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Front cover: Dr Vivek Pandya performing surgery during his vitreoretinal surgery fellowship at the University of British Columbia, see story on page 19

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Our RANZCO forefathers chose a board, with Chief Executive Officer, as the governance structure best able to achieve RANZCO’s goals.

In the coming year these goals include significant items of Australian Medical Council (AMC) review and the Medicare Benefit Schedule review.

RANZCO is a not-for-profit membership-based body that is run by a Board of Directors, with the RANZCO President functioning as chair of the Board. The Board has responsibilities to Fellows who are ‘owners’ of RANZCO and, in turn, Fellows have responsibilities when they are working with RANZCO staff and Board.

Fellows become members of the Board in elections, voted for by the RANZCO Council. The Council comprises over 45 Fellows who represent different geographical areas, special interests and affiliated bodies such as ORIA and ASO. Councillors are nominated by the body which they are representing. Any Fellow may nominate as a Board member. Typically, nominees are already councillors and, in this position, have developed governance skills. Similarly, any Fellow may nominate as President, but typically they are already a Board member who has developed expertise in governance prior to taking on the role.

The RANZCO Board is ‘skills-based’. In contrast to the Council, Board members are not elected to represent any state or special interest group, instead they act in the best interests of Fellows as a whole. The RANZCO Board comprises only ophthalmologists. This was vigorously debated by the Council when we developed our new constitution with the decision eventually made to have only ophthalmologists but to bring in experts in fields such as legal or marketing when we need a particular expertise. The RANZCO Board also does not have community representatives or trainees. Any change to the constitution of the Board to enable this would require revision of our constitution; not an easy task.

The determination of RANZCO’s mission and values lies not just with the Board, however. All Fellows, our patients and diverse stakeholders such as the AMC have an influence on our purpose. The Board’s job is to ensure mission and values are clearly articulated and to function as stewards for Fellows.

The main role of the Board is to appoint the CEO. An excellent CEO, such as our current CEO Dr David Andrews, can run RANZCO well, even with a (theoretically) average Board. On the other hand, selection of a poor CEO by the Board would mean RANZCO could not perform well. The best possible CEO, properly supported, mentored and appraised, is pivotal to our ongoing success.

The Board takes overall responsibility for the success of RANZCO. Internal and external threats and opportunities, short-term and long-term priorities are all determined. Board members accept legal liability on behalf of the College, and for this reason have Directors’ and Officers’ Insurance.

The RANZCO Board is continually refreshed as members have three year terms, to a maximum of nine years before stepping down for a minimum of one year. Another responsibility of the Board is succession planning, done by the Nomination Committee, to ensure that we have the highest calibre of Fellows putting themselves forward to contribute. The Board also regularly reviews its own performance.

The roles of the President include sounding board, mentor and performance monitor for the CEO; external figurehead for RANZCO; leadership of the Board team; facilitator of Board meetings and stewardship of RANZCO’s standards of governance. The President functions as ‘first among equals’ with the Board. It is in this role that I try to attend as many branch and special interest group annual meetings as possible.

Fellows have a number of roles and responsibilities working in this governance structure. Fellows nominate councillors and assist in setting the mission and values of RANZCO. Many Fellows volunteer their time for the benefit of RANZCO. This is why it is important to communicate via the CEO and copy the CEO into important correspondence and submissions. When working with RANZCO staff it is important to recognise they report to our CEO and work under his (and not our) direction.

Every year the Board faces new challenges, many of which are “unknown unknowns”. Fellows are vital in our Board governance structure. The President is the steward for Fellows. It is important for the President to be in touch with Fellows and not function as a remote figurehead – so please do keep in touch with me through my email address president@ranzco.edu

A/Prof Heather Mack
President, RANZCO
Please send the patient file

By Rocky Ruperto, Legal and Policy Officer, Avant

Ophthalmologists often ask Avant’s Medico-legal Advisory Service how they should respond to a request from a third party for a patient’s medical records.

In most cases, you require the patient’s consent to share their medical records with other people or organisations, including their lawyers, employers or insurance companies.

Ideally consent will be in the form of a current written “authority”, which includes the patient’s name and signature and the date it was signed. As a guide we recommend you query any authority more than 12 months old. You can either ask the patient for an updated authority or ask them to confirm (and document in their record), that they are happy for you to provide the records.

Legislation in NSW, Victoria and the ACT specifically requires certain requests for records to be in writing. In other states you can accept a verbal request for records, however it is always preferable to obtain a written request.

Should I send the whole record?

Workers compensation and other insurance company authorities may request a patient’s entire medical record, while in other situations the request will be for specific information.

You should carefully consider what medical information is being requested so that you do not inadvertently breach privacy by providing more information than is asked for.

The patient can authorise you to share the whole record with another party. But if the authority is unclear or unreasonably requests everything you have, or you are concerned some of the information in the record is particularly sensitive, we recommend you clarify this with the patient.

Some medical records contain information about other people such as family members. If you are concerned providing the records will unreasonably impact on another person’s privacy, you should let the patient know. It may be appropriate to redact information about others that is not relevant to the request.

What about the records of deceased patients?

After a patient dies you are still obliged to uphold their privacy. After death, the executor or administrator of the patient’s estate stands in the shoes of the deceased patient and is entitled to access the patient’s records. They can legally consent to releasing the patient’s records to a third party.

Before providing records with the consent/authority of the executor or administrator, we recommend you:

1. Check they are the executor or administrator either named in your patient’s Will or, if there is no Will, the “letters of administration” from the court.
2. Check their identification – for example with a driver licence or passport.
3. Ensure the names on those two documents match.

If you have any concerns about either the identification or the authority of the person requesting the records, you may need to seek legal advice.

We recommend that, where possible, you take a copy of all the documents you receive and view throughout this process. Add them to the patient’s record with details about the request. This will help show that you acted appropriately if there is a dispute or complaint in the future.

Requests from family members

You may also be asked by a family member of a deceased patient for the patient’s medical records. If the relative is not the executor, they do not have an automatic right to the records.

However, there are some circumstances that may allow for limited information to be shared with the family. The legal position varies between Australian states, so this is another area where you may need legal advice.

What if I receive a court order for records? Do I still need patient consent?

You do not need consent of a patient or their legal representative to provide records in response to a court order. However, in limited circumstances, a court order can be set aside.

The issue of third party access to records can be complex and often depends on the individual circumstances of a case. If you have any doubt about whether to provide records to a third party, contact your MDO or other legal adviser for advice.

For more information:

On the release of medical records to a third party, see Avant’s FAQ on Privacy Breaches: https://avant.org.au/Resources/Public/20180313-AAPM-FAQ-on-privacy-breaches/ and article https://www.avant.org.au/Resources/Public/providing-medical-records-to-a-third-party/

On providing medical records to a third party, listen to Avant’s podcast: https://www.avant.org.au/Resources/Public/Podcast--Providing-medical-records-to-a-third-party/

On deceased patients’ medical records listen to Avant’s Podcast: https://www.avant.org.au/Resources/Public/Podcast--Deceased-patients-medical-records/
Censor-in-Chief’s Update

Strengthening our education focus for 2019

It’s always a pleasure at this time of year to welcome our new trainees into RANZCO’s Vocational Training Program (VTP). It’s a daunting time starting as a trainee and I want to thank all those trainers who are supporting them as they settle into their new roles.

I am also pleased to welcome our new Head of Education, Victoria Baker-Smith, who will oversee the day-to-day activities of education, including training and CPD. She will also help ensure we remain on track with our strategic priorities for education and that we continue to meet the Australian Medical Council (AMC) accreditation requirements. To find out more about Victoria, please see her staff profile on page 58.

2019 will be another critical year for RANZCO as we continue our education renewal program to ensure our VTP remains relevant and focussed on the needs of not just today but also the future. This year, the Curriculum Development Project’s emphasis will be on curriculum content with the aim of encouraging practice based learning and assessment and better aligning our VTP with post-graduate practice requirements. Through an intensive review process, working groups will ensure that existing and newly developed curriculum documents are up to date, follow best practice, are evidence based and are comprehensive enough to train truly generalist ophthalmologists. If you would like to be involved in the Curriculum Development Project, keep an eye on the Expressions of Interest section in E-News where opportunities to participate will be advertised.

Recently, RANZCO asked VTP supervisors and clinical tutors to complete a survey to provide feedback on their experiences in these roles. The supervisor response rate was close to 100%, which is astounding and is indicative of the dedication and enthusiasm of our volunteer workforce. I thank you all for your commitment. Your feedback will allow the College education team to strengthen the training program and enhance the support it provides to supervisors and tutors.

RANZCO will be submitting a final report to the AMC within the next few months in preparation for its visit in October. It’s been a very demanding process over the last two and a half years as we have sought to meet all the expectations laid down by the AMC but it has also been a wonderful opportunity to drive some very important improvements to our governance and to our training program. We feel confident that we are on track to meet the AMC’s approval and achieve re-accreditation. During the year the AMC will be approaching Fellows and trainees for feedback on the program and I encourage you to get involved.

Finally, in celebration of RANZCO’s 50th year as a College I have written an article reflecting on how the role of Censor-in-Chief seems to have evolved over the years. This can be found on pages 12 to 13.

Dr Justin Mora
Censor-in-Chief

Neuro-Ophthalmology Society of Australia (NOSA) 35th Clinical & Scientific Meeting and NeuroVision Training Weekend

The 35th Neuro-Ophthalmology Society of Australia (NOSA) Meeting: 6-7 September 2019
NeuroVision Training Weekend: 8-9 September 2019
Venue: Marriott Hotel Brisbane, Australia

Guest Speakers are:
- Dr Steven Galetta
  New York, USA
- A/Prof Aki Kawasaki
  Lausanne, Switzerland.

For further information contact Kathleen Poon
E: kathpoon@bigpond.com

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An elegant solution for the correction of presbyopia
In 2019 we celebrate the 50th anniversary of the establishment of RANZCO as an independent college, although at the time the New Zealanders and Australians were not part of one college.

This is not to say that ophthalmology as an independent medical craft group suddenly appeared 50 years ago. In both countries there were already long standing societies of ophthalmologists which had oversight of the education and standards within ophthalmology. Over the course of 2019 we will be celebrating RANZCO’s 50th year in many ways, and this will include a book and other articles about the history of RANZCO, including articles in this issue of Eye2Eye on how the roles of the RANZCO President and the Censor-in-Chief have changed over the years (featured on pages 10 to 13).

I’m sure much in ophthalmology has changed in 50 years. There is no doubt the technological and pharmaceutical options for patient treatment have expanded considerably. This has meant the skills of ophthalmologists have also expanded and we now see quite distinct areas of subspecialty within ophthalmology. However, one of the important principles of the RANZCO training program is that we continue to produce comprehensive ophthalmologists, and when assessing Specialist International Medical Graduates (SIMGs), we take the same position. A thorough understanding of all areas of ophthalmology only enhances subspecialties. Our current curriculum review will ensure this continues.

As part of my role I attend many meetings, not all ophthalmology specific. Future thinking is currently a hot topic at most meetings. It is a very bold or foolish person who thinks they can predict the future with any certainty, especially as we live in an era of such rapid change and disruption. Trying to resist change is also foolish. A popular quote from the ancient Chinese philosopher Lao Tzu is “Resisting change is like trying to hold your breath. Even if you are successful it won’t end well.” This is certainly the case for the practice of any area of medicine, not just ophthalmology, but with ophthalmology now being so heavily entwined with technology, changes are almost certain to be more rapid and less obvious than many imagine.

Another well used quote is from Jack Welch, the former CEO and Chairman of GE when it was at its peak. He said “The moment the rate of change outside an organisation exceeds the rate of change within, the end is nigh.” It is my job, and that of the RANZCO Board and Council, to ensure RANZCO is still around in another 50 years and beyond. To do this will mean we need to change not only the organisation of RANZCO, but what an ophthalmologist of the future might be. I’m not bold enough to say what this might look like, but what I can say with certainty is that if we resist changes others will find a way to do much more in the education of eye care providers and the treatment of patients. To remain the leaders in eye care we must lead. I can also say with certainty that technology will play a huge part in the teaching and practice of ophthalmology and eye care in general. With this come issues around ethics, models of patient management, standards of care, what needs to be taught and how. RANZCO’s Future of Ophthalmology Taskforce is already considering many of these questions and we are in the final stages of a major IT overhaul in anticipation of what we need to provide to our members. I think whatever comes, the future will be an exciting place for those providing eye care to the public, and for RANZCO in leading changes.

Dr David Andrews
CEO, RANZCO
This year we are celebrating RANZCO’s golden jubilee year – 50 years since the College was set up as an independent medical college, the Australian College of Ophthalmologists. Over the past 50 years a great deal has changed for the College, for ophthalmology more generally, and indeed for the role of the President and other office holders. But, also, a lot remains the same.

The practice of ophthalmology has been transformed. We now have operating microscopes, intraocular lenses, vitrectomy surgery, multiple therapeutic lasers, OCT scanning and anti-vascular endothelial growth factor antibodies and other drugs for local therapy of vitreoretinal disorders. We understand the genetic basis of ophthalmic disorders including retinoblastoma and retinal degenerations. The vast majority of ophthalmic procedures are performed in our rooms or as day case surgery. Outcomes have been transformed, so much so that blindness registrations are falling and diabetic eye disease is no longer the leading cause of blindness in working age Australians and New Zealanders.

Despite all these advances, the core of what we do as ophthalmologists – treating patients and striving for the best outcomes for them – remains the same. Ophthalmology is still about people; that hasn’t changed. It’s about the people we serve, and the aim to continually improve their eye health. It’s about the people who become ophthalmologists and the people who train them. And it’s about the people who strive for ever greater innovation and research to help us improve the eye health service we provide.

Fifty years ago, the College was established as an educational body to coordinate the national training of ophthalmologists in Australia, and this remains our primary endeavour, although our scope is now extended to include practicing ophthalmologists undertaking continuing professional development activities and the public, and our associated membership includes orthoptists, nurses and practices managers. Our reach has also expanded after we amalgamated with the Ophthalmic Society of New Zealand, and with our international development work covering much of the Asia Pacific region.

Despite these expansions, our overall aim is still the same: to produce the best possible ophthalmologists and ensure the best possible eye care for the people who rely on them.

Looking back on the amazing work of Dr James Foster, the very first President of the College and one of the driving forces behind its establishment, I wonder how much of my current role he would recognise and how much has changed.

The meticulous work by Dr Foster on our constitution served the College well for 47 years, with subsequent Presidents able to revise and update the content to suit the changing times. That first Constitution laid out a plan for the College, with the aim of being leaders not just at home, but more widely in our region. Dr Foster’s Constitution laid the groundwork for the College to, in the words of Sir Stewart Duke-Elder, and as commended by Dr Foster, “take the opportunity to be the intellectual and scientific leader of this quadrant of the globe”.

The Constitution was updated in 2015, as we had achieved many of the objectives stipulated in the old constitution such as establishing an academic journal, now known as Clinical and Experimental Ophthalmology. With his eye on the College as an “intellectual and scientific leader”, Dr Foster presciently encouraged the development of subspecialties with standing committees (now known as special interest groups) and we achieved their representation on Council in the recent Constitution update. Working with our Pacific neighbours
was another of Dr Foster’s goals and the College continues to facilitate this, again through having a representative of the International Ophthalmology Committee on our Council. He would surely have approved of the College’s tag line; ‘The Leaders in Collaborative Eye Care.’

Throughout 50 years of change for the College, the role of the President has changed surprisingly little. The President’s role is to lead an educational body, lead the College’s strategy and policies and be its outward face. All these remain the core responsibilities of the President, but in 2019 these are more complex. Running an educational body is highly regulated by the Australian Medical Council, the Medical Board of Australia and the New Zealand Medical Council. The President in effect chairs a small ophthalmology-focused medical university. The President leads strategy and policies, but we have now adopted modern governance standards with the President and a Board informed by the Council, and directing the actions of a Chief Executive Officer, currently Dr David Andrews. Being the outward face of the College has also transformed. We live in a 24-hour news cycle and social media is pervasive. The College needs a website, and the President needs media training and a Twitter handle (#PresidentRANZCO).

Providing a balance to the complexity of what the College does now are the resources at our disposal. The College is fortunate these days to have a body of staff dedicated to everything from education, administration and finance to policy, advocacy and communications. Such resources would, I am sure, have been greatly appreciated by Dr Foster in his time.

Of course, in forming the College, and as its first President, Dr Foster had numerous challenges that I will not have to face, at least not to the same degree. Bringing people together for a new endeavour of this scale, moving away from the tradition and comfort of what they have known, is a difficult task. As is ensuring that they are represented, and that they feel represented, and that, through this, they feel engaged with the organisation. I imagine that keeping the momentum of the formation of the College going was a major challenge for Dr Foster.

Today, we have a much larger and more diverse membership, but I believe we are all united solidly behind the role of the College in maintaining and driving standards in ophthalmology. RANZCO Fellows are today a highly engaged group. Without the dedication of our members as office holders, educators and spokespeople we couldn’t achieve anything like as much as we do. Reflecting on the formation of the College and the role of Dr Foster in that process, it strikes me that the dedication of our members has always been the driving force of the College, since before it even was a College. While much has changed, and will continue to do so, that remains the same.

