politics, grant writing and reviewing with a tiny amount of time to actually do some experiments.

Q Tell us a little bit more about Sight for All.

A I was a founding member of Sight for All which was created to fill gaps in eye health care in the developing world using a ‘teach a man to fish’ strategy. I am the Chief Scientific Advisor to Sight for All and currently Vice Chairman.

My involvement in recent times has been in training glaucoma specialists for developing world regions, including Bhutan, Myanmar, and Laos.

Q What do you like to do in your spare time?

A I like to spend time with my family and I guess I have a lot of interests but I’m not good at anything. I certainly don’t have any hidden talents. I like to walk my dog (Hollywood) through the local golf course after work. My golfing ambition is to one day have a single figure handicap (9, like James Bond, would be a dream). I like tennis and AFL. I’m still an SANFL fan (go Roosters!) I like reading popular science books, maths, and philosophy. I love movies and we have a small movie room in the basement. My favourite movie seems to vary, but is often a toss-up between ‘Alien’ and ‘Cinema Paradiso’. I’ve had crazy ideas about writing a screenplay.

Q What are some things that inspire and motivate you?

A I find mortality a powerful motivator and I’m inspired by goodness that I see in individuals.

Q What are some of your plans for the future?

A We have ideas of establishing an Eye Hospital in Adelaide, which I’m hoping we can get across the line. We have a variety of ideas for new and better surgical and medical treatments for glaucoma which I hope eventually come to fruition.

A/Prof Salmaan Al-Qureshi

Q I understand your parents came to Australia from Pakistan in the early 70s, can you tell us a little bit more about this?

A My parents came to Australia purely for our education. My father was offered the chance to go to the US or Australia and he chose Australia. They arrived here in 1971 and, because my father is a hydrogeologist, a groundwater expert, they moved to Darwin. My sister and I were back in Pakistan and for 18 months we were raised by my aunt. In Pakistan we had a huge private estate so I never grew up in Pakistan, I grew up on the estate, and so I didn’t know what Pakistan was actually like. My earliest memories of growing up were in Australia. The biggest shock was when I moved from Darwin to Adelaide and had to go to university. I had to wear long pants for the first time and had to learn how to tie a tie.

Q How did you become interested in medicine?

A My father just told me you’ll do medicine and so I just had to go with it. In a traditional Pakistani family, you just don’t get that many options, so I was quite happy to abide. I didn’t enjoy studying medicine that much; I became more interested in it after I graduated. I actually wanted to do physics and I sat the American SAT exams and got accepted into an American university. I wanted to go there but my father said no because there’s no future in being a theoretical physicist and that I should do something that will pay the bills and be a doctor instead.

Q How did you get into ophthalmology?

A I was going to do neurosurgery but once again I was talked out of it. One of the ophthalmologists, Dr Masoud Mahmood, whom I knew socially, suggested I go and speak to Prof Doug Coster about doing…
ophthalmology. When I spoke to Prof Coster he basically talked me out of neurosurgery saying that it's a dead specialty and that ophthalmology would be much more interesting, there's much more research and it's a much better specialty. So he persuaded me to do ophthalmology and he was my early mentor along with Dr Mahmood. The thing I enjoy about ophthalmology is that many of the advancements in medicine seem to occur in ophthalmology. Ophthalmology is often at the forefront of discoveries in medicine and retina is really at the forefront of ophthalmology.

**Q** Who inspired you in your career and why?

**A** I think that one of the people I really liked as a mentor was Dr Peter Hamilton; he was one of my mentors at Moorfields Eye Hospital and he was an excellent ophthalmologist. His humanity was very inspiring. He was a very famous and wealthy ophthalmologist but he devoted a large proportion of his time to teaching and to charitable work — something that he didn’t really need to do. For example, he provided a lot of ophthalmic care to the Palestinians in the West Bank, often under threat and he didn’t mind that. Also my surgical mentor, Dr Bruce Noble, in Leeds. The way he set up his department was very efficient. To have such a high-quality service in a public hospital system was unusual.

**Q** How would you describe Prof Casson and what is it like working with him on the journal?

**A** I would describe Bob as very academic and intellectually curious. Bob and I were in the same year in medical school. We sort of got along and had very similar interests and so it became easy to work together on the journal. We both had the same view for the journal which is that it should be a high-quality publication that should reflect on the high standards of ophthalmology in Australia and New Zealand. One of our briefs was to increase the journal’s quality so that it would reflect the quality of the editorial board and the quality of ophthalmologists in Australia and New Zealand.

**Q** What do you think are important factors for a strong journal?

**A** I think one of the things we found to make a huge difference is to have a really good editorial board. The editorial board is key so having really good section editors and a good editorial board is the first step. The next step is to have a unified vision of what you want the journal to be and we try to focus on hard science and avoid wishy-washy papers. The third thing is to be consistent. So, for example, Bob and I have submitted papers to our own editorial board and our own editors have rejected them. We are quite happy with that because we want them to be quite fearless. If they make exceptions for us or we make exceptions for people because of who they are, that quality will become inconsistent and we will lose credibility. So we try to keep our standards consistent. Another thing is to try and internationalise the journal, so we try to attract international section editors. Both Bob and I attend meetings in the US and try to raise the profile of the journal in specialty meetings. We try to do some niche marketing by going to smaller meetings and have a bigger profile.

**Q** What do you like to do in your spare time?

**A** I play tennis. If I could do anything every day, then I would play tennis. Tennis has a lot of similarities with doing surgery, you are by yourself and there are no excuses. There’s no one to blame when things go wrong.

A couple of years ago I wrote the ‘Interactive Atlas of Retinal Disease’ app for iPad and iPhone. I found that very rewarding; I learned how to code and write codes, so that was fun. I am currently rewriting it but the app was available on the Apple App Store from 2009 until 2014. It was downloaded thousands of times and the profits from that went into creating a water well for a village in Burkina Faso.

**Q** What are some things that inspire and motivate you?

**A** I think religion for me is a strong motivator to do good deeds and to try and see a world beyond my own needs; to try and contribute to society rather than focus purely on whatever is in my personal interest. So I think that’s an important motivator for me.
RANZCO Leadership Development Program

The RANZCO Leadership Development Program (LDP) 2016–2017 kicked off with participants attending the mid-year RANZCO Council meeting in Sydney on Saturday 23 July as observers. This was followed by an introduction to leadership by Dr Cathy Green, LDP Director, and a session on communication on the Sunday, facilitated by Simon Abbott (Allergan), and also attended by some of the RANZCO Board members. The interactive session provided a better understanding of participants’ communication preferences. It also provided information for participants on adjusting their preferred style of communication to collaborate more effectively with others.

The LDP seeks to grow the pool of leaders who can contribute to strategic initiatives of the College and participate in its structures, including the Board, Council, committees and Special Interest Groups (SIGs); promote and effectively communicate issues in ophthalmology; and develop self-aware leaders who can question their own and others’ assumptions in a collaborative leadership setting.

Over the next couple of months LDP participants will identify a mentor and initiate their individual projects — an integral component of the RANZCO LDP is the self-directed project to be completed by each participant and presented at the final session of the program, which will be held in Perth in 2017. The purpose of the project is to give participants an opportunity to demonstrate and further develop their leadership skills in a practical way, as well as to add value to the profession with contributions that will have a positive and lasting impact.
Online Chat Forum for Practice Managers

With much anticipation, we are delighted to announce the Practice Managers’ Online Chat Forum is now available on the Practice Managers page of the RANZCO Congress website (www.ranzco2016.com.au).

The initiative comes in response to feedback and will be a useful resource for Practice Managers to freely ask questions, offer advice, share and exchange ideas, or just enjoy a virtual get-together with other Practice Managers.

Available to Practice Manager Associates of RANZCO, to get started, simply email ranzco@ranzco.edu for your personalised login details for the Forum.

The login panel can be found on the upper right side of the Practice Managers page. Once logged in, you will be able to view the discussions, create threads on new topics, reply to existing threads and generally engage with other members.

Non-members cannot see or take part in the Online Chat Forum. If you are not already a member and wish to sign up or know of somebody who is interested in signing up, please contact the RANZCO office for details.

If you are having trouble logging in or if you are experiencing technical difficulties, please contact the RANZCO office for assistance.

Join the Practice Managers Committee

The Committee is looking for new talent to join its existing passionate and dedicated team of seven members. The Committee is also seeking a new Chair and Deputy Chair for 2017. Being a member of the Committee involves:

• participation in teleconference meetings;
• support in devising the program for the Annual Practice Managers’ Conference, run in conjunction with the RANZCO Annual Scientific Congress;
• contributions to College publications and marketing;
• participation in research and group work; and
• resource development and advocacy.

If you are interested in being part of the Practice Managers Committee, please email your recent curriculum vitae and cover letter detailing relevant experience to ranzco@ranzco.edu. For more information on the Committee or the Terms of Reference, please contact the RANZCO office.

Our experience working with hundreds of practice managers has made it clear: no matter how long you have been a practice manager, managing poor performance, dealing with poor behaviour and resolving conflict are among the greatest challenges.

These staff issues can consume more of your time than they should – and much more than you would like. However, your success as a practice manager depends on your ability to address performance and behaviour that is below your expectations. Left unresolved, these issues have the potential to undermine performance, create conflict, frustrate team members and compromise patient outcomes.

This course is designed for current and emerging practice managers.

Practice Manager or Practice Leader

Improving the performance of every team member

www.realllearning.com.au

Date and time: Wednesday 23 November, 9.00am – 4.30pm
Cost: $445 per person
RANZCO members: $375 (all registrations received after 11 November - $495)

Registration and details:
Online at http://pm-wellington.eventbrite.com or email simon.thiessen@realllearning.com.au

The key topics we will be covering:

- How does a practice manager become a practice leader?
- The three critical focuses for all practice managers
- Three behaviours that build practice leadership
- The link between your leadership style and the performance and motivation of your people?
- The three outcomes of performance management – and the one you can’t accept
- Increasing the commitment and engagement of your people - your options when the team is in conflict
- Leading people you don’t like
- Conflict styles and strategies
- Helping diverse personalities get along
Models of collaborative care

General practitioners have the herculean task of looking after people’s comprehensive health. They need to know things about all aspects of medicine and are often confronted by complex medical issues. When it comes to eyes, GPs need to manage ocular conditions both in isolation and as part of the management of chronic conditions.

Being the first point of contact, it is very important for GPs to recognise which situations are sight-threatening, which are life-threatening, which need to be treated and which need to be referred. The only way this can happen is if general practitioners are empowered with the knowledge that is necessary to respond in these situations. Therefore, the answer lies in education.

RANZCO, as the professional College for ophthalmologists with primary objectives to enhance the knowledge of ophthalmology and reduce visual disability and blindness, is the ideal partner to help GPs access this information and to provide education.

There have been rapid advances in all branches of medicine and it is impossible for everybody to keep abreast of the latest developments. RANZCO has therefore developed modules to simplify the vast amount of knowledge available and provide an easy-to-understand reference for GPs when confronted with an ophthalmic problem. This will go a long way toward ensuring that GPs are more confident when dealing with eye health issues and making decisions about when to treat and when to refer to an ophthalmologist.

RANZCO is in the process of making all these resources available online so that they are easy to access and use.

RANZCO is also running a GP session at the start of the Annual Scientific Congress in Melbourne and this is another example of the commitment to promoting collaborative care.

There will be further developments in this space as RANZCO continues to develop collaborative ways of working with GPs to deliver the best possible care for people with eye health issues in all areas of Australia and New Zealand.

A/Prof Nitin Verma
With only two months to go, final preparations for RANZCO’s 48th Annual Scientific Congress are in full swing.

The 2016 Congress, to be held from 19 to 23 November in Melbourne, promises to be one of the best to date with a variety of outstanding symposia, workshops, presentations, and keynote addresses from local and international invited speakers.

“Of particular interest will be the focus on Retina and the most recent developments in management of age-related macular degeneration (AMD),” said Professor Helen Danesh-Meyer, Chair of the Scientific Program Committee.

“Professor Ursula Schmidt-Erfurth from Vienna will provide the Retina Update ‘Advanced retinal imaging: Diagnostics, prognosis and outcomes’. To continue the focus on retina there will be a course on the management of AMD, and on ‘Diagnostic Dilemmas in Retina’, as well as a symposium on the latest developments in Retinal Imaging featuring a cast of retinal specialist from Australia and New Zealand.

“Another special feature of the Congress will be the focus on cataract and refractive surgery. This year’s international speakers of Professor Boris Malyugin and Dr David Hardten will emphasize cutting edge techniques that will be of clinical use to all cataract and refractive surgeons,” added Prof Danesh-Meyer.

The full scientific program can be accessed from the Congress website www.ranzco2016.com.au.
New at Congress

This year, we have incorporated a number of non-scientific sessions, running concurrently with the main scientific program. Several important topics will be covered this year including Ethics, Training and Professionalism and Cultural Awareness in Practice. The Younger Fellows Advisory Group will also have a course focussing on ‘Life Beyond your Training’. Some sessions will be repeated throughout the program to ensure all Fellows have an opportunity to attend.

Social Program

CONGRESS WELCOME FOR DELEGATES & INDUSTRY
Saturday 19 November 2016
RANZCO Exhibition Hall
The Welcome Reception allows delegates to indulge in some amazing hawker-style food and fabulous wine and take the opportunity to meet with friends and colleagues.

GRADUATION & AWARDS CEREMONY & PRESIDENT’S RECEPTION
Sunday 20 November 2016
Mural Hall, Myer
Mural Hall is a hidden masterpiece, with an eloquently decorated interior. The Parisian inspired venue will transport you to another world. Mural received its name as there are eight original murals displayed on the walls, depicting influential figures from the arts, opera, literature, dance and fashion. This has earnt Mural Hall a National Trust Classification.

CONGRESS DINNER
Tuesday 22 November 2016
The Olympic Room Melbourne Cricket Ground
Located at the world famous Melbourne Cricket Ground, the Olympic room offers unique views of the stadium and Yarra Park. Guided tours will be on offer taking in the grounds and the National Sports Museum encompassing the rich history of sport in Victoria.

Award Recipients

Professor Mark Radford has been awarded RANZCO Honorary Fellowship for his commitment and service to the College over many years, benefiting both the ophthalmic profession and community.

Professor Minas Coroneo AO has been awarded the College Medal in recognition for his service to the College and his dedication to the ophthalmic profession for many years.

Prof Radford and Prof Coroneo will be presented with their awards at the Graduation and Awards Ceremony.
RANZCO 2016 event app — make the most of your time at Congress!

Congress is always a very busy few days for everyone in attendance with so much to see and do. Using the official Congress app to make yourself a schedule will ensure you don’t miss a thing.

Important Buttons:
- The Gear takes you to settings where you can enter your profile. You can also invite friends to the app and email all your notes.
- The refresh button (circular arrows) downloads the latest data updates from the server. It will turn red if new data is available.

Your dashboard is your command centre!
From here, you can navigate to:
- My Schedule: A customised list of events that you want to attend. (Just press the ★ on events you want to remember.)
- Exhibitors: An interactive list of all the companies exhibiting at your show. Press the ★ to bookmark booths you want to highlight.
- Maps: Detailed maps where events are taking place.
- Events/Sessions: A complete and up-to-date agenda of events at the show. See who is presenting, add sessions to your personal schedule, take notes directly in the app or using Evernote, rate sessions you have attended.
- Speakers: Everyone presenting is listed here with bios and links to their events.
- Twitter: Keep up to date on the buzz, or add some of your own!
- Alerts: Venue change? Special presentation? Alerts can be pushed right to your device so you won’t miss a thing. They’re all listed under this icon.
- Downloads: If you’ve downloaded a handout from an exhibitor or a session presentation, you can quickly access them here.

TIP: To get back to your dashboard, simply tap the button in the upper left of the app and it will lead you there.
Update on the Senior and Retired Fellows’ Group events

About the Senior and Retired Fellows’ Lounge

The Senior and Retired Fellows’ Group Lounge will once again be available at Congress for Fellows to reacquaint with colleagues, meet new friends, tour the museum section and enjoy complimentary tea and coffee in the light-filled main trade hall. Fellows can also take their meals to the lounge to join in on the following presentations held during lunch breaks:

- **Sunday (lunch starts from 12.45pm)** — Dr Joseph Reich will be giving a talk about George Bartisch and the first textbook of Ophthalmology.
- **Monday (lunch starts from 12.30pm)** — RANZCO Museum Curator, Dr David Kaufman, will showcase some ophthalmic curiosities from the museum website.
- **Tuesday (lunch starts from 12.00pm)** — Dr Richard Travers will be presenting on the Diseases of Books — an excursion into bibliopathology.

About the Graduation Ceremony

Reserved seating with the best view in the house will be prioritised to the Group at the Graduation and Awards Ceremony held on Sunday 20 November. Make sure to identify yourself as senior or retired on the registration form and then simply announce yourself as senior or retired on the night and a member of staff will escort you to the designated seats.

About the Senior and Retired Fellows’ Dinner

The Senior and Retired Fellows’ Dinner will be held at Taxi Riverside located on Federation Square, Yarra Building, ground floor, by the Yarra River, on Monday 21 November at 7.00pm. This includes a three course meal and drinks on arrival. Places for the dinner are limited so please register quickly to make sure you don’t miss out. The event will cost AUS$110 per person. Partners are very welcome to attend.

To register to attend the Senior and Retired Fellows’ Dinner, please visit the RANZCO Congress website at www.ranzco2016.com.au and follow the links to ‘Registration’.

If you have any queries about your registration, please feel free to contact the congress office (Think Business Events) at ranzco@thinkbusinessevents.com.au or on +61 (2) 8251 0045.

---

E-Notices for meetings

Fellows need to be aware that all meeting notices will now be sent electronically. This provision is made under Section 27.2.a(iii) of the RANZCO Constitution. Please keep an eye out for these meeting notices — the next planned meeting is the RANZCO Annual General Meeting, which will be held on the morning of Sunday 20 November as part of the RANZCO Congress in Melbourne. If you do not have an email address, RANZCO will post a hardcopy meeting notice to you.
Congress Convenors

The 2016 Congress is being co-convened by Drs Xavier Fagan and Daniel Chiu.

Dr Xavier Fagan

Q What can we expect at this year’s Congress in Melbourne?
A There is plenty for all at this year’s Congress. The invited speakers span most of the specialty interests in ophthalmology. The opportunity to listen to local and world leaders is always a feature of the Congress, and we expect this year to be no different. We have several visiting lecturers from Europe and the US who will be able to provide us with perspective from abroad.

The social program is also looking promising. There are the regular evening events but they will be particularly special given the venues. The Congress Dinner is to be held at the iconic Melbourne Cricket Ground and the Graduation and Awards Ceremony at Mural Hall in the heart of the city. There are additional organised events for various groups and an abundance of superb dining venues for those wishing to explore on their own. To counteract all these fine offerings, there are two social sporting activities which will aim to show delegates some of the glorious springtime Melbourne weather — umbrellas will not be provided.

Q What are you most excited about for this year’s Congress?
A From an academic perspective, the invited speakers this year are of an exceptional calibre. Having a particular interest in medical retina and uveitis, I am very keen to learn from Prof Wakefield and Prof Schmidt-Erfurth. However, the Congress is always an excellent opportunity to brush up on areas outside one’s sphere of interest and I will be planning to attend many of the other named lectures.

From a social perspective, I think that jogging and cycling will be a superb way to show off my home city. I am hopeful that the run will become a regular feature of Congress in years to come. I very much enjoyed exploring Brisbane and Wellington by foot in the last two editions of Congress.

Background

I completed my ophthalmology training at The Royal Victorian Eye and Ear Hospital in 2010. I was extremely grateful to secure a further 18 months of fellowship at the same institution in medical retina and uveitis. I continue to work in both those areas. In non-clinical roles, I am a section editor for medical retina with Clinical and Experimental Ophthalmology. I am a member of the following RANZCO committees: the Workforce Committee, the Victorian Branch Committee, the Younger Fellows Advisory Group and the Congress Scientific Programme Committee. I became involved in organising Congress this year because of the opportunity to promote both ophthalmology and Melbourne, and because my co-convenor caught me off-guard.

Dr Daniel Chiu

Q You co-chaired the 2012 RANZCO Congress Organising Committee, what made you decide to co-convene this year’s Congress?
A It was Dr John McKenzie’s idea in 2012 that it would enable good continuity with the contacts in the College and the conference organiser. It certainly broadens the appeal for someone younger to come on board to get involved in the convening team.

Q What are some of the responsibilities/challenges of a RANZCO Congress convenor?
A It has all been very positive, with great support from the College and the conference organiser. The combined experience of their staff really have made convening such a large event very manageable. Challenge lies in re-inventing the Congress each time with some excitement and character, whilst maintaining the theme of a solid academic and collegial experience for the attendees.
Q: What makes this year’s Congress different?
A: Apart from the high quality scientific program and content on offer, we hope to highlight Melbourne’s character and what this capital city has on offer.

Q: How would you recommend those attending the RANZCO Congress for the first time make the most of their experience?
A: Take a couple of days off before or after the Congress and explore Melbourne and its surroundings in the November spring!

