QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Rapid access referral for patients with age-related macular degeneration (AMD)

The Macular Disease Society (MDS) highlighted the delay in treatment experienced by some patients with age-related macular degeneration in the document, *Playing Games with People's Sight*. This likened the referral process to a game of Monopoly, with many chances of being held up on the way and it advocated fast-track referrals to ensure patients get optimal results from modern therapies.



The document, based on surveys carried out by the MDS and Novartis, indicated that a significant proportion of patients are either not referred or not receiving photodynamic therapy (PDT) early enough to derive the maximum benefit from it.

Now that we have established centres with good service provision, the focus is on the referral route. The MDS found that patients tended to be referred by optometrists to general ophthalmology units that do not provide PDT and delays can occur whilst the patients are re-referred to treatment centres. It is clearly advantageous if optometrists can identify ophthalmologists that are willing and set up to provide rapid access assessment, whether they perform PDT or not. It is equally important to reduce inappropriate referrals.

Good practice highlighted

The Thames Valley Macular Group have devised a referral template based on the identification of any one or more of the triad of physical signs, namely retinal haemorrhages, subretinal fluid and exudates. They emphasise the importance of recent symptoms and deterioration in visual acuity in association with the fundus signs. To assist identification of physical signs the referral form is accompanied by a colour atlas with examples of various stages of early and late AMD.

The rapid access form for exudative AMD was initially developed by Susan Downes [Oxon], Consuela Moorman [Bucks], Sarah-Lucie Watson [Berks] and Lyn Jenkins [Bucks Primary care] and by local optometrists. It is intended as a template to facilitate rapid access referral for patients with AMD, and it should not supplant any effective existing local referral arrangements.

It is also endorsed by MDS, the College of Optometrists, and the Royal National Institute for the Blind, all of whom contributed to its design.

Audit

Separate audits in Bucks, Oxon and Berks performed after the introduction of the Rapid Access Forms show that although some patients did not have wet AMD, the majority had a type of early or late AMD. Since the audit, the referral pathways have been modified so that now optometrists get confirmation that their referral fax has been received in the eye department and they are given a contact telephone number to assist in troubleshooting.

An example of the process developed in Oxford is shown in the table on page 2.

It was clear from the experience in the

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Articles and information to be considered for publication should be sent to kathy.evans@rcophth.ac.uk and advertising queries

should be directed to Robert Sloan 020 8882 7199 rsloan@rsa2.demon.co.uk

Copy deadlines

| Autumn | 5 August 06 | |
|--------|---------------|--|
| Winter | 5 November 06 | |
| Spring | 5 February 07 | |
| Summer | 5 May 07 | |

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An example of the process in Oxford is as follows:

Fax machine checked at least twice daily, referring optometrist informed, usually by telephone, that fax received.

Appointment time and date to suit patient made by phone for colour/OCT imaging.

OCT and colour images shown to 'Medical Retinal Team' on same day for decision whether to proceed to FFA.

FFA or clinic booked as appropriate.

If proceed to FFA, FFA reviewed same day by the team and appropriate intervention arranged.

Thames Valley that the introduction of such a form needs to be underpinned with training and explanation of how, when and for whom to use the form. The cost effectiveness of PDT is dependent on the early identification of disease. With the advent of new and hopefully more effective therapies, it is increasingly important to identify patients who will be eligible for these treatments and ensure timely referral and intervention. The rapid referral form and atlas are on the College website www.rcophth.ac.uk /scientific/publications

Members may modify the form to adapt to local circumstances. Hard copies will be available from Novartis by contacting Dr John Probert. (john.probert@novartis.com).



Extract from the atlas.

The College and the Thames Valley Macular Group thank Novartis for its contributions in training and specifically for the support of this project.

> David Wong Susan Downes

Avastin

Professor Wong has written a paper on the related topic of Avastin following the July 2005 editorial in Ophthalmic Laser 'Intravitreal bevacizumab for choroidal neovascularization and cystoid macular edema: a cost-effective treatment?' and the publication of the first case report of intravitreal avastin for AMD and cystoid macular oedema for central retina vein occlusion. This treatment has since been adopted in the US, Germany, Australia, Mexico, Turkey and elsewhere. Worldwide, 7,000 cases have been documented in a short space of time. The full text can be read on www.rcophth.ac.uk/scientific/scientificnews

New surgical treatments for retinal disease

Mr Robert MacLaren has been awarded a clinician scientist fellowship from the Health Foundation for his research programme, Development of retinal transplantation for patients with retinal disease. At £3/4 Million this represents one of the largest awards of its kind ever made in ophthalmology. The laboratory component of the project will develop a stem cell approach to the transplantation of individual photoreceptors and explores genetic modification of the adult recipient retina to replicate the ontogenetic events that drive photoreceptor

synapse formation during embryogenesis.