Thinking about the changes in ophthalmology over the past 50 years naturally makes us think about what will change in the next 50 years. It seems clear that the pace of change will only increase. Current research and emerging innovations, particularly in terms of technology, mean that 50 years from now we will again be reflecting on how completely ophthalmology has transformed and how much more we can do for our patients.

I have no doubt, however, that the President’s role will remain much as it is today, much as it was in Dr Foster’s day and I wish my successors well in leading our College through the exciting changes of the next 50 years.

A/Prof Heather Mack

“Thinking about the changes in ophthalmology over the past 50 years naturally makes us think about what will change in the next 50 years. It seems clear that the pace of change will only increase.”
When considering Dr Ken G. Howsam’s life and achievements, it is hardly surprising that the RANZCO medal that bears his name is dedicated to excellence and educational achievement. The K. G. Howsam Medal for Excellence is awarded most years, but not every year, and only to trainees whose performance in their final exams is truly exemplary.

Dr Howsam, or KG, as he was widely known, was our College’s first Censor-in-Chief, and his incumbency was dedicated to achieving excellence in ophthalmology and ophthalmology training. Dr Howsam was one of the driving forces behind the formation of the College 50 years ago and, given his dedication to education, was a natural fit as the first Chair of the Qualification and Education Committee (QEC) and Censor-in-Chief.

Fifty years later it is now my honour to serve in the position that he once held. The role of Censor-in-Chief has changed in many ways, but at its core it remains much the same. Now, as then, the Censor-in-Chief is responsible for the College’s educational offering, overseeing the selection of trainees, the curriculum, training post-accreditation and examinations.

As the first Censor-in-Chief, Dr Howsam had the mammoth task of creating, pretty much from scratch, the educational system upon which ours today is built. To do this he had to bring together the various qualification and educational courses across the country into a single, unified, Australia-wide training program.

50 years of evolution and continued striving for excellence has shaped that first educational program into the vocational training program we have today. Much has remained the same, for example, the training post inspectorate system that Dr Howsam set up still serves us well and remains critical to the training program.

But, of course, a lot has changed. That is as it should be. Education must progress; it must adapt to the changing times and keep up with innovations and technologies. What an ophthalmologist needs to know today is different to what an ophthalmologist needed to know in 1969, not least of all because much of the technology we use today was unheard of 50 years ago.

The role of the Censor-in-Chief

First President of the Ophthalmological Society of New Zealand (OSNZ)
Dr William A. Fairclough (1881 – 1968) trained in ophthalmology in England after graduating from Otago Medical School. He returned to Auckland in 1910 and was eventually head of the ophthalmology department at Auckland Hospital. He became the OSNZ’s first President in 1947.

First female president of the Ophthalmological Society of New Zealand (OSNZ)
Dr Dorothy Potter (1922-2009) trained in medicine at Otago Medical School and qualified in ophthalmology in England, working at The Royal Westminster and Central Eye Hospitals in London. Dr Potter became President of the OSNZ in 1984.

First president of the joint New Zealand and Australian college
Dr Brian Lockhart Gibson was the first President of the joint Australian and New Zealand college when RACO and OSNZ combined activities in 1996. The joint College was given the temporary name of The Royal Australian College of Ophthalmometry (RACO) incorporating the Ophthalmological Society of New Zealand until a permanent name was adopted.

The first President of The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
In 2000, the College officially become the Royal Australia and New Zealand College of Ophthalmologists. Dr Michael Steiner was President at the time of the name change, making him the first official President of RANZCO.
The role of the Censor-in-Chief has changed in some ways as well. Not only has the training program expanded, both in scope and number of trainees, but with the expansion of the College, the Censor-in-Chief is now responsible for training across both Australia and New Zealand.

With the broader scope comes more support. There is a larger RANZCO educational unit, including people with specialist education qualifications, and a Dean of Education who oversees the curriculum. With the support of the whole RANZCO team, we are able to achieve much more.

Our training program focuses not just on academic achievement, but increasingly on a whole person approach, with a greater emphasis on cultural safety, trainee wellbeing and flexibility of training. We also have a much greater awareness of process to ensure trainees are treated justly and that the College’s decisions can withstand any challenge.

The scrutiny that the College is under, particularly in terms of our training program and the policies and processes associated with it, is much greater today than it was 50 years ago. The regulations and requirements set by the AMC and the MCNZ, as well as the objectives we set ourselves, mean that our policies and processes require regular review and updating. This can create additional work for everyone, but it also helps us to ensure that our training remains relevant, that our trainees are well supported and that we continue to produce some of the best ophthalmologists in the world.

There is a recognition that ‘education’ must be viewed in a broader sense and the Censor-in-Chief therefore provides an education perspective on several College committees and working groups including the Board, Diversity, Workforce, Reconciliation Action Plan and International Development.

Of course, changes to the scope and complexity of the training program are not the only things that have impacted the role of Censor-in-Chief. With the advent of email, mobile phones and videoconferencing, there is a greater expectation for the Censor-in-Chief to be immediately accessible and for the turnaround time of any query to be very short. I leave it to you to decide whether this is more of a pro or a con.

The ease of travel nowadays has also changed the role. Australia is no longer a vast, untraversable land, and ‘the ditch’ is only three hours wide so it is now feasible for the Censor-in-Chief to personally attend each of the OBCK and RACE exams, as well as the various other QEC meetings that draw in representatives from all over Australia and New Zealand, and thus remain abreast of all that is going on.

So, 50 years has altered a lot of what we do and how we do it. But looking at what we have now, one thing is clear; it could not have happened without the foundation of excellence on which Dr KG Howsam grounded our College’s education system. So, I thank him for all that he did, as I thank all of the Censors-in-Chief who came before me for continuing that same drive for excellence. I look forward to all that the next 50 years of Censors-in-Chief will achieve and how our profession, and our education system, will continue to progress.

Dr Justin Mora

Dr Ken G. Howsam

Dr Justin Mora
Dr Cornelia Whitehouse (third from left) with colleagues during her medical internship.
## Celebrating 50 years

**– Interview with Dr Cornelia Whitehouse**

*In celebration of RANZCO’s 50th year, we sat down with one of the College’s longest practicing female Fellows, Dr Cornelia Whitehouse, to discuss her experiences as one of the first women in ophthalmology in Australia.*

**Q** Can you please tell us a little bit about your experiences at medical school and during Coopthology training?

**A** When I attended medical school, it was just after the war. We had a lot of ex-servicemen. Overall, we had 250 men in our first year (anybody could do medicine at that time but if they hadn’t done well in the Leaving Certificate, they had to pay) and we only had seven women. It was a very male oriented thing whereas it is very different now. Back then, it was very unusual for women to do medicine. All the women and about half of the men graduated.

In terms of patient care, there wasn’t really much we could treat patients with – for instance antihypertensives weren’t there and sulphonamides and penicillin were still very new. There was very little you could actually do to help patients.

The reason I got interested in ophthalmology was that it was the only term that you could live out. I got married in my fourth year so I still had two years to go. When I did my internship, I had to live at the hospital as an intern – when you had patients at the hospital you had to do a midnight round and a 9am round. I was working at Sydney Hospital and lived on the northern beaches and, of course, the roads weren’t anything like they are now so it was not practical to try to get home.

Actually, they didn’t even have accommodation for women at Sydney Hospital at the time so they put a female friend of mine (who was also at Sydney Hospital) and me out on the veranda, which was very nice except it was open to the view of the public on Elizabeth St. We had to go and get screens from the wards, which we put up so we could get a bit of privacy. The other thing that used to happen is the extremely long hours you’d be on call (and you’d be on call every third weekend) – you’d start your normal day at 9am on Friday and finish at 5pm and then you’d be on call all the way through to midnight on Monday so they could call you at any time. I remember getting out of bed to a call at 3am once and sitting on the side of the bed crying because I didn’t think I could do it. In those days I think they thought that the worse you were treated, the better the doctor you’d be. I’m glad that’s not the case now. Things seemed to have changed for the better.

**Q** What do you miss about your early days at the College?

**A** Well, getting into the College I didn’t know much about anything. I went to London to do my degree – I worked at Moorfields and I got my D.O. there and when I came back someone approached me and asked “do you want to join the College, we’re just forming?” I said yes. I didn’t know anything about it but it seemed like a good idea at the time and I’ve been happy to be a member ever since.

One of the things that stands out is that when the College formed everybody knew everybody else – that’s something I really miss! These days I don’t really know who anybody is.

**Q** Can you please tell us a little bit about your experiences at medical school and during Coopthology training?

**A** When I attended medical school, it was just after the war. We had a lot of ex-servicemen. Overall, we had 250 men in our first year (anybody could do medicine at that time but if they hadn’t done well in the Leaving Certificate, they had to pay) and we only had seven women. It was a very male oriented thing whereas it is very different now. Back then, it was very unusual for women to do medicine. All the women and about half of the men graduated.

In terms of patient care, there wasn’t really much we could treat patients with – for instance antihypertensives weren’t there and sulphonamides and penicillin were still very new. There was very little you could actually do to help patients.

The reason I got interested in ophthalmology was that it was the only term that you could live out. I got married in my fourth year so I still had two years to go. When I did my internship, I had to live at the hospital as an intern – when you had patients at the hospital you had to do a midnight round and a 9am round. I was working at Sydney Hospital and lived on the northern beaches and, of course, the roads weren’t anything like they are now so it was not practical to try to get home.

Actually, they didn’t even have accommodation for women at Sydney Hospital at the time so they put a female friend of mine (who was also at Sydney Hospital) and me out on the veranda, which was very nice except it was open to the view of the public on Elizabeth St. We had to go and get screens from the wards, which we put up so we could get a bit of privacy. The other thing that used to happen is the extremely long hours you’d be on call (and you’d be on call every third weekend) – you’d start your normal day at 9am on Friday and finish at 5pm and then you’d be on call all the way through to midnight on Monday so they could call you at any time. I remember getting out of bed to a call at 3am once and sitting on the side of the bed crying because I didn’t think I could do it. In those days I think they thought that the worse you were treated, the better the doctor you’d be. I’m glad that’s not the case now. Things seemed to have changed for the better.

**Q** What do you miss about your early days at the College?

**A** Well, getting into the College I didn’t know much about anything. I went to London to do my degree – I worked at Moorfields and I got my D.O. there and when I came back someone approached me and asked “do you want to join the College, we’re just forming?” I said yes. I didn’t know anything about it but it seemed like a good idea at the time and I’ve been happy to be a member ever since.

One of the things that stands out is that when the College formed everybody knew everybody else – that’s something I really miss! These days I don’t really know who anybody is.
to extracapsular. I can remember some American surgeons came out to demonstrate this new method. Back then, patients post-cataract would have eyes that were red and inflamed, uncomfortable and sore for weeks, but these [American] surgeons produced four patients on day one post-op and you couldn’t tell that anything had been done to the eyes. None of us believed them [the surgeons] at first and we had to have a really close look to find the evidence that the cataracts had actually been removed. This was a completely new technique where you didn’t traumatise the eyes. I remember that this was a very magical moment.

Another magical moment was the first time I used a microscope to operate because suddenly you could see bits of the eye that didn’t exist for you before except in textbooks. Microscopes have improved vastly during my career. The first one we had, you had to hand focus it and the light wasn’t coaxial so you couldn’t see nearly as well as now and we used to take an hour and a half just to do a cataract. And the incision was very big. It was 180-degree incision and then you had to sew it up with very fine sutures. So the microscopes got better and we got faster and then we were maybe doing cataracts in less than 35 minutes.

Another exciting development for me was when phacoemulsification was introduced. I remember going to New York and observing the first machine that did this process and it was the size of a huge wardrobe and had four technicians dancing all over it to keep the machine running while the surgeon operated. It took a while for surgeons to get the technique right because people had a lot of different techniques and we saw a lot of damage to patients’ eyes until the technique was worked out and standardised.

Now the phaco machine is a little box, the size of a small carry-on bag, and you can have all sorts of different settings that help you do the operation so that you can jackhammer harder or softer, which you couldn’t do before. You can suck harder or softer or increase pressures and use viscoelastics which didn’t exist back then, but now that’s all standard.

Q What’s your most striking memory as an ophthalmologist/Fellow?
A I think it was probably looking down a microscope for the very first time. It was like magic seeing all the bits of the eye that I had only ever read about.

Q What has being a RANZCO Fellow meant for you?
A Being a RANZCO Fellow is a bit like being part of a club – it’s nice to have other people you can ring up if you want to, get some help from or just talk to. I really like the social side of it and I enjoy attending the annual conference when I can.

Q Do you have any words of wisdom, particularly for young women starting out in the profession today? What do you know now that you wished you knew 50 years ago?
A No, I think the women nowadays are so sophisticated and so smart – they know what they’re doing, and they know what they want. They’re doing very well!

On a side note, people keep saying that women are discriminated against and that nobody wants them because they’re a woman but, personally, I’ve never felt or experienced that. I never had that feeling that, because I was a woman, I was a second-class citizen.

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**CEO Journal**

**Clinical and Experimental Ophthalmology 2019 Special Issue – Ocular Inflammation**

This month the RANZCO scientific journal, *Clinical and Experimental Ophthalmology* (*CEO*), publishes its annual special issue, this year focussing on the topic of ocular inflammation. The CEO special issue brings together a number of invited review articles from world experts based around a central theme. The articles in these issues are always well read and usually well cited.

The ocular inflammation special issue features eight comprehensive review articles on many aspects of ocular inflammation, including viral anterior uveitis, OCT and OCTA in uveitis, viral retinitis and the topical issue of emerging infectious uveitis. Further commentary on viral anterior uveitis and intestinal microbiota in ocular inflammatory diseases is provided in the excellent accompanying editorials. The issue will be essential reading for Fellows with an interest in uveitis, but will also be of interest to the general ophthalmologist.

The issue has been offered as free content to enable all readers, even non-subscribers, to read these major reviews. To access this issue, or any other *CEO* article from Issue 1 in 1973 to the current issue, simply log in to the members section of the RANZCO website and click the ‘Journals’ link.

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**“Being a RANZCO Fellow is a bit like being part of a club – it’s nice to have other people you can ring up if you want to, get some help from or just talk to.”**
The getting of ophthalmic wisdom
- Dr Robert Griffits

Interviews for the respective Sydney Eye Hospital (SEH) and Prince of Wales Hospital (POWH) networks involved a trip back from Adelaide.

The pilots of Australia were being distinctly unhelpful by going out on a prolonged strike. It also proved to be a bad move for the pilots, as the Australian government of the day sided with airline companies. One of those airlines was partially owned by a man of some influence, quite possibly related to his ownership of a number of printing presses and TV transmitters.

Anyway, the bus companies were doing a roaring trade, and they came to my rescue. Fortunately, due to a few genetic deficiencies and the fact that I used to throw my school lunches in the bin, I matured with reasonably short legs. These legs were conveniently well adapted to sitting in a bus seat for the 17-hour journey back across the ‘Great Australian Ophthalmic Desert’.

Perhaps due to their planning, or perhaps just due to plain luck, both the SEH and POWH interviews fell on the same day.

The interview at POWH with my new friends Fred and Gary went on for somewhere between 60-90 minutes. It started off structured, but then evolved to general discussion about all types of things, probably more predicated along the lines of chaos theory. Chaos was a clever stunt that subtly encouraged me to gradually let my guard down and relax into candid conversation.

The SEH interview was late in the day, and was running a little behind schedule – in fact it was getting dangerously close to the bus departure schedule. That one consisted of a large cast of interview panel members, who took up three edges of a large table, with me taking up a lonely figure on the fourth boundary. Questioning was formal, polite, and I think absolutely compliant to the NSW Public Hospital Interview Manual.

I thought that the interview style of Fred and Gary was much more effective in eliciting information. My thoughts are that a 10-15 minute interview is only useful in assessing a candidate’s dress sense. Whatever, I was very glad that they gave me a job. I hope that was on the basis of the reports from the two people I had worked for in Adelaide, and my boss of the previous eight years. Because the best predictor of future performance is a thorough review of past performance.

The SEH is a hospital of considerable prestige, even when assessed against the best in the world. It also provides a rich network of peripheral hospitals, both metropolitan and rural.

Surprisingly, early in the proceedings I met a newly minted Fellow of the College who gave some very blunt advice. Raised in the streets of Western Sydney, his manner and speech was a touch like a character from a Quentin Tarantino movie, and he was able to cut to the chase with streetwise candour and precision: “The best way to get through the training is to spend the least time possible at the Eye Hospital.” This was not meant to impugn the academic quality or teaching excellence of the institution, but more a notion that peripheral hospitals offered more hands on experience.

For there are many skilled ophthalmologists and teachers also located west of Missenden Road, Camperdown.

So began the next three year journey, one which would take in eight peripheral hospitals, three of which were rural.

The different hospitals offered different ranges of skill acquisition, and a variety of personalities and styles of the teaching ophthalmologists.