Background
I am a vitreoretinal surgeon locally bred and trained in Melbourne. After being involved in helping the organising committee for the last RANZCO Scientific Congress in Melbourne, I am pleased to have been able to contribute as part of the convening team in 2012 and continue my contribution in 2016.
Invited Speakers

The winter issue of Eye2Eye profiled invited speakers Dr James Muecke, Prof Maarten P. Mourits, Prof Gerard Sutton, and Prof Ursula Schmidt–Erfurth.

Prof Denis Wakefield, Prof Boris Malyugin, Dr Fiona Costello, and Dr David Hardten will give presentations on the topic of uveitis, cataract, neuro-ophthalmology, and refractive surgery.

Professor Denis Wakefield

AO, DSc, MD, MBBS (Hons), FRACP, FRCPA, FFSc

Presenting the Sir Norman Gregg Lecture

Anterior uveitis and HLA B27— progress at last!

Professor Denis Wakefield

is Director of the Centre for Immunology and Head of Immunopathology with the South Eastern Area Health Service. He was Head of the School of Pathology for ten years before becoming foundation professor of the School of Medical Sciences at the University of New South Wales.

He has dual specialist qualifications in internal medicine and pathology. He was appointed Associate Dean and Director of Medical Research in October 2007.

In 2015, Prof Wakefield was awarded the general Division of the Order of Australia for his distinguished service to medicine, particularly in the field of ocular immunology and immunopathology, as a clinician, researcher and academic. Prof Wakefield established the first dedicated inflammatory eye disease clinic in Australia in the 1980s. His major interest is in the pathogenesis of inflammatory eye disease, in particular the role of micro-organisms and genetic factors in the cause of uveitis and scleritis.

Q What inspired you to work in the field of ocular immunology?

A Early in my career I was inspired by Professor Ron Penny to investigate immune mechanisms in patients with uveitis and scleritis. I was intrigued by the clinical manifestations of these diseases and their strong associations with genetic and environmental factors. I was also fascinated by the fact that the eye is the only organ in the body in which one could directly observe all the features of an inflammatory response. The fact that such inflammation could be carefully monitored and quantitated was also a factor in my early studies using a variety of different types of immunosuppressive therapies to control ocular inflammation. The fact that we can now control most forms of ocular inflammation and preserve vision continues to inspire me to pursue a career in ocular immunology.

Q What are some of the rapidly evolving areas of research in your field of interest at the moment and what may they lead to?

A Two related areas of research that are in a state of rapid development and have been the focus of our research would have a profound affect on the practice of medicine. These are the –omics (genomics, metabolomics and transcriptomics) and stem cell studies. As with most aspects of internal medicine the impact of genetics as it informs us of the pathogenesis of disease, particularly the role of familial factors and gene regulation is having and will continue to have a profound impact upon all fields of medicine. New developments in stem cell biology have the potential to significantly change our approach to the treatment of corneal and retinal disease and transplantation. A revolution has also occurred in the use of biologicals and recently small molecules and transcription factors as therapeutic agents to control ocular inflammation and disease will continue to have a major impact in ophthalmology.

Q What have been some of the groundbreaking developments resulting from your research in this field?

A My colleagues and I have contributed significantly to the understanding of the pathogenesis of inflammatory eye disease, uveitis, scleritis, corneal disease, particularly pterygia and Sjogrens disease. In particular the role of HLA-B27 in predisposing to anterior uveitis and the potential role of environmental factors, mainly microbial infections in this area, have been the focus of our research. We’ve also made pivotal discoveries of the role of adhesion molecules and Toll like receptors in the pathogenesis of uveitis. The work on the pathogenesis of scleritis and pterygia revealed the key role of proteases, such as metalloproteinase,
Professor Boris Malyugin is a world-renowned authority and expert in the field of cataract surgery. He is Chief of the Department of Cataract and Implant Surgery at the Fyodorov Eye Microsurgery State Institution in Moscow, Russia.

Prof Malyugin was one of the first surgeons to perform phaco in Russia. He has pioneered several technologies in cataract surgery, received multiple international awards and has been invited to deliver lectures and conduct live surgery sessions all over the world. Prof Malyugin is President of the Russian Ophthalmology Society. He is a member of the ESCRS Board, International Intraocular Implant Club, Academia Ophthalmologica Internationalis, American Academy of Ophthalmology Regional Advisors Committee, ICO Advisory Committee, and several other national and supra-national organisations.

Q What do you enjoy most about your career as a clinician, researcher and academic?
A It is the enduring excitement of discovery that continues to inspire me in my clinical work, research and teaching. Ocular immunology presents a fascinating spectrum of ocular and systemic diseases that would be of interest to any student of medicine. I am also inspired to learn and apply basic science to clinical practice. We live in a fascinating era in medicine and I could not envisage pursuing any other career.

Q What are you looking forward to most at the upcoming RANZCO Annual Scientific Congress in Melbourne?
A I am particularly looking forward to meeting my colleagues, fellow researchers and present and former students, and interacting with and learning of new developments in ocular immunology and allergy. I have a broad-based interest in a large number of autoimmune eye diseases from corneal disease and stem cells to pterygia, uveitis and scleritis and I look forward to hearing new developments in understanding of the mechanisms of these diseases and new diagnostic and therapeutic approaches.

Professor Boris Malyugin MD, PhD
Presenting the Cataract Update Lecture
Complicated cataract surgery: how can we calm the troubled waters!

Russian ophthalmology now meets the highest standards in clinical, educational and research activities. How has ophthalmology in Russia evolved over the years?
A Russian ophthalmology has a very rich historical background and a links with European ophthalmology, especially Germany. Talking about the modern era, the biggest impact on what we now have was made by my teacher Professor Svyatoslav Fyodorov. He is well known for multiple pioneering techniques: radial keratotomy, phakic posterior chamber IOLs, glaucoma draining devices, laser keratoplasty to treat hyperopia and astigmatism to name but a few. Currently the clinic he founded, which bears his name, has 11 branches all over Russia, employs 5,000 people and performs a quarter of a million ocular surgeries per year. His legacy is the reason I can say that Russian ophthalmology now meets the highest standards in clinical, educational and research activities.

Q What stands out as the most important innovation in cataract and refractive surgery?
A I believe that there are many things that can be mentioned here, however the most important in cataract are surgical microscope, intraocular lenses and micro-invasive cataract extraction techniques with the help of ultrasound. Talking about refractive surgery, technically speaking of course I should mention lasers (excimer, femtosecond, etc). But for me the most important was the mind shift in the ophthalmic community finally accepting the fact that optical anomalies of the eye can and should be surgically corrected. And that came from radial keratotomy. After several million surgeries all over the world this technology is definitely obsolete now, however the mind shift is still with us and is driving innovations in that field.

Q What are some changes you might expect to see in the next five to ten years in your area of expertise?
A I believe that ophthalmology is advancing very quickly by absorbing in the pathogenesis of these diseases and their complications. We’ve also been at the forefront of research into new therapeutic modalities for the treatment of inflammatory eye disease from the use of pulse steroids to cyclosporine, mycophenolate and more recently biological agents.
various technologies and translational sciences. Diagnostics of the eye diseases now very much relies on the automated technologies with auto-refractometers, optical biometers, OCT, corneal topographers, etc. In the foreseeable future I think that surgery, at least some steps of the procedures, will also be more and more automated. We are entering the robotic era when the personal skills and experiences of the physician will be concentrated on the challenging cases, while the routine ones will be solved by machines. This will not happen tomorrow but this is a trend that will stay with us in the years to come.

One of the most recent interesting developments is the experiment on the regeneration of the natural lens. Who knows but may be some day after phacoemulsification we will inject stem cells into the eye instead of the IOL and these cells will build a new ‘young’ lens which is able to accommodate.

Q Can you tell us a little bit about your invention ‘the Malyugin Ring’?
A I am deeply humbled and honoured to have had the privilege of creating technology that became so popular all over the world. Being easy and very safe it solved the unmet needs of the surgeons. I am not going to tell you the whole story right now, but will keep the intrigue until my lecture. Please come and I will tell you the full story.

Q What knowledge or experiences do you hope to gain from the upcoming RANZCO Annual Scientific Congress in Melbourne?
A I am very excited to come to Australia and to attend the RANZCO Congress. There are many very bright ophthalmologists in your countries. And I am very happy to know some of them personally and admire their skills, their true devotion and impact on our profession. That is why I am very much looking forward not only to coming and sharing my experiences but also to learn from you.

Dr Fiona Costello MD, FRCPC

Presenting the Neuro-Ophthalmology Update Lecture
The Eye is a Window to the Soul: Understanding Central Nervous System Disorders through the Afferent Visual Pathway

She completed her medical school and neurology residency training at Memorial University of Newfoundland, and then embarked on a clinical fellowship in neuro-ophthalmology at the University of Iowa. She runs a busy clinical practice in Calgary to serve the needs of patients with disorders involving the visual pathway and the central nervous system. Dr Costello’s area of research focuses on using the eye as a model for brain disorders including multiple sclerosis and tumours. In 2013, Dr Costello was named Director to the Roy and Joan Allen Investigatorship for Vision Research, and is working to establish a translational vision research program at the Hotchkiss Brain Institute.

Q How did you become interested in neuro-ophthalmology?
A I was drawn towards neuro-ophthalmology as a neurology resident. I am a diagnostic junkie, and I love the thrill of the chase. I relished the challenge of localising causes and mechanisms of neuro-ophthalmic disorders. I was also intrigued by the apparent discomfort many of my colleagues expressed with the subject matter. I guess you could say I felt compelled to run towards the fire, instead of running away…for better or for worse.

Q What has been your main inspiration in your career?
A There has been no main inspiration for me, no eureka moment. Instead, I am inspired on a daily basis by people who work to achieve a standard of excellence in whatever they do to better the world around them.
**Q** What are some of the main projects you are currently working on and what do you hope to achieve?

**A** I have been working over the last decade to develop a model of central nervous system (CNS) inflammatory injury, which is based on vision-related structural and functional outcome measures. My overarching goal has been to identify factors that contribute to neuro-repair in multiple sclerosis. I am currently extending these principles to a compressive model of CNS injury.

**Q** What are some changes you might expect to see in neuro-ophthalmology in the next few years?

**A** I believe many neurological diseases can be better understood through the eye. My hope is that neuro-ophthalmology will play a greater role in team-based, multi-disciplinary research across a spectrum of neurological disorders. Over the last decade, vision related research has changed how we investigate and follow multiple sclerosis patients. I would like to see this happen in other areas of neurology, including stroke and dementia.

**Q** How do you feel about presenting the Neuro-Ophthalmology Update Lecture at the RANZCO Annual Scientific Congress?

**A** The RANZCO Annual Scientific Congress has a worldwide reputation for its innovative program, which highlights both scientific discoveries and clinical advances in the field of ophthalmology. I am honoured, delighted and excited to be a part of this wonderful meeting!

---

**Dr David Hardten**

**MD, FACS**

**Presenting the Refractive Update Lecture**

**Merging the Fields of Lens and Corneal Surgical Corrections**

Dr David R. Hardten is a prominent leader in the treatment of the cornea, external disease, anterior segment, cataract, refractive and laser surgery — as well as in research and education.

As director for the Minnesota Eye Consultants’ Clinical Research Department, Dr Hardten leads research projects on LASIK Eye Surgery, refractive surgery, complex case management, cataract surgery, natural lens replacement surgery, glaucoma management, corneal transplantation, iris reconstruction, surgical instrumentation and drug therapies.

Dr Hardten has received numerous awards for his dedication to the eye care industry including the 2011 Casebeer Award for outstanding contribution to the research and development of refractive surgery from the International Society of Refractive Surgery, the 2011 Allina Hospital Outstanding Patient Experience Award, and the 2010 American Academy of Ophthalmology Lifelong Education for the Ophthalmologist Continuing Education Recognition Award. In addition to an active clinical and surgical practice, Dr Hardten is an adjunct professor of ophthalmology at the University of Minnesota Department of Ophthalmology and serves as an adjunct professor for the Illinois College of Optometry. Additionally, he is an instructor for VISX/AMO and TLCVision, where he teaches ophthalmologists from around the world to perform LASIK.

**Q** What are some of the recent advancements in eye surgery that enable treatment to be more efficient and successful?

**A** We have had a tremendous advancement in the refractive aspects of lens based surgery. When I started my career, we were very happy to have the improvement in best-corrected vision with large incision extracapsular cataract surgery and it was expected to have a four to six-week recovery and glasses after that time frame. We now have the ability to target astigmatism for distance vision or monovision. We now have the ability to create a variety of presbyopic results postoperatively with various IOLs that would not be successful without the accuracy of IOL calculations, astigmatic results, and the ability to combine the implants with postoperative laser vision correction if we don’t end up on target.

I have also been involved now for almost 20 years with iris reconstruction including artificial iris implantation for patients with complex iris disease, especially those with trauma. We now have iris prosthetic devices that can be placed through small incisions with excellent cosmesis, as well as stability over a long time frame with improved transscleral suturing techniques.

In laser vision correction, we have seen improvement from simple spherical corrections to sphero-cylindrical corrections with PRK and a long recovery to the current femtosecond laser flap creation with advanced optical correction of higher order aberrations.
for excellent quality of vision in addition to improvements in uncorrected vision.

Q What is your most significant accomplishment in your career so far?

A I am proud to have been involved in many areas of refractive, corneal and implant surgical advances. I’m most proud of the ability to incorporate these many advances in the care of my patients on a day to day basis. When I see a patient that I took care of 20 years ago that still is able to enjoy the benefits of the care that I gave them at that point in their life, that is very satisfying. I am also very proud of the residents and fellows that I have taught, and that are now scattered across the world providing excellent care, doing high-impact research, and training the next generation of eye care providers.

Q What has been the biggest challenge in your career?

A The biggest challenge in medicine is the never-ending balance of quality and access of care with the costs to society of providing that care and planning for the future. I am ever aware of this balance and challenge, and I know that it will continue to be a challenge in the future.

Q What do you enjoy the most about your career?

A The day-to-day patient care and seeing the impact on their daily lives of the medical and surgical services that we provide to them.

Q What do you look forward to the most at the upcoming RANZCO Annual Scientific Congress in Melbourne?

A I look forward to getting a more in-depth view of the unique aspects of care and perspective of the Australian and New Zealand ophthalmologists in their home country. I have always enjoyed learning from this group of surgeons at various US based and other international meetings, and I look forward to being on their home turf and taking advantage of the educational opportunities.

OXFAM Australia Chief Executive Dr Helen Szoke to speak at RANZCO Graduation Ceremony

OXFAM Australia Chief Executive Dr Helen Szoke will be the Guest of Honour at this year’s RANZCO Graduation and Awards Ceremony, to be held on Sunday 20 November in Melbourne.

Dr Szoke is a leading thinker and advocate for foreign aid and international development, human rights, gender and race discrimination.

Dr Szoke joined Oxfam in 2013. Prior to this appointment, she served as Australia’s Federal Race Discrimination Commissioner and as the Victorian Equal Opportunity and Human Rights Commissioner. She is an Executive Committee member of the Australian Council for International Development (ACFID), and the ACFID Humanitarian Reference Group (HRG) Champion.

The HRG provides a mechanism for Australian agencies engaged in humanitarian assistance work to share information, strengthen coordination, and drive policy dialogue and development for the improvement of humanitarian relief work.

Dr Szoke was a member of the Royal College of Surgeons’ Expert Advisory Committee examining bullying, harassment and sexual harassment. In addition, she sits on the Australia Federal Police Future Directions Advisory Committee.

She received an Honorary Doctorate of Laws from Deakin University in October 2015 for her contribution to Human Rights. In 2011, Dr Szoke was awarded the ‘Law Institute of Victoria Paul Baker Award’ for her contribution to human rights and in 2014 she received the ‘University of Melbourne Alumni Award’ for leadership. She is a graduate of the Australian Institute of Company Directors and a fellow of the Institute of Public Administration.

Dr Szoke has spoken to us about the challenges and responsibilities that come with her role as Chief Executive of OXFAM.
Oxfam is a big brand with a big ambition — a just world without poverty. Everyday I am humbled to fulfil the responsibilities of being the Chief Executive of Oxfam because of the power of this mission. I spent some time as an equal opportunity and human rights commissioner and, during that time, my focus was very much on working to embed the rights that relate to equal opportunity and fairness into everyday life — work places, the work of government, sporting organisations and community groups. It is a basic tenet that we should treat others fairly and more so that we should proactively engage to build fairness and equity into our practices. We know there is still a lot of work to be done. This has been revealed in the work of the Royal Australasian College of Surgeons when they surveyed their members to find the predominance of bullying and harassment. This is endemic in the work that I am overseeing within the Department of Health and Human Services in Victoria. My concern remains that if this work is challenging in a relatively wealthy and comfortable and safe country like Australia, then how challenging must that be when we are also dealing with people who are trapped by poverty.

Oxfam’s work extends to ninety countries across the world. Our objective is to work with the poorest and most marginalised communities and to try to achieve equal opportunity and fairness and, most importantly, ensure that they have a voice about their own lives. At the heart of fairness is the need for people to be able to have a say, to participate in decisions that affect their lives. This is why Oxfam always works with partners in communities. In our view there is no point just going into communities to deliver services. If we want to see lasting change we need to work with people — taking the mantra from the disability community — ‘nothing about us without us’. And we also need to work on systemic change.

The challenge of my work as a commissioner was to identify how to make the systemic changes — changing institutional culture, changing legislative frameworks, changing the policies and practices of institutions whether they be workplaces or sporting organisations. The challenge of our work in Oxfam is similar — how do we tackle the barriers that prevent people achieving fairness and equity, and living their life without poverty? The statistics globally are still very stark — one in nine people go to bed hungry every night. How can that still happen? So, in Oxfam, we do the long term development work, partnering with groups across the world. But we also do the systemic work — working with communities to achieve change locally, regionally, nationally and globally.

I visited the Solomon Islands earlier this year. Poverty is still a major challenge, and coupled with this is the endemic proportions of violence experienced by women in communities. Many village communities are patriarchal, and the rates of violence are horrific. Our work there is to work with communities to tackle this violence — working with men and women, boys and girls — to talk about why violence is unacceptable and why behaviours have to change. We work at the village level and the regional level, and also advocate for legislative changes at the national level to build in legal protections. There is much work to do.

I was heartened to hear, when visiting villages, the local church leader explaining that when they looked at this issue of violence, they realised at the heart of violence is power and this is power over women. So they realised that not only did they need to change men’s behaviour, but they needed to create the opportunity where power is shared — in decision making forums in the village, in by-laws that govern how the village works — and that this will filter down when women’s voices are heard.

Work such as this is being replicated in many countries and in many ways across the world — in safety programs in PNG, in political empowerment programs with Aboriginal and Torres Strait Islander peoples, in political connection programs in Indonesia — Beyond Numbers — ensuring Indonesian women are prepared to take an active role in government at all levels. This work is focussed in our work along the Mekong River, where we look at the voices of women in decision making about relocation, resettlement and compensation for communities. It is critical to the work we do in African countries where Australian mining companies are involved in community negotiations. If we want to build fairness and equity, we need to look at all transactions and make sure that all voices are heard. It is also replicated in our humanitarian response work, where we know that involving women in the decision making about responses ensures a more sustainable outcome for communities.

I am looking forward to speaking at the RANZCO Graduation and Awards Ceremony later this year, because I know a little bit about the work that RANZCO does overseas — skilling local people to take on the responsibility of eye care for their communities, understanding the gender imbalance in the experience of preventable blindness in women and also recognising the importance of this work in ensuring that people can participate fully in their communities. Your work is in poor communities overseas and in Australia and the basic principles of fairness and equity must also apply.

We live in a world which is unsettled in many ways — conflict, terrorism, climatic impacts. It is our obligation to continue to strive to achieve fairness and equity in all of our work — and in how we treat each other. At the heart of what we do, we should also ensure that we live those values in our own behaviour, and this will help us work towards lasting change at home and overseas.

Dr Helen Szoke
Chief Executive, OXFAM Australia
Associated meetings and workshops

There will be a number of associated meetings and workshops held before and during the Congress including the International Development Workshop and the ANZSRSE meeting. The Orthoptics Conference, the Australian Ophthalmic Nurses Association Victoria Biennial Conference, and the Practice Managers’ Conference will run concurrently with the RANZCO Congress.

International Development Workshop

2016 will see the fourth year of the International Development Workshop (IDW) convened by the RANZCO International Development Committee. The workshop is to be held on Friday 18 November 2016.

The theme 'Diabetic eye disease in low resource settings’, featured at the 2015 Workshop held in conjunction with the Congress and co-hosted by RANZCO and PacEYES, was very relevant to the Pacific Islands region. The 2015 workshop reported positive feedback:

- “It is a very powerful workshop, in that it empowers us with information and knowledge of how to steer our clinic to the direction of success by still using the limited resources that we have.”
- “Very enlightening, encouraging, educational, very helpful ideas on how to set up and operate diabetic retinopathy services.”
- “Brilliant overview of work that otherwise doesn’t get heard about.”
- “Networking and refreshing.”
- “Shared learnings from various settings, very helpful.”

The 2016 Workshop, co-hosted by Vision 2020 Australia, will focus on Advocacy: Influencing Change and Eye Health Sector Development. The Workshop aims to achieve the following outcomes:

- clear understanding of advocacy backed up by concrete examples of advocacy in action;
- awareness of the variety of experiences of advocacy and efforts to influence changes that improve eye health outcomes across the region;
- identification of strategies to maximise approaches to influencing change for improvement in eye health outcomes; and
- building and strengthening connections between participants to support their efforts to influence change and development in the region.