The clinical component of the project will develop transplantation of the retinal pigment epithelium for patients with age-related macular degeneration and inherited retinal diseases. Mr MacLaren will take up a dual appointment with the Institute of Ophthalmology and Moorfields Eye Hospital.

Since completing registrar training and a vitreoretinal fellowship at Moorfields in 2004, he has worked as an MRC Research Fellow with Professor Robin Ali at the Institute of Ophthalmology and as a locum consultant at the East Surrey Hospital, Redhill. Mr MacLaren formerly completed a PhD with Dr Jeremy Taylor at the University of Oxford, showing that the mammalian optic nerve could regenerate successfully during embryonic stages of development. Currently, Mr MacLaren receives research funding from the Special Trustees of Moorfields Eye Hospital, the Royal National Blind Asylum and School and the Scottish National Institute for the War Blinded. He is also a lecturer in medical sciences at Merton College Oxford.

The Duke of York The College Patron, the Duke of York was made a Knight of the Garter as part of the Queen's 80th birthday celebrations. His correct title is His Royal Highness The Duke of York, KG, KCVO, ADC.

Obituaries

Charles Schepens

(1912-2006)

Charles Schepens was born in Belgium and studied mathematics before turning to medicine at the University of Ghent and then training at Moorfields. During the war, under the alias Jacques Perot, he worked for the French Resistance using a lumber and logging enterprise as a front to help over 100 people escape Nazioccupied Europe. He did not speak of his experiences to colleagues and they were only uncovered by chance in the 1980s. After the war, Mr Schepens returned to Moorfields but in 1947 became a fellow in ophthalmic research at Harvard Medical School. He later established the Retina Foundation at Harvard, now the Schepens Eye Research Institute.

He revolutionised techniques for retinal reattachment with the development of the retinal scleral buckling operation which has been credited with raising success rates in the technique from 40% to 90%.

He is survived by his wife Marie Germaine, a son and three daughters.

Professor David Sevel

(1933-2006)

Professor David Sevel will be remembered for his work in embryonic ophthalmic pathology, the treatment of ocular muscle abnormalities and ocular plastic surgery.

He attended medical school at the University of Witswatersrand, studied at the Institute of Ophthalmology, London, (to which he later donated his pathological slides) and he received a PhD from the University of London for research into the ophthalmologic complications of rheumatoid arthritis. He was appointed professor and chair of ophthalmology at the University of Cape Town in 1969, the youngest professor and chairman appointed in the medical faculty. He moved to San Diego in 1979 and to the chair of ophthalmology at the University of California, Medical School. From 1988 to 1998 he was the chairman and head of the Division of Ophthalmology at Scripps Clinic in La Jolla, California.

Professor Sevel was committed to his work and patients to the extent that when asked about his hobbies, he said: 'Ophthalmology and my patients are my life, my passion and my hobby.' However, he was a keen rugby fan and had an avid interest in collecting antique prints, maps and old books. In retirement he lived in Cannes and in London.

He is survived by his wife Golda, a son, a daughter and a grandchild.

We also note with regret the death of **Mr Robin Arthur Owen**, Bromley, Kent.

Members' News

The Western Eye Hospital (formerly known as the Western Ophthalmic) was founded 150 years ago on the Marylebone Road, London. It's still there and as busy as ever despite numerous attempts to move or close it. We will celebrate the occasion with an Open Day at the hospital on 23 November and a scientific meeting on 24 November entitled *Training in Ophthalmology: past present and future,* followed by a dinner in the elegant, prestigious Landmark Hotel, directly opposite the Hospital. We would particularly urge alumni to attend the dinner and the meeting. Wives and husbands are also welcome. We will be writing to as many alumni as we can but please contact us if you would like to attend any of the occasions.

catherine.pattemore@st-marys.nhs.uk

Site Manager, Western Eye Hospital, Marylebone Rd, London NW1 5QH.

Ron Marsh

Peter Watson has been appointed President of the Academia Ophthalmologica Internationalis.

