system as locum consultants in Dorchester and then applied for jobs with us knowing exactly what the work would entail.

Initial problems

We have had some initial problems. There is no slack in the system to provide internal cover for leave, so we still depend on middle grade locums.

We insisted on decent sleeping accommodation—there is usually the chance to get a bit of sleep on night shifts—but what we were offered was unacceptable. We felt that consultants were entitled to something a bit more comfortable than the accommodation for juniors, and management is now addressing this.

MAURO FERMARIELLO/SPL

More resident consultants in future?

Will we be seeing more resident consultants in the future? Yes, I think so, particularly in acute specialties where 24 hour resident skilled cover is essential, cross cover from other specialties is inappropriate, and trainee numbers are limited. As well as paediatrics, anaesthetics and obstetrics and gynaecology spring to mind, especially in small district general hospitals that cannot reconfigure their acute services. The Royal College of Paediatrics and Child Health has specific guidance on resident consultants in its recently published *A Charter for Paediatricians*, which includes the ability to opt out[1]; other specialties may follow suit. It's expensive for trusts, but complying with the EWTD and modernising the NHS was never going to be cheap.

Anyone considering a career in these specialties, and perhaps others, should not assume that becoming a consultant means the end of sleeping in. But with the right working conditions and contractual arrangements, maybe that isn't so bad.

Robert Scott-Jupp *consultant paediatrician Salisbury District Hospital, Salisbury*

1 www.rcpch.ac.uk/publications/recent_publications/charter.pdf (p 26)

Starting an eye project in Africa

After taking his college exams, ophthalmology registrar **Daniel Morris** decided to work on a trachoma eradication programme in Africa. It broadened his experience—and didn't jeopardise his job prospects when he got back

It's more acceptable these days to take a year out during postgraduate training. If you don't spend your time away usefully, however, you may find that doors are closed to good jobs when you return. This often discourages doctors, which is a great shame as many people have ideas for travel and work abroad but don't want to risk their future career.

After taking my college exams I wanted to work abroad for a year. Ophthalmology is a specialty that travels well but I was advised to get a registrar job before even contemplating taking time off. With no break from exams since I was 12 years old, however, I ignored this advice.

Deciding where to go and how to fund the venture is not easy (see box 1). A family contact drew me to Africa and in October 2004 I went to northern Kenya with my fiancée to work with a mobile clinic. My basic skills were tested to the limit but I was also aware that many people were complaining of failing sight and sore eyes.

Trachoma

Unlike the cataracts that are the staple diet of British ophthalmologists, trachoma was the main problem in this part of Africa. It's a chlamydial infection spread by direct contact and flies. In children this just causes a sticky eye but constant reinfection eventually leads to scarring under the eyelids. Then the eyelashes turn in, scratching on the cornea until they cause painful blindness.

Trachoma is the leading cause of infectious blindness worldwide, with 150 million people affected. It soon became apparent that this was a massive problem. We examined the children in every school we visited and nearly half were actively infected with trachoma. Blindness was having a big impact on the social infrastructure and local economy. Without any nearby eye services, there was a definite need for a formal trachoma eradication programme in this area.

The Samburu

The Samburu people are nomadic pastoralists who live in the north of Kenya and are similar in many ways to their more famous Masai cousins. They lead a simple but happy life and are extremely fit, living on a diet of milk, blood, vegetables, and occasionally meat. Their rural impoverished lifestyle makes them an easy target for trachoma. They live with their animals so there are flies everywhere and they have poor access to water so washing themselves is a low priority. We decided to target this tribe for a trachoma eradication programme called the "Ol Malo Eye Project."

The SAFE strategy

The World Health Organization has outlined a simple way of eradicating trachoma from a defined area, called the SAFE strategy (see box 2). Before starting, we needed to find out how many people lived there and how many had trachoma. So we carried out a prevalence survey.

The results showed that the problem was even bigger than we first thought, a major public health issue, and we started to look for ways of setting up an eradication programme. Unfortunately, the big charities we spoke to were unable to help, so we decided to go it alone. There are two key points to the success of this

Box 1: Points to consider before you start

- Professional indemnity—the Medical and Dental Defence Union of Scotland were very supportive to me
- Malarial prophylaxis and other immunisations
- HAART therapy in case of needlestick injury
- Medical registration in the country you are working
- Consider a diploma in tropical medicine (London or Liverpool)

Box 2: The basis of trachoma eradication is the SAFE strategy

S = Surgery
A = Antibiotic distribution
F = Facial hygiene
E = Environmental improvement

The author, with a tame kudu taking an interest in the operating theatre

project—good local knowledge and advice from people with practical experience of trachoma eradication.

