The ROYAL COLLEGE of OPHTHALMOLOGISTS

Refractive Surgery Standards Working Group Terms of Reference V1.4

Purpose:

To develop, promote and uphold improved standards in the practice of refractive surgery in the UK for the benefit of patients.

1. Definition of Refractive Surgery

Surgery aiming to reduce dependence on spectacles or contact lenses or improve the quality of vision

Examples of procedures include (and not exhaustive):

- Laser corneal reshaping (laser eye surgery)
- Incisional corneal surgery (astigmatic and radial keratotomy)
- Corneal implants (presbyopic inlays and ring segments)
- Scleral expansion and laser surgery for correction of presbyopia
- Refractive cataract surgery and lens exchange (multifocal, accommodating, toric and conventional intraocular lenses)
- Secondary and piggyback intraocular lens implantation
- Phakic intraocular lens implantation

2. The Refractive Surgery Working Group

2.1. Refractive surgery is functional, not cosmetic. Reducing dependence on spectacles and contact lenses allows patients to engage in a healthy, active lifestyle more easily with clearly documented gains in quality of life. In common with cosmetic surgery however, for most patients, refractive surgery is elective and self-funded. Provision of routine refractive surgery is dominated by the independent healthcare sector and a competitive market place. It is important therefore that current refractive surgery guidelines from the Royal College of Ophthalmologists (RCOphth guidelines: Refractive Surgery Standards July 2011; Statement on Refractive Surgery Standards 2012) are updated in line with relevant guidance from the Keogh Report (1) and the GMC (2) for cosmetic surgery, addressing concerns over patient information, marketing and quality of care.

2.2. Most refractive surgery procedures are safe and highly effective. Contact lens wear, the main alternative for most patients, may be uncomfortable and is far from risk free (3). Public and professional perceptions of efficacy and safety in refractive surgery have been damaged by imbalanced press coverage in recent years and suboptimal delivery of care. Refractive surgery is under-represented in training curricula, and treated with suspicion by many optometrists and ophthalmologists in other subspecialties. Beyond simply updating RCOphth guidelines, the Working

Group will aim to promote engagement with the wider ophthalmic community, a more balanced discourse, and a restoration of public and professional confidence in refractive surgery.

Participants

Bruce Allan (BA) – Chair
James Ball (JB) – member
David Teenan (DT) – member
Sheraz Daya (SD) – member
John Marshall (JM) – member
Kieren Darcy (KD) – ophthalmologist in training representative
Bernard Chang (BC) – Vice President and Chair of the Professional Standards Committee
Michael Burdon (MB) - Vice President and Chair of the Scientific Committee
William Newman (WN) – Honorary Secretary
Rea Mattocks (RM) – Lay Advisory Group Member
Susan Blakeney (SB) – College of Optometrists

3. Process

- *Strategy*
- *Timelines*
- *Delegation*
- *Group Emails*
- *Meetings*
- *Responsibilities*
- *Confidentiality*
- *Publication of outputs*

3.1 Strategy

A set of objectives for the Working Group has been developed by group email. Outputs should include:

1. Revised patient information for the RCOphth and NHS Choices websites
2. Guidelines for marketing in refractive surgery
3. Guidelines for quality of care in refractive surgery
4. An independent registry of patient reported outcomes
5. A public list of RCOphth certified surgeons

3.2 Timelines

The Working Group will have an 18-month turnaround on the objectives above, covering points 1 and 2 in 2015. Point 3 is multifaceted, and will form the bulk of the work in 2016. Point 4 can proceed in parallel and point 5 is clearly a coda to the exercise.

3.3 Delegation

Participating surgeons will each be tasked with authoring draft (v1.1) guidelines or other outputs by the Working Group Chair (BA), collating input by group email, and seeking appropriate external input at an early stage.