New look for College news

We have expanded *College News* so that it is now 16 pages with more space to report on the College's activities and achievements. We have incorporated Focus but it can be easily detached by those who prefer to keep the technical updates together. By the strange economic laws that govern printing, it is slightly more cost effective to produce *College News* in this new format but our overriding aim is to produce a more valuable resource for members.

FAME! 8 April-6 August 2006 An exhibition created by blind and partially sighted people, National Portrait Gallery St Martin's Place, London WC2H 0HE. Daily 10.00-18.00, Thursdays and Fridays until 21.00 Admission Free

THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Summer **2006**

Consent to treatment

There is nothing intrinsically wrong with an operation taking less time to perform, than is spent seeking consent to perform it, but such a situation highlights a dilemma facing many clinicians: just how much should a patient be told about their treatment? There is no shortage of advice on the topic, and the only justification for this article will be if it allows the clinician to decide what course they personally are going to adopt. The General Medical Council give nearly 1,500 words of advice on providing and presenting information to patients when seeking consent to treatment⁽¹⁾, and a typical NHS trust 'consent policy' runs to 42 pages.

There are two reasons for seeking consent. Firstly, 'to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person.....this will not, however, provide a defence against a charge that the treatment was negligently undertaken or advised'.⁽²⁾ Thus is debunked a common myth, that providing you mention a complication on a consent form, you won't be sued if it should occur. The corollary, that if you don't mention a particular complication, you will have no defence is also incorrect.

The second reason is to allow

patients to decide what is (or is not) going to be 'done' to them, so that they can weigh up the risks and benefits. A potential source of confusion in this context is the term 'informed consent'. It is commonly used in medical ethics, but also has a defined legal meaning. When used as a legal term, it should be to distinguish between two approaches as to 'what to tell the patient'. Some North American courts adopted a 'what a prudent patient would want to know' test. 'The issue of nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs.' (3) This patient-based disclosure of risk is known as 'informed consent'. Other jurisdictions, including our own, maintain the concept of 'what a reasonable doctor would tell the patient' should be the standard.

The House of Lords discussed the two approaches in Sidaway ⁽⁴⁾, and concluded that the Bolam ⁽⁵⁾ principle applied as much to the information to be given to patients as to their diagnosis and treatment. Their Lordships thus supported the 'reasonable doctor' test, when deciding what information should be given to patients; and stated that the 'doctrine of informed consent is not recognised in English law'. ⁽⁴⁾ The Bolam principle in this context would mean, for example, that should a patient become blind after 'faultless' ptosis surgery, and this possibility had not been mentioned beforehand, it would be possible to argue that such a warning was not universally given, providing a group of reasonable ophthalmologists would not give a specific warning either.

Our common law system allows modification of the law as new situations arise. Some recent cases have been portrayed as indicating a drift towards a more patient centred approach, and hence introducing 'informed consent' to English courts. However, careful examination shows that their 'headline impact' is more than the nuts and bolts of the decisions. For instance, the Australian case of Roger v Whittaker (6) is often cited as an example of how even very rare complications should be mentioned pre-operatively. This case concerned a patient who developed sympathetic ophthalmitis after a 'cosmetic' operation on a blind eye, rendering her blind in both eyes. This risk was accepted as 1 in 14,000. In this case there were special circumstances; in that the patient had 'specifically and persistently asked' if there was any risk to her good eye, and the surgeon had not given her a straight answer!

One of Lord Wolfe's judgments is also quoted to suggest that English law is changing. 'If there is significant risk which would affect the judgement of a reasonable patient... it is the responsibility of the doctor to inform the patient so



they can determine the course they wish to adopt'. $\ensuremath{^{(7)}}$

However, the facts of this case are worth closer inspection. A child was stillborn after delayed labour. It was claimed that had she been warned of this risk, the mother would have insisted on earlier induction or Caesarean section. The risk of stillbirth was '1 or 2 per thousand'. The court concluded that such a risk was 'not significant' in the circumstances, and disclosure of it would have done more harm than good; 'this is a case where it would not be proper for the courts to interfere with the clinical opinion of the expert medical man responsible for treating Mrs Pearce."