It was also fascinating how the style of ocular trauma varied. At the ‘Royal Hospital for Better Homes and Gardens’, a common cause of penetrating eye injury occurred when a good dowager spiked her eye on a cactus plant while gardening. Out in the ‘Wild West’, things were much more feral, with the trauma often inflicted by an alcohol fuelled broken glass or fist.
In amongst the seemingly quiet, quaint rural paddocks, lurked the roll of fencing wire which could spring up like a viper and non-surgically evicerate an unprotected globe.

By and large our teachers were very competent, thorough, and kind to both patients and we underlings. I found bullying behaviour to be rare, and confined to a couple who were that way by nature, and probably had been so since the schoolyard. At least they were generally consistent, so there was not too much need to take it seriously or personally. Group counselling with fellow registrars was usually very helpful in this regard.

Fellow registrars were generally great to work with, and free at dispensing knowledge and wisdom. Colleagues were an integral part of the teaching milieu. They were also a source of information that was not necessarily found in the textbook.

The A&E Department at the SEH was a wonderful confluence of registrar interaction. Con showed us the problem of self-inoculation if one did not clean the slit lamp or wash hands adequately after examining a patient with adenovirus conjunctivitis. Neale displayed the subtlety of terminating a long-winded patient history by gently guiding the said patient's head forward and firmly planting the patient's chin on the slit lamp rest. I marvelled in the smooth style that had a finesse akin to that of James Bond. And Deano showed us that conjunctival concretions do matter to patients and can be flicked out like a pea from a pod, providing a quick cure with an elegant simplicity.

At the beginning of the third year, the Part Two Examination loomed, and I was the first and only one of my seven-person cohort to sit the exam on that occasion. I had learnt a good deal from the Part One Examination in terms of exam preparation, an experience that still haunts me. The exam was clinical and therefore much more directly relevant, and there was a better sense of direction as a product of working within a well-constructed training program. It was a great relief to my family, that I managed to knock it over the first time around.

I signed up for all the three rural terms on offer. Competition for these posts was not exactly fierce, and most registrars had to be drafted into these secondments. But these terms offered excellent ophthalmic experience and a totally different structure to that found in the metropolitan hospitals.

The Albury experience occurred at the beginning of the second training year. It was lovely being able to walk to work. The practice set me up with my own consulting room within their practice rooms and I set to work. The doctors and staff were very inclusive, and I felt very much part of the team.

Those ophthalmologists taught me about medical philosophy and ethics as well as the medicine and surgery.

Surgery was plentiful, particularly by Dr Howson, who would invariably say “well you can open the batting”, and it worked out that I also fulfilled the middle order and tail ender responsibilities as well.

It was in Albury that Felicity experienced her first day at school. Lydia attended the public schools at which the son of one of the ophthalmologists was school captain. That is the thing about the bush: community.

The Lismore and Darwin terms were back to back in the third year, after the Part Two examination was tucked away.

The slickest pair of surgical hands that I had seen were found in Lismore. He could knock over an extracapsular cataract operation in quick time with great precision and result. I don't think that I have seen better since. That VMO had been geared towards a great career in Sydney, but had turned his back on the metropolis for a rural lifestyle.

The thrill of crawling my way back and forth daily through the Sydney traffic and the joy of sharing the air with four million other souls was not enough to bind me to Australia's largest metropolis, and after five years away I was more than ready to return home.

“The Darwin term I think was my favourite of the training program. It was just so different, and you do not even feel that you were living in a part of Australia.”
It was an immense privilege to be selected to undertake the UBC Vancouver vitreoretinal surgery fellowship from July 2016 to June 2017. International subspecialty fellowship training represents a wonderful opportunity to enhance clinical and surgical skills, as well as develop ideas and attitudes that form the basis of future consultant practice. Often, these fellowships are minimally remunerated, and this can form an economic barrier to seeking training. I was thus very grateful for the support I received via the RANZCO/Bayer Industry Scholarship and would thoroughly recommend an overseas fellowship experience to all Australian trainees.

The fellowship

I was certainly excited to leave an unusually crisp Sydney winter for the balmy summer on the west coast of Canada. Flying into Vancouver highlighted the beauty of the city with the large harbour contrasted to the majestic north shore mountains. What was not apparent at the time was the fact that for 10 months of the year, Vancouver tends to be cloudy, cool and rainy, with locals escaping to Hawaii or Mexico on a regular basis. However, such conditions seemed ideal for a busy surgical fellowship experience!

The fellowship program for vitreoretinal surgery was established by William “Billy Buckle” Ross in 1985 and quickly developed an international reputation for excellence in surgical training. The University of British Columbia arranges fellowship training in all ophthalmic subspecialties and cultivates an environment that maximises the clinical and surgical opportunities available to the various fellows. The health system in British Columbia (and in Canada generally) is almost entirely funded by the provincial government with very little medical care provision in the private sector. Therefore, the fellowship training program provided a wealth of experience in both elective and emergency cases, as all patients present via the public hospital system. The vitreoretinal unit at UBC is a tertiary referral centre for the entire province and serves a large population, including patients from the northern frontier of Yukon territory.

Two fellows are selected each year in vitreoretinal surgery, with a very busy on call roster of one in two. In a typical week, three to four full days were spent in the “OR” with seven to eight per list, followed by laser clinic and consultations on any emergency presentations. There was a strong emphasis on teaching and supporting the fellows, with consultant staff present for all clinics and theatre lists to maximise learning. I was able to gain extensive experience in the full spectrum of vitreoretinal surgery including macular surgery, retinal detachment repair, endophthalmitis, ocular trauma, diabetic eye disease and complications of cataract surgery. A distinctive feature of the training in Vancouver was the ongoing emphasis on scleral buckling techniques in specific retinal detachments, which is a skill that is now seldom taught in many other programs. In addition, I was able to perform novel surgery for secondary intraocular lens fixation.
and other techniques such as endoscopic vitrectomy as part of the fellowship.

The academic culture at the UBC Ophthalmology Department is strong, with research integrated closely with clinical services in the department. Due to the heavy clinical and surgical load, there was limited time to do research during the fellowship, though there was involvement in the latest clinical trials as a treating investigator. The fellows were also responsible for the organisation and teaching of the ophthalmology residents (registrars) in weekly Retina Rounds, further cultivating the rich training environment.

Life in Vancouver

The annual Global Liveability Report from the Economist magazine has consistently ranked Vancouver as one of the most liveable cities in the world, and it was not difficult to enjoy the time spent away from work. A culturally diverse city with a laidback feel, as well as an emphasis on green space, the city provides a fantastic lifestyle for its residents. One of the highlights for me was exploring the food scene, which was high quality and reflected the myriad of cultures found in the city. A particular passion in Vancouver is microbrewing, with specialty brewpubs often boasting dozens of unique beers on tap. As with most of Canada, ice hockey is an obsession and I was fortunate to attend several games at Rogers Arena to support the local Vancouver Canucks.

Interestingly, ice hockey also provided a steady stream of ocular trauma cases to the hospital, mostly from fights between players rather than pucks! In recent times, Hollywood has discovered Vancouver as an ideal (cheap) site to base film productions and it was not unusual to see crews and actors dotted around the city, including a chance encounter with several members of the cast of Game of Thrones.

However, the defining feature of most Vancouverites is their collective love of the outdoors. The north shore mountains and beyond have hundreds of hiking trails, with long mild summer days ideal for exploring – just be sure to avoid the bears! In the winter, snow sports understandably dominate and on most weekends off call, I would head to Whistler Blackcomb for arguably the best skiing in North America. The active lifestyle pursued by most people in British Columbia corresponds to a strong emphasis on health and wellbeing, and it is difficult to avoid becoming a devotee of yoga, barre or the latest version of pilates in the city!

Overall, I would highly recommend an international fellowship in Vancouver, and Canada in general. There are relatively few administrative barriers to pursuing a position and the training opportunities are excellent.

Dr Vivek Pandya
RANZCO/Bayer Industry Scholarship recipient
WHAT IS A BYSTANDER?
A bystander is a person who observes an event or incident but is not an active participant. The 2012 report by the Australian Human Rights Commission Encourage. Support. Act! Bystander Approaches to Sexual Harassment in the Workplace defines bystanders as “…individuals who observe an act of violence, discrimination, or other problematic behaviour, but who are not its direct perpetrator or victim. Rather, bystanders are onlookers, spectators or otherwise present in some sense. However, in some accounts of bystander intervention, the term 'bystander' expands to include those who directly perpetrate violence.”

One of the areas the RANZCO 2018 Bullying, Harassment and Discrimination Survey focussed on was the experience of bystanders; those first-hand witnesses to inappropriate behaviours. Of the 514 people who completed the survey, 19% (almost 100 people) witnessed a colleague experiencing discrimination, bullying, sexual harassment or harassment (DBSH) in the workplace over the past three years and around half attempted to intervene when witnessing these incidents.

The concept of bystanders stems from a study on an event that took place in New York in 1964 where a young woman, Kitty Genovese, was brutally raped and stabbed to death within the span of half an hour. During the attack, approximately 38 of Kitty’s neighbours either watched the attack from their windows or heard her pleas for help but were unwilling or unable to effectively intervene.

WHAT IS BYSTANDER INTERVENTION?
Bystander intervention is when those who witness a potentially harmful incident or situation take definitive action – either before, during or after the event (as outlined on page 22).
BEFORE
→ Role modelling the correct behaviour
→ Setting norms of appropriate behaviour
→ Quashing “innocent” jokes and poor behaviour

DURING
→ You can see harassment when it occurs – recognise the behaviour for what it is, name it, and do not ignore it. For a harassing boss or someone who holds power over your career or livelihood, where direct confrontation could be riskier, defusion, distraction, or interruption are still possible tools for bystanders in the moment.

AFTER
→ Consider having a conversation with the perpetrator after the fact, when tensions have cooled, laying out why the behaviour you witnessed was offensive. If this isn’t possible, seek out a supervisor or influencer, make a report, or help a target make a report.

→ You can also, with the permission of the person experiencing the harassment:
  - speak to your employer
  - speak to your human resources manager
  - speak to your colleagues.

→ You can support the person experiencing the harassment by:
  - listening to them
  - referring them to your organisation’s policies and procedures about bullying, harassment and discrimination
  - assisting them find information about how to make a complaint
  - encouraging them to report the problem
  - offering to accompany them when they report the problem.

The 2012 report by the Australian Human Rights Commission Encourage. Support. Act! Bystander Approaches to Sexual Harassment in the Workplace describes four categories of intervention behaviours:

- **SUPPORT**: The bystander supports the target when he/she reports the incident after the incident or confronts the perpetrator after the incident.

- **CEASE AND DESSIST**: The bystander directly intervenes by instructing the perpetrator to cease the offensive conduct during the event or publicly encourages the target to report the conduct.

- **PRIVATE**: The bystander intervenes privately but does not get personally involved.

- **REDIRECT**: The bystander redirects the perpetrator after the incident.
The cost of doing nothing

In each instance where a person might be a bystander, they alone make the choice of what to do. If they have power or authority, their actions in intervening are more likely to succeed. Similarly, doing nothing sends a very strong message that they are okay with what they’re witnessing. Moreover, the bystander contributes to shifting the blame from the perpetrator to the victim; the victim must now avoid the perpetrator, bend to their will and remain silent.

Fostering a safe and harmonious workplace

According to a 2018 Harvard Business Review article, bystander training is one way organisations can prevent harassment in the workplace – that is by fostering an environment where every staff member feels ‘safe’ to intervene in problematic scenarios: “Bystander training and interventions tap into the strategy that, when it comes to workplace culture, everyone is responsible for creating it, every day, in every interaction.” For this reason, if it is safe to do so – intervene.

Furthermore, the 2012 Australian Human Rights Commission report highlights that “A salient issue in terms of bystander decisions to assist targets in workplace sexual harassment is the nature of preventative and remedial organisational systems, that is, the extent to which the organisational environment supports advocacy for targets and the way the organisation responds once a complaint is made.” For this reason, RANZCO has a policy on Discrimination, Harassment and Bullying outlining the appropriate behaviour all Fellows must adhere to in the workplace as well as a Training Post Accreditation Policy, which stipulates that all accredited training sites must have policies on Bullying, Discrimination and Harassment and Complaints.

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**GET HELP & SUPPORT**

You can speak to qualified counsellors by contacting the RANZCO Employee Assistance Program – free for all members and their immediate families.

To make an appointment or to speak with a RANZCO Support Program Consultant call 1300 687 327 (AU) or 0800 666 367 (NZ).

**KEEP A LOOK OUT**

The next issue of Eye2Eye will look at practical tips on how to safely take action as a bystander. RANZCO will also add bystander training resources to Moodle in due course.

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**FROM THE RANZCO POLICY**

**DISCRIMINATION**

- Discrimination means treating someone less favourably than others on the basis of particular attributes (under the Australian Human Rights Commission Act 1986). Discrimination includes imposing an unreasonable requirement or policy that is the same for everyone but has an unfair effect on people with a particular attribute.

**HARASSMENT**

- Harassment means behaviour which is unwelcome and unsolicited and creates a hostile environment. Harassment is behaviour that intimidates, offends or humiliates a person on the basis of an attribute and can be a single act or a series of acts; it does not need to be repeated or continuous to constitute harassment.

**BULLYING**

- Sexual harassment is an unwelcome sexual advance, unwelcome request for sexual favours or other unwelcome conduct of a sexual nature which makes a person feel offended, humiliated or intimidated, where a reasonable person would anticipate that reaction in the circumstances.

- Bullying is repeated, unreasonable behaviour directed towards a person or group of persons which creates a Risk to Health and Safety. Unreasonable Behaviour means behaviour that a reasonable person, having regard to the circumstances, would expect to victimise, humiliate, undermine or threaten. Bullying does not include a robust and respectful exchange of views or a lawful and reasonable management direction or training/supervisory request.

Remember that societal norms, upbringing, culture and personal experiences and beliefs affect each person’s tolerance, or not, for particular behaviours.
Telling people you suffer from anxiety is no easy task. The response can range from a dismissive statement like “there’s nothing to worry about” to a patronising comment like “it’s all in your head”. More often than not, people seek to reassure you by asking if you are okay and offering to help. As someone who has suffered from debilitating anxiety for many years and having had many awkward conversations on the topic, I can tell you that the latter is the most desired response when you share your diagnosis.

There is, of course, the times when someone doesn’t mean to offend but does so by being insensitive or by failing to understand.

A couple of weeks ago, I mustered up the courage to confide in an old friend about suffering from anxiety. It didn’t go quite as I had hoped or expected. Her response was quite brutal. “You just need to toughen up and get over it,” she snapped. Needless to say, her reaction left me feeling a deflated and distraught at the prospect of unloading on someone again.

What my friend said really stuck: why can’t I just get over it? Why am I at a constant battle with my own mind? I persistently worry and I probably over-analyse every single situation. I’m often exhausted even when I’ve had a good night’s sleep, feeling as though I have just run a marathon. My mind is constantly cluttered with negative thoughts and, on really bad days, I can barely string a sentence together. Then there are the panic attacks: my heart starts to pound, my hands shake, my mind is foggy and I feel an overwhelming sense of helplessness. In these moments, life is at a standstill and all I can do is wait for the storm to pass. This can last for minutes, hours or even days.

The sad reality is that while there is increased public awareness about mental health issues, many people still do not understand the seriousness of mental health conditions and the extent to which they can affect a person’s everyday life. Unlike other conditions, you do not display any physical symptoms. There are no signs of fever, broken bones, bruises or scratches. Instead, the symptoms are hidden deep within you.

If someone reacts negatively when you finally open up about your mental anguish it can reaffirm the negative beliefs you hold about yourself or, even worse, cause a full-scale mental breakdown.

I know my friend didn’t intend to hurt me, but she did. I soon came to realise that...
her response stemmed from ignorance, not malice. She meant well but she just didn’t know how to respond. Many people don’t and that’s okay. In such situations, it is probably best to stay silent.

Having anxiety means that confiding in someone can be considered an act of bravery in itself. The condition can leave a person overwhelmed by the most basic tasks and many sufferers may find it difficult to articulate their feelings to get the support they need.

Then there's the stigma attached to mental health issues, which can cause as much pain as the anxiety itself.

It is important to acknowledge that people with anxiety disorders have different coping mechanisms to ‘normal’ people and we don’t need to be constantly reminded of this. Being told to snap out of it or to relax doesn’t help and only adds to an anxious person’s list of worries. After all, you don’t just wake up one day and decide to be anxious.

Dealing with anxiety is difficult for everyone, including the person suffering, carers and loved ones. Being supportive can be particularly difficult when you don’t understand the complexities of mental health issues. Seeking help is a daunting process for most people living with anxiety so it’s important to be mindful when you respond to them. It is more than likely that a person with anxiety is their own harshest critic so be compassionate and try to understand where they are coming from.