3.4 Consultation

Outputs will be progressed through a defined series of iterations in consultation:

- v1.1 - completed first draft from the lead author(s); v1.1 circulated to the working group.
- v1.2 - builds in comments from the working group; v1.2 circulated to the reference group, professional standards, lay advisory group.
- v1.3 - builds in comments from reference group, professional standards and lay advisory group; v1.3 tabled at the RS Working meeting with a summary of unresolved issues.
- v1.4 - builds in the product of resolution discussion at the RS Working group meeting; v1.4 published on www.rcophth.ac.uk for 40 day public consultation.
- v1.5 - builds in comments from public consultation; tabled at RS Working Group meeting with a summary of unresolved issues.
- v1.6 - finalised output on www.rcophth.ac.uk

3.5 Group emails

Group emails will be circulated to all members of the Working Group with the title line: *RS Working Group – Subject*. BA will take requests for new 'subjects', initiate all group emails, and keep a log of subjects discussed. BA will also set a reasonable timetable for input from the group (normally within 2 weeks of initiation of the email thread).

3.6 Meetings

Meetings will be held at the College of Ophthalmologists every 3 months. The primary purpose of meetings will be to finalise and approve draft outputs or send them back to the author with a clear set of guidelines and timelines for revision. Meeting minutes will be circulated within 1 week with the title line: *RS Working Group –meeting minutes DD/MM/YYYY*. Objections or amendments to the minutes should be sent in copying the Working Group on the same email thread within 2 weeks. Meetings are an important opportunity for open discussion of work developed in group emails and should help refine the outputs; but the expectation will be that draft outputs should be brought to the meeting requiring fine tuning only, and that much of the work will be done in preparatory group emails.

3.7 Quorum

The quorum for a meeting is a minimum of 50% of the total number of Working Group members.

3.8 Dispute resolution

The Working Group will work on evidence and operate by consensus and will ensure that its advice reflects the combined expertise of its members. The Working Group will endeavour to arrive at all decisions by unanimous agreement but when this is not possible the view of the majority plus two will prevail and will be adhered to by all members. However, the Working Group will always try to resolve any conflicts in an amicable way.

The membership of the Working Group has been determined to ensure that there is an appropriate weighting between various interests should any issue become the subject of a vote.

Neither the chairman of, nor any other member presiding at, the committee shall vote, unless the votes of the other members are equally divided, in which case he shall give a casting vote. Usually a show of hands is enough to tell the result of a vote, but a poll can be used if not.

3.9 Responsibilities

Surgeons tasked with authoring outputs should indicate at an early stage if they are not going to hit the deadlines agreed. Membership of the working group is a chance to steer some important developments in refractive surgery, and a mark of prestige for participating surgeons. It is therefore reasonable to expect hard work, timely and constructive input to group emails, and a good record of attendance at meetings.

The main task for non-refractive surgeons in the group is timely review of the outputs, ensuring that we remain patient focused and in step with expectations from the wider ophthalmic community.

Membership of the committee will be reviewed as a standing item at each meeting. Requests to drop non-performing members and recruitment of replacements will be dealt with by members of the original selection committee (BB & BC).

3.10 Publication of outputs

All outputs from the Working Group should be accessible via www.rcophth.ac.uk. All outputs will be under the group authorship of the Refractive Surgery Working Group and should only be released to the public domain once fully formulated. Preliminary discussions and draft documents will be remain confidential and will not be circulated outside the Working Group, the Reference Group or the College Executive.

4.0 Reference documents

1. Keogh report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf

2. GMC guidance
http://www.gmc-uk.org/Guidance_for_all_doctors_who_offer_cosmetic_interventions_consultation_220515_FINAL.pdf_61261996.pdf

3. Pasquale TA et al. Long-term follow-up after laser vision correction in physicians: quality of life and patients satisfaction. J Cat Refract Surg 2014; 40(3):395-402.

4. Pesudovs K et al. A quality of life comparison of people wearing spectacles or contact lenses or having undergone refractive surgery. J Refract Surg 2006; 22(1):19-27

5. Ieong et al. Quality of life in high myopia: ICL implantation versus contact lens wear. Ophthalmology 2009; 116: 275-80.

6. Stapleton F et al. The incidence of contact lens related microbial keratitis in Australia. Ophthalmology 2008;115:1655-62

7. Collier SA et al (CDC). Estimated burden of keratitis – United States 2010. MMWR Morb Mortal Wkly Rep. 2014; 63:1027-30.

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