The GMC have added an additional burden on doctors with their advice on seeking consent. 'Wherever possible, you must be satisfied, before you provide treatment or investigate a patient's condition, that the patient has understood what is proposed and why, any significant risks or side effects associated with it, and has given consent.'⁽⁸⁾ Making sure your patient has understood is a tall order. The courts take a more realistic view. A recent judgment quotes an earlier ruling: 'A clinician must take reasonable care to give a warning which is adequate in scope, content and presentation, and take steps to see that the warning is understood."⁽⁹⁾; but goes on to refute it, saying the standard was 'too high'. It was 'too onerous to expect a clinician to ensure that the information had been understood' and all that could be expected was that 'reasonable steps' had been taken to ensure that it was. (10)

A somewhat perplexing decision of the House of Lords has caused some confusion. In Chester v Afshar ⁽¹¹⁾, they concluded that if a warning of a rare but serious complication had been given, surgery would have been delayed, and as the complication was rare, it would not have occurred, on balance of probabilities, if surgery had been undertaken on another day. Reading the case carefully, one factor may have been that the patient's questions about possible complications were answered in a manner which could be construed as flippant. Fortunately, the decision is being respectfully sidelined, and the reasoning used to decide it was specifically criticised in a later House of Lords decision. ⁽¹²⁾

In a sense 'Consent' has been hijacked. It is, or should be, part of every medical consultation, but is now being formalised by lawyers, ethicists and healthcare administrators or regulators, all giving advice from different angles.

There is no reason why consent for an almost universally safe procedure like YAG laser capsulotomy should be 'required' in written form, whilst potentially damaging interventions such as prescription of immunosuppressive agents are not. Consent should run through the whole consultation and not just be brought in at the end, if surgery is being considered. It should be based on trust, and guided by clinical judgment. Every patient is different, and will require different amounts of information. The risk of cataract surgery in an elderly myopic patient with endothelial changes, whose vision in the other eye is poor because of macular disease, is not the same as a young person with posterior subcapsular cataract. It is not necessary that every possible complication is mentioned, although significant risks should be pointed out. What any one patient might deem significant is a matter of clinical judgment, and the courts which have considered the point still allow scope for the exercise of this. Clearly, the possibility, no matter how remote, that the situation may be made worse rather than better will usually apply, and should therefore be mentioned. By which precise route such deterioration might arrive is probably less critical. If a particular complication would be likely to make a particular patient decline intervention, this

should be specifically discussed.

Questions must be answered accurately, and patients' concerns not simply dismissed. This, of course is as true when prescribing eye drops, as it is when listing for penetrating keratoplasty. It is important to remember that it is the patient's consent that is required, not their families. Elderly patients in particular often ask younger relatives 'what they should do', but the final decision must be theirs.

The final word should go to Lord Templeman in his speech from Sidaway: 'The doctor impliedly contracts to act at all times in the interest of the patient.... No doctor in his senses would impliedly contract to give the patient all the information available to the doctor as a result of the doctor's training and experience... Some information might confuse... or alarm a particular patient. When the occasion to discuss treatment arises, the doctor must decide in light of his training, experience and knowledge of the patient what should be said, and how it should be said.'

While Sidaway remains the law, and as long as a sufficient number of ophthalmologists continue to try and adapt the 'consent process' to part of treatment, talking to our patients as individuals, who in the main trust our judgement, we should be safe from legal action; and I suspect most of our patients will thank us.

Graham Kyle

References:

- I www.gmc-uk.org/guidance/library/consent.asp
- 2 Re W (a minor) (medical treatment) (1992)9 BMLR 22,CA
- 3 Canterbury v Spence (1972)464F2d772, US App DC;cert denied409US1064
- 4 Sidaway v Bethlem Royal Hospital Governors (1985) I BMLR 132 HL
- 5 Bolam v Friern Barnet Hospital Management Committee (1957) I BMLR I, HC
- 6 Roger v Whitaker(1992) 16 148, Aust HC
- 7 Pearce v United Bristol Healthcare NHS Trust[1998] CA Civ 865
- 8 www.gmc-uk.org/guidance/good_medical_practice
- 9 Lybert v Warrington Health Authority [1996] 7 Med LR. 334
 10 Hamwi v Johnson and North West London Hospitals NHS Trust [2005] EWHC 206 para. 43
- II Chester v Afshar [2004] 3 WLR 927
- 12 Gregg v Scott [2005] 3 Lloyd's Rep 130

Museum piece **Ophthalmotropes**

An ophthalmotrope is a mechanical model constructed to demonstrate the movements of the eye and the action of the different muscles which produce them.

The first ophthalmotrope was made by Theodor Ruete in 1845 and it was he who gave it the name 'ophthalmotrope'.