A call has been made for abstract submissions for contributions demonstrating examples which have influenced, or seek to influence, a change or improvement in the quality and reach of eye health services. The emphasis will be on learning how the change was influenced, and what the impact was or is expected to be.

The likely audience will be interested RANZCO Fellows and other eye health sector stakeholders with an interest in eye health development in the region, plus delegates from the region also attending the Congress. Participants will be encouraged to share their experiences and challenges and an opportunity will be provided to discuss potential solutions with the group.

We hope the 2016 IDW on the theme of Advocacy: Influencing Change and Eye Health Sector Development will be as well received as previous workshops and we look forward to seeing you in Melbourne on 18 November 2016.

For further information and to submit your abstract please go to https://ranzco.edu/international-development/educational-and-scientific-exchanges.
2016 ANZSRS Satellite Meeting — Saturday 18 November, Melbourne

This year’s ANZSRS Satellite Meeting will again be held on the Saturday afternoon prior to the commencement of the main RANZCO Annual Scientific Congress, and the scientific program is being convened by A/Prof Ivan Ho.

The first half of the meeting will comprise an Ocular Trauma Symposium, with a range of speakers addressing important practical aspects of ocular trauma.

The second half of the meeting will be a special event — a Festschrift for John and Shirley Sarks. Many RANZCO Fellows do not appreciate the incredible contributions this formidable duo have made to our understanding of retinal, in particular macular, disease and its clinicopathological correlation. They are internationally renowned and respected clinicians and researchers whose work will be showcased in a series of presentations by local and international speakers, including Professors Alan Bird (UK) and Christine Curcio (USA). Further details of the Satellite Meeting program will be available on the ANZSRS website shortly.

ANZSRS Courses and Symposia at RANZCO 2016

ANZSRS will again run its AMD Update Symposium, which will include our invited retinal speaker Professor Ursula Schmidt-Erfurth. A/Prof Anthony Kwan will also chair a symposium ‘ Pearls in diagnosing retinal diseases — a modern retinal imaging perspective by ANZSRS:

The ANZSRS Annual General Meeting will be held during the RANZCO Congress on Monday 21 November 2016, from 1 to 2pm.
AONAVIC Biennial Conference in Melbourne

We are pleased to announce that once again we have taken the great opportunity to work with RANZCO and hold the Australian Ophthalmic Nurses Association Victoria (AONAVIC) Biennial Conference in conjunction with the RANZCO Annual Scientific Congress in Melbourne.

Feedback from our members tells us this is very worthwhile both professionally and for access and logistical reasons. Many workplaces have a downtime whilst the orthoptologists are attending the Congress and so it makes sense for other eye care professionals to take advantage of this period for their own professional development.

This year we have again had a great response from ophthalmic nurses and others to present at our conference. AONAVIC maintains its commitment to joining our nurses with the international ophthalmic community and is very pleased to again have the opportunity to invite international keynote speakers Professor Janet Marsden and Mrs Mary Shaw from the UK. We are fortunate to have such high profile international nurses with a history of many ophthalmic nursing publications to their credit. We welcome their input to our conference.

With such enthusiasm of nursing presenters we look forward to providing an inspiring and varied program. Along with the opportunity for networking, we hope to provide, a great day for nurses in theatre, clinics and emergency in whatever setting they may be.

As part of our keynote speakers’ visit, and requests from nurse practitioners to learn more about eye care, we have, in liaison with the Australian College of Nurse Practitioners, taken the opportunity to provide a pre-conference ophthalmic emergency workshop for nurse practitioners.

Also as part of this initiative, Prof Marsden is visiting with our Western Australian colleagues and presenting at their clinical meeting.

We welcome you to visit our website as registrations for both the conference and the emergency workshop are now open on our website (www.aonavic.com.au). You will need to get in quick as spaces are limited for the emergency workshop and it is almost full.

We again look forward to working together with RANZCO and our industry partners to provide a great day for our delegates.

We look forward to seeing you there.

Pam Armstrong
President, AONAVIC

73rd Orthoptics Australia Annual Scientific Conference 2016 — Melbourne

The Orthoptics Australia (OA) Annual Scientific Conference is fast approaching and is scheduled to be held from Sunday 20 to Tuesday 22 November 2016.

This year the OA Conference will be held in line with RANZCO’s 48th Annual Scientific Congress at the Melbourne Convention and Exhibition Centre.

Both the scientific and organising committees have been busy at work putting together the scientific and social programs. The scientific committee for 2016 is Myra McGuinness and Jane Schuller and the organising committee for 2016 is Karen Mill and Donna Corcoran.

An array of guest speakers have been confirmed including Michelle Gallaher, co-founder and Creative Director of The Social Science; Linda Santamaria, senior orthoptist and manager of the ophthalmology department at Monash Health; Professor Jonathon Crowston, Ringland Anderson Professor of Ophthalmology at the University of Melbourne, Managing Director of the Centre for Eye Research Australia (CERA) and a practising glaucoma specialist clinician at the Royal Victorian Eye and Ear Hospital; Dr Laurence Sullivan, fellowship trained corneal specialist and a Clinical Associate at the University of Melbourne Department of Ophthalmology and CERA since 1994; Dr Dermot Cassidy, fellowship trained in the medical and surgical treatment of diseases of the front of the eye, including cataract, corneal transplantation, pterygium and laser refractive surgery; Lindsay Horan, an American Orthoptic Council certified orthoptist and an active member of the American Association of Certified Orthoptists; and Shayne Brown, a fellow of the Orthoptic Association of Australia (now Orthoptics Australia) and a past President of the International Orthoptic Association and of the NSW and Victorian Branches of the Orthoptic Association of Australia.

The welcome reception will be held at the Alto Event Space situated on the top floor of Melbourne’s iconic GPO building on Sunday 20 November. The Conference dinner will be at Melbourne Park Function Centre on Tuesday 22 November, which is host to many events and features stunning Melbourne views.

We would like to thank our sponsors Bayer, BOC Instruments and Quantum for their continued support of Orthoptics Australia and for sponsoring our Scientific Conference.

We look forward to finalising the program in the coming months and invite all orthoptists and orthoptomologists to attend what is looking to be an exciting and successful Annual Scientific Conference for 2016.

Allanah Crameri
Orthoptics Australia PR Coordinator
The 2016–2017 Federal Budget included an announcement of funding for two new Medicare Benefit Schedule (MBS) items for retinal photography, aimed at GPs. The items are available for use from 1 November 2016 with a $33.8 million budget allocation over four years.

The MBS items will support improved retinal screening for people with diabetes. Advocacy for the item was initiated in 1994 and Professor Hugh Taylor, Head of Indigenous Eye Health (IEH) at the University of Melbourne, regards the introduction of the new items as a game changer. Retinal screening rates are currently around 20% for Indigenous Australians and 50% for mainstream and the new items are expected to benefit around 370,000 people, many of whom are living in rural and remote locations.

IEH hosted a sector meeting in Melbourne in July to discuss introduction of the new items. RANZCO attended the roundtable with representatives from national peak bodies including the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the National Aboriginal Community Controlled Health Organisation, Vision 2020 Australia, Optometry Australia, Diabetes Australia, the Australian Diabetes Educators Association, the University of Melbourne’s Department of General Practice and the Australian Government Department of Health.
The meeting included discussion of the use of the new items in mainstream general practices, diabetic clinics and Aboriginal Medical Services. The item descriptors require assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for presence or absence of diabetic retinopathy. Patients must have medically diagnosed diabetes and the item must be performed by ‘the medical practitioner providing the primary glycaemic management’ of the patient (this excludes optometrists and ophthalmologists). The service is available for Aboriginal and Torres Strait Islander people every 12 months and for other patients every 24 months. The service is not available to patients who have already been diagnosed with diabetic retinopathy, visual acuity less than 6/12 in either eye or a difference of more than two lines of vision between the two eyes. Detection of any diabetic retinopathy should be followed by referral to an optometrist or ophthalmologist in accordance with the National Health and Medical Research Council (NHMRC) guidelines.

The Department of Health has also engaged the Fred Hollows Foundation to undertake an eye care equipment audit of cameras, slit lamps and the need for training in Aboriginal Medical Services. An additional $4.8 million has been budgeted by the Australian Government to support the purchase of cameras, slit lamps and training over the next three years.

The new measure is expected to particularly help Aboriginal and Torres Strait Islander people who are at risk of vision loss from diabetic eye disease. The service has been designed for patients who would not regularly attend an optometrist or ophthalmologist for a comprehensive eye exam, often due to remoteness and/or socioeconomic barriers. The service will enable GPs and diabetic clinics to promptly provide this service at the point of consultation and then refer patients with problems for a definitive eye exam.

IEH at the University of Melbourne has developed a number of eye health promotion resources for Aboriginal and Torres Strait Islander people with diabetes (see Check Today, See Tomorrow resources at http://iehu.unimelb.edu.au/diabetes-eye-care/resources).

A report of the meeting is available at www.iehu.unimelb.edu.au.

Mitchell D Anjou
Indigenous Eye Health, The University of Melbourne

Equal outcomes for Māori eye health

15% of New Zealanders identify themselves as Māori. Some areas have a Māori population of 35%. Do Māori fare as well as Europeans in their health? Not at all. Do they get offered the same care by doctors? Sadly, research shows they do not. Is this something we will continue to just accept? No, we want to see this changed.

We have a professional duty to achieve equal health outcomes for our Indigenous populations. The RANZCO New Zealand Branch has begun to engage with Te Ao Māori, initially based on a model that has been developed by the Royal New Zealand College of General Practitioners, and which includes:

Partnership: Māori must be key players in our governance and planning. RANZCO have received a warm welcome and very valuable initial guidance from the Māori Medical Practitioners Organisation, Te Ora. The Indigenous Committee was privileged to have representatives from Te ORA speak at our Committee meetings at Congress in Wellington. We have formally approached Te Ora to assist the RANZCO New Zealand Branch to develop our plan to achieve cultural competency.

Participation: whether ophthalmologists, optometrists, nurses, allied staff and patients or lay people. Achieving equal outcomes for Māori will be best achieved when care is provided in a way that meets the needs of Māori. We need to ensure that Māori are equally represented at all levels of eye care, and to advocate for health systems that minimise barriers to care.

Equal health outcomes: this is our goal. Achieving this may require individual and profession-wide changes in how we treat people. It could require extra resources, culturally appropriate models of care, and tackling poverty or systemic problems.

It is time for a focus on research and a better understanding of Māori eye health and the determinants of good outcomes. Some facts from what we do know:

• Self-reported rates of vision loss among Māori found to be more than twice those of non-Māori for people aged younger than 75 years.
• Optometric visits for Māori over 15 are 50% of the non-Māori.
• Māori have twice the incidence of diabetes than non-Māori (i.e. as a whole group), but three times the rate of moderate to severe diabetic retinopathy.

There is a lot of good research waiting to be done, and a very positive and progressive environment when it comes to Māori healthcare.

The future of eye care for Māori, Aboriginal and Torres Strait peoples can be bright. Health equity for Māori will be achieved when Māori have the same health outcomes as other New Zealanders. For this to occur, all organisations and individuals that can impact on Māori health outcomes need to adopt a similar vision. Service delivery to Māori needs to be appropriate and effective and ensure equity of access. This does not mean a reduction in service delivery to other New Zealanders, but rather improving service delivery to Māori.

Dr Antony Bedggood
RANZCO Indigenous Committee member
Lions Outback Vision Van

Lions Outback Vision Van Coordinator Sharon Brown laughingly admits that the 20-metre-long rig she has driven on 18 visits to regional locations so far in Western Australia attracts a fair bit of attention.

It’s something that comes with the territory when you have the responsibility of driving the Lions Outback Vision Van — fitted with three consulting rooms and world leading eye health technology. But driving the van is only part of Sharon’s unusual combination of skills — she’s also a nurse.

“I’m lucky enough to have the most unique job, I think. I can drive the truck to site, get it all organised, service it, do all the things to keep it on the road and then I take that hat off and put my nurse’s uniform on and nurse in the back and have the patient interaction that way.”

Sharon jokes that it’s her input that the Director of Lions Outback Vision, Associate Professor Angus Turner, sought when he went truck shopping for the vehicle to deliver on his plan to bring state of the art eye care to patients in regional Western Australia.

A/Prof Turner said the Vision Van meant regional patients with eye conditions could be treated earlier, potentially saving their sight:

“I have been working in country areas in Western Australia for over five years and it’s really rewarding work, but one of the frustrations has been watching the equipment improve in the city and we’re not keeping up in the country areas. The Vision Van changes this for patients. You can see the difference it makes and that is really rewarding.”

The Outback Vision Team is also a strong advocate for the use of telehealth to augment outreach specialist visits in regional Western Australia. In the nine months since the new Medicare item numbers were introduced, 600 video consultations have resulted in 300 direct surgical bookings improving effective management outcomes during regional visits. A non-attendance rate of just 3.5% is a large improvement on traditional clinic visits.

A/Prof Turner said the team is committed to addressing the unique challenges of delivering quality specialist eye health care to regional, remote and Indigenous communities across our state:

“At Lions Outback Vision we believe in the development and implementation of innovative, integrated and sustainable models of service. We support local health care providers and planners to deliver accessible, equitable, effective and culturally appropriate eye health care programs.”

Christine Stott
Manager, Lions Outback Vision

Residents Dr Lucy Dobson (left) and Dr Irene Tan (right) ready for clinic on the Outback Vision Van
Policy and Advocacy Matters

Eyes on collaborative care in diabetic retinopathy: improving detection in primary care

In Australia, the number of people with diabetes has risen rapidly over the last 25 years. With prevalence now approximately 7.5%, diabetes is set to become the highest contributing condition to the national burden of disability by 2017.

Consequently, diabetic retinopathy is becoming more common and this raises important public health considerations. How do ophthalmologists play a leading role in shaping the delivery of health services to meet demand and address the leading cause of vision loss and blindness in working age Australians?

In this three-part series, we explore our evolving roles in collaborative care for better diabetes management. This article is the second in a three-part series.

We hope you find this article of interest.

Professor Stephanie Watson
Chair, RANZCO Public Health Committee

The introduction of a national screening program in the UK has led to a significant fall in vision loss due to diabetic retinopathy, such that it is no longer the leading cause of blindness in patients of working age in that country. Screening rates as high as 90% have been achieved, and most of the decrease in blindness is attributed to the earlier detection of diabetic retinopathy, rather than the later introduction of intravitreal treatments.

Since October 2014, Diabetes Australia, the Centre for Eye Research Australia (CERA) and Vision 2020 Australia have been working with representatives from the eye health and diabetes sectors to develop, and advocate for, a national diabetic retinopathy screening program in Australia, called the Diabetes Blindness Prevention Program.

Achieving this has been a difficult and slow process, hampered partly by the lack of a National Diabetes Strategy, and by the complexities of dealing with government and numerous stakeholders. Most recently, indicative support has been provided by Health Minister Sussan Ley and collaboration with Primary Health Networks is being explored. This could mean testing some elements of the proposal, including the transfer and sharing of retinal scans, as part of second stage trials of the MyHealth Record.

In this article, we interview Dr Peter van Wijngaarden of CERA and Prof Greg Johnson, CEO of Diabetes Australia, two key instigators and champions of the proposal, to further understand the way a national diabetic retinopathy screening program would work, and its benefits.

Why do we need a national screening program?

Diabetic retinopathy is currently a leading cause of vision loss and blindness in working age Australians. Current estimates suggest that over one million Australians will be living with blindness or vision impairment by 2020 and that a significant portion of this burden will be due to the epidemic growth of diabetes and diabetic retinopathy.

As identified by Prof Johnson, “Vision loss and blindness is one of the most preventable complications of diabetes. Despite the National Health and Medical Research Council Guidelines being in place for well over 10 years, clearly articulating the need for two yearly eye checks, we have [retinopathy screening] rates as low as 50% for non-Indigenous Australians with diabetes, and it’s far worse for Indigenous Australians with 80% not having an eye examination at the recommended frequency.”

“We need to see patients earlier. The current approach to eye examinations for Australians with diabetes is not working and is not systematic and this unfortunately means that people are going needlessly blind,” added Dr van Wijngaarden.

“Our health system only works if you live in the city and have access to good collaborative care arrangements. Within our health system there are too many
disconnects, far too many fall through the cracks. I think we need to challenge ourselves as a nation to prevent the complications of diabetes. We are not screening adequately and to fix this requires a change in attitude and approach,” said Prof Johnson.

What would it mean for consumers?

“A national screening program would mean that all Australians would have access to screening and early intervention and treatment,” said Prof Johnson.

“We know from consumer research that most consumers don’t understand that diabetes causes eye damage and blindness. It’s the leading cause of blindness in working age Australians and they don’t know about it.

“For cultural or other reasons, consumers are hearing quite soft messaging from their health providers about the risk of complications. When they visit their health provider because they can’t see very well, they are really angry to find out that, due to their diabetes, there is a risk of blindness,” explained Prof Johnson.

The UK experience

Dr van Wijngaarden was involved in the UK national screening program during his Medical Retina Fellowship in the UK.

“The national screening program in the UK is a major public health initiative, funded by the British government. In as little as 10 years, 90% of the population with diabetes are now being screened for diabetic retinopathy,” said Dr van Wijngaarden.

“Consequently, diabetic retinopathy has fallen off the UK’s Blindness Registry as the number one cause of blindness amongst the working age. This is somewhat ascribable to the improvements in treatment but is also a testament that universal screening has had a huge impact,” added Dr van Wijngaarden.

In the UK, the National Screening Committee is responsible for diabetic retinopathy screening. It mandates that every patient with diabetes older than 12 years of age should be offered diabetic retinopathy screening using digital fundus photography every year. Responsibility for screening is devolved to local authorities, and involves screening, grading and treatment pathways.

A validated list of patients with diabetes was created, generally from GP databases. The screening service sends an invitation to the patient to visit a screening venue close to their home, where a short history is noted, visual acuity checked, pupils dilated and digital fundus photographs are taken.

The photographs are then forwarded to a grading centre and graded by trained and accredited professional graders.

There are stringent quality protocols in place to ensure appropriate and high screening rates and that accurate and timely grading of images is maintained.

Depending upon the grade of diabetic retinopathy present, patients are advised of the need to return for screening in one year (if normal or minimal retinopathy), or to attend a clinical centre for evaluation and treatment. For example, patients found to have proliferative diabetic retinopathy need to be seen at an eye clinic within two weeks, whilst those with referable retinopathy or maculopathy would be seen within 13 weeks.

How might the model work in Australia?

The Diabetes Blindness Prevention Program proposal aims to develop a more integrated approach to the detection and management of diabetic retinopathy (and hence ‘Blindness Prevention’) by:

• better identifying patients with diabetes who require eye examinations;
• better, targeted communication strategies (using mail, email and text messaging) with patients to increase the uptake of eye examinations;
• improved sharing of information between members of the healthcare team and patients, so that the results of eye examinations can inform the management of diabetes and risk factors, as well as the treatment of retinopathy;
• the collection of accurate data about diabetic retinopathy, to inform public policy.

Key to any successful screening program is the creation of an accurate and complete database of those to be screened. In Australia, the National Diabetes Services Scheme (NDSS) was established by the Federal Government to give patients with diabetes access to diabetes related products, information and support services. It is envisaged that the NDSS database could be used as the basis of a screening program to improve diabetic retinopathy screening.

“The NDSS is an untapped resource: 90% of those with diabetes are registered. We have 1.1 million registrants for whom we have up-to-date demographics data that could be utilised to send out invitations for screening and to establish a centralised recording of outcomes. We are also thinking about how we can link to other data sets such as Communicare (often utilised by Aboriginal Community Controlled Organisations),” said Prof Johnson.

Patients with diabetes would then attend their ophthalmologist or optometrist for diabetic retinopathy screening, which would be based around digital fundus photography. A collaborative eye care model would be established with ophthalmologists co-ordinating the patient’s eye care with the screening optometrist.

“Nothing tells a story like a picture. It’s well established that digital retinal photography is a highly effective means for screening for diabetic retinopathy. The idea would be that everyone invited for screening is listed in a centralised database and that the retinal photographs can be accessed by all providers,” explained Dr van Wijngaarden.

Once screened, it is vital that the information obtained is shared with the patient and their health practitioners so that it can influence...
diabetes management, as well as the treatment of diabetic retinopathy.

The Diabetes Blindness Prevention Program sees an important role for electronic health records in the retinopathy screening program, for uploading photographs and sharing the outcomes of screening examinations between patients, GPs, optometrists and ophthalmologists. It is anticipated that the MyHealth Record will permit such an exchange of information and it is likely that one or two Primary Health Networks will conduct a trial encompassing the upload of retinal photographs in the near future.

What would be the benefits?

“Ultimately, improved screening rates for diabetic retinopathy, with earlier and more timely treatment, will lead to a fall in diabetes related blindness and vision impairment, as has been seen overseas,” said Dr van Wijngaarden.