For information on how to support someone with anxiety, please visit the beyondblue website: www.beyondblue.org.au/the-facts/supporting-someone/supporting-someone-with-depression-or-anxiety

SURVEY RESULTS

Results from the 2013 beyondblue National Mental Health Survey of Doctors and Medical Students showed that:

→ 21% of respondents reported a history of depression, while 6% had an existing diagnosis.
→ Doctors are more likely to experience an anxiety disorder (9%) when compared to the general population (5.9%).
→ Doctors are more likely to have a current diagnosis of an anxiety disorder (3.7%) when compared to the general population (2.7%).
→ The most commonly cited reasons for work-related stress were:
  - the need to balance work and personal responsibilities (26.8%);
  - too much to do at work (25%);
  - responsibility at work (20.8%);
  - long work hours (19.5%); and
  - fear of making mistakes (18.7%).
ANXIETY: THE STATS

→ Anxiety is the most common mental health condition across Australia and New Zealand.
→ Women are more likely to experience anxiety than men.

In Australia:
→ One in four people – one in three women and one in five men – will experience anxiety in their life.
→ In the span of one year, over two million Australians experience anxiety.¹

New Zealand:
→ Approximately one in four New Zealanders will be affected by an anxiety disorder at some stage in their lives.
→ At any one time, 15% of the population will be affected.²

¹ABS National Survey of Mental Health and Wellbeing: Summary of Results, 2007
²Mental Health Foundation of New Zealand: Quick Facts and Stats 2014

GETTING HELP

If you or someone you know is struggling with a mental health condition, there are places to go to seek help.

Speak to your friends and family about how you are feeling.

Seek help from a GP.

Contact the RANZCO Employee Assistance Program – free for all members and their immediate families.

To make an appointment or to speak with a RANZCO Support Program Consultant call 1300 687 327 (AU) or 0800 666 367 (NZ).

OTHER HEALTH SUPPORT SERVICES:

AUSTRALIA
→ Australia: beyondblue – call 1300 22 4636 or browse online at https://www.beyondblue.org.au/
→ Australia: Lifeline – call 13 11 14 or visit https://www.lifeline.org.au/

NEW ZEALAND
→ New Zealand: Mental Health Foundation New Zealand – https://www.mentalhealth.org.nz/get-help/a-z/resource/5/anxiety
→ New Zealand: https://depression.org.nz/is-it-depression-anxiety/anxiety/

AUSTRALIA AND NEW ZEALAND
→ Australia and New Zealand – Doctors’ Health Advisory Service (DHAS)

INTERNATIONAL
→ International - Check the government website of the country you are in to find support.
The biggest ever eyecare & eyewear show in Australia

Bringing the best of SRC and ODMA FAIR together

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In 2019 RANZCO will be hosting its 51st Annual Scientific Congress in conjunction with the American Association for Paediatric Ophthalmology and Strabismus (AAPOS) and the Asia-Pacific Strabismus and Paediatric Ophthalmology Society (APSPOS) at the International Convention Centre (ICC), Sydney from 8 to 12 November.

RANZCO’s Annual Scientific Congress is the highlight scientific event of the College, bringing together a wide range of ophthalmologists, registrars and allied health professionals from across Australia, New Zealand and internationally to share the latest clinical, scientific, research and practice developments in eye care. This is a significant year for RANZCO as 2019 marks our 50th year as an independent college of ophthalmologists in Australia. As such, the Congress will be an extraordinary meeting with many opportunities to reminisce about the past and anticipate the future.

This year Sydney will also host both the AAPOS and the APSPOS meetings, which will precede the RANZCO Congress. This will offer delegates a unique opportunity to attend all three meetings in one convenient location.

The event will welcome prominent speakers from around the world such as Prof David A Plager MD, Dr Emily Y Chew, Prof John Marshall, Prof David (Ted) Garway-Heath, Prof Soon-Phaik Chee, Prof Tien Y Wong, Dr Anasaini Cama and Dr Santosh G Honavar, MD, FACS. The line up will also feature many of our esteemed colleagues from across Australia and New Zealand including A/Prof Penelope Allen.

We invite you to join us in Sydney for what will be an exciting and stimulating Congress to celebrate RANZCO’s 50th birthday. We hope you will take the opportunity to explore and embrace our glorious city and the many treasures that Sydney and wider New South Wales have to offer. We look forward to welcoming you!
About the host city

Sydney, Australia’s largest and most historic city, is globally recognised for its iconic harbour and architecture including the Sydney Opera House and Sydney Harbour Bridge. The vibrant city is full of incredible attractions to visit from world-class restaurants, trendy cafés and bars to stunning beaches and blissful nature reserves. Less than two hours from the city, visitors can explore the rugged terrain of the Blue Mountains, visit some of the region’s oldest and best known wineries, or escape the hustle and bustle of the city in tranquil coastal getaways.

For more information on things to do and see in Sydney, please visit: www.sydney.com/

Key dates

Call for Papers/ Posters/ Films/ Audits opens:
15 April 2019
Registration opens:
June 2019
Call for Papers/ Posters/ Films/ Audits closes:
28 June 2019
Authors notified of abstract submission:
23 August 2019
Early Bird closes:
4 September 2019

Keep up to date with everything Congress related by visiting the official 2019 website:
http://www.ranzco2019.com/

Contact:
For more information, please contact the Congress organisers:
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Sydney NSW 2000
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E ranzco@thinkbusinessevents.com.au
W www.thinkbusinessevents.com.au
Social Program

Welcome Reception
The Welcome Reception is the perfect opportunity to visit one Sydney’s most iconic venues. Located right on the historic harbour foreshores, it is the ideal location to commence celebrations for RANZCO’s 50th anniversary year.

Date: Friday 8 November 2019
Venue: Museum of Contemporary Art
140 George Street, The Rocks

Graduation & Awards Ceremony & President’s Reception
Welcome our newest Fellows and congratulate our college award recipients, trainers of excellence and examination medallists onsite at ICC Sydney. Join us to commemorate an amazing 50 years of RANZCO at this special ceremony. Enjoy canapés and drinks afterwards at the President’s Reception in the foyer of the convention centre, overlooking Darling Harbour and the night lights of central Sydney.

Date: Saturday 9 November 2019
Venue: International Convention Centre, Sydney

Younger Fellows’ Dinner
Make the most of your trip to Sydney by catching up with friends and taking the opportunity to network with other younger Fellows. The 2019 dinner will be held at Ventuno Italian Restaurant, located along the finger wharves of Walsh Bay. Enjoy some amazing Italian food and enjoy the harbour views at night.

Date: Sunday 10 November 2019
Venue: Ventuno Restaurant
21 Hickson Road, Walsh Bay

Senior & Retired Fellows’ Dinner
Enjoy the beautiful finishes and gracious atmosphere of the centrally located Establishment Ballroom. A wonderful opportunity to reconnect with friends and colleagues once again. We will be providing a complimentary bus shuttle from ICC Sydney on the night.

Date: Sunday 10 November 2019
Venue: Establishment Ballroom
252 George Street, Sydney

Congress Dinner
This will be a very special night of celebration and commemorations for all RANZCO Fellows, members and associates. The unique heritage venue, with stunning views of the city skyline and Sydney Harbour Bridge, provides the perfect setting for what will be a very memorable evening. The venue is easily accessible from light rail (from Central Station to the Star Casino Station), with ICC Sydney and many of the congress hotels only a couple of stops away.

Date: Monday 11 November 2019
Venue: Doltone House, Jones Bay Wharf
Level 3/26-32 Pirrama Road, Pyrmont
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Policy and Advocacy Matters

An update from the Public Health Committee

The Public Health Committee provides expert advice on policy for improving eye health across Australia and New Zealand. In 2019, the Committee will be leading a number of initiatives to address emerging public health issues impacting eye health through collaborating with others, building an evidence base and developing patient information tools.

The agenda for 2019:

Collaborating with experts
Dr Jane Khan, Chair of the Public Health Committee, has begun a process of connecting with high profile academics working in the public health space to consult them on the intersection between ophthalmology and broader public health priorities.

Building an evidence base
In the context of an ageing population, a key factor in maintaining independence is vision. Most vision loss remains preventable or reversible: with cataract surgery the perfect example. RANZCO Fellows are collaborating with the George Institute to establish reliable baseline data on the correlation between vision loss and falls and investigating interventions such as vision checks with fall victims in hospitals.

Patient information tools
The Public Health Committee is in the process of investigating current best practice around provision of information to patients who are considering participating in a clinical trial. The Committee is currently reviewing clinical trial patient information resources.

Highlights so far: UV Light

The RANZCO UV Position Statement was developed through a collaboration with Cancer Council Australia’s National Skin Cancer Committee and finalised and approved by the RANZCO Board in March 2018. The aim was to increase public awareness about the impact of UV on the eyes, risks associated with sun exposure and what constitutes adequate protection and to issue a call to action to prevent UV damage to the eye. In March 2019 the following media release, including a relevant case study showing the risks and harms associated with regular sun exposure, was disseminated via relevant digital and mainstream media outlets.

Media Release

What a lifetime of sun can do to your eyes

Sun safety is a hot topic over summer, but did you know that it is important to protect your eyes all year round? Ultraviolet (UV) light is present whenever we step outside during the day and while it is important for children to have a small level of exposure to sunlight to help prevent myopia, a lifetime of sun can have very risky consequences for your eye health and vision. A common result of UV exposure is a growth on the eye that is often referred to as Surfer’s Eye (pterygium). While usually benign, Surfer’s Eye has the potential to interfere with vision and can grow into something more harmful. UV exposure can also cause cancer of the eye and cancer on the delicate skin around the eye (including on the eyelid) which can result in irreparable eye damage, vision loss and, in extreme cases, death. There is also evidence that accumulative UV exposure can accelerate the progression of cataracts, making it difficult for patients to see through a cloudy lens that covers the pupil.

It is especially important to protect your eyes from sun damage when UV levels are high. Across Australia during the summer months there are long periods of the day when the UV level is three or above, presenting increased risk of UV damage. However, it is recommended that, if you spend a lot of time outdoors, you take care to protect your eyes all year round as cumulative exposure at lower UV levels can also result in serious eye damage.

The best way to protect your eyes from sun damage is to wear wrap around sunglasses, with the technology to cover peripheral vision, prevent UV radiation from passing through the lenses and reduce UV damage to the surface of the eye and eyelid.

It is also recommended that people spending long periods outdoors in the summer months invest in glasses labelled either “UV400” or “100 per cent UV protection”, classified by Australian standards as category 3 or 4. Many sunglasses have only glare reduction and do not wrap around. While these may look more fashionable, many still let in dangerous UV light.

For more information about RANZCO’s position on eye protection the position statement, developed through a collaboration between Cancer Council Australia’s National Skin Cancer Committee and The Royal Australian and New Zealand College of Ophthalmologists (RANZCO), please see the ‘Policies’ page on the RANZCO website.
Case study: John

John, age 67, grew up in the Sutherland Shire and got a lot of sun growing up, especially at the beach. He didn’t wear sunscreen, hat or sunglasses. It was this lifetime of unprotected sun exposure that lead to the emergence of growths developing on both eyes. The growths were soon diagnosed as Surfer’s Eye (pterygium). To begin with they were only a cosmetic issue. Two years later, the growth on John’s left eye had grown substantially and had become a cause for concern. Ophthalmologist Dr Daya Sharma performed eye surgery on John to remove the suspicious growth, thought to be a tumour. John also needed to undergo cryotherapy (freezing therapy), and six months of postoperative chemotherapy eye drops. Pathology results confirmed that the growth was a squamous cell carcinoma (SCC) in situ, which is one small step away from being a dangerous and invasive cancer of the eye. Furthermore, due to a sun filled lifestyle, John now has a history of skin cancer on his face and was also required to have a sun related growth surgically removed from his eyelid.

John has also undergone cataract surgery on both eyes. Cataracts are known to progress more quickly in people who, throughout their lifetime, have had a significant amount of UV exposure. John now knows the importance of protecting his eyes with UV-blocking wrap around sunglasses, but is keen to tell his story so that other people, especially young people, will protect their eyes properly and hopefully avoid experiencing the kind of problems he has.

“Many people with UV-related diseases of the eye grew up at a time when the importance of wearing wraparound UV-blocking sunglasses was not recognised. Now we are very aware of the fact that UV protection of the eyes from childhood onwards can reduce the risk of these diseases, and prevention is better than cure,” says Dr Daya Sharma.

Case study: Patricia

Patricia, age 86 grew up in Northern Ireland and spent a lot of time outside playing sport, including tennis and athletics, without sun protection. Patricia explained that, at that time, there was no discussion about sun safety other than wearing a hat to avoid sun burn. Patricia’s long-term exposure to UV light has resulted in several cancers appearing on and around her eyes. Patricia has needed to undergo surgery several times to remove the cancers and, more recently, a reconstruction procedure. In December 2018, Patricia needed radiation treatments to manage the recurring cancers resulting from her lifetime in the sun. Patricia is now very conscious about sun safety and wears wrap around sunglasses with full UV protection when she is exposed to UV light.

“Many people with UV-related diseases of the eye grew up at a time when the importance of wearing wraparound UV-blocking sunglasses was not recognised. Now we are very aware of the fact that UV protection of the eyes from childhood onwards can reduce the risk of these diseases, and prevention is better than cure.”

- Dr Daya Sharma
RANZCO has engaged four ophthalmologists from the Pacific Islands region in an In-country Fellowship Training (IFT) program. The program aims to build capacity of local medical and nursing eye care personnel in subspecialty areas chosen according to proven local need and technical feasibility.

The fellowship training model, implemented through funding and support from Commonwealth Eye Health Consortium (CEHC), follows a structured program of teaching visits by international ophthalmologists, both in-country and in Australia/New Zealand. The program is customised to ensure maximum participation and exposure of the ophthalmologists, while also trying to minimise disruption to the work of the fellowship recipient’s work routine and workplace as much as possible. The fellowship model minimises the fellows’ time away from their normal duties (home and family life), and equips each fellow to handle the clinical cases they commonly encounter (locally).

The multiple visits undertaken through the one-year program intend to establish a strong and enduring relationship between the fellows and preceptors. The geographic spread of the in-country facilities are also harnessed to maximise caseload for training and service delivery. This also ensures meaningful follow-up by ensuring patients are treated in their own area, rather than requiring them to travel to a central location.

Fellowship recipients have been well supported by fellowship preceptors, led by Brian Sloan and Malcolm Capon and with Richard Hart and James Slattery (occuloplastics) and Vicky Lu, Mark Gorbatov and Vivek Pandya (retina). This is together with support from in-country facilities such as the Pacific Eye Institute in Suva and the Regional Eye Centre in Honiara.

The Australian and New Zealand observership visits have also proved beneficial and been enthusiastically supported through collaboration, input and time from ophthalmologists at Sydney Eye Hospital and the Greenlane Clinical Centre, Auckland and with contributions from various hospitals in Adelaide.

Fellowship recipients

Oculoplastics: Claude Posala (Solomon Islands) and Salome Lolokabaira (Fiji)
Medical Retina/Vitreoretinal: Nola Pikacha (Solomon Islands) and Varanisese Rorogasa Naviri (Fiji)

Two of the fellowship recipients share their stories:

“The Medical Retina and Vitreoretinal Surgery Fellowship in the Pacific Islands is welcomed, considering the burden of diabetes in the region and the severity of retinopathy associated with it. Currently patients have to travel abroad or wait for visiting subspecialists for further care so having this fellowship would enable a locally trained ophthalmologist to treat more complex vitreo-retinal related issues locally. Only those who can afford it end up overseas for treatment, which is the minority of the group.

“My work is based at the busy Labasa Hospital, which is the referral centre for all health centres on the island of Vanua Levu where I am the only ophthalmologist and we cover a population of a little over 130,000 people scattered over large land masses and oceans.

“The fellowship has highlighted clinical and surgical skills related to the field of vitreo-retina that with re-enforcement will help bridge the gap of such services in my country. It is also a blessing for us because it will bring closer to home what patients would have otherwise travelled long distances for and spent their life savings on.

“Seeing the services available overseas and the networks formed during the overseas component of the fellowship has given me some ideas on how to set up such services in our country. As challenging as it may seem, I believe that a collaborative effort is
needed in order for this to become a reality. I have also learnt that no matter where we live (developing/developed or under-developed country) the one thing we have in common is the challenges we face. It is how we rise to these challenges that matters at the end of the day. The Commonwealth Eye Health Consortium has provided us with an opportunity and we now need to rise to the challenge and see this dream through.

“...The fellowship has been an eye opener and an inspiration to me at both a professional and personal level. Lifelong lessons and skills have been learnt and I look forward to sharing the knowledge and skills learnt with my colleagues. I hope that eventually we will be able to train our own sub-specialists locally.”

Dr Varanise Rorogasa Naviri, Labasa Hospital, Fiji

“I was trained to be a general ophthalmologist focussing mostly on cataract surgery and diabetic retinopathy management, which are two of the most common causes of reversible blindness in Fiji. I work at one of the three main hospitals in Fiji. We have a total of four qualified general ophthalmologists in our hospital but only one had fellowship training in medical retina.

“...Since I have started my in-country oculoplastic fellowship training in mid-2018, I have noticed an increase in the load of oculoplastic cases. Through the fellowship training I'm now identifying cases easily and, for those difficult cases, I'm discussing them with RANZCO Fellows specialising in oculoplastics to get their input on further management. In addition, the fellowship training has enabled me to identify some of the problems related to instruments and consumables that our clinic will need to have to be able to better manage oculoplastic cases.