Theodor Ruete (1810-1867) will, however, be remembered for his invention of the first indirect ophthalmoscope in 1852 and for the detailed explanation of the method of indirect ophthalmoscopy in his monograph of the same year.



Theodor Ruete

Frans Donders (1818-1889) became interested in eye movements on reading Ruete's work and his subsequent studies were not only for physiological interest but also for its application to the correction of ocular muscles most particularly in squint.

There followed several 'laws' relating to muscle interaction, the best known being Donders's Law and Listing's Law. It is not surprising that because of the complexity of the actions and counter actions of the eye muscles that ophthalmologists of the 19th century, most of them well known, should have sought a practical solution with the construction of mechanical models.

Ruete's second model of 1857 which is in the College's Collection is an altogether more sophisticated



Ruete's 1857 model. This instrument was rescued from a skip outside the hospital in Halle in the 1970s.

model. The eyeballs, made of palm wood, contain lenses and at the back of the eye there is an opaque screen with a cross on it. The optical system can be moved backwards and forwards to simulate accommodation. Both Donders's and Listing's Laws can be demonstrated on this model.

Ruete's 1857 model can be used to demonstrate both the movements of the eye and more importantly the action of the ocular muscles. Black and red coloured threads represent the muscles, the red ones being the oblique muscles and the black the rectus muscles. The degree of muscle contraction or extension can be measured on a scale at the back of the model.

Later ophthalmotropes such as those of Landolt, Knapp and Snellen were demonstration models only to show the controversial 'centre of rotation of the eye'.

> Richard Keeler museum curator



Hermann Knapp's ophthalmotrope, 1861.



Close-up of Edmond Landolt's ophthalmotrope, 1893.

'Do Once and Share' for diabetic eye disease

Do Qnce & Share

Do Once and Share (DOAS) is a national initiative which will help shape the computer systems being introduced into the NHS over the next five years as part of NHS Connecting for Health (National Programme for IT (NPfIT). The main aim of DOAS is to involve clinicians and patients in the development of the software across a wide range of specialities. There are currently 45 DOAS projects, including diabetes, cataract, glaucoma, and diabetic eye disease, each with a corresponding Action Team. The work of the Action Teams will feed into the NPfIT Technical Office, where it will inform the design, development and integration of the software systems.

The DOAS for diabetic eye disease is a 6 month project that began in December 2005. It aims to develop a systematic approach to diabetic eye disease across primary care, screening and secondary care. A reference group was established consisting of clinicians, managers, IT system suppliers, voluntary organisations and patient representatives. A list of the members of this reference group and action team can be seen on the DOAS for diabetic eye disease website: www.doas-ded.org along with further information about the project.

The aims of the project are to define a national pathway for the detection, assessment and treatment of diabetic eye disease. The project will define a minimum dataset to be collected across primary and secondary care, in addition to that already defined for screening, and aims to ensure that data is recorded in a consistent form to facilitate data transfer where appropriate. It also aims to define the information to be shared between primary care, screening and the hospital eye service for patients with diabetic eye disease. The draft outputs will be placed on the website for wider consultation in the near future. Overall this is an excellent opportunity to shape the software development for diabetic eye disease and your comments would be most welcome.

Clare Bailey

An evolving association

The Medical Contact Lens and Ocular Surface Association (MCLOSA) is undergoing further evolution. Over 20 years ago its forerunner (MCLA) was established as a largely London-based forum for ophthalmologists fitting contact lenses for specialist indications. It rapidly grew to cover the whole nation, and included "ocular surface" into its name to reflect the increasing interest and scientific developments in this field.

In recent years MCLOSA has taken on an international flavour. Our Annual Scientific Meeting always includes a significant number of guest speakers from overseas, but we have also successfully hosted annual meetings for both our international (IOSS, 2002) and European counterparts (ECLSO, 2005).

Meetings are appropriate for specialist corneal and anterior segment surgeons and trainees, as well as those wanting to keep abreast of the field. Lectures on diagnosis and management are well supported by basic and clinical research, including immunology and bioengineering. There is an increasingly surgical feel to the meeting with the inclusion of topics such as high risk corneal grafting, and modern techniques including corneal rings, and endothelial and cultured limbal stem cell transplantation.

The expanded programme now includes opportunities for delegates

to present original research, and the commercial exhibition is becoming more comprehensive. This year will see the launch of the "MCLOSA Toy Shop" where there will be an emphasis on trying and evaluating new devices first hand. A "Contact Lens Workshop" will provide hands-on experience with standard and new lenses.