Retinopathy is also an important biomarker of the risk of other complications of diabetes including kidney disease, stroke and myocardial infarction. The presence of diabetic retinopathy is thus important information for patients, GPs and endocrinologists, since it indicates an increased risk of systemic complication and a need for improved systemic control of diabetes and all vascular risk factors.

With low screening rates, this key information has been missing for GPs. There has been a real disconnect for GPs, which has evolved over time. Eye assessments for diabetes are beyond the clinical remit of most GPs who are hampered by a lack of time, appropriate equipment and, in some cases, a lack of experience in retinal examination.

“I think it’s important that we bring eyes back into primary care. With access to retinal photographs, GPs can take a more comprehensive approach. We want to save sight but also contribute to the systematic management of diabetes complications,” said Dr van Wijngaarden.

What are the challenges and opportunities?

“Making it happen and getting the proposal on the national agenda is a real challenge. Initially we were working with Minister Peter Dutton and then with the change of Ministry we had to start again. It’s been two years since we put forward the concepts to government. There are also of course a number of complex issues to work through such as privacy, data storage and security,” said Dr van Wijngaarden.

Asked about the opportunities for new technology, Dr van Wijngaarden said, “Across the globe there are nearly half a billion people needing eye checks; these people are sending each other photos, yet we can’t manage to send a digital photograph to check their eyes? Given that we simply can’t meet the huge and growing demand for healthcare, we need to be open to the ways that we can best utilise technology to assist us.”

Role of new technologies

New technologies offer opportunities for diabetic retinopathy screening such as improved retinal image acquisition, automated interpretation of retinal images, and the facilitation of improved communication between patients and their health practitioners.

The advancement of digital camera technologies will improve access to retinal photography and it is not too great a leap to envisage the use of smartphones for personal retinal imaging. When combined with the use of validated computerised decision making applications, or automated image analysis platforms, these technologies could transform eye care delivery for patients with diabetes.

This would facilitate screening in GP practices, so that a major barrier to retinopathy screening — the need for patients to travel to an optometrist or ophthalmologist for retinal examination — would be removed.

Dr van Wijngaarden adds that there has been a “huge boost to diabetic retinopathy screening by the commitment of the Government to reimburse GPs for retinal photography”. This outcome is the culmination of a great deal of work over many years by a committed team led by Professor Hugh Taylor. We look forward to seeing how the scheme is implemented and how we can integrate this into a national program.

In terms of improved communication between patients and providers, the use of web based programs could also be transformative.

“Several large companies are considering the possibilities in this area which could have benefits for rural and remote patients and in improved co-ordination of the whole diabetes care sector,” said Dr van Wijngaarden.

Why is collaborative care important?

“Our community faces a great challenge to provide appropriate screening and care for the increasing number of patients with diabetes. Even with a national approach to screening, communication with patients and between providers is crucial to both screen and manage diabetic retinopathy effectively,” said Prof Johnson.

“Our overall aim is to have those with non-vision threatening diabetic retinopathy seen by GPs and optometrists. If this happens we can then ensure people at greatest risk are seen by a specialist.

“We need to ensure that GPs and optometrists are front and centre in working with ophthalmologists to tackle the problem. If screening can be managed well in the community, then ophthalmologists are better placed to commence sight-saving therapies in a timely manner,” said Dr van Wijngaarden.

Where to from here?

It is acknowledged there is much work to be done to refine the model of care for the Diabetes Blindness Prevention Program, and to implement a national diabetic retinopathy screening program. Currently, program directors are waiting to see whether a couple of sites can
be secured to trial the use of retinal photography via the MyHealth Record. To integrate the management of diabetic retinopathy appropriately within general diabetes management will require a great deal of coordination and support at the primary health care level. "Ideally, and hopefully in the near future, I would like to see every Primary Health Network accountable to ensure that every person with diabetes has their eyes checked every two years, using existing technologies such as retinal photography," said Prof Johnson.

**RANZCO Public Health Committee and RANZCO Policy and Programs team**

A national screening program for diabetic retinopathy will be a critical advance in the management of patients with diabetes in this country, and it is important that the proposal being advanced as the Diabetes Blindness Prevention Program be adopted.

Vision loss from diabetic retinopathy is too frequent in Australia, but doesn’t occur due to a simple lack of resources. We have a skilled ophthalmic and optometric workforce, which is relatively widely dispersed. Treatment is subsidised and theoretically available to all. The greater issue is a lack of education of patients and their health care practitioners of the importance of diabetic eye screening, poor co-ordination and allocation of screening and treatment resources, and poor communication between all participants.

Low screening rates for diabetic retinopathy have negative implications for vision loss due to diabetic retinopathy and for the general health and management of patients with diabetes. Retinopathy is a sentinel condition, indicating an increased risk of myocardial infarction, stroke and diabetic nephropathy, and a need for improved glycemic and risk factor control. Information about retinopathy is therefore important to patients, ophthalmologists, GPs and endocrinologists.

There are also equity issues, with screening rates for patients with diabetes being significantly lower amongst disadvantaged groups in our community.

Improved screening for diabetic retinopathy is a first step towards improving the management of diabetic retinopathy in our community.

The National Diabetes Services Scheme (NDSS), which registers the majority of patients with diabetes, is a golden resource that could be better utilised, as proposed by the Diabetes Blindness Prevention Program. The use of the NDSS database as the basis for a system of regular prompts to patients (and their GPs) to have an eye screening examination is a vital first step towards improved screening for diabetic retinopathy, and a reduction in vision loss due to this condition.

Mandating photographic screening is also an important part of the proposal, as it will allow for greater standardisation and reliability in the detection of retinopathy, as is appropriate for a national screening program. It will also offer a ready means of review and quality control, and of information sharing.

The management pathway once a patient with diabetes has had their screening examination needs clarification: who is responsible for the interpretation of images and grading of diabetic retinopathy, and determining and organising the next step in management (for example, return for screening in two years if no retinopathy is present, or referral for ophthalmic care if more advanced retinopathy is found)? Is it envisaged that this will be centralised, or will decision making and responsibility be devolved to the practitioner performing the screening?

The need for improved communication between providers and with patients is also recognised in the proposal. Too often, information that a patient has diabetic retinopathy is not fed back to the GP or endocrinologist, meaning that an opportunity to intensify management of diabetes, and slow the progression of diabetes complications, is lost. Clearly, an electronic medical record would be very beneficial in this regard, but its implementation in this country seems to be a long way off. The UK diabetic retinopathy screening program has achieved impressive benefits without an electronic medical record, and it will be important not to delay the implementation of an Australian diabetic retinopathy screening program whilst a personalised electronic health record is being developed.

It also seems likely that technological advances will move screening for diabetic retinopathy into the community, and possibly to the province of GPs. Smart phone devices like ‘D-Eye’ and ‘Peek’ technology are being developed and could make screening for diabetic retinopathy in GP surgeries a reality. From 1 November, GPs will be able to claim two new MBS item numbers (at $50) specifically designed for diabetic retinopathy screenings using non-mydriatic retinal photography. The two item numbers include one for Aboriginal and Torres Strait Islander diabetes patients (12325), which can be claimed every 12 months, and one general population diabetes patients (12326), which can be claimed every 24 months.

For ophthalmologists, this is an important opportunity to lead the move to improved management of diabetes and diabetic retinopathy in
Advisory Group formed to improve Aboriginal eye health in NSW

According to the National Indigenous Eye Health Survey, Aboriginal children have better vision than non-Aboriginal children, but by the time they are adults they are six times more likely to experience blindness. 94% of vision loss for Aboriginal patients is preventable or treatable, where accessible eye care services are available.

Stakeholders from across the eye care sector were invited to come together at the NSW Rural Doctors Network’s Sydney office on Tuesday 26 July to commence the first of many discussions about improving access to eye care services for Aboriginal patients in NSW and the ACT. Representatives from the Commonwealth Department of Health, RANZCO, Optometry Australia and outreach ophthalmology and optometry representatives were present. The group agreed there is a need to support sustainable access to eye care services for Aboriginal patients. Importantly, many of the organisations present offered to provide advocacy, health promotion and other skills to enhance access to eye care services for Aboriginal patients where a local need is identified. Participants also agreed that the role of community controlled health service delivery should be central to any needs assessment or co-ordination planning.

The terms of reference of the newly established Advisory Group — Aboriginal Eye Health — will be finalised over the next couple of months.

Therapeutics Committee re-established

The RANZCO Therapeutics Committee was re-established in July, following a restructuring aimed at improving the Committee’s coverage of therapeutics-related areas of work via the introduction of specified portfolios. These portfolios/areas of work include drug regulation (especially with regards to the TGA), pharmacological research trials, post-marketing audits and safety reporting, therapeutic needs of comprehensive/rural ophthalmologists, cell-based therapies, device regulation, and New Zealand therapeutic issues.

The relaunched Committee is chaired by Dr Andrew Symons, and also includes the following members: Drs Penny Allen, Georgia Cleary, Michael Goggin, Alex Ioannidis, John Males and Keith Ong and, Profs Mark Gillies and Stephanie Watson. It is expected that the Committee will be strengthened soon with the nomination of a New Zealand Branch member.

RANZCO would like to thank outgoing members of the Therapeutics Committee for their contribution: Profs Minas Coroneo, Drs Lewis Levitz, Andrew Thompson, and Ian Wechsler.

For more information about the work of the RANZCO Therapeutics Committee, please contact Guy Gillor at GGillor@ranzco.edu.
I was saddened to hear of David’s recent passing. I have known him for many years and our paths crossed on many occasions on professional boards, various clinics and conferences. He was also my patient and he brought his encyclopaedic knowledge of optics to the clinical decision-making table.

David was one of those people who always had a sparkle in his eye and a smile on his face. He exuded positivity and compassion. He was always willing to share his ideas and was indeed a critical and original thinker. His PhD titled ‘The efficacious correction of refractive errors in developing countries’ was his seminal research contribution. In it he concluded that addressing refractive error in the developing world would improve productivity in the global community by $269 billion dollars. He thus correctly highlighted the significance of uncorrected refractive error on visual impairment in the world. His other major contribution was in highlighting the future prevalence of myopia, which he predicted would affect 50% of the world population by 2050. Food for thought.

David occupied many diverse professional leadership roles including President of the International Opticians Association and Honorary Research Fellow at the University of KwaZulu-Natal, Durban, South Africa.

David’s professional legacy is considerable and those of us who shared a small part of his journey are grateful to have known him.

David is survived by his wife Jan and son Andrew. Our thoughts and prayers are with them both.

Prof Gerard Sutton
Professor of Corneal & Refractive Surgery Sydney University
International Development

RANZCO Scholarships program

The RANZCO Scholarships program allows for ophthalmologists and eye doctors from developing countries to apply for the opportunity to attend the RANZCO Annual Scientific Congress, and to engage Fellows in areas of interest.

We are pleased to announce the recipients of the RANZCO 2016 scholarships:

- Dr Ly Marina, Cambodia
- Dr Kham Od Nouansavan, Laos
- Drs Jambi Garap, David Pahau and Geoffrey Wabulembo, Papua New Guinea.

The program is overseen by the International Development Committee (IDC) and 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 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.

The five scholarship recipients will also participate in the International Development Workshop (IDW) on Advocacy: influencing change and eye health sector development scheduled for 18 November prior to the Congress. Recipients will have the opportunity to share experiences and workshop issues pertinent to their home country where advocacy efforts have influenced, or are proposed to influence, a positive change in the eye health sector in their institution, community and/or country. Proposed topics from scholarship recipients will include sharing experiences of advocacy and public private partnerships in rural Papua New Guinea, advocacy and trachoma, challenges facing pediatric ophthalmology services in under-sourced countries, and issues facing the establishment of a Continued Professional Development program.

Scholarship recipients look forward to the opportunity of meeting ophthalmologists at the RANZCO Congress and engaging in discussions on particular interest areas as well as sharing their own experience from the perspective of their home countries. Indicated interest areas are cataract, glaucoma, ocular trauma, retinal diseases and trachoma.

Ophthalmology curriculum, leadership and teaching will also be explored as will exposure to international conferences with a view to hosting meetings in home countries.

Following completion of the scholarship, recipients provide a report on their experience of the Scholarship program. We look forward to sharing some of the stories, insights and images in the next edition of Eye2Eye.

International Development Workshop

The 2016 International Development Workshop will be held from 9:00am to 5:00pm on Friday 18 November at the Melbourne Convention and Exhibition Centre, Melbourne. For more information please refer to page 40.
Pacific Links Program

The United Nations Millennium Project in 2002 emphasised, as one of the Millennium Development Goals, the importance of global partnerships to improve the health sector in developing countries. Links between institutions are one way of achieving this aim and an imaginative and innovative means to enable skilled people in developed countries to help underserved communities.

A Vision 2020 Links Program originated as part of the Vision 2020: Right to Sight initiative (established through the World Health Organization and the International Agency for the Prevention of Blindness (IAPB) to eliminate avoidable blindness worldwide) linking an institution in the UK with another institution in Africa to build capacity of hospitals and colleges, and the skill sets of health practitioners and administrators. The methodology has been established by the International Centre for Eye Health (ICEH) to build capacity in low resource settings and to allow for mutual learning.

To date there are around 20 Vision 2020 eye links in development and a number of organisational and clinical linkages established, mainly between UK and African institutions. Through this initiative the Pacific Links Program has unfolded.

The Pacific Links Program, focussing on the Pacific Islands region, builds on pre-existing relationships linking an Australian institution (RANZCO) with the Pacific Eye Care Society (PacEYES) and the Pacific Eye Institute (PEI) in Fiji, with the objectives of further strengthening local capacity and professional expertise, and addressing diabetic eye disease and related eye health service delivery in the Pacific.

The program is a mutual cooperation and exchange project between RANZCO and PacEYES with the objective to strengthen the capacity of PacEYES as a credible organisation capable of leading the fight against eliminating avoidable blindness in the Pacific Islands region. The goals are:

- strengthening PacEYES into a credible regional advocacy body;
- embedding lifelong quality professional development for members;
- strengthening the RANZCO-PacEYES mentoring/advisory link for developing and growing eye care education and professional standards in the region;
- building on and seeking to increase contributions from individual PacEYES members and RANZCO fellows to international ophthalmology; and
- developing innovative models which may have applicability in other regions and medical specialties.

PacEYES holds the key to growth, success and addressing key eye care issues in the region. Given the expanse and remoteness of the Pacific, PacEYES has a huge task bringing together and mobilising the regional eye care workforce. However, within this there is the opportunity for PacEYES to play a key role in quality assurance — promoting the standardising and regulating of eye care practice and education in the region.

The program aims to form part of a multiyear capacity building link with PacEYES building on earlier engagements of RANZCO Fellows in the region and leadership development opportunities RANZCO provided to PacEYES members. Support through the Pacific Links Program promotes RANZCO-PacEYES collaboration and mentoring, with coordination support drawing on collegial strengths of the RANZCO College and access to RANZCO Fellows.

Underpinning the project is strategic oversight provided through the Pacific Links Steering Committee. The Committee is established as a standing committee mandated to championing the development of, and ongoing contribution to, eye health care in the Pacific for the years ahead. Central to the Steering Committee and overall project is the coordination of activities, with RANZCO hosting the Links coordinator position. The following organisations are represented on the Steering Committee: IAPB – Western Pacific, PacEYES, Fred Hollows Foundation New Zealand (FHFNZ), and RANZCO.

In addition, and also coming under the umbrella of the Pacific Links Steering Committee, the RANZCO-PEI/FHFNZ (funded by the Queen Elizabeth Diamond Jubilee Trust) serves to further strengthen local capacity and professional expertise to address diabetic retinopathy and related eye health service delivery in the Pacific. Otherwise known as the DR-Net program, the project focused initially on identifying where gaps in service existed and strengthening diabetic retinopathy links and services in four countries in the Pacific Islands. The program has since expanded to additional areas in the region.

Gail van Heerden
Project Officer Asia-Pacific RANZCO

"Links are about changing the health of people rather than only professional-to-professional support. We need to constantly remind ourselves that the outcome of any link is to provide better services to more people."

— Professor Allen Foster, ICEH
A glimpse of the forthcoming RANZCO 2016 Melbourne Museum exhibit

The RANZCO Museum will host an exhibit at the College’s Annual Scientific Congress in Melbourne. This year the exhibit will feature a number of unusual collections.

Here is a glimpse of what you can expect to see:

- The development of perimetry from the smallest handheld model to the two metre arc perimeter.
- Collections of the history of magnets and devices for removal of intraocular foreign bodies.
- Colour vision testing and the remarkable story of Dalton who defined defects and the testing instrumentation that followed.
- The teaching of ophthalmology using artificial retinas, 19th century stereoscopic viewers and models of ocular pathology.
- The work of Dame Ida Mann and her Gullstrand slit lamp donated by past President Andrew Stewart.
- Dr Kevin O’Day researched the eyes of Australian fauna in the 1940s. His unique histology collection has been collated by the Anatomy Department at Monash University revealing many specimens described for the first time. The magnificent cabinet and examples of his work will be on display at the exhibit.
- Lunchtime talks in the adjacent Seniors’ Lounge include the first illustrated ophthalmology text, ophthalmic curiosities and ‘Diseases of Books’.

I look forward to seeing you at the exhibit.

Dr David Kaufman
Curator, RANZCO Museum

Dame Ida Mann’s Gullstrand slit lamp

Model eye and adnexa

240 volt hand held electromagnet for extracting ferrous foreign bodies

Gullstrand Slit Lamp
Role of the ophthalmologist in the management of Dyslexia

(Specific Learning Difficulties)

Synopsis

- Dyslexia is a brain dysfunction.
- Management must be based on science. Remedial reading intervention is currently the best management.
- There is no credible evidence to support claims for treatments such as vision training/therapy with or without combined neurodevelopmental training, Irlen tinted lenses and the Lawson anti-suppression device.
- The ophthalmologist has a role in the diagnosis and correction of vision deficits. They should help guide the parents towards appropriate remedial assistance for their child.

The role of the ophthalmologist in the management of children with dyslexia is above and beyond a full eye examination. The ophthalmologist needs to understand the process of learning to read, the theories of dyslexia, and controversial and non-controversial therapies. This understanding will in turn allow the ophthalmologist to guide parents towards appropriate science-based remedial intervention for their child.

Learning to read

The process of reading involves extracting meaning from print. The phonological model of reading is the most widely accepted. Reading is a decoding skill while spelling and writing are encoding skills. In alphabet-based languages (such as English) there is a sequence that allows reading to proceed: symbol (letter or grapheme) > sound (phonemes) > words and meanings (semantics).

To understand the process of reading, we need to be aware that this involves phonemes which are the smallest meaningful segment of language. A different combination of 44 phonemes produce every word in the English language. As an example, the word ‘cat’ is broken up into three phonemes — kuh/aah/tuh. The phonological module automatically assembles phonemes into words. These are known as letter sound rules.

Children go through several stages as they learn to read. There is good evidence that the brain is ‘rewired’ as a child learns to read. In immature readers, the reading process is bi-hemispheric and has significant involvement of frontal, temporal, parietal and occipital lobes while in more mature and skilled readers the left hemisphere is predominate, with mainly frontal and...
occipital lobe involvement with relative bypassing of the temporal and parietal lobes. Early language exposure by being read to influences subsequent learning to read; it appears this early experience helps the child understand many basic language rules before the more formal process of learning to read commences. In the initial stages of learning to read the child learns a small sight vocabulary, they then learn how to sound out, then use sounding out to build up a bigger sight vocabulary, they eventually give up sounding out as they become a fast and fluent reader.

When a child reads aloud, they can either recognize the word in their mental dictionary or apply the letter-sound rules. The English language is amongst the most difficult language to learn to read as there are so many irregular words where sounding out does not give meaning or sense to the word. An example of an irregular word is ‘yacht’; no amount of sounding out will correctly allow the reader to read this word aloud. Irregular words need to be identified by prior exposure. However, regular words such as ‘trout’ can be read by applying the letter-sound rules.

Dyslexia

Reading difficulties can be divided into a primary form (dyslexia) and secondary forms that may be the result of visual or hearing disorders, intellectual disability, life experience and/or educational deficits. Lyon et al have defined dyslexia as “...a receptive language-based learning disability that is characterized by difficulties with decoding, fluent word recognition, and/or reading-comprehension skills. These difficulties typically result from a deficit in the phonologic component of language that makes it difficult to use the alphabetic code to decode the written word. Secondary consequences may include reduced reading experience that can impede growth of vocabulary, written expression, and background knowledge.”


The most compelling theory for dyslexia is that it is due to an abnormality of brain function. In the brain the inferior frontal gyrus is the phoneme producer, word analysis occurs in the parietal-temporal region and word form and automatic detection of words occurs in the occipital-temporal area of the brain. Neuroanatomical changes with an absence of normal asymmetry between the left and right hemisphere of the brain in dyslexic children have been documented in a number of studies. Functional neuroimaging (fMRI) for normal readers as compared to dyslexic children have also been performed and show a difference in brain function between the two groups. After successful remedial treatment this difference is no longer present. The review of evidence strongly supports the view that dyslexia is due to brain dysfunction.

This is further supported by the neuropsychological studies that have shown that dyslexia is a language based disorder with a primary underlying deficit involving problems in phonological processing. Phonological difficulties probably interact with other neurocognitive risk factors.