The fellowship has helped increase my knowledge and skills, which will improve with more training. It has created a platform to be able to correspond not only with RANZCO oculoplastics Fellows but other RANZCO Fellows as well.”

Dr Salome Lolokabaira, Lautoka Hospital, Fiji

“Lifelong lessons and skills have been learnt and I look forward to sharing the knowledge and skills learnt with my colleagues.”

“The fellowship has helped increased my knowledge and skills, which will improve with more training.”

Dr Salome Lolokabaira, Lautoka Hospital, Fiji
My first year in practice

Following years of training and education, as a new RANZCO Fellow it can be a relief to finally put the pressure of qualification and exams behind you. However, the transition from trainee to ophthalmologist can be a daunting, albeit exciting, experience when you’re newly qualified – whether you are planning to work for someone or start your own practice. As you reach this important milestone in your career, you might not be sure quite what to expect or how the important decisions you make early on may affect your future as an ophthalmologist.

To get some insight into what an ophthalmologist’s first year in practice is like, and how a trainee can prepare for and navigate their first year, we spoke to some trainees looking ahead to their first year in practice, some new Fellows in their first year of practice and some Fellows looking back on their transition from training to clinical practice.
Choosing the right role

Dr Jonathan Kam has recently completed RANZCO’s vocational training program (VTP) and he is excited about beginning his career as a fully trained ophthalmologist.

“It has taken 15 years to get here,” says Dr Kam, “and I feel ready. We get such excellent training and experience that by the time we’re ready to stand on our own feet we know what we can handle. I recently completed a fellowship in advanced cataract surgery at the Royal Victoria Eye and Ear Hospital (RVEEH) under Dr Jaqueline Beltz and a second fellowship year at the Alfred Hospital, under Associate Professor Anthony Hall. I learnt so many new techniques to help me manage complex surgical cases. Still, it was difficult to decide on my next step – whether to do a third fellowship in oculoplastics that I was offered overseas or whether to move into a permanent local consultant position. In the end, I felt ready, so I took up consultant roles at the Royal Victorian Eye and Ear Hospital and with Northern Health, where I have been appointed as Supervisor of Training.”

Dr Nisha Sachdev, who is seven years into her practice, agrees.

“You have to make the decision that is right for you,” she says. “Early on I decided to focus on doing fellowships, which was great for me. You learn so much plus you get to focus on a subspecialty that you enjoy. And no exams! All my mentors told me I would love it, and they were right. I considered doing another, overseas, fellowship, but due to my circumstances I decided to stay in Melbourne and begin in practice.”

Dr Albie Covello is a final year trainee from New Plymouth in New Zealand and hopes to settle there for his first consultant role. “It can be difficult in smaller towns as there are less frequent vacancies” he explains. “Luckily, I always knew that I wanted to come back to New Plymouth when I qualified, so in my second year of training I expressed my interest in returning to the region and have kept in regular contact with the department since then. I am lucky to have received excellent general training, and I ensured my corneal fellowship would be a valuable addition to the other subspecialties currently offered in the region. I also did a three-month locum position in the department that I am hoping to join, which I would definitely recommend as it gives you the chance to meet the team, see how the practice and hospital run and familiarise yourself with the environment.”

Seeking advice and support

Dr Divya Perumal, currently in her first year of practice, says seeking guidance from mentors and colleagues has helped her to better navigate some of the challenges that come along with starting a career in ophthalmology. “Now that I’m in practice, I still have questions and still draw on the expertise and advice of mentors and colleagues,” she explains. “I have several mentors who I consult with routinely. I also have a glaucoma support network, which includes my fellowship colleagues and previous fellowship and clinical supervisors. My work colleagues are also really supportive. My mentors, Prof Charles McGhee and Prof Helen Danesh-Meyer, have been great in helping me to direct my career choices. Overall, I feel well supported and I know there’s always someone I can turn to when I need advice or a second opinion. That being said, I think we can do better in supporting trainees. I have a strong network now, but that takes time to build up. As trainees it can all seem a little overwhelming.”

Both Dr Covello and Dr Kam also emphasise the importance of drawing on the knowledge and support of their colleagues and managers, which has helped them in planning their next steps.

“As trainees we learn so much about ophthalmology and treating patients,” says Dr Covello. “But there is a whole other side to practicing ophthalmology, from finding an initial position, negotiating contracts, buying into a business through to managing staff and finances. The increase in responsibility when
becoming a consultant will be a big transition, so seeking help from colleagues, mentors and friends will definitely be important. With many steps still to be taken, it is difficult to know which questions I should be asking now. However, once I have hit the ground running, there will no doubt be a list of things I wish I had known sooner.

Dr Kenneth Chan, past chair of RANZCO’s Younger Fellows Advisory Group, understands how important it is for new consultants to know that there is support available. Looking back on the challenges of his first year in practice, Dr Chan explains, “It can be difficult in your first year of practice to get your head around the fact that you are directly responsible for the wellbeing of your patients and knowing that you need to delegate the assessment and management of patients to junior colleagues. Dealing with surgical complications without a more senior colleague in the room can be quite stressful too. It is always good to draw upon the support of your peers as well as more senior colleagues – almost everyone is very happy to provide advice on difficult cases and challenging situations and it is likely that they have been there before themselves!”

Asked what he wished he knew then that he knows now, Dr Chan says “Don’t be too worried about not having enough work. It will come!”

Dr Sachdev agrees. “It comes with time,” she says. “Before you know it, you’re snowed under with so much work. It’s easy to overcommit and hard to drop back once you have started, so try to achieve a balance!” she says. “The important thing is to not stretch yourself too thin. Don’t work in too many places and try to minimise the time you spend on the road. I would definitely advise working in the same practice or hospital for a whole day.”

**Striking a balance**

Dr Perumal says that choosing between private and public practice, or a mix thereof, is a big decision. “I think that having better knowledge of the difference between public and private ophthalmology practice would have been useful when I was planning my ongoing career plans,” she says.

Dr Chan also reflects on the difficulty finding a balance between private and public work, particularly in New Zealand. “In New Zealand it can be tricky finding the right balance,” he explains. “We often start off doing a lot of public work and it is easy to overcommit. It is important to maintain some flexibility in your schedule. Perhaps leave at least one half day session per week for non-clinical work, so that you don’t get swamped by administrative work.”

Dr Sachdev says one of the most important things you can do is to make the decision to achieve a good work/life balance. “Find something outside of ophthalmology,” she says. “Bearing in mind that one day you will want to retire and you will need something else to keep you motivated. And you don’t now how long you have. One of my best friends from medical school passed away last year from breast cancer. She was 40. At 18 years old you never think that you might only have 12 years left. That’s why it’s so important to make the most of the time you have. Ophthalmology is important, but it’s not everything. And the happier and more fulfilled we are as people, the better we will be as doctors.”

The Younger Fellows’ Advisory Group has developed welcome packs with information for new Fellows. These are available for Fellows on their RANZCO dashboard.
“... It’s so important to make the most of the time you have. Ophthalmology is important, but it’s not everything. And the happier and more fulfilled we are as people, the better we will be as doctors.”

- Dr Nisha Sachdev
My journey to ophthalmology

It was 1938 and I was only 17 when I started a medical course at the University of Queensland. In the next year World War II would break out and, while some of my fellow students would leave the course to join the war, I decided to stay on (I would later serve as a medical officer). Graduating from a shortened war course in May 1943, I became a resident medical officer at the Brisbane General hospital.

I had six two-month terms of well-chosen medical fields. No childcare, obstetrics or anaesthesia, but medicine, surgery, gynaecology and casualty. It was before the introduction of penicillin, and at a time when communicable diseases were widespread and life expectancy was short. It was tough; few doctors nowadays can imagine the severity of the problems we faced.

In June 1944 I joined the Australian Imperial Force (AIF) as a medical officer. After two excellent training schools (how to be a medical officer and army hygiene) I spent six months as a medical officer at Wallangarra catering to several thousand healthy men, and six months in an army general hospital.

I sailed on a troopship to an active campaign in Bougainville, but the atomic bombs landed before we got there. After several months of meeting the Japanese and working with them, I volunteered for the British Commonwealth Occupation Force (BCOF) for Japan. I was with one of the three infantry battalions of BCOF for 15 months.

During this time, I sat for a day in the War Trials watching General Tojo, survived a cholera outbreak and a severe earthquake, and dealt with a venereal disease outbreak by regulating a brothel. My last six months were spent in an army general hospital.

After the army I had another 15 months of civilian hospital residence, catching up with missing bits of experience. I planned to do surgery and worked on the basics of a degree.

In August 1949, crossing the Indian Ocean in the ship Orcades, I heard that the Royal College of Surgeons of England had a new degree in ophthalmology in which field my brother Dr James Hart had qualified in London in 1939. I decided on this degree too. I passed the Part One of basic sciences, married Margaret Smith from Sydney in September 1950, and had a year’s residence in the Bristol Eye Hospital. In May 1952, I faced Sir...
Stewart Duke-Elder in Part Two – the clinical examination. From sheer lack of clinical experience, I made a dreadful blunder: I missed the diagnosis of a malignant melanoma of the choroid and was lucky not to be sent down for a year. But in November that year, with much more experience, I passed.

Then my wife and I headed home by ship with our first son. We found somewhere to live in Brisbane, and I joined my brother Jim in an eye practice for another 26 years.

The Ophthalmological Society of Australia (OSA)

The Ophthalmological Society of Australia (OSA) was founded in 1938 and in 1953 I would become an active member. My first Congress in Brisbane in 1958 had a startling revelation; a senior Sydney ophthalmologist, Darcy Williams, who had denied it for years, finally admitted that he owned the spectacle-dispensing firm Optical Prescriptions Spectacle Makers (OPSM). At the same moment, he donated a large sum to the OSA to form the Ophthalmic Research Institute of Australia (ORIA). The OPSM passed from his hands to become a public company. It was agreed – perhaps ordered – that no member of the OSA should hold shares in OPSM.

I was appointed to the Board of ORIA, whose chairman was Archie Anderson of Melbourne. This highly respected man had been one of ‘Kitchener’s Hundred’ in 1914 (desperately short of doctors, Lord Kitchener, British army commander, had appealed to Australia for doctors, and Archie was one who responded, and served in France). When I addressed him as ‘Doctor Anderson’, he laughed. “We’re colleagues” he said. “And you should call me ‘Archie’.” This gesture had a surprising and overwhelming effect on me. From then on, the colleagues I would meet, from every state – old and young – were to be friends, good friends and no longer strangers.

The Royal Australian College of Ophthalmologists (RACO)

My memories of the College are fond. I remember when the OSA formally disbanded and reformed as the Australian College of Ophthalmologists (ACO) – a single body regulating all ophthalmology training and education activities across Australia. I even remember the day – 8 October 1969 – of the inauguration of the (then) Royal Australian College of Ophthalmologists (RACO) as though it were yesterday.

My wife Margaret and I flew to Melbourne on 2 October for a crowded week of personal and College meetings. Having just been elected Vice President the year before, I was pre-occupied with the political problems ahead.

At 2pm I assisted Gerard Crock and Geoff Sutherland in conducting the Victorian Diploma of Ophthalmology examination. The next day I sat in three committee meetings – Qualification and Education; Undergraduate Education, and the Board meeting of ORIA. The Council meeting lasted for the rest of the morning, all afternoon and even the next day, Saturday 4 October. Even then, there was so much left to decide that we reluctantly agreed to another Council meeting on inauguration day, 8 October.

In our 10 years of congresses Margaret and I had made many friends, and it was a delight to see them again. There was a meeting for councillors and their wives to greet new member couples, and on Sunday 5 October a picnic was held at the home of our President, James ‘Jimmy’ Foster – a highlight being a group of Aboriginal performers with boomerangs. There was also a Presidential Reception and a dinner at Hugh and Beryl Ryan’s place.

It was, for us, a troubling political time. More than 30 years before the current amicable relations with optometry, we had considerable tensions with optometry for decades. Along with eye disease, optometry seemed to be our enemy as well. We believed that organised optometry was making claims of competence and seeking territory far beyond their training. As a sour result, much of our Council time was taken up by the strategy and tactics of this conflict. Both sides were approaching the government about a fair handling of resources in the coming Health Act revision.

On 8 October, the Council’s discussion about optometry was still left unfinished at 3pm when our President Jimmy Foster insisted that I come with him and Jim McBride White to inspect Wilson Hall for further arrangements of the night’s inauguration. The other two were very concerned with the ceremony, both quite tense. In fact, Jimmy’s family were so concerned with his peace of mind that he had not been told that his brother had died that morning.

My concern was with the business we had left unresolved. I was determined that as soon as possible we should separate the President’s responsibility of running the College from his duty of running a congress or other events. What I’d just witnessed was the impossibility of doing the best possible for both tasks. This separation worked the following year, in my presidential term, when Mark Harrison ably ran the congress, leaving me to worry about the governance of the College, particularly the issue of optometry that was looming. Just as well, for it turned out to be quite challenging.

The inauguration ceremony was a brilliant success, with impressive achievers from all walks of life, and eye colleagues from the UK. To fit in with Jimmy Foster’s wish, councillors wore long tail coats and white ties – for me, it would be the last time ever.

My diary records bacon and eggs in our hotel room the next morning, with my wife Margaret and I hosting the Hudsons from London, Bob Herron, Bernard Bowden and Grosvenor Burfitt-Williams.

After years of planning, we were at last a College with all its prestige and responsibility.
The Council elected me as the second President of the College on 9 October 1969, and I had to speak at the dinner that night. It was a night I will never forget; the dinner took place at the Cultural Centre under the new Norman French glass ceiling.

Over my first six months of office, things went smoothly with RACO executive meetings in Sydney, and planning for the October congress taking up much of my time.

After the mid-year Council meeting at the end of April, there were weeks of intense political flurry. There were endless phone calls and interstate phone conferences. We did not feel that we were getting support from the Australian Medical Association (AMA) in our struggle with optometry.

On 1 May, I flew to Canberra, meeting Max Moore and Leo Shanahan in King’s Hall. We met to discuss the coming health debate with several ministers.

Brian Wilson and I met the Director General of Health, Sir William Refshauge, showing him the list of investors in Optical Prescriptions Limited. This was to rebut a story from organised optometry that the firm was owned by doctors, (not true since 1958).

At the end of May, with Reuben Hertzberg, Geoff Harley and Max Moore, I met the AMA Council for a fairly angry meeting, which ended with their offer for better support.

On 9 June a group of us visited Canberra again, where the Health Act was being debated. We interviewed ministers and fronted the Liberal Health Committee and the Labor Committee, where I had a heated debate with a member, Dick Klugman.

Max Moore and I spent some time with a member of Parliament and later listened to him ventriloquising our lines in the House.

The Health Act was changed to include optometry, with a benefit for prescribed spectacles.

At the same time, the controversial Item 1/1A was removed from the Act. This was a provision, presumably included in the old Act at the persuasion of optometry, that a consultation with an ophthalmologist, of whatever duration or complexity, would not attract a benefit if spectacles had been prescribed at the time.

My term as President ended at the Annual General Meeting (during Congress) at Chevron Hotel, Surfer’s Paradise in October 1970, after a busy week of meetings and entertaining local and overseas visitors.

### ANZEF

The Australian and New Zealand Eye Foundation (ANZEF) is an internal RANZCO committee dedicated to raising funds for important education and research projects across Australia, New Zealand and developing countries. As an internal RANZCO committee, the Foundation relies on the support of RANZCO members to drive the work that we do and we have been delighted by the generosity that members have shown over the past months. We are also now able to take donations from the public and we will soon be approaching business supporters to raise funds for important projects in the future.

Watch this space for more exciting news and developments from ANZEF. In the meantime, please do use the methods below to make a donation to this excellent cause.

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**HOW TO DONATE**

**DIRECT ELECTRONIC TRANSFER**

**EFT**

**Account Name:** RANZCO/ANZEF  
**BSB:** 062-016  
**Account #:** 11614360  
**Reference:** ANZEF donation/Your name

**VIA CREDIT CARD**

(we only accept Visa or Mastercard). To donate by credit card, please call the RANZCO Finance Officer Alvin Lau through the RANZCO switchboard on +61 2 9690 1001.

For either donation method, please follow your donation with an email to anzef@ranzco.edu confirming your donation amount and name.
Experience the power of swept-source OCT technology at its best. Perform the most relevant anterior segment exams in one modular, upgradeable platform.

Introducing ANTERION®.

Take the lead with a dynamic, workflow-efficient imaging platform that delivers powerful results.

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Personal Development Plans (PDP)

Personal Development Plans (PDP) have been a part of the CPD framework for a number of years, with the activity attracting five points under Professional Values Level 1. Following the AMC review and in line with the proposed introduction of the Professional Performance Framework (PPF) in Australia and updates to recertification in New Zealand, there is an emphasis to mandate CPD planning as part of a self-evaluation process for CPD. According to the Board’s decision, as of 2020 the personal development plan will be renamed to ‘Professional Development Plan (PDP)’ and will become a mandatory component of the CPD program.