Surgical camps

Our survey highlighted an urgent need for surgical treatment so this was arranged a few months later. Most of the equipment we needed (not a great deal) was donated or bought. The same ranch that helped us with the survey, Ol Malo, offered us the use of a shed as an operating theatre. Our translators had sent word out so that our patients were waiting when we arrived. We had no idea what to expect but having spoken to people who had been involved with trachoma projects before, we were able to avoid most of the pitfalls (see box 3). Our nurses spent time explaining the operation to each patient with translators before getting consent using a thumbprint. Follow up was arranged on day one and day seven after the operation, when the stitches were removed.

Public health measures

Children with active trachoma infection can be given a six week course of topical tetracycline therapy (very cheap) or a single oral dose of azithromycin (very expensive). Fortunately Pfizer has agreed to donate millions of doses of azithromycin to trachoma projects, which makes mass treatment of communities much more possible and effective.

Surgery and antibiotic distribution are not effective, however, unless there are also interventions at the community level aimed at improving water quality, access to latrines and personal hygiene, and reducing overcrowding and the density of flies in the environment. We have therefore hired a nurse to go out to all the homesteads and teach the Samburu how to wash their hands and faces. She also distributes the antibiotics and encourages them to cover their faeces. This is where good local knowledge comes in, as the Samburu are both nomadic and very shy about their toilet habits, so building expensive latrines is not the answer.

Hazards

You ignore HIV at your peril in Africa. Official estimates of infection are likely to be underestimates, so as a surgeon you have to assume that everyone is HIV positive. The risk of Hepatitis B is also high and much easier to catch. It is vital that you protect yourself and your staff from a needlestick injury, especially if some of the project team are not trained doctors or nurses. Accordingly, this project has a strict sharps policy and needlestick injury protocol with appropriate antiretroviral therapy on hand. Other immunisations and malarial prophylaxis were provided for the project team.

It is important to always be aware that you are a privileged visitor in a foreign country. Sometimes patients do not want the treatment offered, even if it means that they will go blind. The patient's opinion and privacy should be respected at all times. Cultural issues should be understood before any contact is made, such as the correct way to greet people without causing offence.

Unexpected hazards have included sheep drinking the sterilising solution, geckos landing on the operating drape, and a curious kudu poking her head through the window of the operating shed.

The future

The project has grown and we have recently received substantial funding from the Standard Chartered Bank in Nairobi. This will enable us to also start improving the quality and reliability of the water supply. Taking time away from formal training does not appear to have harmed my career prospects as I got the first registrar job I was interviewed for after arriving back in the United Kingdom. The government is keen to rush us through our training but do not be scared off by reluctant superiors or by peers who are racing on down the yellow brick road. I have gained an enormous amount in terms of experience and management skills from this project. I hope this encourages others to do the same and gives some practical tips on how to make your ideas work.

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Box 3: Keys to starting a successful project

- Start small—don't overstretch your resources
- Set clear, realistic aims
- Take practical advice from others before you start
- Build a good relationship with local health professionals
- Know the local culture and respect it
- Be flexible but persistent

Tips on . . .

Night visits

Despite all the innovations in providing out of hours services, there may still be occasions when a general practitioner has to visit a patient in the middle of the night. If so, it's essential that your sleep is disrupted as little as possible. Ideally, you should be able to take the call, complete the consultation, and return to bed without waking up at all. But if this is not possible, the following rules should ensure a swift return to REM sleep.

Prepare your exit

Ensure everything you may need on the journey is ready by the door. Thus you will avoid waking your family, neighbours, and pets by banging around the house searching for your car keys.

Know your destination

Otherwise sane patients may have little idea where they live. If their directions include such phrases as "Where the shop used to be" or "About 10 lamp posts," tell them to switch on all the house lights and stand in the road holding a placard reading, "Doctor Stop Here."

Take care with car radio settings

Commercial stations and local phone-ins are liable to induce swearing at the windscreen. The BBC World Service is the perfect soporific, unlike Radio 2, which may leave you humming "Chirpy Chirpy Cheep Cheep" to yourself for the rest of the night.

Keep warm

Layers of sweaters, a thick coat, and a woollen hat will maintain core temperature, inspire sympathy for the muffled figure, and deflect the weapons of muggers. Wear gloves while driving, and warm your hands on feverish patients. Set the electric blanket to "overload" for your return, do not remove socks on returning to bed, and ensure you have a warm blooded (and uncomplaining) spouse.

Keep cool

On the drive home, avoid muttering sarcastic remarks to yourself about the severity of the patient's illness, necessity for a visit, or parentage. Save these for your letter to the primary care trust in the morning removing the patient from your list.

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