The neurobiological nature of dyslexia has been supported by the finding that 23%–65% of children with dyslexia have a dyslexic parent and 40% a dyslexic sibling. Six candidate genes have been identified for dyslexia.

A number of alternative theories have been proposed to explain dyslexia. These include abnormalities of visual function and eye movements. Although the ability to read involves vision, the process itself fundamentally includes parts of the brain beyond the visual pathways; vision is only one of the initial steps. Children with severe visual impairment and nystagmus may have some difficulty learning to read but this is a secondary form of dyslexia. Most visual impairment, refractive errors and abnormalities of binocular vision and accommodation/convergence have been shown to have no significant effect on the ability to learn to read. There is a lack of good evidence in the literature to support that visual dysfunction is the cause of reading difficulties such as dyslexia.

It has been suggested that abnormalities of saccadic (rapid) eye movements underlie dyslexia. In normal reading, as the child reads there are forward saccades of the eyes with fixation pauses. There are also regression or backward saccades as the child tries to extract meaning from print. The eyes also undergo small vergence adjustments. In the child learning to read and the child with reading difficulties, there are shorter saccades, longer fixation pauses and an increased number of regressions as the reader has increased difficulty in understanding the text. As reading develops, the saccades lengthen, the fixation pauses are shorter and the number of regressions is decreased. The eye movements in the child with dyslexia are similar to that of the child learning to read. The so-called abnormal eye movements observed in dyslexic children are the result, not the cause, of the reading difficulty.

Effects of the magnocellular (transient) visual system have also been blamed for dyslexia. The magnocellular visual system responds to rapid changes in visual stimulation whilst the parvocellular mediates colour vision and perception of fine spatial details. The magnocellular system in dyslexia is thought to not be able to suppress the parvocellular system. The evidence for this theory is based on contrast sensitivity studies and is equivocal.

Controversial therapies

There have been a number of controversial treatments proposed for dyslexia. These include vision training, combined with neurodevelopmental training, Irlen tinted lenses and fringe therapies such as the Lawson anti-suppression device.

Vision training is based on the premise that reading is primarily a visual task. Vision training involves muscle exercises, ocular pursuits, tracking exercises, training glasses (with or without bifocals or prism) and these are often combined with neurodevelopmental training. Eye exercises have been shown to improve convergence insufficiency, help develop fine stereoscopic skills and improve visual field recordings after brain damage. There is no clear scientific evidence published in mainstream literature to support the use of eye exercises in other conditions including learning disabilities and dyslexia. The American
The role of the ophthalmologist

Ophthalmologists are often consulted by parents of children who have been experiencing difficulty with reading. Visual problems can interfere with the physical aspects of reading, therefore the visual system should be assessed to rule out any ocular disorder before specific treatment is initiated for learning difficulties. Reading discomfort can be related to uncorrected refractive errors and to disorders of ocular motility, binocular function (especially convergence), or accommodation. If eye conditions are diagnosed at the time of the visit, they should be treated appropriately. Treatment may include glasses for refractive error or convergence exercises for convergence insufficiency. However, if the eye examination does not reveal any major pathology, the parents should be counselled about their child’s learning deficiency and reassured that subtle ocular deficits are not the cause of reading difficulties.

Eye professionals should not be considered the expert in reading education. A variety of trained specialists are available for children in need of help and there is an enormous body of literature regarding reading and learning from the educational perspective. Effective intervention remediates the underlying problem in phonemic awareness.

The role of the ophthalmologist is to take an accurate history, including questions about development and the family history; perform or arrange for a full orthoptic workup; perform cycloplegic refraction and ophthalmoscopy to exclude eye disease; correct refractive error and treat ocular muscle imbalance (convergence insufficiency etc.) The ophthalmologist should explain to the parents of the child the process of reading, the theories of dyslexia and the controversial and non-controversial therapies whilst working with a multidisciplinary team to ensure that the child receives appropriate remedial treatment.

In conclusion, reading is a complex process requiring a number of sub-skills. Parents of dyslexic children are looking for a quick fix but understand common sense.

• Dyslexia is best explained by the theory of brain dysfunction.
• Management must be based on science, not on arbitrary and capricious dogma.
• There is no credible evidence to support claims for treatment not based on appropriate remedial reading intervention.
• All children with dyslexia must have a thorough orthoptic and ophthalmic examination.
• The ophthalmologist has a role in diagnosis and correction of sensory deficits relating to vision, and must guide the parents towards appropriate remedial assistance for their child.
• As doctors, ophthalmologists have a responsibility to help families make the best use of limited resources. We should steer families away from unproven interventions that consume resources and thus interfere with the implementation of proven methodologies such as educational and language based therapy.

RANZCO has endorsed the joint statement from the American Association of Paediatrics, American Association of Paediatric Ophthalmologists and Strabismus, the American Association of Certified Orthoptists and the American Academy of Ophthalmologists on ‘Learning Disabilities, Dyslexia and Vision’. This statement was reaffirmed by the groups in 2014 and has appended to it a references and resource list for professionals and parents of children with dyslexia.

Prof Frank Martin, Lindley Leonard, Dr Craig Donaldson, Dr James Elder, Prof Glen Gole and Prof Geoffrey Lam

References:
A detailed reference list is available on request from eye2eye@ranzco.edu.
Western Australia

Chair:
Dr Nigel Morlet

Hon Secretary:
Dr David De La Hunty

Hon Treasurer:
Dr Tom Cunneen

The RANZCO Western Australia Branch Annual Scientific Meeting was held from 13 to 14 May on Rottnest Island.

Rottnest Island is an island about 18km west of Fremantle, and is a popular holiday destination, known for its beautiful swimming bays and a strong historical interest. Sixty ophthalmologists and trainees, and 30 practice managers and allied health staff embarked upon the choppy ferry ride to reach Rottnest. RANZCO president Dr Brad Horsburgh and several RANZCO staff also made it all the way over west to attend.

The meeting was held in an outdoor marquee, with speakers occasionally battling wind, sun, and even noise from a triathlon being held on the same weekend! Despite the challenging conditions of holding a meeting on a holiday island, the weather held and we had a very enjoyable and relaxed meeting.

Our registrars opened the meeting with interesting case presentations, with the best delivery earning a bottle of fine wine. The meeting had a cornea focus and our guest speakers were Professor Stephanie Watson from Sydney and Professor Charles McGhee from Auckland. Together they presented interactive corneal cases to challenge the registrars and everyone else in the audience. Prof Watson presented the Eye Surgery Foundation Lecture and spoke about dry eye and innovative ways to treat this common complaint.

The ‘Practice Wisdom’ session saw experienced colleagues share on how their management of certain ocular conditions has changed with time. A practice managers and allied health staff meeting took place concurrently to the clinical meeting on the first day. The managers meeting had ‘Performance Indicator’ talks on topics such as practice numbers, patient feedback, and good staff. Whilst the allied health staff had workshops on ‘dealing with difficult people’ and ‘working as a team’.

The pre-dinner drinks were held in the Hotel Rottnest restaurant, with quokkas, a small native marsupial, also visiting the function! An enjoyable dinner with colleagues was accompanied by fine Margaret River wines.

Dr Andrea Ang, WA Branch Councillor and A/Prof Mei-Ling Tay-Kearney, Head of QEC
New South Wales

Chair:
A/Prof Andrew Chang
Vice Chairperson:
Dr Robert Griffits
Hon Secretary:
Dr Daya Sharma
Hon Treasurer:
Dr Christine Younan
Country Vice Chairperson:
Dr Neale Mulligan

NSW RANZCO working to grow its influence

In August NSW Branch Committee members and our trainees contributed again in the Australian Medical Association (AMA) Medical Careers Day. This annual event sponsored by the AMA provides the 330 registered medical undergraduates opportunity to explore careers in various specialties by speaking with representatives of all Colleges.

This year Drs Alina Zeldovich and Daya Sharma as well as A/Prof Andrew Chang worked the stand during the day promoting the career in ophthalmology to enthusiastic students. Our NSW trainees Drs Calvin Fong, Luke Northey, Jenna Besley and Jerome Ha provided perspectives and advice on how to prepare and apply for training positions. The event also proved valuable in interacting with representatives of other Colleges.

The RANZCO NSW Branch continues to interact with other Colleges as we convened in the Committee of Chairs Meeting. This Committee aims to provide a structure for all Colleges to share information and expertise. It became clear that we shared similar challenges of education, gender equality and bullying, and public hospital funding. Terms of reference for the Committee are currently being worked on.

A/Prof Andrew Chang
Chair, RANZCO NSW Branch

Tasmania

Chair:
A/Prof Paul McCartney
Hon Secretary:
Dr Andrew Traill
Hon Treasurer:
Dr Andrew Jones

The RANZCO Tasmanian Branch was pleased to welcome over 60 delegates to our Annual Scientific Meeting held at the Henry Jones Art Hotel 18–19 June in Hobart.

During the course of the meeting, attendees from Tas., NSW, SA, Vic., Qld., and New Zealand further developed their knowledge of ophthalmic genetics, listening to a series of high quality presentations delivered by a panel of world leading experts. Ophthalmic genetics is a subject that is becoming more and more important and it is appropriate for ophthalmologists to keep abreast of the changes in this field as well as that of stem cell therapy.

The Branch would like to thank Dr Andrea Vincent, Dr Jonathan Ruddle, Associate Professor Kathryn Burdon, Dr Livia Carvalho, Associate Professor Alice Pébay, and Dr Rick Liu for taking the time to participate in this year’s meeting and for their contributions.

Delegates also enjoyed the opportunity to hear from colleagues in a dynamic free papers, challenging cases and audit session held during the meeting. Presentations included audits on cataract outcomes and corneal cross-linking, a number of challenging cases and a unique perspective on ‘Red Bull — Gives Your Vision Wings!’ by Dr Rob McKay.

There was a GP up-skilling session on the Saturday afternoon, which was well attended by GPs as well as GP registrars, both from the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. This has become a regular feature of meetings in Tasmania and the GP sessions are becoming more and more popular.

The meeting is well supported by the industry and the trade delegates got a chance to sit in on the lectures which many of them, like the rest of us, found very useful.

The scientific program was well complemented by a number of social events that took place during the meeting. A highlight for many delegates was the opportunity to enjoy Hobart’s mid-winter festival — Dark MOFO — with a variety of activities taking place in and around the city waterfront.

RANZCO is moving towards appointing professional congress
organisers for the smaller Branch meetings and this was the first time a professional conference organiser looked after the annual scientific meeting as opposed to the Branch members doing all the work. We found that the meeting ran very well and that this is a useful template to follow in other Branches so as to ensure continuity and that the standard of each meeting is maintained.

The Branch and Organising Committee would like to thank everyone who attended this year’s meeting and we look forward to welcoming you back to Hobart again in 2017.

A/Prof Nitin Verma AM
RANZCO Tasmanian Branch Annual Scientific Meeting Convener

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

On 27–28 May, the RANZCO New Zealand Branch held its Annual Scientific Meeting at the Dunedin Centre, Dunedin.

Undaunted by the prospect of chilly southern weather, 92 intrepid ophthalmologists and registrars, 105 ophthalmic nurses, and 16 ophthalmic technicians attended. The conference theme was ‘The developing eye, developing techniques and developing therapies’. The three visiting speakers were Professor Andrew Lotery (Medical Retina, Southampton), Dr Mark Chehade (Anterior Segment, Adelaide) and Professor Glen Gole (Paediatrics, Brisbane).

Highlights of the scientific program were the keynote talks from the visiting speakers. Prof Lotery spoke on his pioneering research on macular degeneration, gene therapies and stem cell therapy. Prof Gole gave a masterful review of the evidence-base for treatment of amblyopia from the Paediatric Eye Disease Investigator Group. He also reviewed the evidence from the ATOM studies on the use of atropine for progressive myopia in children. Dr Chehade’s talk on a consultant’s role in training registrars demonstrated his thoughtful and effective approach to this important task. Prior to the conference, Prof Gole and Dr Chehade had also imparted many pearls of wisdom to the registrars at their training day.

There were a number of notable talks from local ophthalmologists. Dr Andrew Thompson (Taumarua) spoke on his research into the unequal access for patients to VEGF inhibitors for macular degeneration across New Zealand’s 20 District Health Boards. His work, entitled ‘Where you live determines how well you see’, was his RANZCO Leadership Development Program project and is a great example of a project that can be used to advocate for change in a public health system.

Dr Justin Mora (Auckland) described the International Paediatric Ophthalmology and Strabismus Council Survey on the widespread increase in the incidence of retinopathy of prematurity as economic conditions improve in the third world.

Dr Brian Kent-Smith (Whangarei) described how his team of nurses performed all the technical and clinic duties, theatre nursing, and perioperative patient care in an eye clinic and day case surgery facility. This model yielded benefits in patient continuity of care and high levels of professional satisfaction for staff.

Dr Jo Sims’ talk on uveitis was an entertaining and illuminating review, based on cases from her referral service, of less common causes of uveitis.

As always, there was a very high standard of presentations from registrars, with Dr Peiyun Wang winning the prize for the best registrar presentation.

Sincere thanks go to the Organising Committee of Drs Mary-Jane Sime, Logan Mitchell and Casey Ung (Dunedin), and Prof Charles McGhee (Scientific Committee) for organising an excellent scientific program, Exhibitors’ Hall and a well-attended social program.

The RANZCO New Zealand Branch looks forward to welcoming delegates to its next Scientific Meeting at Paihia, in the beautiful Bay of Islands on 12–13 May 2017.

Dr Stephen Ng
Chair, NZ Branch

Queensland
Chair:
Dr Russell Perrin
Hon Secretary:
Dr Anil Sharma
Hon Treasurer:
Dr Oben Candemir

RANZCO Queensland Branch Updates

The Queensland Branch Annual Scientific Meeting was held recently on the Gold Coast and was a resounding success. Local speakers and the international guest speakers presented an excellent program. The topic was Ocular Oncology and Oculoplastics. Guest speakers Professor Sarah Coupland, Dr Heinrich Heimann and Mr Simon Woodruff presented entertaining, informative and practical papers on oncology and eyelid surgery. Conference organisers Drs Andrew Smith, Luke Maccheron, David Hilford and Sunil Warrier are to be congratulated on their efforts. Queensland’s winter weather was, as expected, exceptional.

Queensland registrars performed well at the recent College examinations, with Dr David Gunn winning the College Medal. Congratulations to the successful registrars and their trainers.

Dr Russell Perrin
Chair, RANZCO Qld Branch
Special Interest Groups

Women in Ophthalmology

Mother–daughter ophthalmologists

It is now over 70 years since the late Dr Nancy Lewis established the Eye Clinic at the Royal Children’s Hospital (RCH) in Melbourne. Dr Lewis and Associate Professor Anne Brooks are Australia’s first mother and daughter ophthalmologist duo.

Dr Nancy Lewis was born on 28 August 1913 in Malvern, Victoria and died in East Melbourne on 27 March 2002. In between, she practised as an ophthalmologist in Melbourne for over 60 years, achieving an MBBS, MD, DO, FRACS, FRANZCO and FRCOphth(UK). She graduated in Medicine from The University of Melbourne in 1935 and was then a resident medical officer at Royal Melbourne Hospital (RMH), the Royal Victorian Eye and Ear Hospital (RVEEH) and the Royal Women’s Hospital.

In 1940–41, Dr Lewis was Medical Superintendent at RVEEH and then decided to pursue a career in ophthalmology — at this time she was one of only three female ophthalmologists in Australia. In 1942, Dr Lewis was appointed to RCH. Her major contribution to ophthalmology was the establishment of the Eye Clinic at RCH. Children had previously been referred to RVEEH for treatment as the RCH had no appropriate equipment or facilities. Dr Lewis was able to obtain both, and she remained in charge of the Eye Clinic until 1963. She continued as Honorary Consultant Ophthalmologist at RCH until 1986.

Nancy Lewis also excelled at tennis, winning the Melbourne University Tennis Club Singles Championship in 1930 and 1931, and the Australian Girls under 21 Singles Championship in 1932 and 1933.

Dr Lewis had a private practice in Collins Street, Melbourne and later in East Melbourne, near RVEEH. She mixed professional and family life at a time when limited numbers of women were able to do so. In 1951, she married John Vickery Brooks, an engineer, and they had a daughter Anne Marie Vickery Brooks.

Although Nancy Lewis did not want her daughter to follow her into medicine, she accepted Anne’s choice. Anne Brooks graduated MBBS from the University of Melbourne in 1977, then trained at RMH and St Vincent’s Hospital before undertaking her ophthalmology training at RVEEH, gaining her FRACS, FRACO and FRACP in 1984. Following this, Anne achieved her Doctor of Medicine, Master of Medicine, FAAO, FRCOphth(UK), PhD (Univ of Melb), MRACMA and then AFRACMA.

Anne has been Head of Clinic (3S) since 1989 and an ophthalmologist to the Glaucoma Clinic at RVEEH since 1985. She has published in peer reviewed journals and lectured extensively on glaucoma, working in her early career with the late Dr Bill Gillies who founded the Glaucoma Club of RANZCO, now the Australian and New Zealand Glaucoma Interest Group (ANZGIG). After serving many years as the inaugural secretary, A/Prof Brooks is now Chair of ANZGIG, and presented the Gillies Lecture in 2012. She is currently Glaucoma Section Editor for RANZCO’s journal Clinical and Experimental Ophthalmology.

At the RVEEH, Anne is actively involved in teaching registrars, post-graduate medical students, GPs and overseas trained ophthalmologists. She has won the College Award for Excellence in Teaching for Victoria, six times.

A/Prof Brooks has been Chair of the RANZCO Victorian Branch, Chair of the Eye Section Senior Medical Staff at RVEEH, and Chair of Senior Medical Staff at RVEEH, and has served on many committees at RVEEH. She was awarded the Dr J Aubrey Bowen Medal in 2011.

In 2013 A/Prof Brooks was made an Honorary Clinical Associate Professor, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, after having been a Senior Associate and then Senior Fellow in the department.
Australian and New Zealand Society of Retinal Specialists

ANZSRS 2016 Annual Meeting

The Australian and New Zealand Society of Retinal Specialists (ANZSRS) held its Annual Scientific Meeting at the Westin Hotel in Sydney on 28 and 29 May. The meeting was well attended, with over 200 delegates. The Heritage Ballroom provided a more intimate venue which was well received by attendees. As there was limited space outside the ballroom, we will look at the use of an additional reception area for next year’s meeting to ease congestion during breaks.

The Scientific Program again combined updates in common and important areas of medical and surgical retina, along with case presentations and panel discussions of challenging situations in ‘real world’ clinical practice.

A highlight of the meeting was the Neil Della Memorial Lecture which was delivered by Professor John Forrester, an internationally renowned uveitis researcher and clinician. The first annual Practice Patterns survey of ANZSRS members was conducted prior to the meeting, and highlights of the results were presented and discussed. Full details of the survey will be available on the ANZSRS website shortly.

The Committee would like to express its thanks to Meredith Damon of MD Events, who so capably organised the conference; and to Francine Dutton at RANZCO who provides invaluable support to ANZSRS throughout the year. The 2017 meeting will be held on the weekend of 3–4 June, and it is then planned that the meeting will be held in Melbourne in 2018, alternating between Sydney and Melbourne thereafter. MD Events will again be our conference organiser in 2017.

ANZSRS Committee

Following a meeting of the ANZSRS Committee, several changes were decided. Dr Willie Campbell has retired from the Committee — we are most grateful to Willie for his enthusiastic and spirited contributions to ANZSRS over the years, including his time as ANZSRS Chair, and look forward to his continued involvement with the Society as one of its respected senior members. A/Prof Anthony Kwan has finished a three-year term as Chair and has vacated this position. The Committee voted unanimously in favour of appointing Dr Jennifer Arnold as the next Chair. It was also unanimously agreed to invite Drs Stephanie Young and Xavier Fagan to the Committee, and we are delighted that they have accepted.

The current Committee is therefore: Dr Jennifer Arnold (Chair), Dr Rachel Barnes, Dr Rohan Essex, Dr Xavier Fagan, Dr Wilson Heriot, A/Prof Alex Hunyor, A/Prof Anthony Kwan, Prof Ian McAllister, and Dr Stephanie Young.

Inaugural Retina World Congress

ANZSRS has been invited to participate as a society partner of the first Retina World Congress planned for 23–26 February 2017 in Ft Lauderdale, Florida. The meeting is described as “the first-of-its-kind international congress uniting retina societies from around the world and leading retina specialists to support global scientific and clinical exchange on advances in retinal health”. More information is available at http://retinaworldcongress.org.

Membership

ANZSRS is a RANZCO Special Interest Group and has two categories of membership open to College Fellows — full membership is open to practicing fellowship-trained retinal specialists, and associate membership is open to any College Fellow. Membership enquiries should be directed to Francine Dutton at fdutton@ranzco.edu.

A/Prof Alex Hunyor
ANZSRS Committee member

Note: This article has drawn some material from Strength of Mind: 125 years of Women in Medicine, Dr Jacqueline Healy (ed.). The author would like to acknowledge A/Prof Anne Brooks for her assistance in preparing this article.
The Neuro-Ophthalmology Society of Australia (NOSA) consists of members who are either ophthalmologists or neurologists, in about equal numbers. NOSA runs an annual two-day meeting followed by a two-day instructional course in neuro-ophthalmology (alternate years cover the afferent and efferent aspects of neuro-ophthalmology) and are essential for those candidates hoping to pass the RACE Exam.