To ensure RANZCO Fellows meet imminent AHPRA and MCNZ requirements, the RANZCO Board and CPD Committee would like to advise all Fellows that as of the 2020 CPD year, all Fellows will be required to annually complete a PDP. As this will become a compulsory practice, the attached points for completion of a PDP will be removed. Further information regarding the PDP and requirements will be released shortly to the Fellowship, including a template of the documentation that needs to be completed.

CPD Handbook

In line with the new requirements for 2020 and the introduction of the PDP, the CPD handbook has now been updated to include information and a template of the PDP, a new general audit guide and an overall refined handbook to assist Fellows with understanding the RANZCO CPD framework and program. The CPD handbook also contains a break down of the types of activities that can be claimed under each category and level. A copy of the current CPD handbook can be downloaded directly from the CPD diary, or alternatively please contact the CPD team at cpd@ranzco.edu.

NUCLEUS Update

NUCLEUS Australia and NUCLEUS New Zealand are now available on the RANZCO website for Fellows and their staff to use. Both versions of the program are available with their own handbook, gap analysis workbooks and templates. NUCLEUS aims to assist Fellows and their staff to improve the safety and quality of care they provide in their clinics using the NSQHS Standards (Australia) and 8164:2005 and 8165:2005 (New Zealand) Standards as a framework. NUCLEUS may be used as a quality improvement tool in its own right or to assist Fellows in preparing the necessary documentation for accreditation against the appropriate standards. Similar to version one of NUCLEUS, RANZCO has provided a list of consultants who are available (costs for consultation are at the discretion of each consultant) to assist Fellows and their staff with working through the standards and developing the required documentation for both Australia and New Zealand.
### Branch Musings

#### Queensland

**Chair**
Dr Stephen Godfrey

**Hon Secretary**
Dr Mark Chang

**Hon Treasurer**
Dr Oben Candemir

The Queensland Branch sends a very meteorological hello to the extended College in the first quarter of 2019. It is hard to imagine 500mm of rain falling in 24 hours, but our colleagues in Townsville have had to endure this type of weather. Dams that were previously empty have risen to 250% of their capacity. I have talked to some of our Northern Queensland colleagues and they have had a significant disruption to their practicing lives but, thankfully, they are safe and well and have resumed normal practice after Cyclone Penny. We can only watch with amazement at the difficulties in our fellow states with searing heat and bushfires. We wish you all well for the first quarter of 2019.

The Queensland Branch has organised a very exciting meeting for its scientific conference in August this year, which will explore all matters glaucoma related. Given the tremendous change in the profile of glaucoma practice of the last few years, this will be an important scientific meeting for us all to attend.

Queensland is hosting the RANZCO Annual Scientific Congress in 2020, which not only is a very symbolic year in visual terms, but also a huge privilege and honour for the Queensland Branch. We hope to maintain the high standard of scientific and practical ophthalmological programming, but also be able to offer a typical Queensland cultural and recreational interval for our delegates.

Over the Christmas break the Queensland Branch was working with Queensland Health and its Patient Safety and Quality Improvement Service (PSQIS) in developing a public health website to access expanded reporting of public and private hospitals in Queensland.

It has been interesting to be involved with the input to this website and, from a public health point of view, the majority of input was from midwifery and obstetric enquiries. The exposure to ophthalmology will purely and simply report personnel available and, at most, waiting times for assessment.

I would like to personally thank and congratulate Phung Vu who has stepped in to become the new Director of the Guide Dogs Association Queensland. Phung will bring an experienced and fresh input to the Guide Dogs Association Queensland. Our thanks to Mark Loane who has retired as Director as of the AGM in 2018. Mark is a tireless worker for the Guide Dogs along with his expanded work for the Cape York Eye Health Project. He will no doubt be missed in this role.

Apart from a few organisational hiccups, the rollout of integrated electronic medical records (eMR) is powering ahead in Queensland. Gold Coast University Hospital is up to its advanced release and this follows wide uptake of the electronic medical records across Queensland generally. We will keep you informed as to the benefits and ease of assimilation into the public hospital system. Our congratulations to Tom Maloney who has been awarded the Topham Queensland Scholarship for Queensland graduates. Tom is going to train in anterior segment overseas and we wish him all the very best in 2019.

**Dr Stephen Godfrey**
Chair, RANZCO Qld Branch

#### Victoria

**Chair**
Dr David Van der Straaten

**Hon Secretary**
Dr Xavier Fagan

**Hon Treasurer**
Dr Lewis Levitz

The RANZCO Victoria Branch has continued to discuss health services regulations with the (Victorian) Department of Health and Human Services, particularly in regard to the safety of performing blepharoplasties in the rooms.

The Department is keen to ensure that patient safety is not compromised due to inadequate facilities or monitoring when surgeons perform blepharoplasty in their offices and has been discussing this issue with ophthalmologists, plastic surgeons and cosmetic surgeons. Reports from local oculoplastic colleagues indicate that complications that could be attributed to inadequate facilities are very rare, within their clinical experience. Complications of blepharoplasties are more likely to occur due to poor surgical technique, which is outside the jurisdiction of the Department. The Branch is keen to ensure that patient access to services is not restricted by unnecessary regulation.

The Branch is keen to support trainee exposure to the health care needs and issues of Indigenous Australians and has sponsored a number of vocational trainees to spend a week with the Lions Vision Van in remote Western Australia. It is hoped that this experience will enable young ophthalmologists to further close the gap on Indigenous eye care. The program has been keenly received by registrars with excellent feedback after their trips.

Final preparations are underway for the 2019 Victoria Branch scientific meeting, which will have occurred by the time of this publication. This continues to be a general ophthalmology meeting, with presentations by visiting and local consultants and a strong focus on contemporary clinical issues. Sincere thanks to Andrew Symons who has now arranged clinical content for five successive meetings and will soon step down from this role.

**Dr David van der Straaten**
Chair, RANZCO Victoria Branch
Our 2018 activities finished with the Registrars’ Society dinner with the Branch Fellows on Saturday 8 December. The dinner at Tsunami welcomed the incoming registrars and congratulated the senior registrars who have completed their training with Geoff Lam speaking on behalf of the Branch Fellows. There was a good attendance despite many competing festive season functions.

There was a good contingent from WA at the RANZCO Congress in Adelaide in November and the program was received well by all reports. The annual pathology imaging meeting in September provided fascinating insights into the fast-evolving developments in cancer diagnosis and treatment, focussing on melanoma with Prof Michael Millward delivering the Eye Surgery Foundation Lecture.

We are fortunate to have ongoing support for the Branch’s educational activities by the ESF, which was established by colleagues in the Branch over 25 years ago. They had a strong vision for an organisation to support Western Australian ophthalmic education, research and the development of international and remote ophthalmic services. The ESF lecture is a highlight of our meetings throughout the year, and the ESF recently committed to us a very generous educational grant for our meetings over the next three years.

Fremantle Hospital will host the most recent Inter-Hospitals meeting on Friday 8 March, focussing on the use of OCT in the diagnosis and management of many ophthalmic problems. The 2019 collaborative audit has an OCT theme and was launched at that meeting. Our Branch Annual General Meeting was held at the end of that day.

Our Branch Meeting will be in Albany 17-18 May at the fabulous regional Entertainment Centre on the foreshore. There will be a cocktail reception on Friday evening and a dinner on Saturday night. We will be looking at the Future of Ophthalmology at the meeting with confirmed speakers Prof Justine Smith from Adelaide, Dr Peter van Winjgaarden from Melbourne, Dr Daniel Ting from Singapore and Dr Bob Griffiths from Newcastle. Along with a host of local speakers, the program should be a compelling outline of the rapidly changing developments in ophthalmic care.

Sadly, longstanding WA Branch Fellows Doug Candy and Malcolm Wham passed away in the last year; there are now very few of the old guard, from before the establishment of our local training program, remaining.

Our training program has expanded over the years and a new selection process will be implemented this year. Competition remains strong, but there are now incentives for rural and Indigenous applicants and a new rural based training program, which we hope will improve the likelihood of Fellows returning to practice in currently poorly serviced rural and remote areas. Key to this initiative is to establish sustainable services in the North West so that the area can be fully integrated in the rural training scheme.

Dr Nigel Morlet
Chair, RANZCO WA Branch

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Dr Nigel Morlet
Chair, RANZCO WA Branch

Though I hate to admit it, there are times we have to play catch-up with our Australian colleagues over the ditch. There have been two such instances in the past few months.

For many years RANZCO has included named lectures in its annual meeting. These recognise exceptional contributions to the field of ophthalmology by deceased Fellows. It was recently suggested that the New Zealand branch should do so too. Following much discussion among members of the NZ Branch executive we are pleased to announce that the inaugural named lectures will take place at this year’s meeting in Auckland. The two named lectures honour leading New Zealand ophthalmologists: Professor John Parr and Dr Dorothy Potter.

Professor John Parr is remembered as New Zealand’s foremost ophthalmic educator and made by far the greatest contribution to ophthalmic education in New Zealand. As Professor of Ophthalmology at Otago, John taught a generation of medical students. He established the course for the part one examination in the ophthalmic sciences, assisted by Gordon Sanderson. John and Gordon later established the course for the part two examination. Both courses were residential and hugely well organised. They were very highly regarded even in Australia and were therefore attended by many Australians. John’s book *Introduction to Ophthalmology* was published by the Oxford University Press and received good reviews in the *New England Journal of Medicine* and in the *British Journal of Ophthalmology*. He also did significant research on the retinal circulation.

New Zealand rightly prides itself on being the first country in the world to legalise women’s suffrage. That was in 1893. One hundred and twenty-six years later our College has an aspirational goal of 35% female representation on College committees. As a 21st century male, I can only imagine the prejudices and hurdles faced by female Fellows in the last century, and we as a Branch decided it would be appropriate to recognise that. Dr Dorothy Potter was a medical ophthalmologist who was inspired by Professor Ida Mann, the first female professor of ophthalmology in Britain. Dorothy became the first, and to date only, female president of the Ophthalmological Society of New Zealand. She started the New Zealand Glaucoma Society and helped establish the Glaucoma Trust Fund. She helped establish the Wellington branch of the Medical Woman’s Association. She did clinical research among Māori in the East Cape region and published several papers on ocular allergy. For all these endeavours Potter was deservedly awarded the CBE in the New Year’s Honours List of 1993.

Our second area of catch-up is Vision 2020. This is a well-established brand in Australia but has struggled to get off the ground in New Zealand. Darren Ward of the Eye Health Coalition has recently taken this on and aims to make Vision 2020 the primary advocacy group for eye health professionals in New Zealand. A strategy day was held in Auckland on 22 February and we were fortunate to be joined online by Drew Keys of IAPB and Judith Abbott from Vision 2020 Australia. Both expressed their willingness to share their expertise and wished us well in our endeavours. We hope that by presenting robust population-based data we will be able to influence the Ministry of Health and advocate for better eye care for all New Zealanders.

Dr Brian Kent-Smith
Chair, RANZCO NZ Branch
New South Wales

Chair
Dr Robert Griffits

Vice Chair
Dr Diana Farlow

Hon Secretary
Dr Alina Zeldovich

Hon Treasurer
Dr Nisha Sachdev

Country Vice Chairperson
Dr Neale Mulligan

At the time of writing, the 2019 NSW Branch ASM was still two weeks away. Interest from delegates and sponsors was very high, boding well for a successful conference which was constructed to look at evolving technologies and to attempt to extrapolate how these will impact on the practice of ophthalmology.

Preliminary planning is underway for the 2020 Branch ASM, which will be held in a regional or rural venue with Port Macquarie the most likely venue.

This conference will focus on the practice of ophthalmology in metropolitan, regional, rural and remote communities.

There is a maldistribution of ophthalmologists with a crowding out in the capital cities and a paucity of practitioners in regional and rural areas.

Dr Ashish Agar has been co-opted to the NSW Branch Committee to strengthen the rural and Indigenous inputs into the committee, which is heavily skewed towards metropolitan Sydney in terms of its representation.

RANZCO is committed to closing the gap for health outcomes for Indigenous peoples, and the NSW Branch is also committed to playing its part in improving eye health delivery within the state of NSW.

Dr Robert Griffits
Chair, RANZCO NSW Branch

Special Interest Groups

ANZSOPS update
This year, ANZSOPS collaborates with the RANZCO Tasmania Branch for its annual branch meeting, which will be held from 21-23 June. Members of ANZSOPS will run a daylong masterclass on Friday 21 June called Oculoplastics for General Ophthalmologists: Manage Common Conditions Like a Subspecialist. The masterclass aims to provide practical strategies for generalists to incorporate into their management plans for a variety of oculoplastic problems that they can treat themselves. The weekend will coincide with the Dark Mofo festival and promises to be rewarding for all those involved.

Dr Charles Su
Chair, ANZOPS

ANZCS update
The Australian and New Zealand Cornea Society (ANZCS) & Eye Bank meeting was held in Adelaide from 6-8 March. The ANZCS is encouraging young College members with an interest in cornea to become involved in the society. The ANZCS currently operates as a RANZCO special interest group, advising the College on matters relevant to cornea and external eye disease. In the last two years it has formed strong relationships with the Cornea Society (USA) and the Asia Cornea Society. At RANZCO’s 2018 Congress the ANZCS and the Cornea Society (USA) held a joint symposium for the first time. Next year at the Asia Cornea Society Meeting in Osaka, Japan, the ANZCS has been invited to deliver a complete symposium. It will be an exciting opportunity for us to showcase the innovative clinical and translational work being done Down Under. I invite anyone interested in being involved in this symposium to contact me directly.

The second annual Corneal Bioengineering Workshop was held at the Sydney Eye Hospital late last year. It brought together all corneal specialists and scientists who are interested in this rapidly evolving field from across Australia. It has facilitated many new collaborations. The meeting will be held again later in 2019 and all are welcome to attend. Please contact Dr Jing Jing You at jing.you@sydney.edu.au if you wish to attend.

Finally, I would like to take the opportunity to recognise and congratulate Dr Greg Moloney (NSW) who received the prestigious Troutman Award in 2018 for his paper Descemetorhexis Without Grafting for Fuchs Endothelial Dystrophy – Supplementation With Topical Ripasudil.

Prof Gerard Sutton
Chair, ANZCS

ANZSRS update
ANZSRS reminds all members that its annual mid-year meeting will be held at Westin Hotel in Sydney on Saturday 1 and Sunday 2 June. Professor Lee Jampol is the invited international speaker.

All members are invited to attend the Annual General Business Meeting following the close of the scientific sessions on Sunday afternoon.

Dr Jennifer Arnold
Chair, ANZSRS
In 1996, ORIA was assigned the copyright to the art work of Australian artist Sydney Long, who is best known for his art nouveau inspired paintings of Australian scenery. Over the years, ORIA has created awareness of eye research and received some royalties when pictures of these beautiful and iconic artworks have been used in books and other merchandise.

From 1996 onwards, ORIA has received many requests from all major and regional galleries in Australia to sign a Licence to Reproduce Sydney Long’s works. In 2013, a major retrospective of Australian Art was held at the Royal Academy of Art in London. The Spirit of the Plains formed part of the exhibition and reproduction rights were granted.

ORIA’s relationship with the copyright of Sydney Long’s works will cease at the end of 2025, 70 years past the date of Sydney’s death. We are keen to make the most of this bequest, although we are at a loss about how to do that. We are therefore calling on the art lovers and marketers among you to come to our aid with suggestions on how we can best realise the potential of this copyright and use it to raise much needed funds for ophthalmic research.

If you have any ideas or thoughts to share, please email us at oria@oria.org.au
ONZ’s focus in New Zealand is currently mostly on health insurance, particularly on one provider that practically has the monopoly in health insurance.

Unlike Australia, where approximately 46% of the population has private health insurance, in New Zealand only 29% of the population holds private health insurance. This is due to a few factors; the main being New Zealand’s comprehensive public health system and the presence of a universal insurance program for injury via the Accident Compensation Corporation (ACC).

But in a limited market, a near monopoly insurer – such as the one mentioned with 62% of the market share – is able to dictate terms and remuneration for services to providers.

ONZ spends much of its time in meetings and correspondence with the insurer, attempting to negotiate realistic clinical criteria for services reimbursed by the insurer and limit cost shifting to providers in New Zealand.

Our main focus currently is concerning anaesthetist use in cataract surgery provided privately. The insurer referred to has decided that it will no longer remunerate for anaesthetist use in cataract surgery and, where an anaesthetist is used, the cost will be borne by the ophthalmologist.

The monopoly insurer has reviewed its claims and identified that not all ophthalmologists use anaesthetists – according to said insurer, 23% of the highest volume cataract surgeons do not use anaesthetists so for them anaesthetist costs are not an issue. These surgeons may as well, for instance, exclude patients based on the assumption that they are not safe for non-anaesthetist supported surgery and send them to the local public facility. Thus, it is not correct to assume that they never use anaesthetists, only that they choose their case mix.

This situation creates a windfall for the private insurer as these patients will not be able to access privately funded surgery in that particular area and, thus, the insurer does not have to part with their surgical costs as they are borne by the public sector. For those surgeons that consider using an anaesthetist vital for safe surgery this is a major issue and, as such, it is also of concern to ONZ.