The evolution of MCLOSA will continue, sculpted by the interests of its members and developments in the field. New members are always welcome, so do join us as we look forward to the future.

Melanie Corbett

Annual Scientific Meeting:

Friday 17th November, London. www.mclosa.org.uk, events01@globalnet.co.uk

The Human Tissue Authority (HTA) and ophthalmology

From 7 April 2006, the HTA started licensing establishments across the UK storing tissue for human application to meet the EU Tissue and Cells Directive. For ophthalmology, this includes corneas, sclerae, corneal epithelial cells, and even skin excised during lid surgery and retained for subsequent autologous use. All other sectors, including research establishments, should be licensed from 1 September 2006.

The role of the HTA is to regulate the removal, storage, use and disposal of human bodies, organs and tissue for a number of 'scheduled purposes' set out in the Human Tissue Act 2004 (HT Act) which covers England, Wales and Northern Ireland, separate legislation exists in Scotland – the Human Tissue (Scotland) Act 2006.

The HT Acts make consent (called authorisation in Scotland) the fundamental principle underpinning the lawful removal, storage and use of tissue from the living or the deceased for scheduled purposes. The new legislation directly affects a number of sectors: establishments storing tissue and cells for human application or research purposes, pathology services, anatomy schools, the transplant community, and sites displaying human material.

The HTA's licensing exercise for cell and tissue establishments has been very successful but there may also be a small number of ophthalmologists and plastic surgery units who may not consider themselves to be involved in tissue banking, yet may be associated with activities that require a licence. These activities include not just storage of ocular tissue and cells but, for example, storage of skin for lid surgery. If you think this may include you and you have not yet applied for a licence, please contact the HTA as soon as possible (see below). Hospitals will not need to be licensed for the holding of corneas or sclerae received through UK Transplant provided the tissue is used or disposed of by the use-by date specified by the Corneal Transplant Service Eye Banks (normally 48 hours).

To apply for a licence, establishments need to complete an online compliance report which was developed following consultation with the sector.

If you have any questions about the licensing process, please visit the HTA website at www.hta.gov.uk or call 020 7211 3400.

> Professor John Armitage director of the Bristol Eye and Heart Valve Banks

Dr Sandy Mather director of regulation, Human Tissue Authority

Changes in the examinations department

Emily Beet has recently been promoted to head of the department having been the deputy for three years. Emily's predecessor, Nina Leontieff, left the College after four years to take up a post closer to home at the University of Reading. The department has been expanded so that we are well placed to cope with the challenges that the new exam structure will bring. The staff are:

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| Emily Beet | head of examinations department | 210 |
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| Sophie Cox | senior examinations co-ordinator | 212 |
| Sheila Patel | examinations co-ordinator | 225 |
| Naomi Pakeel | examinations assistant | 213 |

News from the RNIB

New Beacon, the sight loss and eye health magazine has been relaunched as NB with a new look and new direction for all sight loss and eye health professionals. It will be published every month and members can order a free sample from Nbmagazine@rnib.org.uk The annual subscription for UK customers is £28.80 (UK customers).

For more information visit www.rnib.org.uk/nbmagazine

ORYCLE Report

Ophthalmic Registrars and Young Consultants Learning Essentials (ORYCLE) meeting

30 March-I April, Leeds

De Vere Oulton Hall was a magnificent setting for our best attended meeting yet. Over 60 delegates enjoyed excellent food and service, some live entertainment and heard knowledgeable, experienced speakers cover a range of pertinent topics. The meeting, organised by the Ophthalmic Trainee Group (OTG), gave ophthalmologists a forum to ask questions about their future careers. It was also a wonderful opportunity to meet trainees from around the country and we were delighted that many of the speakers stayed on to talk to the delegates.

The programme began with an overview of current ophthalmology from the president, Nick Astbury. Modernising Medical Careers (MMC) is about to radically change medical training and details of the developing structure were explained by the chairman of the Training



The Soul Surgeons.

Committee, Peter McDonnell.

Professor Alan Maynard, health economist and chair of York NHS Trust, gave a thought-provoking talk on transparency in clinical practice. Emma Hollick, consultant at King's Hospital, London provided an excellent insight for registrars considering consultant posts. The afternoon ended with Ian Wilson on the new consultant contract, including the importance of a job plan and an explanation of program activities.