Last year’s Annual Scientific Meeting was organised by Professor Helen Danesh-Meyer and held in Auckland in September 2015. The Guest Speakers were Professor Peter Savino from La Jolla, California and Professor Gordon Plant from London. This excellent two-day meeting was followed by the regular two-day didactic Neuro-Vision Course covering the afferent half of neuro-ophthalmology.

The NOSA September 2016 meeting will be held in the Stanford Plaza Hotel, Adelaide, on 8 and 9 September with invited speakers being Professor Andy Lee from Houston, USA, and Professor Dan Milea from Singapore. Sumu Simon and I are convening this meeting. It will be followed by the Neuro-Vision Course on 10 and 11 September, covering essentially the efferent half of neuro-ophthalmology.


Prof John Crompton
President-Elect, NOSA

Planning underway for ISOO 2017 combined Conference

In March 2017 the International Society for Ocular Oncology (ISOO) Biennial Conference will be held in conjunction with the RANZCO NSW Branch Annual Scientific Meeting.

The venue for the combined conferences will be the newly and completely rebuilt International Convention Centre on Darling Harbour, a state of the art facility on the waterfront in the centre of Sydney. Numerous good hotels are situated within an easy walking distance from the convention centre.

The RANZCO NSW Branch Annual Scientific Meeting will run from 24 to 25 March and ISOO 2017 will run from 24 to 28 March. The two separate conferences will take place simultaneously in two separate side-by-side auditoria, each with a capacity to hold 400 audience members and separated by a sliding wall.

The theme for the RANZCO NSW Branch component of the combined meeting will be ocular oncology/oculoplastic. Although the two meetings will be separate, there will be a 90-minute combined session on the morning of Saturday 25 March, the theme of which will be how our knowledge of ocular melanoma can benefit from the study of cutaneous melanoma. The session will feature six lectures, with three from ocular oncologist opthalmologists and three from Australian medical experts in the field of cutaneous melanoma.

In addition, four didactic 90-minute sessions have been organised by overseas experts: ‘The White Pupil’, ‘Lymphoma’, ‘Conjunctival Tumours’, and ‘Eyelid and Orbital Tumours’.

On Friday 24 March there will be a workshop on ocular pathology run by Dr Hans Grossniklaus from Emory University, Georgia, USA. Dr Grossniklaus, who is both an ophthalmologist and an ocular pathologist, is assembling an international team of world renowned ocular pathologists. This workshop should be of interest to general ophthalmologists, ocular oncologists, oculoplastic surgeons, ophthalmology registrars and others who want to update themselves on this subject, which is the foundation of our specialty. The workshop will be for either a whole day or half a day and will run in parallel with the plenary session. The workshop is open to delegates attending the RANZCO NSW Annual Scientific Meeting as well as those attending ISOO 2017.

The social program will feature a welcome cocktail reception on the evening of Friday 24 March at the Darling Harbour International Convention Centre. This will also be attended by ISOO delegates and will be a great opportunity to meet international leaders in the field of ocular oncology.

Dr Gina Kourt is Chairman of the NSW Branch meeting component and she joins me in welcoming you to Sydney in March 2017.

Dr Michael Giblin
Convenor, ISOO 2017
Kirk Pengilly encourages Australians to donate $1 for every year they have enjoyed good sight

For the first time in its nine-year history, The Eye Surgeons’ Foundation, as part of its annual community awareness campaign JulEYE, asked Australians to donate $1 for every year of good sight they have experienced. Outlining this new messaging, a new national community service advertisement (CSA) featuring JulEYE Ambassador Kirk Pengilly gathered significant support from Australian media outlets.

The Eye Surgeons’ Foundation, a national not-for-profit organisation, changed its name from The RANZCO Eye Foundation earlier this year to provide a clearer vision of the vital work it does through Australasia. The new CSA brings that vision to life.

The foundation is recognised for its vital work in medical eye research and sustainable development programs across Australia and the region. This year, the Foundation wanted its call for donations messaging to be more prominent in its annual JulEYE campaign. With 75% of Australians suffering from unnecessary vision impairment and the other 25% needing a cure, it is only through the continued support of world-class research and investment in the future of eye health diagnoses, treatments and cures that the Foundation can continue to make a real difference.

The direct appeal by Kirk Pengilly for the CSA was a concept developed by Morey Media and produced by Brightworks. It was seen via the Seven Network, WIN, Prime 7 and a variety of Foxtel channels across both their metropolitan and regional markets. In addition, Shopper Media Group featured ads in their new SmartLite™ digital advertising panels in over 101 shopping centres across the country. The Foundation cannot thank the individual media outlets enough for their philanthropic support of JulEYE 2016.

The CSA shows INXS band member and Ambassador for JulEYE Kirk Pengilly telling his personal story in what is an earnest appeal: “When I was 27 I almost lost my sight to glaucoma. Had it not been for pioneering eye research and surgery my life would have been very different. We need to continue to fund vital research to find new treatments and cures to prevent eye disease.”
JulEYE is about Australians thinking about and looking after their sight. The Australian community has the power to save our sight and the sight of others — now and into the future. Donations to fund vital research will deliver profound and lasting outcomes in eye health. We implore all Australians to donate and to help us create a future where no one is blind.

**JulEYE founders focus on Australian business for sight saving support**

The Eye Surgeons’ Foundation, creator of the successful JulEYE community awareness campaign, has launched a new fundraising initiative inviting Australian businesses to support crucial sight saving research.

Vision 500 asks 500 Australian businesses to commit $500 to raise $250,000 each year. The funds will fast track five innovative research projects to be undertaken by Australia’s leading medical eye research investigators.

Following a successful 2016 JulEYE campaign, which asked the Australian public to donate $1 for every year they had enjoyed good eyesight, the Foundation is now hoping the Australian business sector will become involved.

With less than 11% of all research applications securing government funding and an increasingly competitive charity space, securing donations overall is difficult. To this end, we are asking Australian businesses for the first time to also help us make a difference.

Companies and businesses that donate to Vision 500 will join an impressive group of like-minded people and organisations that are all passionate about making a difference. Law firm Ash St. was the first organisation to come on board alongside other Founding Members Hunter Health Services and EzyPay.

Chair of The Eye Surgeons’ Foundation Mr Peter Keel said he wanted his law firm to lead the way in contributing to eye saving research by becoming a Founding Member of the Vision 500 program.

“When Ash St. first heard of the collaborative giving initiative Vision 500, we knew we needed to be a part of it,” Mr Keel said.

The Eye Surgeons’ Foundation, in partnership with the Ophthalmic Research Institute of Australia, has supported more than 200 eye research programs since its inception. One such grant seed-funded the discovery of new genes linked to glaucoma, shedding light on the causes, treatment and management of rare eye diseases. We have seen that by supporting the innovative and inspirational work of Australia’s visionary researchers, we can impact vision loss of individuals, families and communities. Now we are looking to Australian businesses to share that vision and join us in creating a future without blindness.
ORIA — increasing its support for research into macular degeneration

ORIA is pleased to announce the Richard and Ina Humbley Foundation has now been established. ORIA will be the sole beneficiary of the new perpetual Foundation with funds being distributed annually to support research into macular degeneration. The first ORIA/Richard and Ina Humbley Foundation Grant will be announced at ORIA’s Annual General Meeting in November. The project funding will commence from 2017. ORIA is most grateful for this generous legacy which will assist in the organisation’s longstanding support of research into macular degeneration.

- It is only six months since completion of the 18 research projects ORIA supported in 2015, but a lot has already been achieved:
  - Five New Investigator projects are complete. Each of these new and up-and-coming scientists were supervised by RANZCO Fellows.
  - Each New Investigator now has a track record to enhance their research and professional careers.
  - To date 58 papers have arisen out of the research; 15 presentations and 13 posters.
  - The ORIA funding has led to one Category 1 National Health and Medical Research Council Grant and four applications for additional larger grants.

We will await with interest the long-term benefits of the results of the research.

ORIA has now received over 125 peer reviews for the 51 Australian proposals for project funding in 2017 as well as four from New Zealand. ORIA’s 15-member Research Advisory Committee will meet in August to make its assessments.

Anne Dunn Snape
Executive Officer, ORIA

ASO update: health reform in limbo

In the post-election wash up Sussan Ley defied detractors by retaining the mantle of Health Minister.

To date no commitments on lifting the rebate freeze — something many were predicting after the Mediscare backlash — have been forthcoming.

Ms Ley has simply stated her role includes “protecting the future of Medicare and ensuring it remains universally accessible to all Australians”.

The Minister has offered little detail on where to from here for health policy.

What of the system-wide review of Medicare and Private Health Insurance that were in full swing prior to the election? We don’t really know.

This term around the Turnbull Government needs to show major improvement in how it communicates policy direction to voters. It appears the Department of Health has been given this message, and recently the Department released of a number of policy responses on key election platform issues. These issues include funding for the treatment for macular disease, and the use of medical cannabis.

The Australian Society of Ophthalmologists (ASO) will soon visit key health representatives in Canberra to discuss the way forward on these and other health issues.

OCT on the MBS

The Medical Services Advisory Committee has provided a recommendation to the Minister for Health that optical coherence tomography (OCT) be added to the Medicare Benefits Schedule for diagnosing macular disease only. A once per year rebate of $40 is recommended for patients.
The ASO advocates access to the OCT item number for ongoing monitoring of disease progression and a fee more accurately reflective of the practice costs involved in delivering the service.

**RANZCO branch donations to ASO clarified**

Fellows may have seen the recent advice provided by RANZCO on whether state Branches are able to donate to the ASO without affecting RANZCO tax obligations. The determination is that donations can be provided to the ASO for a specific purpose that is in-line with the objectives of RANZCO.

We welcome this clarification.

The role of the ASO is to represent the interests of ophthalmologists and their patients. ASO activities are in pursuit of ensuring equitable access to specialist eye care for all Australians.

The ASO is and will remain a separate organisation to RANZCO because our work is different to that of the College. This separation does not mean, however, that ASO and RANZCO are not closely aligned. We share common members and the overarching aspiration to advance the specialty of ophthalmology.

The ASO has a clear budget for operating expenditure. We derive an income from membership fees and this covers the cost of our day-to-day activities as an organisation.

However, when circumstances dictate that we must take on large scale medico-political campaigns additional funds are required. In these cases, we often look to donations to meet shortfalls.

Should Branches wish to donate to ASO, a meeting motion along with an accompanying letter specifying use for the donation is recommended.

Currently about 50% of Australian ophthalmologists are members of the ASO. Our goal as an organisation is to continue to work towards 100% membership. If we could achieve this, we would be able to lessen our reliance on donations in the face of campaign work.

*Dr Michael Steiner*

*President, ASO*

---

**Your Invitation**

**WHAT:** The ASO Advocacy and Practice Skills Workshop & Inaugural Andrew Stewart Lecture

**WHEN:** Saturday 19 November, 9:30am – 12:30pm

**WHERE:** Melbourne Convention Centre.

**COST:**
- Advocacy Workshop (9:30am – 11:10am): Free for ASO members and $50 for non-members
- Andrew Stewart lecture (11:30am – 12:30pm): Open invitation – no cost


**WHY:** The ASO Advocacy and Practice Skills Workshop will offer fascinating insight into the medico-political state of play including challenges and opportunities for specialist practice. Attendees will hear from high profile experts in the health sector and also be brought up to speed on the latest developments and techniques in finance, employment, technology and more.

This year to pay tribute to Dr Andrew Stewart the ASO will present the inaugural Andrew Stewart Lecture. Delivered by a key political representative the Lecture will cover the importance of health to our nation and address many issues within our changing health landscape. All RANZCO Fellows and Associates are invited to attend the Andrew Stewart Lecture.


For enquiries contact the ASO via email: info@ASOeye.org or phone: 07 3831 3006
In this year’s Queen’s Birthday Honours List, Dr Peter Charles Heiner has been made a Member (AM) in the General Division of the Order of Australia for significant service to medicine as an ophthalmologist, to medical education and eye health research and to professional organisations.

Dr Heiner has had a passion for innovative cataract surgery throughout his career. He co-founded The Eye Centre (now Vision Eye Institute) and pioneered the introduction of phacoemulsification and micro-incision cataract surgery. He also founded The Laser Vision Centre (now Vision Laser), one of the largest providers of laser eye care in Australasia.

He is Adjunct Associate Professor at Bond University's School of Medicine, which he helped establish in 2005, and was involved in the establishment of the Clem Jones Research Centre for Stem Cells and Tissue Regenerative Therapies. He is a founding member of the Australasian Society of Cataract and Refractive Surgeons (1995) and has served as chairman, treasurer and secretary of the RANZCO's Queensland Branch.

Dr Heiner has a passion for education and has lectured both overseas and in Australia. He has received numerous awards including the Asia-Pacific Association of Cataract and Refractive Surgeons Certified Educator Award, a Gold Medal by the Indian Intraocular Implant and Refractive Society and a Gold Medal at The Eye Advance Conference, Mumbai, India for outstanding contribution to cataract surgery.

RANZCO Fellows awarded NHMRC fellowships

RANZCO Fellows and Centre for Eye Research Australia (CERA) researchers Professor Robyn Guymer and Associate Professor Alex Hewitt received top honours from the National Health and Medical Research Centre (NHMRC) at an event held in Canberra in July.

Prof Guymer was awarded a prestigious NHMRC Elizabeth Blackburn Fellowship to support her research into age-related Macular Degeneration (AMD), whilst A/Prof Hewitt has been recognised as the top-ranked NHMRC Practitioner Fellowship applicant.

The Elizabeth Blackburn Fellowships are awarded annually to the highest ranked female applicant in each of the biomedical, clinical and public health pillars of the NHMRC’s Research Fellowship scheme. Prof Guymer received the award for the Clinical Science and Medicine category.

Prof Guymer is a clinician-researcher focusing almost exclusively on AMD, the leading cause of vision loss and legal blindness in Australians over 50 years of age. Prof Guymer’s research over the past two decades has looked at all aspects of this disease, from better understanding the pathological causes and risk factors of AMD to defining the clinical signs and severity of the disease in a living eye to testing of novel treatments for every stage of the disease.

“This fellowship will enable me to continue expanding the AMD research field by collaborating with basic scientists to address underlying mechanisms of the disease and then take our research findings into the clinic,” said Prof Guymer.

A/Prof Alex Hewitt (CERA and the University of Tasmania) received a Research Excellence Award as the top ranked NHMRC Practitioner Fellowship.
applicants for his work on patient-specific stem cell lines and emerging gene-editing techniques. A/Prof Hewitt’s research aims to understand the precise molecular mechanisms leading to blinding disease and develop novel therapies for these diseases.

“The overarching goal is to ensure that through targeted, evidence-based intervention, the next generation of people genetically predisposed to blinding ocular diseases have a dramatically different natural history to their forebears,” said A/Prof Hewitt.

NHMRC Practitioner Fellowships are designed to support research that results in the translation of evidence into improved clinical practice and health policy, delivering improvements in health and healthcare to Australians.

Associate Professor Kerry Fitzmaurice has been included in Marquis Who’s Who biographical volumes in recognition of her commitment and contribution to orthoptic education over many years. Individuals profiled in Marquis Who’s Who are selected on the basis of current reference value. Factors such as position, noteworthy accomplishments, visibility, and prominence in a field are all taken into account during the selection process.

A/Prof Fitzmaurice is a fellow and past president of Orthoptics Australia and Chair of the Australian Orthoptic Board. She is currently Head of the Department of Clinical and Community Allied Health at La Trobe University. Her recent positions at La Trobe include Associate Dean Academic of the Faculty of Health Sciences and Head of its Department of Clinical Vision Sciences. A/Prof Fitzmaurice has worked as a low vision rehabilitation practitioner, teacher and researcher for over 30 years. Her work on low vision rehabilitation strategies has been recognised internationally and her research has been published in a number of influential journals.

In light of her accomplishments, A/Prof Fitzmaurice has been featured in the 9th edition of Who’s Who in Science and Engineering, and the 4th through 8th editions of Who’s Who in Medicine and Healthcare. She has also appeared in several editions of Who’s Who in the World published since 2005.
APAOGP MoU signed by Prof Dennis Lam (front row, right), APAO President, and Dr James Muecke (front row, left), Sight for All Chairman, APAO Congress 2016 (Photo courtesy of APAO)

APAOGP launches new project to help reduce visual impairment and blindness in Asia-Pacific region

The Asia-Pacific Academy of Ophthalmology (APAO) is one of the largest professional associations of ophthalmologists in the world and has members from the Asia-Pacific region which is home to the bulk of the world’s population.

APAO was founded in 1960 and has grown to become a significant force in ophthalmology in the region. According to global data on visual impairment published by the World Health Organization in 2010, an estimated 285 million people around the world are visually impaired. Over 180 million of these people reside in the Asia-Pacific region.

APAO has made great inroads in removing the barriers in ophthalmic education and services in the region. To this end the Academy has launched a large number of initiatives including an annual Congress, the Leadership Development Program, the International Fellowship Program, the Asia-Pacific Journal of Ophthalmology and more recently the Gateway Project (APAOGP).

The APAOGP was the brainchild of Professor Rajvardhan Azad, the past president of APAO, and Associate Professor Nitin Verma, who is the secretary of the project.

The APAOGP aims to reduce inequality between countries in the Asia-Pacific region in terms of eye health, visual disability and blindness. APAO recognises that there is a lack of coordination between the large number of local and international non-governmental organisations working in the region, some in isolation and others within the framework of the relevant ministries of health and national health plans. The APAOGP aims to encourage collaboration between all the organisations working in a particular country in the areas of research and training, infrastructure development and public eye health education with the overall aim of consolidating the position of the national eye health plans and the ministries of health. This is to ensure that sustainable eye care delivery programs that work towards the ultimate aim of reducing ocular morbidity and blindness in the region are established.

Laos was the first country to receive support through the APAOGP and Sight for All was chosen as the lead organisation to co-ordinate these activities. The program was endorsed by the APAO Council and launched in March 2016 during the APAO Congress in Taiwan. A memorandum of understanding was signed by Prof Dennis Lam, President of the APAO, and Dr James Muecke, Chairman of Sight for All. Partnerships were then established with the Thai Ophthalmic Society, the Ophthalmic Society of Taiwan, the Malaysian Ophthalmic Society, the Aravind Eye Hospital and representatives from the Laotian Ophthalmologists Association. The Project Plan is based on the most recent Laos National Eye Health Action Plan. RANZCO will be involved with the education component of this initiative.

It is hoped that Myanmar will be the next country adopted by the APAOGP, with the potential launch of this project at the APAO Annual Congress in Singapore next year.

The APAOGP is a very exciting initiative of the APAO and will have a positive long-term impact on eye health in the region.

A/Prof Nitin Verma
APAOGP Secretary
Dr David Gillespie was elected to the Australian Parliament in 2013 and was appointed to the Australian Government Ministry following his return at the 2016 election. Dr Gillespie and his wife Charlotte have three children — Isabelle, Oliver and Alice — raising the family on their farm in the Hastings Valley on the outskirts of Wauchope and Port Macquarie, on which they run grass-fed Angus beef for the export market. Dr Gillespie graduated from the University of Sydney and is a Fellow of the Royal Australasian College of Physicians. As an undergraduate, he gained experience training both in Papua New Guinea and British Columbia. Dr Gillespie’s post graduate specialist training included stints at hospitals in Bathurst, Orange and Dubbo, while based at the Royal Prince Alfred Hospital in Sydney. He also gained two years of paediatric experience at the Royal Alexandra Hospital for Children in Camperdown, St George Hospital in Kogarah, and at Sydney’s St Vincent’s Hospital. Dr Gillespie obtained a Diploma of Anaesthetics (London) and Diploma of Child Health (UK) after working in the UK National Health Service.

Before entering Federal Parliament, Dr Gillespie had 33 years of medical practice, including 21 years as specialist gastroenterologist and consultant specialist physician in Port Macquarie. Dr Gillespie was active in postgraduate medical training as Director of Physician Training at Port Macquarie Base Hospital and was instrumental in the hospital achieving accreditation by the Royal Australasian College of Physicians for specialist training and becoming a centre for college examinations.

Dr Gillespie and Charlotte built, licensed and ran the Hastings Day Surgery in Port Macquarie for 12 years. During this period, Dr Gillespie also lectured and tutored at UNSW Rural Medical School from its inception.

Dr Gillespie is using his first-hand experience in public and privately managed health delivery and small business to ensure Australia’s health system delivers high quality, cost-effective care in an affordable and fiscally sustainable manner.

Q What are some of the key issues for you in your new role as Rural Health Minister?

A The role of Rural Health Minister covers essential areas such as rural workforce planning and delivery to ensure that we have improved access to quality healthcare, allied health and both primary and specialist care. We have a strong commitment to the integrated rural training pipeline that was announced in the 2015/16 Mid-Year Economic and Fiscal Outlook and to bringing the rural generalist training pathway and regional training hubs to reality. These initiatives are aiming to address the distribution of primary and specialist allied health and dental access across rural, regional and remote Australia.

Q How does being a medical professional shape how you view health policy and rural health in particular?