Why? Unlike Australia, where pressure has also been brought to bear on private cataract prices, service providers for a particular insurer’s members are unable to charge any out-of-pocket costs to patients. This is due to the package that the insurance members are offered. The members – our patients – have signed up to this package as it states there will be no out-of-pocket costs to them. The agreements with the insurer also have a confidentiality agreement. This means that the provider cannot charge for anaesthetist care, and this is not able to be shared with the patient, who believes all costs are covered.

Providers have no choice but to absorb the cost completely. Therefore, when an anaesthetist is required, the cost of care comes from the surgery centre and/or the ophthalmologist’s remuneration.

This situation is unacceptable to ONZ as it introduces another risk into the equation in which it does not allow the ophthalmologist to pass on the additional costs of more complex individual cases. We believe our members are thoroughly committed to their patients’ wellbeing and would not base a clinical decision on commercial matters, but the landscape around these decisions is now very different. The risk profile is now different and the patient is unaware of this change.

ONZ has met with the insurer concerned several times, the last at the top level, to voice their concerns and has committed these to writing. We have placed a submission with the Insurance Contracts Law Review and fielded many concerns from our members.

We will continue to represent our members’ interests and may be forced to take a more public stance in future. But at this time we are still in correspondence with the insurer and hope that a compromise can be negotiated on behalf of our patients.

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A REMINDER ABOUT OUR UPCOMING ANNUAL ACTIVITIES

Clinical Leaders Forum
Where: Buddle Finlay Boardroom, PwC Tower, 188 Quay Street, PO Box 1433, Auckland.
When: Monday 18 March

ONZ Business Forum – The Other Matters
Where: The Pullman Hotel, Auckland
When: Thursday 9 May 2:30pm – 3:30pm

We thank our sponsors for making the Business Forum and our activities possible:

Allergan Legacy
Australian Society of Ophthalmologists

The proposal we must all be aware of

A new proposal has surfaced in the last few months which will require attention by all medical colleges, societies and the AMA. It comes on the back of continued discussion about perceived shortages in most medical specialties.

Traditionally, medical colleges oversee the training and standards of specialties so acceptance into a training program usually requires entry via a college. The new proposal, however, suggests that the Australian Health Practitioner Regulation Authority (AHPRA) would instead decide who is to be trained and in what numbers — in short, specialty trainees would be whichever candidates AHPRA deems suitable.

The subject is due for discussion at the next Council of Australian Governments (COAG) meeting – the date of which is yet to be announced. Lobbying of state health ministers in the lead up to the meeting will be necessary.

At present, medical colleges fulfill this important entry point role and are accredited by the Australian Medical Council (AMC) to do so. Under the new proposal, the role of the AMC to accredit specialty colleges would also be taken over by AHPRA. The great danger here, as I see it, would be cross-training and role substitution. Hypothetically, AHPRA could decide, for example, that five chiropractors per year must be trained in spine surgery by RACS or that 10 optometrists per year must be trained in cataract surgery by RANZCO.

What is also at risk is the quality of training and supervision and Australia’s long record of producing medical specialists of the highest calibre.

Those who champion nationalisation of medicine are keen to eliminate the door keeper role of medical colleges. They would rather have bureaucrats assessing training eligibility than doctors from a national body. They want a national law according to their own workforce designs. AHPRA was such an initiative and replaced the state health boards. Now the Authority could broaden its powers further and take charge of doctor numbers, training and accreditation via the colleges as captive vessels.

With a change of government very possible this year, it is no coincidence that these proposals are coming to light now. The British Medical Association was blindsided by the implications of nationalised health and now has the NHS to deal with. These things are silently slipped through by ideological bureaucrats with time, patience, policy expertise and the inner contacts in government and academia to enact them. By comparison, we are time poor, distracted and resemble the feeding gazelle on an Attenborough documentary just prior to the lion attack.

This issue, combined with the ideological motivations of the MBS Review, has raised the alarm. The ASO can’t work alone here. We need the colleges, the AMA and vociferous support when requested.

We enthusiastically encourage Fellows to join the ASO, stay informed and play an active role in the future of our specialty, indeed our profession, by being an ASO member.

Dr Peter Sumich
President, ASO
Interview with CERA’s new Managing Director, Professor Keith Martin

Professor Keith Martin is the Managing Director of the Centre for Eye Research Australia (CERA) and Ringland Anderson Professor and Head of Ophthalmology at the University of Melbourne.

Until January 2019, he was Head of Ophthalmology at the University of Cambridge, Deputy Director of the University’s John van Geest Centre for Brain Repair and an Affiliate Principal Investigator at the Wellcome Trust – MRC Cambridge Stem Cell Institute. He was also Academic Lead for Ophthalmology and Lead Clinician for Glaucoma at the Cambridge University Hospitals NHS Foundation Trust.

He graduated from the University of Cambridge with a ‘Triple First’ in Medical Sciences and Neuroscience before completing clinical training at Oxford University Clinical School, Ophthalmology Residency in Cambridge and clinical and research fellowships in glaucoma at Moorfields Eye Hospital in London and the Wilmer Eye Institute in Baltimore.

He is co-founder of Quethera, a Cambridge-based company which has developed a gene therapy for glaucoma that is currently progressing towards human clinical trials.

He is also currently President of the World Glaucoma Association. For this issue of Eye2Eye, we sat down with him to discuss his new role at CERA.

Q: You moved to Melbourne from the University of Cambridge to take up your new role at CERA; what has the transition been like and how are you finding Australia so far? Is there anything in particular that you miss about home?

A: The transition has been pretty straightforward. Cambridge is a difficult place to leave but Melbourne is a pretty easy place to settle in. I’m loving getting to know the city; the first thing I did was buy a bike – like Cambridge, Melbourne is a fantastic cycling city so that’s been good. Since starting at CERA not too long ago, I feel like I’m already among friends – it’s a great team and I’m following on in the footsteps of Jonathan Crowston who did a fantastic job building up the science here, and Peter van Wijngaarden, who has done a really great job steering the ship over the last year. So, I’m very lucky to come in off the back of people who have been very successful here.

The only thing that was a bit of a shock to me was the weather – when I left the UK it was minus five and when I got here it was just over 38 degrees so that was a bit of a change. And I’ve experienced every sort of weather since, so you’ve got to love the variety!

In terms of missing things about home, I guess the main thing is family. My wife Susie and kids are still in the UK and they aren’t able to join me until August, but they’ve visited already and they’re really looking forward to the move.

Q: What do you hope to achieve in your new role at CERA and what are you looking forward to most?

A: I’m really looking forward to working with a great team of dedicated researchers. We have a lot of people here who are passionate about protecting and restoring vision and my job is to really help drive that research forward in a way that will make a real difference to patients in the future. We’re focused on aging eye diseases, regenerating visual systems and bringing new treatments to patients. Within these broad themes, we’ve got a whole range of different projects going on. We’ve got work on bionic eyes, national diabetic screening programs and early diagnosis of Alzheimer’s disease; a huge amount of work on genetics and stem cell research and work on improving communications between optometrists and ophthalmologists. With all that going on as well as our internal projects, I really want CERA to continue to look outwards; to continue to develop existing partnerships as well as build new ones with other organisations around Australia and around the wider world. We are very fortunate to have strong relationships with the University of Melbourne, where I am Ringland Anderson Chair of Ophthalmology, and the Royal Victorian Eye and Ear Hospital. This places us in a great position to do translational research, taking the discoveries we make...
in the lab to develop new treatments for patients. I think there’s a fantastic vision research community with lots of strong collaborative work going on already and I think the new funding environment is encouraging us to think big and is encouraging collaborative work across medical research. I think we, in the vision research community, are certainly stronger together. I want CERA to work to build strong partnerships that will be internationally competitive and bring real depth to Australia.

Q: You’ve been at the forefront of ground-breaking research into gene therapy and stem cell therapy to reduce optic nerve damage. What progress do you hope to see in this area over the next 10 years?

A: In the last few years, we’ve seen amazing advances in our understanding and in the treatment of eye disease. Gene therapy has advanced further in the eye than in any other organ. As a speciality in ophthalmology, we’re the first to have a gene therapy license by the FDA in the US and a license in Europe for an inherited disease – that’s a really exciting stage of development! I think in the next 10 years we’ll see gene therapy becoming established for the treatment of a variety of rare, single gene disorders and it will start to be used in more common diseases like glaucoma, diabetic retinopathy and, possibly, macular degeneration. Our own work has been focused on developing gene therapy for glaucoma and my dream is that over the next 10 years we can start to use gene therapies and stem cell technologies not just to slow the decline of vision but to enhance visual function in patients with glaucoma.

Q: What do you see as your proudest achievement?

A: I guess many of my proudest achievements are family related but beyond that there are the clinical and scientific achievements that I’m reasonably happy with. I guess on the research side, the experience of co-founding a gene therapy company from my lab at Cambridge and seeing that project being taken forward to clinical trials by major pharmaceutical companies has been a great learning experience. Clinically, seeing some of the babies I’ve treated with congenital glaucoma turning into happy and successful young adults has been pretty amazing. And, of course, I’ve had a string of Aussie and New Zealand fellows – over the last few years I’ve had nine fellows from down here – who came to work with me in Cambridge and it’s great to see them doing great things back home.

On a more personal note, I enjoy music very much and one of the things I was proud of was that I set myself a challenge to learn a very difficult Chopin piano piece and perform it in public at an international meeting, which was one of the scariest things I’ve done!

Q: What are some of your hobbies outside of work and how do you maintain a healthy work/life balance with such a busy schedule?

A: I’m quite active outside of work – I cycle 16km to work most days, I play tennis regularly and I love to sail and windsurf on the weekends when I get a chance.

Q: Can you tell us something about yourself that most people don’t know?

A: You may not know that I hold a black belt in karate. But I’ve been beaten up by too many 16-year-olds in training recently, so it might be time to call it a day on that one!

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© MD EyeCare 2018.
The University of Sydney and the University of Otago have delivered the inaugural Australia and New Zealand Microsurgical Skills course at the Sydney Eye Hospital.

Building on a longstanding collaboration between the institutions, the course aims to teach microsurgical skills to aspiring ophthalmologists from Australia and New Zealand. Through a combination of online lectures and intensive wet lab training, students learnt essential skills in:

→ **wound repair on pig eyes**: lamellar corneal wounds, full thickness corneoscleral wounds, ruptured globe repairs;

→ **oculoplastic techniques on human cadaver heads**: lid wedge excision, periorbital anaesthesia, skin excisions and flap repairs, subtenons anaesthesia, peritomy, ocular muscle detachment and re-attachment, enucleation, tarsorrhaphy techniques, canthotomy and cantholysis; and

→ **cataract surgery** using artificial eyes including capsulotomy, phacoemulsification, IOL folding and implantation, draping and surgical antisepsis.

Dr Graham Wilson from the University of Otago was inspired to create the course after attending the very popular microsurgical skills program run by the Royal College of Ophthalmologists in the UK. Established in 1990 by consultant ophthalmologist Mr Nigel Cox, the UK course now runs eleven times a year and is compulsory for all UK trainee ophthalmologists. Mr Cox has been generous in his support of the ANZ course and came to Sydney as an invited lecturer for the two-and-a-half-day wet lab component. The 19 doctors attending the course greatly benefitted from his experience and expertise in training registrars and residents in the skills and approach to microsurgery.

In addition to Dr Wilson and Mr Cox, academics from across Australia and New Zealand contributed to the course ensuring a staff to student ratio of 1:3 for the face-to-face teaching. All the teachers involved with the course are clinicians as well as academics and brought a wealth of knowledge and real-world clinical experience to the program:

- Dr Paul Baddeley, St George’s Eye Care, Christchurch
- Dr Oliver Comyn, St George’s Eye Care, Christchurch
- Mr Nigel Cox, Royal College of Ophthalmologists, UK
- Dr Yves Kerdraon, University of Sydney
- Dr Logan Mitchell, University of Otago
- Dr Con Petsoglou, University of Sydney
- Dr Simon Taylor, University of Sydney
- Dr Graham Wilson, University of Otago
The course was held in the Sight for Life Foundation wet lab at the Sydney Eye Hospital. This world-class training facility provided several unique innovations in training. The attendees had access to human cadaver heads, which provided the most authentic way of practising their surgical techniques. All students also trained on the Eyesi cataract surgery simulator to assess and improve their intraocular dexterity and skills.

Support from industry provided vital enhancements to the course that would not have been possible otherwise. An educational grant from Johnson & Johnson (J&J) Surgical allowed for the purchase of 10 Pharmabotics surgical skills boards. These boards were developed for the UK course and enable doctors to practise surgery on artificial skin and globes. This is the first time such skills boards have been used in Australia or New Zealand for training. In addition to the boards, J&J Surgical provided artificial eyes, two phaco machines and all consumables, catering for all sessions and a textbook on cataract surgery for all trainees. Alcon Surgical provided four cataract machines with consumables and held a course dinner at Lotus Restaurant in the Sydney CBD and Zeiss Australia provided two additional microscopes.

The academic staff noted that it was very encouraging to see the progress all the students made. On completing the course, several students commented on the improvement of their technical skills and confidence and expressed the positive effect this will have on their future patients. Given the success of this first course and a high demand for places, the University of Sydney and the University of Otago are delivering the program on 4-6 April 2019 and 6-8 November 2019.

**Student feedback:**

“The instructors were extremely patient and helpful. Overall, I was very happy with the course. Rotating between succinct lectures, breaks and practicals was helpful to keep the mind alert and constant feedback during practical sessions was most helpful and set it apart from many other surgical courses.”

- Anonymous
Spotlight on family link to AMD

Macular Disease Foundation Australia (MDFA) will be shining the spotlight on the hereditary nature of age-related macular degeneration (AMD) when it launches its latest public awareness campaign for Macula Month in May.

MDFA’s annual awareness campaign morphed from a week-long campaign into a focused month of activities for the first time last year. Now called Macula Month, it runs from 1-31 May, with the aim of educating Australians about the importance of regular comprehensive eye health checks and the need to take early action to prevent sight loss from macular disease.

In 2007, when we started our general awareness drives, one in three (1.9 million) Australians in the 50+ ‘at risk’ age bracket were having an eye examination every two years. We’ve moved that dial to two in three – or six million Australians over the age of 50 – being tested regularly. But with the growing prevalence of AMD, we can’t afford to stay still. We need to make sure the message – that early action saves sight – gets to everyone.

While age and smoking are two of the biggest risk factors for AMD, there is a strong genetic component to the disease. It is estimated that genetic factors play a role in up to 70% of AMD cases and the risk of AMD is greatly increased by having an affected first-degree relative. It is estimated that there is a 50% risk of developing AMD if a parent or sibling has the disease.

Yet many callers to MDFA’s National Helpline seem to be unaware that genetic factors can play a role in their disease. They’ll often disclose that a sibling has AMD or that a parent ‘had bad eyes’ but ‘they didn’t know about macular degeneration in those days.’ However, they claim not to have received specific advice of the hereditary nature of macular degeneration.

Many of these callers have adult children either in or approaching the 50+ ‘at risk’ age group. MDFA is concerned that these adult children are not being warned that they have a predisposition to AMD and, therefore, are not getting regular checks of their macula, or taking steps to maintain the health of their macula.

It may be that warnings about the hereditary nature of AMD are not being heard, simply because patients receive a lot of information about their diagnosis in a relatively short space of time.

This is where MDFA can help. The National Helpline provides information and advice to people ‘at risk’ or living with macular disease, their families and carers.

It is not uncommon for our education team members to spend up to an hour on the phone with a client – reinforcing the advice they’ve already received, answering follow-up queries and directing people to relevant community supports and government subsidies.

Over the course of a year, we receive more than 6,000 calls to our National Helpline and send out more than half a million free publications and resources. In addition, MDFA’s education team hosts free community education seminars that reach thousands more.

As an ophthalmologist, we encourage you to refer your macular disease patients to MDFA for the non-clinical support services we offer.

You can do so through our online referral form (you’ll find it on MDFA’s website under ‘Resources – Refer a Patient’). For those using the Oculo platform, a referral option will be available soon. We hope to roll this out across other patient management systems this year.

MDFA Research Grants Program

We would like to remind Australian researchers and institutions that you are invited to apply for the next round of Macular Disease Foundation Australia (MDFA) Research Grants funding. MDFA is a major contributor to local macular disease research. To date, $3.6 million has been committed to 18 projects. A new grant pool of up to $600,000 will be available for the next round of research, due to begin in 2020.

Successful applicants will be announced in October, on World Sight Day.

Applications open on 1 March and will be received until 2 June 2019. Further information is available on the MDFA website.

Dee Hopkins
CEO, MDFA

About MDFA

MDFA is recognised as the peak body for the macular disease community in Australia. MDFA operates a National Helpline 1800 11 709—to provide information and support to people living with macular disease, their families and carers.

Our services are free.

www.mdfoundation.com.au

Note: This article draws on a number of sources.
Please email eye2eye@ranzco.edu for the complete list of references.
Register with KeepSight and help reduce diabetic eye disease in Australia

A large scale community awareness campaign has been launched to encourage people with diabetes to get their eyes examined, as part of the national KeepSight program.