On Saturday, Council member, Simon Kelly, gave two excellent talks; on the National Patient Safety Agency and on independent sector treatment centres. Ishtiyak Mahomed, gave a personal account of consultant management issues and how these will effect changes in consultant practice. These talks stimulated much discussion over lunch.

Ian Simmons, spoke about consultant income, expectations and how to maximise earning potential whilst maintaining a happy balance of work and quality free time. The talk became a very amusing interactive session, and a great way to end the meeting.

ORYCLE was a resounding success; a stimulating mix of presentations and a friendly atmosphere.

With thanks to Novartis for its educational grant.

Rajen Gupta Amit Patel

Awards and fellowships

The **BUPA Foundation Awards** of £10,000 are made to health care and medical professionals in recognition of excellence. They are designed to encourage innovation in different areas of healthcare including care, research, epidemiology and clinical excellence. www.bupafoundation.co.uk iona@chessells23.fsnet.co.uk Closing date: 3 July 2006

The Harkness/Health Foundation Fellowships in Healthcare Policy

give fellows the opportunity to spend a year in the US whilst their organisations receive full salary replacement costs. www.cmwf.org or contact Robin Osborn ro@cmwf.org **Closing date: 1 September 2006** **The Keeler Scholar 2006** of £20,000 was awarded to Miss Srilakshmi Missula Sharma, an SpR at Bristol Eye Hospital who will be undertaking MD research focusing on the pathogenesis of posterior uveitis at the Casey Eye Institute, Portland, Oregon, USA.

College study tour of Egypt 17-26 February 2006



At the Research Institute of Ophthalmology, Cairo.

The telephone rang. It was 3.00 am and the helpful night porter was telling everyone that the wake-up call would be brought forwards to 5.00 am. President Mubarak was also going to the airport and the roads would be shut. We left at 6.00 am to battle with the Cairo traffic in dense smog and the 5km to the airport was lined with police every 20 metres. So ended our trip to Egypt, packed with memories of 5,000 years of history, wonderful hospitality, teeming souks, flowing galibea and the ubiquitous Nile.

The study tour arranged by Master Travel and ably led by Christopher Liu and Tarek El Kashab included 23 participants with ages ranging from 2 to 82. The group included nine ophthalmologists, two optometrists, a veterinary ophthalmic surgeon, two anaesthetists and a College president.



Abu Simbel.

Egypt has a population of 77m, the majority of whom live within the Nile valley and delta, an area that covers less than 4% of Egypt's total area. Along with thousands of other tourists we experienced the remains of an ancient civilisation and some of the world's most stunning ancient monuments including the Giza Pyramids, the Karnak Temple, the Valley of the Kings and the Temple of Horus.

The pace was frenetic as the group was transported over nine days by bus, plane, boat and dhow between Cairo, Luxor, Edfu, Aswan and Abu Simbel. But it was not all sightseeing; we also visited the University of Cairo Medical School Museum, the Maadi Military Hospital, Cairo International Ophthalmic Hospital, the Cairo Research Institute of Ophthalmology and the Aswan Ophthalmic Hospital. The programme included presentations on training, case studies and ophthalmic practice in Egypt. There were also formal lectures on the history of Egyptian medicine, canine phacoemulsification, sensory physiology and illusions, osteo-odonto-kerato-prosthesis and the nail-patella syndrome.

Ophthalmic facilities vary widely throughout the country. The 3,000 Egyptian ophthalmologists are based mainly in Cairo and Alexandria where the standards are high compared to smaller towns and rural areas. The Maadi Military Hospital was conspicuously well equipped compared with the Aswan Ophthalmic Hospital (whose staff had to manage with one Schiotz tonometer). However, all the hospitals we visited extended traditional warm Egyptian hospitality. Ideas for future collaboration were discussed, including holding the part I FRCOphth in Cairo and appropriately shaped pyramidal College plaques were presented to our hosts.

Ophthalmic care in Egypt varies from the UK in that patients can access the service without referral from the GP; there are relatively few optometrists and no orthoptic services. As well as military and government hospitals there are well equipped university hospitals which offer a free public service with a high degree of sub-specialisation. Medical Insurance Hospitals cover students, government employees and other insured individuals. The Ministry of Research and Development equips some hospitals to a very high standard and state of the art technology is found in the private sector. This is in stark contrast to the state provision of health services.

This study tour provided the participants with an unforgettable insight into Egypt, both ancient and modern, and gave us the opportunity to build up and renew relations with our ophthalmic colleagues in Cairo and Aswan.