A Having lived a life on the front line of rural and regional health delivery I have a genuine appreciation of the difference between metropolitan and rural practice. I have a firsthand understanding of the inequities, the barriers, the frustrations and, importantly, the potential solutions.

Q Cataract remains the leading cause of avoidable blindness amongst Aboriginal and Torres Strait islander people — will your government consider increasing support for medical specialist visits to rural and remote areas to address this issue?

A We have specialist outreach funding in place through various
A recent study carried out with RANZCO members on the management of microbial keratitis in Australia has found the distribution of ophthalmologists and trainees in Australia who manage microbial keratitis to correspond closely to the distribution of the eye health labour force in the country.

The study, conducted by Dr Yen Cheng from Prof Stephanie Watson’s group at the Save Sight Institute and the University of Sydney, surveyed RANZCO members — ophthalmologists and trainee ophthalmologists — currently practicing in Australia, or who have practiced in Australia within the last 12 months.

Of 91 responders, there were 80 ophthalmologists and eight trainees who treated microbial keratitis. The majority of clinicians who treated microbial keratitis did not identify as corneal subspecialists. The majority of ophthalmologists who treated microbial keratitis practiced in NSW (39%) and Victoria (30%), and most worked in major cities (78%). Of corneal subspecialists, 92% worked in major cities.

The study found a difference in the nature of care received in inner and outer regional areas compared to that received in major cities. A patient with microbial keratitis in the city was more likely to be seen by a corneal subspecialist than a patient in a regional area.

Microbial keratitis is a potentially sight-threatening infection of the cornea, often associated with contact lens wear, ocular trauma or ocular surface disease. Current practice promotes the early use of broad-spectrum antibiotic therapy in order to prevent a decline in vision or permanent vision loss.

For more information on the study please contact Prof Stephanie Watson at stephanie.watson@sydney.edu.au.

RANZCO survey yields useful results on corneal infection

The study found a difference in the nature of care received in inner and outer regional areas compared to that received in major cities. A patient with microbial keratitis in the city was more likely to be seen by a corneal subspecialist than a patient in a regional area.

Microbial keratitis is a potentially sight-threatening infection of the cornea, often associated with contact lens wear, ocular trauma or ocular surface disease. Current practice promotes the early use of broad-spectrum antibiotic therapy in order to prevent a decline in vision or permanent vision loss.

For more information on the study please contact Prof Stephanie Watson at stephanie.watson@sydney.edu.au.
The NSW Statewide Eyesight Preschooler Screening (StEPS) program provides free universal vision screening to preschool children aged four years in NSW through preschool, day care and other children’s services. The program was introduced in NSW in 2008 and is now fully operational in all Local Health Districts (LHDs). The StEPS program has been implemented on good evidence that a visual acuity test at approximately four years of age enables detection and treatment of vision disorders before a child starts school. The program is unique in Australia as it does not rely on the child attending regular health checks, a system which is known to have variable participation rates.

The StEPS program is overseen by the NSW Ministry of Health and administered by StEPS coordinators in each LHD, who identify and target all four-year-olds to offer them a vision screen. Trained vision screeners visit local preschools, day care centres and children’s services to conduct a monocular visual acuity screening test on all children who have a completed consent form. If their visual acuity result following screening indicates a need for follow up, these children are referred to specialist follow-up services. For example, a result of 6/9-2 in either eye is a routine referral and a result of 6/18 or less in either eye is a high-priority referral. These children are referred for further testing, diagnosis and follow up to services across NSW, including to ophthalmologists and optometrists in the public and private health systems. Dedicated StEPS Paediatric Ophthalmic Outpatient Clinics are also available in some LHD.

StEPS results

There were 99,677 StEPS screening offers made in 2012/13, with 75% of these accepted and screened. One in 10 (7,444) children were referred to an eye health professional based on StEPS findings. The StEPS program has had excellent results, and children referred from the StEPS program have been diagnosed with a range of eye disorders including amblyopia, refractive error, strabismus, and other vision disorders. Around 44% of high-priority referrals (screening visual acuity result of less than 6/18 in either eye) are prescribed glasses, and 28% of these children are diagnosed with amblyopia. Only a small proportion of children referred (2% of high-priority referrals) are found to have no visual abnormality after further investigation.

The role of eye health professionals in StEPS

The StEPS program relies on eye health professionals to report outcome data for children referred from StEPS. This can be done using the tear-off slip provided on the referral letter, or by a brief phone call or email to the local StEPS coordinator. Contact details for the coordinator in your LHD can be seen on the next page. Reporting of accurate, timely outcome data is important for all public health programs to enable continuous improvement. Publication of StEPS results will occur regularly to disseminate results within Australia and internationally.
StEPS coordinator contact details for LHD in NSW

<table>
<thead>
<tr>
<th>Local Health District</th>
<th>Name of coordinator</th>
<th>Phone number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Coast</td>
<td>Marisa Lawler</td>
<td>02 4328 7900</td>
<td><a href="mailto:Marie.Lawler@health.nsw.gov.au">Marie.Lawler@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Western NSW</td>
<td>Sandra Ford</td>
<td>02 6369 3300</td>
<td><a href="mailto:Sandra.Ford@health.nsw.gov.au">Sandra.Ford@health.nsw.gov.au</a></td>
</tr>
<tr>
<td></td>
<td>Sue Ashton</td>
<td>02 6841 2253</td>
<td><a href="mailto:Sue.Ashton@health.nsw.gov.au">Sue.Ashton@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Far West</td>
<td>Dianne Johnson</td>
<td>08 8080 1100</td>
<td><a href="mailto:Dianne.Johnson@health.nsw.gov.au">Dianne.Johnson@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Southern NSW and Murrumbidgee</td>
<td>Allison Zucco</td>
<td>02 4475 7208</td>
<td><a href="mailto:Allison.Zucco@gsahs.health.nsw.gov.au">Allison.Zucco@gsahs.health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Hunter New England</td>
<td>Alison Boehme</td>
<td>02 6538 5071</td>
<td><a href="mailto:Alison.Boehme@hnehealth.nsw.gov.au">Alison.Boehme@hnehealth.nsw.gov.au</a></td>
</tr>
<tr>
<td>Northern Sydney</td>
<td>Therese Salole and Jodi Simons</td>
<td>02 9462 9550</td>
<td><a href="mailto:NSLHD-STEPS@health.nsw.gov.au">NSLHD-STEPS@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>South Eastern Sydney and Illawarra Shoalhaven</td>
<td>Nadya Shulgin</td>
<td>02 8545 4662</td>
<td><a href="mailto:SCHN-SCH-STEPS@health.nsw.gov.au">SCHN-SCH-STEPS@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Western Sydney</td>
<td>Rowena Urweiss and Trish Woolley</td>
<td>02 8759 4150</td>
<td><a href="mailto:Rowena.Urweiss@health.nsw.gov.au">Rowena.Urweiss@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Nepean Blue Mountains</td>
<td>Acting StEPS coordinator</td>
<td>02 4730 5100</td>
<td><a href="mailto:kate.gillard@health.nsw.gov.au">kate.gillard@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>South Western Sydney</td>
<td>Vicki Blight</td>
<td>1300 273 290</td>
<td><a href="mailto:Victoria.blight@sswahs.nsw.gov.au">Victoria.blight@sswahs.nsw.gov.au</a></td>
</tr>
<tr>
<td>Sydney LHD</td>
<td>Paola Gordon</td>
<td>02 9515 6346</td>
<td><a href="mailto:paola.gordon@sswahs.nsw.gov.au">paola.gordon@sswahs.nsw.gov.au</a></td>
</tr>
<tr>
<td>Northern NSW</td>
<td>Jennifer McKay</td>
<td>02 6620 2836</td>
<td><a href="mailto:Jennifer.McKay@ncahs.health.nsw.gov.au">Jennifer.McKay@ncahs.health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Mid North Coast</td>
<td>Wendy Mutton</td>
<td>02 6656 7061</td>
<td><a href="mailto:Wendy.Mutton@ncahs.health.nsw.gov.au">Wendy.Mutton@ncahs.health.nsw.gov.au</a></td>
</tr>
</tbody>
</table>

For more information


StEPS screening is undertaken in child care centres and preschools — a non-threatening environment for the children. (Photo courtesy of NSW Health)
Minister announces NDIS roll out across Australia at RIDBC

In June, the Royal Institute for Deaf and Blind Children (RIDBC) played a key role in a significant milestone, when the Minister for Disability Services, The Honourable John Ajaka MLC, officially announced the launch and roll out of the National Disability Insurance Scheme (NDIS) for NSW at their North Rocks campus.

The NDIS is a new way of providing support to Australians with disabilities. The scheme is intended to fund reasonable and necessary supports that help a participant to reach their goals and aspirations and build skills so they can participate in the community and employment.

RIDBC is well prepared for the roll out of the NDIS after having participated in trial sites in the Hunter, ACT and Nepean Blue Mountains districts.

Mr Chris Rehn, RIDBC Chief Executive, said “The introduction of the NDIS has a significant and positive impact on the way services are provided to people living with a disability, allowing for greater control, flexibility and choice.

“RIDBC already leads the way in providing individualised and tailored services to meet the unique needs and life goals of the children, adults and families we support. Access to our services is strengthened under NDIS, ensuring the best outcomes for people with vision or hearing loss.”

Connor McLeod, who is blind, is an inspirational young man who lets nothing hold him back.

The 14-year-old is a passionate advocate for the blind and low vision community and is looking forward to what the future holds for him under the NDIS. At 10 he advocated for his right to represent his school at Cross Country after he qualified, but was originally denied that right due to his vision loss. At 13, he advocated for accessible bank notes, to have a tactile feature incorporated on the new issue to ensure blind and low vision users could independently identify the banknotes correctly. As a result, the first generation of tactile banknotes are due to be issued into circulation in September by The Australian Reserve Bank.

Connor furthered his campaign for change by advocating for text to speech technology on EFTPOS machines to ensure blind and low vision users knew how much was being withdrawn from their account at the point of purchase.

In 2015, Connor was awarded the Pride of Australia Medal in the ‘Young Leader’ category and he also jointly won the ‘Emerging Leader in Disability Awareness’ at the 2015 National Disability Awards, for his fantastic efforts in making a difference to the lives of people with vision loss across Australia.

Connor was diagnosed with lebers congenital amourosis, a recessive genetic eye condition, at four months old, five days before his first Christmas.

“It was a terrible shock to be told your child is blind,” said Connor’s mum, Ally. “I had no idea what was involved in raising a blind child and was very frightened of what his future may be. This was the time we got involved with different services and began to develop a complete understanding of his needs.”

Connor began attending RIDBC VisionEd Preschool when he was three years old.

“RIDBC VisionEd Preschool was simply remarkable. Connor first learnt his braille skills there and just being able to read has opened his world up to so many different things that he may not have otherwise been able to identify with.”

“RIDBC has helped him build his confidence, independence and social skills. Today Connor is a well-adapted
young achiever who just also happens to be blind.

“RIDBC VisionEd director Glenda used to tell Connor he could do anything or be anything he chose when he grew up. So when Connor was five he wrote to the then Prime Minister, The Honourable Mr John Howard, and politely informed him that he wanted his job and his aim was to be the boss of Australia,” said Ally.

“John Howard wrote back to him telling Connor he could be whatever he chose to be when he grows up as long as he worked hard at it. Knowing my son and with the supports that are now available to him, we may just be watching the making of Australia’s first blind Prime Minister…who knows?”

Connor attends mainstream school and receives support from RIDBC School Support Service (Vision Impairment). He has earned a place in an academically gifted class for years 5 and 6 and now has an academic scholarship for high school.

“Connor has loved abseiling, rock climbing and exploring wild caves since he was five years old. Camping and riding a tandem bike with his dad are high on the list too and last year he completed the Sydney to Wollongong bike ride. He plays the drums and the keyboard and just like most teenage boys he loves his technology, online games and keeping in touch with his mates via Skype.”

Ally and Connor are looking forward to what the future holds under the NDIS. “No two disabilities and no two people are the same. So, unlike the previous block funding, the NDIS is more in line with people with disabilities working toward their own personal needs, goals and achievements,” said Ally.

“Our plan is only just starting so we are hoping to ensure that Connor has the opportunity to receive occupational therapy, learning things such as kitchen skills, mobility training to be able travel independently and assistance with gaining work experience and general independent living skills.”

Connor wants to be a contributing member of society and to become employable once he leaves school. He wants to live a full life and to be as independent as possible.

“The NDIS can be a little daunting at first however. As I learn more about the scheme both Connor and I do believe it will offer many more personal opportunities for Connor to excel at whatever he chooses to do,” said Ally.

“With the scheme being aimed at personal options it opens the door to a plethora of opportunities that Connor may not have had previously.”

“Connor now has the option to say I require assistance to gain some work experience and assistance to teach me how to travel, and his funding can be centred around those goals.”

RIDBC supports people with vision or hearing loss to access the NDIS. Further information is available online at ndis.ridbc.org.au or you can call 1300 581 391 to speak to an RIDBC consultant.

RIDBC is a charity and Australia’s largest non-government provider of therapy, education and cochlear implant services for people with hearing or vision loss, supporting thousands of adults, children and their families, each year.

RIDBC relies heavily on fundraising and community support to be able to continue to make a difference in people’s lives.

The Royal Institute for Deaf and Blind Children

ICO releases Guidelines for Glaucoma Eye Care

The International Council of Ophthalmology (ICO) has announced the release of ICO Guidelines for Glaucoma Eye Care. The guidelines summarise core requirements to care for patients with open and closed angle glaucoma. ICO expects the guidelines will have relevance to ophthalmologists around the world as they provide guidance on the management of glaucoma in both low and intermediate to high resource settings.

The Guidelines are currently available in English, French, Spanish, Chinese, Turkish, Hindi, Russian, Arabic, and Portuguese, and can be downloaded at www.icoph.org/glaucoma.

These guidelines are based on internationally recommended standards of care, and ICO hopes that they will be incorporated into resident and fellow training programs, and used by members to improve patient outcomes.
Researchers from the Save Sight Institute at the University of Sydney have reported that a simple ‘chewing gum’ test could be the key to identifying Giant Cell Arteritis (GCA), a disease that causes blindness, strokes and death.

Also known as temporal arteritis, GCA involves inflammation of the arteries typically in the temple region and the vessels to the eyes. Symptoms can include headaches, scalp tenderness, jaw pain and vision problems. GCA is only observed among patients aged 50 and older.

“GCA is one of the most common causes of blindness in older people,” says Professor Peter McCluskey, director of the Save Sight Institute. “Not only can it send you blind, but it can kill you. It can also affect vision extremely quickly. If one eye is already involved, around one third of people go blind in the other eye within a day, another third within a week and the remaining third within a month, if it is untreated. It’s a very serious condition which requires rapid and correct diagnosis.”

The condition can be hard to diagnose because early symptoms are often subtle and also found in a range of other diseases. For example, claudication of the jaw muscles (cramping pain caused by inadequate arterial blood flow) is a specific indicator of GCA, but there is no current clinical test to differentiate it from other causes of jaw pain, such as temporal mandibular joint dysfunction, a common benign condition. GCA patients with jaw claudication have a higher risk of permanent visual loss, but this symptom isn’t commonly reported because many people favour soft food as they get older.

The research team, Prof McCluskey, Dr Chih-Hung Kuo, and A/Prof Clare Fraser, have proposed a straightforward ‘chewing gum’ test to unmask this important jaw symptom. By chewing gum at a rate of one chew per second the test can reproduce a patient’s tell-tale pain, prompting a doctor to further investigate with a blood test and an arterial biopsy to confirm a diagnosis.

The research team is doing further research to validate the chewing gum test, and will incorporate dentistry, rheumatology and nuclear medicine specialist researchers.
Aida Zeric and find out where Master of Orthoptics student University of Technology (UTS) Hear from second year UTS: Orthoptics

Hear from second year University of Technology (UTS) Master of Orthoptics student Aida Zeric and find out where she has undertaken the clinical placement component of her degree and what her experience has been so far!

During my time in Orthoptics, I’ve done quite a few placements. I’ve gone to Mount Druitt Hospital, Bankstown Hospital, Blacktown, Prince of Wales Hospital, Sydney Eye Hospital, and then a lot of little private clinics like Hunter Street, McCorey Street and Nepean Valley Eye Surgeons.

Every week, you’re based in a new place, but then there are a few places which you go to at least four times, and they’re your major block assessments. It’s great because you really get a great mix of everything.

I think the biggest highlight was when I was at Mount Druitt Hospital. That was actually my major assessment place, and it’s a stroke ward. On this particular placement we treat people that have just had a stroke, and assess their vision.

It’s been a real highpoint for me because I didn’t know I was interested in stroke. In the minute I was kind of hesitant, but I think I’ve learnt the most out of it, because you’re working with people that are injured and providing them support. Whereas all the other placements I’ve been to, everyone’s fine, fit, and healthy and getting check-ups. At the stroke ward I’m presented with patients who have complete vision loss, or double vision. It was really interesting and I think I’ve learnt a lot.

The benefits of a practice-based degree are that I already feel like I’m ready to start working. I’m not going to hesitate and think “I don’t know how to do it”. I suppose at other universities the degrees are all theory-based. I’ve spoken to a lot of supervisors on placements and they tell me that, when they did their degrees, it was more theory-based, and when they started working, they had to learn on the job.

From my experience so far, I feel the UTS approach is the best way to learn because when you’re just observing, you can watch all you like, but it’s different when you start doing it.

On placements, you can’t just sit down and say, “oh, it’s okay, the supervisor will take care of me.” You have to work for yourself, work it out, and you feel happier with yourself when you do it.

My future career goal is to become an interactive orthoptist, one that continues to work in conjunction with many other health professionals for the benefit of my future patients.

A piece of advice for future students looking to study a master’s degree at UTS Orthoptics is to practice a lot.

Don’t just rely on the set practical two-hour time that exposes you to the equipment and resources. Keep coming back into UTS outside of your regular hours, stay back, practice and keep revising because you’re not just learning content to pass the test. You are learning what you will actually be practising in your career and you have to keep on top of it. You have to keep everything fresh. Don’t just learn something in your first year and think you can forget it. You have to keep revising. Even now in second year, I’m going over my first year content.

This World Sight Day — #snapforsight!

#Snapforsight, an initiative of Vision 2020 Australia, has been designed to raise awareness of eye health during the month of October and on World Sight Day, Thursday 13 October.

The #Snapforsight initiative is a fun and engaging way of encouraging Australians to focus on capturing their moment and raising awareness about the importance of eye health and regular eye examinations.

Building on last year’s inaugural campaign, Vision 2020 Australia aims to inspire Australians through images, video and sound.

Getting involved in #snapforsight couldn’t be easier:

• capture your moment with a camera, mobile or mp3 player,
• post your picture, video or audio file to Twitter, Instagram or Facebook, and
• make sure you include the #snapforsight hashtag in your post.

Vision 2020 Australia CEO, Carla Northam, encourages all ophthalmologists to get involved and share the campaign with patients.

“#Snapforsight is a great opportunity to promote the importance of eye health. We hope more Australians and healthcare professionals, including ophthalmologists, get involved,” said Ms Northam.

A range of free #snapforsight support materials are available, including digital content, social media support and promotional posters.


Please get involved and help us raise awareness on eye health and the importance of regular eye examinations this World Sight Day. Can you capture one moment a day this October?

Capture your moment #snapforsight
Macular Disease Foundation Australia has committed a three-year $100,000 research grant to part-fund a new project aimed at improving support services and programs available to family carers of people with age-related macular degeneration (AMD).

The project, led by Associate Professor Bamini Gopinath from Westmead Institute for Medical Research (WIMR), is a direct result of a large research project entitled ‘The Ripple Effect of Vision Loss’ conducted by Macular Disease Foundation Australia in 2013. That project, which involved people with AMD and their carers, revealed the significant and often unexpected impact on those who care for someone with AMD.

The research identified that while looking after someone with wet AMD, carers had felt frustrated (38%), sad (28%) down (25%) or depressed (7%), and for over half of those surveyed, it had a negative impact on their life — similar levels to that reported by people with wet AMD. The research also found that the majority of carers (55%) felt their role as carer impacted upon other people. Most commonly these were family members (48%), including their children (30%), partner (28%) or grandchildren (12%).

“The ripple effect of vision loss beyond the individual is extensive. The majority of the time, spouses are bearing the brunt, with the flow on effects impacting the carer’s family, the community and the healthcare system,” said Julie Heraghty, CEO of Macular Disease Foundation Australia.

“From assisting with everyday tasks like cooking, getting dressed and doing the finances, to attending regular doctor appointments, the heavy burden of wet AMD can rest squarely on the shoulders of the carer. “So many carers feel the constant worry about accidents and falls; the continuous need to stay positive; and the relentless amounts of patience, tolerance and understanding they need every day, as well as the sadness at seeing their partner lose their enjoyment in life — it is a side of caring that many just don’t see,” Ms Heraghty added.

Ms Heraghty said the ultimate aim of the new research project was to enhance the health and wellbeing of family carers of people with AMD by improving the design and delivery of existing support services and programs.