Ophthalmologists are critical to the success of KeepSight and are being encouraged to register for the program so that they and their clinical staff are prepared to respond to any requests from their patients to participate.

KeepSight is a national eye screening reminder program designed to help prevent vision loss from diabetic eye disease by targeting the 1.3 million people with diabetes registered on the National Diabetes Services Scheme (NDSS). The goal is to target and engage with almost half of these people – those who aren’t getting recommended eye examinations and, as a result, are unnecessarily at risk of vision loss.

From March to June 2019, the first phase of a public communications campaign will be implemented encouraging people to register for KeepSight and get their eyes examined. The campaign includes direct electronic and SMS messaging to people currently registered with the NDSS, as well as a broad awareness campaign including television, radio and digital advertising. It will also include more intensive targeted communications in three key regions with higher rates of people with diabetes including western Sydney, the Sunshine Coast and south-east Melbourne.

By participating in the program and recording when KeepSight registered patients have eye examinations, ophthalmologists and their clinical staff will help reduce the overall rates of diabetic eye disease in Australia.

How can ophthalmologists and orthoptists get onboard?

Ophthalmologists and their clinical support staff who already use the Oculo system can simply log on to Oculo, select a patient and follow the prompts for KeepSight registration.

For those practices without Oculo, ophthalmologists register through the KeepSight web portal with three easy steps:


2. Provide your email address and create a password. You will then be sent a confirmation email.

3. Click on the link in the confirmation email, and then log in with the password you have just created. Follow the prompts to enter your information – please note you will need your AHPRA number as part of the registration, or an Orthoptics Australia membership number for orthoptist staff.

You only need to do this once but you do need to be registered with the system before you can register patients.
Registering your patients with KeepSight

1. Log in to the KeepSight website using the email and password set up during registration.

2. Follow the prompts to record a patient visit.

3. You’ll need to record the patient’s name, some basic information about the eye check provided and when the patient will need a follow-up eye check. If possible, the patient’s NDSS number should also be recorded if they can provide it.

Practices using Oculo will be prompted to register patients with diabetes to KeepSight when managing referrals and clinical correspondence.

Patient information will be strictly managed in accordance with industry best practice to safeguard data security and patient privacy. Identifiable patient information will only be available to Diabetes Australia as the KeepSight lead partner to remind the patient when eye examinations are due in the future and will not be released or shared.

For more information:
Visit www.keepsight.org.au
Call 1300 136 588
Email support@keepsight.org.au

KeepSight is led by Diabetes Australia and Vision 2020 Australia and funded through a public-private partnership with matching funding from the Australian Government and Specsavers. Bayer is also providing some funding towards the initiative. Oculo is the technology provider for KeepSight. The Centre for Eye Research Australia is leading the program evaluation.

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Isabelle Stransky
Membership Assistant

I have just returned to work after an extended maternity leave. I have two daughters; one is two and a half years old and the other is one. Now that they are both in full time care, I am excited to have joined the friendly and welcoming team at RANZCO as the Receptionist and Membership Assistant. I will also be working with the Practice Managers’ Committee, the Archive and Museum Committee and the Senior and Retired Fellows’ Group.

You will notice an American accent if we speak on the telephone – while my background is Czech and French, my accent was ‘perfected’ during my time at Connecticut College (in the north east of the United States) where I graduated with a degree in Hispanic Studies and Sociology.

Most of my career pre-children was spent working in admin in various roles at the American School in London (coincidentally my alma mater), most recently as the Associate Dean of Admissions. This was before moving to Australia to be with my husband in 2013. On arriving in Sydney, I decided to try something new and studied early childhood education and care. I worked in the industry for a year before coming to the quick realisation that I preferred to interact with adults on a daily basis rather than babies. My next role was in international student recruitment at the New York Film Academy, based at Fox Studios. I had my eldest daughter nine months later.

In my spare time (haha...what is that?!?) I love to cook, bake and, most of all, eat. Food is my passion. I also enjoy swimming and catching up with family when I can, although we are scattered all over the world – my parents are in the south of France and my siblings are spread across Hong Kong, Italy and New York.

I look forward to speaking with you all on the phone and hopefully meeting everyone at Congress in November.

Victoria Baker-Smith
Head of Education

I’m excited to have recently joined RANZCO as the Head of Education where I’m responsible for the day-to-day activities of education, ensuring that our training and CPD activities are aligned with our strategic goals and continue to fulfil the accreditation requirements of the AMC. My aim is to make sure that we maintain the best standards in the practice of ophthalmology across both Australia and New Zealand so we can continue to produce some of the best ophthalmologists in the world. While there is much work to do, I am looking forward to the challenge.

In terms of my background, I have over 15 years’ experience managing and delivering quality education programs for colleges and health organisations. In fact, I worked for RANZCO over a decade ago developing the curriculum for the five-year VTP and preparing for RANZCO’s first AMC accreditation. Since then, I have continued developing my expertise in this field in management positions in health education organisations and by completing a Masters in Higher Education (Learning and Teaching) at Macquarie University.

On a personal note, I love to drink tea and consider myself a bit of a tea connoisseur. In my spare time I also enjoy reading detective novels.
RANZCO Museum

50 years ago – Management of glaucoma at the time RACO was founded

The standard diagnostic instrument for measuring pressure was the Goldman tonometer and to a lesser extent the Schiotz tonometer. Visual field testing used a Bjerrum screen in most practices with some practices and hospitals having purchased a Goldman perimeter. The pathophysiology of glaucoma was still in its infancy and visualising the optic disc required a guess with a direct ophthalmoscope or using the Huby lens on the slitlamp.

Visualising the fundus of glaucoma patients was made even more difficult as the standard medication used was Pilocarpine which constricted the pupil and, in elderly patients with lens opacities, this made the task even harder. Side effects of drugs such as epinephrine and physostigmine inhibited compliance. Surgery often required fistulising procedures, which failed by either leaking or closing. The progress in diagnosis and treatment has been incremental, however, patient numbers have increased with longer life expectancy and better diagnostic tools.

New acquisition

A trove of memorable correspondence from Ringland Anderson, an outstanding ophthalmologist from Melbourne after whom the first chair of Ophthalmology in Australia was named, has been presented to the College Museum by his grandson Professor Hugh Taylor.

Notable is the letter and photograph of Anderson with Helen Keller whose worldwide contribution to services for the blind included setting up institutions in Australia. The biography of Ringland Anderson is now on the website.

New presentation on the website

The following presentation is now available on the website under ‘RANZCO Museum Presentations:’ Eye disease in Europe at the time of the first fleet and its impact on the Aboriginal population thereafter.

To celebrate the 50 years of the College, Eye2Eye will feature articles on important topics and notable people from the time of its foundation.

David Kaufman
Curator, RANZCO Museum
Julian Bernard Heinze was born on 20 November 1933 in Melbourne. At the time, his father, Sir Bernard Heinze, was a Professor of Music at Melbourne University.

He was educated at St Kevin’s College, Melbourne and graduated from medicine at Melbourne University. He trained in ophthalmology at Moorfields Eye Hospital, beginning in 1964, during which time he also gained Fellowship of The Royal College of Surgeons (RACS).

Dr Barry Taranto recollects: “I arrived in England in 1963 in the coldest winter for 80 years, and met Julian at London House, which was an institution for Commonwealth postgraduate students. I was immediately impressed with his friendly personality and quirky sense of humour. We studied the Diploma of Ophthalmology together at the Institute of Ophthalmology, and I was somewhat in awe of his ability to study and yet enjoy life with such enthusiasm.”

Dr Heinze was fortunate to train under a number of remarkable surgeons while at Moorfields. These included:

- Barrie Jones, a New Zealander, who introduced the hospital to microsurgery and to the concept of subspecialisation. Specialist clinics sprang up overnight, all staffed by enthusiastic young doctors, such as Julian, keen to develop their unique expertise, making Moorfields the first specialist eye hospital in the world;

- Lorimer Fison, who introduced the photocoagulator; and

- Hyla Bristow Stallard, who pioneered cobalt plaque radiotherapy for the treatment of ocular tumours, particularly in children.

It was at Moorfields that Julian met and fell in love with Gisela, a German orthoptist who, like Julian, was a foreign graduate working in the melting pot that was Moorfields (indeed London) at that time. They were married in Germany in 1965. Their son Stefan was born in 1966 and the young family returned to Australia in 1968, at which time Julian was appointed Assistant Professor of Ophthalmology at the University of Melbourne’s Department of Ophthalmology (MUDO) at RVEEH. There he became involved in all branches of ophthalmology with a special interest in the evolving surgical techniques for treatment of retinal detachments. He was an active member of both a general clinic, where he later became head, and in the Retinal Unit, where he was a senior ophthalmologist and where he enthusiastically participated in the teaching of residents and fellows. Julian became well known to trainees as an energetic and inspiring teacher. He was a great microsurgeon who taught many generations of ophthalmologists many excellent techniques.

With the introduction of vitrectomy at the RVEEH, Julian became involved in the evaluation of new instrumentation and techniques as they evolved over several years. He was a great team member and encouraged other members of the unit (now the Vitreoretinal Unit – VRU) to share their opinions on more complex cases. Julian became co-head (with James D. Cairns) of the VRU in 1987.

Despite running a busy ophthalmology practice, Julian found time to serve as Chair of the Eye Section of RVEEH’s senior medical staff (1977-79) and later as Deputy Chair of the Senior Medical Staff (1980-83).

Julian’s legacy remains seen in the numerous vitreoretinal surgeons both in Australia (including the current head and members of the VRU) and overseas who owe much to his enthusiastic teaching. His high standards are a shining example of true professionalism for all who aspire to excel in their chosen ophthalmic specialty.

Julian loved his ophthalmology, music, golf and gardening, but most of all he loved Gisela and his beautiful family. He is survived by his devoted wife, Gisela, children Stefan, Alexa and Vanessa and nine grandchildren.

Stefan Heinze
James Cairns
Barry Taranto
Richard Stawell
## Calendar of Events

<table>
<thead>
<tr>
<th>EVENT</th>
<th>DETAILS</th>
<th>CONTACT</th>
</tr>
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<tbody>
<tr>
<td>New Zealand Branch Meeting</td>
<td>10-11 May 2019</td>
<td>P: 06 833 7440 E: <a href="mailto:karen@cml.net.nz">karen@cml.net.nz</a></td>
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<tr>
<td>Western Australia Branch Annual Scientific Meeting</td>
<td>17-18 May 2019</td>
<td>W: <a href="http://www.ranzco.edu/view-all-events">www.ranzco.edu/view-all-events</a></td>
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<td>The Melbourne Ophthalmic Alumni Meeting</td>
<td>25 May 2019</td>
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<td>Australian and New Zealand Society of Retinal Specialists (ANZSRS) Meeting</td>
<td>1-2 June 2019</td>
<td>P: 0410 304 721 E: <a href="mailto:debbie.kerr@scopeconference.com.au">debbie.kerr@scopeconference.com.au</a></td>
</tr>
<tr>
<td>Tasmanian Branch Meeting</td>
<td>21-23 June 2019</td>
<td>E: <a href="mailto:andrew@conferencedesign.com.au">andrew@conferencedesign.com.au</a></td>
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<tr>
<td>2019 Paediatric Special Interest Group Annual Scientific Meeting</td>
<td>11-13 July 2019</td>
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<tr>
<td>The Melbourne Ophthalmic Alumni Meeting</td>
<td>25 July 2019</td>
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</tr>
<tr>
<td>Queensland Branch Annual Scientific Meeting</td>
<td>1-4 August 2019</td>
<td>P: +61 7 3851 4298 E: <a href="mailto:tdf@conferencelink.com.au">tdf@conferencelink.com.au</a></td>
</tr>
<tr>
<td>Ophthalmic Pathology Course</td>
<td>9-11 August 2019</td>
<td>E: <a href="mailto:diane.kenwright@otago.ac.nz">diane.kenwright@otago.ac.nz</a></td>
</tr>
<tr>
<td>South Australia Branch Biennial Scientific Meeting</td>
<td>10-11 August 2019</td>
<td>P: 0400 280 881 E: <a href="mailto:janine@seedevents.com.au">janine@seedevents.com.au</a></td>
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<tr>
<td>Neuro-Ophthalmology Society of Australia (NOSA) 35th Clinical &amp; Scientific Meeting and NeuroVision Training Weekend</td>
<td>5-8 September 2018</td>
<td>P: 0402 891 804 E: <a href="mailto:kathpoon@bigpond.com">kathpoon@bigpond.com</a> P: 0417 544 310 E: <a href="mailto:e.gmelig@bigpond.com">e.gmelig@bigpond.com</a></td>
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<td>Dunedin Ophthalmology Course</td>
<td>14-25 October 2019</td>
<td>E: <a href="mailto:sally@events4you.co.nz">sally@events4you.co.nz</a> W: <a href="http://www.events4you.co.nz/docc">www.events4you.co.nz/docc</a></td>
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<tr>
<td>AAPOS APSPOS RANZCO Joint Meeting</td>
<td>7-8 November 2019</td>
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</tr>
<tr>
<td>RANZCO 51st Annual Scientific Congress</td>
<td>7-12 November 2019</td>
<td>W: <a href="http://www.ranzco2019.com">www.ranzco2019.com</a></td>
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Positions vacant

Associate Ophthalmologist
Mildura, Victoria

Associate Ophthalmologist with a long term view is invited to join a well-established and expanding practice in Mildura. The practice has recently relocated to a new state-of-the-art large premises. It is fully equipped with multiple consulting rooms and a minor operating room. Mildura is a growing regional city in Victoria which has doubled in population over the last two decades. There is unmet demand from the high percentage of older patients in the region with cataract and age related macular degeneration. The position is suitable for a general ophthalmologist with an interest in cataract surgery or medical retina. Applicant must be AHPRA registered and a Fellow of RANZCO.

E: info@eyecentre.com.au
C: Bree Doolan

Ophthalmologist, Melbourne & county Victoria

Ophthalmologist Associate with a long term view. Career opportunity exists for an ophthalmologist to join a well established and expanding practice with two branches in the northern suburbs of Melbourne and two in country Victoria. The position is suitable for a general ophthalmologist with interest in medical retina, glaucoma or oculoplastic surgery. We are seeking a motivated young ophthalmologist with a long term view to be part of a successful growing service.

The successful applicant must be an AHPRA registered medical specialist with Fellowship of The Royal Australian and New Zealand College of Ophthalmologists.

E: info@eyecentre.com.au

Glaucoma Fellowship
Royal Perth Hospital

Full-time glaucoma fellowship available for immediate start at Royal Perth Hospital. High volume surgical glaucoma unit in a central tertiary referral hospital. Timetable and funding details available on application.

C: Helen Lefroy (admin assistant)
E: helen.lefroy@health.wa.gov.au
P: +61(08) 9224 2326

Ophthalmologist
Mornington Peninsula, Victoria

An exciting opportunity exists to join a well established, expanding private practice based on the popular Mornington Peninsula. We aim to provide high quality, effective specialist ophthalmology services to adult and paediatric patients. This position will provide you with the opportunity to work in a great multidisciplinary team where each ophthalmologist’s knowledge and subspecialties are valued and respected.

We are able to offer a flexible number of consulting sessions per week. Sessions are Monday to Friday, with no weekends. This position is suitable for an associate with an interest in paediatric ophthalmology, glaucoma and/or oculoplastic surgery.

C: Bree Doolan
E: pm@heatherhilleye.com.au

Clinical Paediatric Ophthalmology Fellowship
Brisbane, Queensland

12 month fully funded clinical fellowship in paediatric ophthalmology & strabismus surgery in South Bank, Brisbane.

E: shuan.dai@health.qld.gov.au

General Ophthalmologist
NSW

iVision Clinic is seeking applications for a general ophthalmologist.

Our modern clinic provides up-to-date diagnostic equipment and a large treatment room equipped for minor procedures including intravitreal injections. We have an established and growing base of patients with a variety of conditions.

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

E: admin@ivisionclinic.com.au

For sale

Practice for Sale/Lease
Kogarah & Marrickville NSW

Calls for expressions of interest - practice up for sale or lease in Kogarah NSW 2217 and Marrickville NSW 2204. Established solo ophthalmic practice of 42 years, available for takeover. Suitable for a young and enthusiastic ophthalmologist with a view to take over the practice.

There is plenty of potential to develop the practice into one’s eye speciality or subspecialty. Parking for two cars available.

Terms and conditions are negotiable. Interested ophthalmologists.

M: 0416 184 015 or
P: +61 (02) 9546 4332 (after 5pm).
Please do not ring between 9 September to 2 October 2019.
“I urge my colleagues to work in close partnership with Vision Australia.”

Julian Rait

When to refer?

On diagnosis of a permanent, non-correctible or progressive eye condition.

or

Visual acuity is 6/12 (BEO) &/or Visual field of 30 degrees (BEO).

or

Vision loss may be putting your patient at risk.

or

Support is needed to adjust to vision impairment.

Associate Professor Julian Rait OAM
President of AMA Victoria.

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