Nick Astbury



The Eye of Horus.

College Seminar Programme 2006

Diabetic Eye Disease

I3 SeptemberThe Institute of Physics,76 Portland Place, LondonCHAIRED BY: Miss Clare Bailey, Bristol

Advances in the Investigation and Treatment of Corneal Disease

29 September The Institute of Physics, 76 Portland Place, London CHAIRED BY: Mr Jeremy Prydal, Leicester

Elizabeth Thomas Seminar

 Macular Disease
 I3 October
 East Midlands Conference Centre, Nottingham
 CHAIRED AND ORGANISED BY: Mr Winfried Amoaku, Nottingham

Vitreo-Retinal Update

27 October Venue tbc CHAIRED BY: Mr Ian Pearce

Clinical Skills and Imaging Techniques in Age Related Macular Degeneration

I November The Royal College of Ophthalmologists, London CHAIRED BY: Mr Ian Pearce, Liverpool, Mr Yit Yang, Wolverhampton

Neuro ophthalmology

22 November The Royal Society of Medicine CHAIRED BY: Mr James Acheson

Regional Study Days

Yorkshire Retinal Society 9 June CHAIRED BY: Mr Martin McKibbon, keith.jackson@leeds.nhs.uk

State of the Art Refractive

and Cataract Surgery 16 June Hull CHAIRED BY: Mr Milind Pande, joan@visionsurgery.co.uk

2006 other events

BOAS

British Ophthalmic Anaesthesia Society 8th Annual Scientific Meeting 28-29 June The Burlington Hotel, Birmingham www.boas.org boas06@aol.com

I 3th Annual Scientific Meeting of the British Society for Refractive Surgery (BSRS) I-2 July St. Catherine's College, Oxford OX1 3UJ www.bsrs2000.fsnet.co.uk julia.bandy@quantum-pr.com

Oxford Ophthalmological Congress 2-5 July The Randolph Hotel and The Playhouse Theatre, Oxford www.oxford-ophthalmological-congress.org.uk o_o_c_@btinternet.com

Corneal & Oculoplastics Course 13-14 July East Grinstead CHAIRED BY MR SHERAZ DAYA clare.bryant@QVH.nhs.uk

Retinal Imaging Course

13-14 July Renaissance Hotel, Horley Chaired by: Mr Amresh Chopdar vision@nearpoint.fsnet.co.uk

The British Society for Clinical Electrophysiology of Vision Stoke Mandeville 4-5 September richard.smith@buckshosp.nhs.uk

New appointments

Gerard Ainsworth Carolyn Atherley Jayne Best Gurpeet Bhermi **Elizabeth Bristow Alex Buller Evgenious Dagres** Tina Duke Kin Sheng Lim William Meacock Mohammed Muhtaseb Mahesh Ramchandani Ash Sharma **Constance Sloper** Atul Varma Sampat Venkatadri

36th Cambridge Ophthalmological Symposium

6-8 September St John's College Cambridge Childhood Visual Impairment CHAIRMAN: PROFESSOR TONY MOORE b.ashworth@easynet.co.uk

UKISCRS Annual Meeting at ESCRS 9 September Excel, London ukiscrs@onyxnet.co.uk

European Oculoplastic Meeting Joint ESOPRS and BOPSS (European Society of Ophthalmic Plastic and Reconstructive Surgery) and (British Oculoplastic Surgery Society) 13-16 September Imperial College, London www.bopss

Vision Research 2006

15 September University Of Bristol www.bris.ac.uk/ophthalmology/ news.html maggie.cook@bristol.ac.uk

Macular Course

2-6 October The Museum of London courses@moorfields.nhs.uk

Medical Contact Lens & Ocular Surface Association Annual Scientific Meeting 17 November The Royal College of Obstetricians & Gynaecologists, London www.mclosa.org.uk jackie@events01.globalnet.co.uk

Cumberland Infirmary, Carlisle Pinderfield General Hospital, Wakefield Royal Victoria Hospital, Belfast Southend Hospital Chesterfield and North Derbyshire Hospital Chesterfield and North Derbyshire Hospital James Cook Hospital, Middlesborough Llanfrechfa Grange Hospital, Cwmbran Guy's Hospital, London Royal Hampshire County Hospital, Winchester Singelton Hospital, Swansea Royal Bournemouth Hospital Birmingham and Midland Eye Centre Moorfields Eye Hospital, London Pinderfield General Hospital, Wakefield Kettering General Hospital

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