The project is being conducted in partnership by Macular Disease Foundation Australia, the WIMR and Carers NSW, and has attracted a National Health and Medical Research Council (NHMRC) partnership grant. It will be supported by direct funding of almost $440,000 from the Foundation, Carers NSW and NHMRC, along with a telephone support group, a cognitive behaviour therapy program, and information about other available carer resources and support.

“Macular Disease Foundation Australia is committed to supporting world leading Australian researchers in their work and has contributed over $2.8 million through the Research Grants Program since its inception in 2011,” said Ms Heraghty.

“We are very proud to be supporting this new research, led by A/Prof Bamini Gopinath, which we hope will improve quality of life for those who care for a person with AMD. As part of our contribution, the Foundation will also provide in-kind support by providing part of the coordinated multi-component intervention program designed to reduce caregiver burden and stress.”

A/Prof Gopinath said findings from the Foundation’s 2013 research into the ripple effect of vision loss “underscored the difficulty of coping with the challenges related to assisting persons with late AMD”.

Speaking of the new research project, she said, “This intervention has potential to be a valuable addition to existing caregiver services, by reducing the burden and distress among family carers of people with AMD, leading to improvements in their overall wellbeing”.

At the conclusion of the three-year project, researchers will evaluate the health and social outcomes, and the costs of running this intervention over a 12-month follow-up period.
The Melbourne Ophthalmic Alumni Meeting

The 25th Melbourne Ophthalmic Alumni meeting was held on Saturday 18 June at the Auditorium, St Vincent’s Hospital, Melbourne, while the Royal Victorian Eye and Ear Hospital undergoes redevelopment. The meeting showcased the strength of the local Neuro-Ophthalmology Unit of the Royal Victorian Eye and Ear Hospital, with four invited speakers. These included presentations from Dr Neil Shuey (head of unit) with an update on neuromyelitis optica and multiple sclerosis; Associate Professor Justin O’Day (past head of unit) on ocular perfusion disorders; Dr Oded Hauptman on OCT and the utility of ganglion cell layer maps; and Dr Brent Gaskin on sleep apnoea, non-arteritic ischaemic optic neuropathy and phosphodiesterase 5 inhibitors. The invited speakers gave stimulating and wide-ranging presentations that informed, entertained and captured the attention of the audience.

The meeting was filled with a range of free papers given by RANZCO Fellows, registrars and aspiring registrar trainees. These included presentations in neuro-ophthalmology and many other fields of ophthalmology from refraction, uveitis, the orbit, anterior segment, lens, glaucoma, retina, trauma and eye safety. The McBride White medal is awarded each year to the best presentation from a resident or registrar as judged by the organising committee. This year the winner was Dr Jack Kane for his fascinating and innovative presentation on intraocular lens measurements, entitled ‘A New Horizon? Comparison of novel methods for IOL power selection’.

The conference dinner was held at Taxi Riverside on Federation Square, overlooking the Yarra River, where the Guest of Honour, Dr Joseph Reich, was recognised for his many years of service to The Royal Victorian Eye and Ear Hospital. The tradition of celebrating the registrar groups that began at the Royal Victorian Eye and Ear Hospital 20 years prior was continued, with a presentation by Dr Lance Liu.

Overall, the meeting was felt to be one of the highest quality and well attended meetings in recent years.

Dr Thomas Hardy
Alumni Secretary

Sydney Eye Hospital Alumni Association Biennial Meeting

The eleventh Biennial Sydney Eye Hospital Alumni Association Meeting was held at the Sofitel Wentworth Hotel on Saturday 30 July.

The meeting again proved to be a great success, with a record registration, thanks to the continued strong support of both sponsors and delegates. There was a packed and wide ranging scientific program, which included original research papers and posters, the ‘best of’ Sydney Eye Hospital grand rounds and sub-specialty focused cases and controversies panel discussions. The meeting panels were on uveitis, glaucoma, neuro-ophthalmology and medical retina, all of which generated lively debate amongst the experts. The research undertaken at the Sydney Eye Hospital continues to be one of its greatest strengths, a taste of which was given in the research of the Save Sight Institute session. The highlight of the meeting was the Donaldson lecture given by Professor Justine Smith. Justine currently holds the position of Research Strategic Professor at Flinders University, and has had extensive experience internationally in the world of ophthalmology and research, including having served as president of The Association of Research in Vision and Ophthalmology. Justine’s talk on her ground-breaking work in infective uveitis and toxoplasmosis was both thought-provoking and inspirational. The meeting concluded with a cocktail reception and a further chance to enjoy the company of colleagues. We all look forward to the next meeting in two years’ time as well as the opportunity to again celebrate and share in the great work that is being done by the alumni of Sydney Eye Hospital.

Dr Michael Jones
Head of Strabismus Unit, Sydney Eye Hospital
Throughout my registrar training I have always been keenly aware just how important it can be to one’s future career, as well as personal experience and growth, to choose the right fellowship. I chose the oculoplastics fellowship with Mr Simon Madge in Hereford, UK over better-known posts because it suited my style of learning and offered a wonderful mentor and a great working environment. Although Simon is one of the most humble surgeons I have ever had the privilege to work with, it was clear from my first meeting with him that he has a wealth of oculoplastics knowledge and experience and, most importantly, that he is a very enthusiastic and approachable mentor who is keen on sharing his knowledge.

Arriving in England in winter to an unfurnished house with a toddler and a five-year-old had its challenges, but we quickly settled in. My husband had put his career on hold to look after the family during the fellowship and his support has been invaluable. The ophthalmology department at Hereford County Hospital, The Victoria Eye Unit, had a well-established oculoplastics clinic where I saw a wide spectrum of conditions affecting the eyelid and the lacrimal system as well as some orbital cases. I had three to four theatre sessions per week, including one unsupervised operating list, plus one procedure room session a fortnight. As I was the only oculoplastics fellow in the department, my surgical training was very hands on right from the very first session. One of many things I found particularly useful in this fellowship was the discussions on various ways of tackling a particular surgical scenario. While some surgeons tend to stick to their favourite surgical approach, Simon has always taken the time to discuss advantages and disadvantages of all possible surgical techniques and he made sure that I become familiar with most of them.

I was also closely involved in registrar teaching and supervision and was part of a refreshingly enjoyable journal club. I am grateful to Simon for regularly inviting me to attend his operating lists in his private rooms, which enabled me to extend my experience of oculoplastics beyond the treatments usually offered in a public hospital. I was fortunate to attend many meetings and conferences during that year.

Once a week I enjoyed a very picturesque drive into Brecon, a characterful market town in Wales where my clinic rooms overlooked the majestic Brecon Beacons. Having a nurse sit in with me during those clinics and pass me anything I might need, from lacrimal cannulae, to surgical booking forms (and a steady supply of cups of tea!) was an interesting experience.

Simon was a fantastic mentor and he became a great friend. He and his wife often invited us to their home for a meal and our children, who are of similar age, became good friends. My fellowship in Hereford was a wonderful experience that I will always treasure. (Continued on next page.)
Medical Retina fellowship in Exeter

Having long ago decided to subspecialise in both oculoplastics and medical retina, my next fellowship took me to the West of England Eye Unit (WEEU) in the Royal Devon and Exeter Hospital to join their retinal team. Once again, I found myself in a very busy unit working in a great team. I will always feel grateful to Mr Anthony Quinn who sponsored me for this fellowship. He was also always willing to lend a friendly ear and always found the time to listen to and offer advice to all the fellows in the department.

I had the privilege of working with a wonderful retinal team, who possessed a wealth of knowledge and experience in medical retina as well as other areas of ophthalmology. Mr Peter Simcock, who was my official fellowship mentor, is renowned for his teaching ability and innovative mind, having pioneered several surgical approaches in cataract surgery and vitreoretinal surgery, which are now widely used in the UK. His patient-centred approach to vitreoretinal surgery is highly regarded both by his patients and his colleagues. Although his clinics were extremely busy and often carried on long after other clinics had finished, he always found the time to see a patient personally if asked for advice by a registrar. Peter’s calm, approachable and friendly demeanour made him a wonderful mentor and it was a pleasure as well as a privilege to work with him.

Miss Hirut Von Lany is a very inspirational ophthalmologist, with a wealth of knowledge not only in the area of medical retina but also in eye trauma and uveitis. She has a very clear and logical approach to clinical problems and her practical advice in difficult clinical scenarios has been much appreciated during my fellowship. I am also very grateful to Hirut for making me and my family feel welcome in Exeter. On our first weekend in Exeter, Hirut took us to the Killerton Estate, a beautiful historical house and gardens that became one of my family’s favourite destinations.

Mr Roland Ling’s vitreoretinal clinics were very helpful in consolidating my knowledge of medical and surgical retina overlap and this has enabled me to make confident decisions as to which patients would benefit from surgical intervention and which would be best managed conservatively. Experience gained in his clinics has served me well since the completion of the fellowship.

My typical week in the WEEU would start with a Fluorescein meeting attended by all retinal consultants, registrars and fellows. It was a wonderful learning opportunity to see a huge range of pathologies and hear expert opinions on management options. Each week I had one surgical retina clinic, one to two diabetic retinopathy clinics and two clinics with a mix of age-related macular degeneration and other retinal pathologies including uveitis. There was one laser clinic per week as well as exposure to an electro-diagnostic clinic. I was also very fortunate to have had the opportunity to not only maintain my cataract surgical skills but to also learn new techniques and ways to tackle tricky cases. The week would finish with a teaching session on Friday afternoons. The on-call roster was shared between eight fellows and registrars which was another advantage of this fellowship as it kept my general ophthalmology knowledge and skills fresh while not interfering with my medical retina experience.

My fellowship in Exeter has been a wonderful experience and I gained not only extensive knowledge of medical retina, but also wonderful friendships and memories that will stay with me forever.

I am very grateful to all my mentors and colleagues for making both my fellowships such wonderful experiences. I am also grateful to RANZCO and Abbot Medical Optics for awarding me their scholarship.

Dr Andrea Zarkovic
RANZCO Office

New RANZCO staff members

RANZCO welcomes new staff members Emma Carr, Simon Janda, Eli Deldar, Lenn Fay and Helen Hunter.

Emma Carr
General Manager, Communications

I recently joined RANZCO as General Manager of Communications, where I have responsibility for the strategic direction and implementation of the different communications, media and social media activities that RANZCO undertakes. My team works to promote RANZCO and the work of ophthalmologists across a wide range of audiences, including the media, the public, government and the wider healthcare sector. The communications team also seeks to advocate on behalf of the ophthalmology profession and represent the best interests of patients who rely on ophthalmologists for their eye health.

Before joining RANZCO, I was Group Account Director at Res Publica, a Sydney-based PR consultancy, where I led the corporate communications division representing a wide range of clients.

Simon Janda
Post-Vocational Education and Standard Coordinator

In my role as Post-Vocational Education and Standard Coordinator, I am responsible for the coordination of RANZCO’s CPD program. I work with the CPD Committee to ensure that Fellows are compliant with their CPD. I also work with the Professional Standards Committee to assist with the Practice Accreditation Program.

I come from a background in medical colleges, having spent the last two years managing the Oral and Maxillofacial Surgery Training Program for the Royal Australasian College of Dental Surgeons and, prior to that, coordinating the Training Site Accreditation Program for the Royal Australasian College of Physicians.

When not at work I enjoy spending time with my wife and five beautiful children. I am also studying a Bachelor of Arts, majoring in History and English Literature.
Lenn Fay
Manager, Monitoring and Evaluation

Since taking up the role of Manager, Monitoring and Evaluation in June 2016 I have assumed responsibility for the development, implementation and management of RANZCO’s Monitoring and Evaluation Program. This program is designed to objectively monitor and gather information from all aspects of the Vocational Training Program (VTP) from Selection to Graduate Outcomes through a range of quality assurance and quality control activities. The aim of these activities is to obtain information regarding the efficiency and effectiveness of the VTP and to detect any irregularities between the actual and desired state of affairs.

I am also responsible for the management of our education and training policies and providing educational advice and guidance on current educational practices.

I have spent the past 15 years in a variety of learning and development management positions. Most recently I worked as a Training Systems Manager within the Royal Australian Navy where I held a number of key training management roles both ashore and at sea, these roles included various operational postings and exchanges with the US Navy.

I have completed a Bachelor and Master’s Degree in Adult Education and Training (UTS) as well as a Master of Business (UNSW). I am currently in the final stages of finishing a Master of Project Management (UNSW).

I am presently a Lieutenant Commander in the Naval Reserves and a NSW Justice of the Peace. My passions include surfing and traveling. I am in my element when I am lucky enough to have the opportunity to combine the two in my favourite destinations of Indonesia and/or Hawaii.

Eli Deldar
CRM Business Analyst

I work as CRM Business Analyst with RANZCO. In this role I am responsible for configuring and customising the application to meet the users’ requirements. I am also responsible for in-house development and maintenance of the system. Prior to starting my career in Australia, I spent 10 years working for a diverse range of IT organisations, including a core banking provider and an ISP in my homeland, Iran.

I have a Bachelor’s Degree in Software Engineering and have experience in computer network configuration and development, ITIL project and CRM systems.

I moved to Sydney with my husband 15 months ago. Although I miss my family and friends as well as my homeland, I am enjoying the relaxed atmosphere of Sydney and the quality of life that it offers. I am adjusting well to my new life in Australia.

I really enjoy road trips; they make the journey the adventure. Road trips were a big part of my childhood and some of my fondest memories. I also like photography and I’m happy to be living in a country with stunning landscapes and beautiful nature. I still attend a daily course to keep myself updated with latest technologies and innovations.

I’m happy to see many trainees and Fellows from my country as members of RANZCO.

Helen Hunter
New Zealand Branch Officer

I recently began work as RANZCO’s only Wellington-based employee in the revamped role of New Zealand Branch Officer, which is part of the RANZCO Policy and Programs Team. In the wake of the incumbent, Cameron McIver, retiring, the position has been expanded from one to three days per week. A physical office space has also been established in the Wellington CBD on Lambton Quay, hosted by the Royal Australian and New Zealand College of Radiologists.

My background has been as a Senior Policy Analyst who has spent twelve years working for the New Zealand Ministry of Health. I have worked on a variety of policy areas and have developed a
comprehensive understanding of the New Zealand health sector but my real passion is for public health and non-communicable disease issues, in particular. I have undertaken policy work on alcohol and illicit drug harm minimisation, problem gambling, mental health promotion and suicide prevention as well as working on improving service delivery for forensic mental health, oral health, maternity and child health.

I live with my partner, Lewis, and six-year-old son, Riley, at Pukerua Bay — a quiet coastal suburb half-an-hour north of Wellington. This new role marks my return to the workforce after two years spent as a stay-at-home parent and working on a Master of Arts in Creative Writing.

I am looking forward to learning about eye health, getting to know the local sector, and working to increase equitable access to services and to prevent blindness in New Zealand and across the Tasman.

RANZCO Communications

Over the past few months, the RANZCO Communications team has been laying the groundwork for a more proactive approach to how RANZCO engages with the public, the media, government, and other healthcare professionals. We are also looking at how we ensure that we are having dynamic, two-way conversations with all RANZCO members and RANZCO staff.

This is all part of delivering against our strategic objectives to lead the policy debate as the trusted, authoritative source of information and research on eye health and to promote ophthalmology as a medical specialty, body of knowledge and career.

To achieve this, we need to build recognition of RANZCO and ophthalmology among all relevant audiences — including the public, the media and government — and develop relationships with political and policy decision makers at all levels.

We also need to tell our story — the story of ophthalmologists and the patients who rely on them — to as many people as possible. This means using the media and social media. It also means identifying stories to tell. I have already been in touch with a number of our Fellows who have provided excellent media stories and case studies and we have put out media releases and social media stories on, among other topics, diabetes and the eyes, visual impairment in the Paralympics, protecting your eyes during sport, ocular cancer and prevention, and how an eye test can save your life.

My experience of speaking with Fellows about these and other topics has shown me that we have barely begun to scratch at the surface of the interesting, inspiring and thought provoking stories that ophthalmologists and their patients have.

So I am putting out a call for any ideas or stories that come to mind that might be of interest to the public or to your fellow ophthalmologists, in particular if you have a case study and a patient who might be willing or keen to work with us to tell their story.

With this information coming in throughout the year, we will never be at a loss for a story to tell about the difference that ophthalmologists make to people's lives and the importance of ensuring that people have access to the specialist care they need, no matter who they are or where they live.

Finally, we need to identify and prioritise the issues which are the most important so that we can focus our efforts on pushing for policy or legislative change that helps us achieve our goals of ensuring the best possible eye health outcomes for people in Australia, New Zealand and elsewhere. To a large extent this is covered in our new business strategy, which includes an awareness raising and advocacy focus on GP engagement, Indigenous eye health and workforce planning. But this is also something which all RANZCO Fellows, as the frontline in eye health care, can feed into on an ongoing basis. In the future I hope to speak to as many RANZCO Fellows, Groups and Branches as possible to ensure that we are accurately representing the interests of ophthalmologists and their patients and achieving the greatest impact on the eye health of people in Australia, New Zealand and further afield.

If you have any story ideas, potential case studies or other information for the Communications team, please email us at communications@ranzco.edu.

Emma Carr
General Manager, Communications
RANZCO

Call for Expression of Interest: Practice Managers’ Committee Chair and Deputy Chair

RANZCO seeks nominations for a new Chair and Deputy Chair for the Practice Managers’ Committee. The existing Chair, Lisa Hartley, intends to complete her two-year term at the end of this year. The Deputy Chair is a new role created to work closely with the Chair as well as support the Committee.

For full position descriptions go to www.ranzco.edu/classifieds
C: Keo Chiem
E: kchiem@ranzco.edu
P: +61 2 9690 1001

Applications should include a recent curriculum vitae and cover letter detailing relevant experience.
Applications close Friday 21 October 2016
Classifieds

Positions vacant

**Ophthalmologist wanted 2-4 days**  
**Country Wagga Wagga**

A thriving practice in Rural NSW is looking for a doctor willing to do between 2-4 days a fortnight.

You will enjoy
- an interesting and varied case-mix, reflecting the diverse population of Rural NSW;
- support from a fully trained administrative team; and
- a fully equipped practice with up to date Humphrey visual fields, IOL master, OCT, YAG/SLT/Retinal laser.

With a short 1 hour flight from Sydney or Melbourne this presents a wonderful opportunity to work in a large rural area and stay connected to the city.

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

**Ophthalmologist required**  
**Melbourne, Vic**

General ophthalmologist positions available at various locations in Melbourne.

Applicants must be AHPRA registered medical practitioners with Fellowship of The Royal Australian and New Zealand College of Ophthalmologists.

To apply please submit your CV/resume to Mohammed Kibria  
E: mokibria@gmail.com

**Ophthalmologist Parramatta**

Hunter Street Eye Specialists are seeking a long term Associate in glaucoma and general ophthalmology.

Modern and fully equipped rooms in Parramatta CBD.

C: Michelle  
P: +61 2 9635 0663

**Unaccredited ophthalmology registrar 2017 - Sydney**

Well-supported, active training role for 12 months in general ophthalmology with an emphasis on the management of medical and surgical retina.

The clinical component involves hands-on outpatient management including emergency care in a clinical and surgical setting.

Surgical experience with assisting in cataract/vitreoretinal surgery.

Participation in all stages of surgery and emergency on-call roster enhances the ophthalmic experience.

Research includes participation and analysis of clinical trials; clinical research and publication at scientific conferences. Research leading to the award of a postgraduate degree may be considered.

The location is based at Sydney Retina Clinic incorporating an accredited Day Surgery in Macquarie Street, Sydney.

Candidates must be registered with AHPRA. Ophthalmology experience is not essential. The position will commence 2017.

C: Fiona Thomson  
P: +61 2 9221 3755  
E: fthomson@sydneyretina.com.au

**Associate Ophthalmologist**  
**Western Sydney**

Work in an established practice, in a brand new, architect designed state of the art facility with all the latest equipment, and access to surgical caseload.

We are a patient focused practice, with a multidisciplinary team, including orthoptic and nursing staff.

We are seeking an ophthalmologist (prefer generalist with subspecialty interest in either glaucoma, vitreoretinal or medical retina) to join our practice.

The successful candidate must possess collegial integrity and be patient focused.

C: Marcelle Gibson  
E: marcelleg@nepeaneye.com.au

Practice for sale

**General ophthalmology practice for sale Noosaville**

This stand alone solo practice is now for sale due to the impending retirement of the principal. Essentially an unopposed practice with a high referral rate of cataract, glaucoma, AMD, etc.

Fully equipped with up to date Humphrey visual fields, IOL master, OCT/fundus camera, YAG/SLT/Retinal laser and small operating theatre. Situated less than 2 hours from Brisbane, this presents a wonderful opportunity to live and work in a popular coastal resort area in Queensland.

C: Jenny  
P: +61 7 419 535 506

**Equipment for sale**

Equipment available for inspection at 2/75 Grafton Street, Bondi Junction:

- Nidek Ophthalmoscope F-10 (Fluorescein Angiography + floater Camera)
- Zeiss Visucam Pro NM (retinal camera)
- Zeiss Humphrey Matrix (visual fields)
- Zeiss OPMO 6-CFC XY (theatre microscope)
- Bausch & Lomb Manual Keratometer
- Topcon OM-4 Manual Keratometer.

C: Michael Nguyen  
P: +612 9386 3666  
E: Michael.nguyen@vgaustralia.com