The St. John of Jerusalem Eye Hospital

A Personal Account of the years 2002 to 2008

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Order Hospitaller

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Introduction

This is a simple account of events that occurred during my term of office, between 2002 and 2008, as Hospitaller of the Most Venerable Order of the Hospital of St.John of Jerusalem. I have felt most privileged to have been entrusted by the Order with the care of its Hospital during this short period of its history. I have not attempted a detailed analysis of the hospital operation, restricting myself only to some observations over the six-year period to try to capture the flavour of the changes that have taken place.

Before my appointment, my contact with the Order and its Hospital in Jerusalem had been very limited - a visit in 1982 to do some retinal surgery at the request of the then Hospitaller and a further short trip about 15 years later.

Before relating what happened from 2002 to 2008 it is helpful to describe some of the events just prior to 2002 and, therefore, what I found when I began my term of office.

The Order had undergone fundamental constitutional change in 1999, not only to give parity to its eight Priories, but also to define its Hospital in Jerusalem as a separate entity. The Hospital was reconstituted as its own English based charity and was incorporated as a wholly owned subsidiary company of the Order with its own board of Directors.

I have, in the narrative, briefly explored these changes as they affect the Hospital. My predecessor, Noel Rice, had resolutely addressed problems that had arisen during the difficult transitional period and had established the platform on which we were able to build. It was, however, clear that the Hospital was going through a difficult period.

There were two major problems. Firstly, in the two combined years of 2000 and 2001 there was a large financial deficit (approximately £2 million) and secondly, the onset of the second intifada in 2002 in the region resulted in the loss of senior expatriate medical staff. Thus, we were not only in financial difficulty but, due to the political climate, we were finding it difficult to deliver modern ophthalmic services.

Between 2000 and 2002 outpatient attendances had reduced by 16,000 to 46,000 patients and major operations performed in 2002 had diminished to 1,700. In 2002 the income of the Hospital Company was only just under £3million and, to prevent further draining of slender reserves, job cuts at the Hospital had, unfortunately, been necessary.

The first of what were to be my many visits to the Hospital was in 2002 and it showed that we were in a weakened state – for example, on the medical staff there was no surgeon capable of performing a modern cataract procedure, nor was there postgraduate expertise in retinal, oculoplastic or glaucoma surgery. The selection, teaching and training of medical staff was at a low ebb. St.John has always been the main provider of ophthalmic services in the area and our frailty threatened this position and opened the way for competing interests.

This rather depressing picture was reflected, in 2003, in my first report to the Grand Council of the Order.

The progress that has been made over the last few years, patiently building up our capacity to deliver high quality care, and doubling both numbers of patients seen and major operations performed has been as a result of a great deal of work by both staff and volunteers. I believe that the pre-eminent position of St.John as a major provider of ophthalmic care in the region has been reaffirmed. The development of a business culture has been an important part of this progress and Professor John Stopford has given me much sound advice in this area.

I have received a great deal of help (sometimes quite spontaneous and unexpected) from, not only those who know the Hospital well (particularly Sylvia Holmes in the London office and Jackie Jaidi at the Hospital), but also from other friends and colleagues whom I had encountered in previous charities. To all of these I offer, not only my own thanks, but also the gratitude of all those who have benefited from our work. To those who have visited the Hospital in a professional capacity, and many have done so repeatedly, I offer my most especial thanks − without you the Hospital would not have survived.

Non-medical visitors are just as welcome and the gathering of the St.John family (including a big St.John Fellowship presence) in Jerusalem in May 2007 to celebrate the anniversary of our foundation in 1882 was particularly memorable. We were very flattered that so many came to be with us and we were reminded of the proud place the Hospital occupies in the minds of so many.

Humanitarian work can be, and is, done by any organisation or individual without any adherence to a formal creed or belief. However in St John we base our efforts on the non-denominational Christian ethos of the Order. How fitting it is that a Christian order should be serving a mainly Muslim population in a Jewish dominated region. What an example we give!

The Hospital, as relevant to-day as it was when founded, is very proud of what it does, and will continue to do, for all those who seek its help.

Anthony Chignell
October 2008

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The Hospital and the Orders of St.John

The Hospital occupies a central position within the Order and is the most obvious manifestation of the ambition of the Order to be an International Humanitarian Charity.
The Grand Prior (HRH the Duke of Gloucester), the Lord Prior and the other non Royal Great Officers, assisted by the Secretary-General of the Order, have been hugely supportive of the Hospital during the last six years − not only in general matters but particularly by visiting the Hospital in Jerusalem for events and investitures and attending Hospital occasions both in the UK and abroad.
The visit to the Hospital of the Grand Prior accompanied by HRH the Duchess of Gloucester in 2007 was especially memorable as it was the first visit of a Grand Prior since the late Duke of Gloucester visited in 1963. We were delighted that they should have joined us, and they were warmly received by patients, staff and volunteers. Her Royal Highness opened the recently refurbished Women and Children's Ward, which had been generously endowed by the American Priory.
HM the Queen, in her role as sovereign head of the Order, accompanied by their Royal Highnesses the Duke of Edinburgh and the Duke and Duchess of Gloucester, honoured the Hospital by attending a reception given by the Chairman of the Hospital Board at St.John's Gate in March 2008.
The Directors of the UK based Hospital Board, have numbered about twelve over the last few years. (Appendix 1) These appointments to the board are made by the Order after recommendations by the board. Directors are now appointed after a proper consultative process and each Director is expected to have a portfolio of special expertise to add value to the Board.
We now have one "local" Director, namely the British Consul-General in Jerusalem. In addition to duties to the Board, successive Consul-Generals (Geoffrey Adams, John Jenkins and Richard Makepeace) have been most generous in the time they have given to

update and instruct me on political and local matters. This advice has had an invaluable influence on the formation of Hospital strategy.
The Board meets four times a year, and one of these meetings is held at the Hospital.
In 2002 the Hospital board recommended a division of the roles of Hospitaller, to whom it was agreed that the Chief Executive Officer (CEO) should report, and of the Chairman (Lord Vestey), and this has been the arrangement for the last few years. The governance model was somewhat confusing and the two roles have again been merged.
The supporting subcommittees of the board have been reviewed and revised, and are now Finance and General Purposes, Audit, Investment, Honours and Awards, and the Guild. (previously the Ladies Guild). The Chairman of the Board chairs the Finance and General purposes and the Honours and Awards committees and a board member chairs the Audit Committee. (Nic Ridley) The Investment and the Guild Committees are chaired by non Board members (Mark Canon Brooks and Lauretta Ridley respectively). The Guild is responsible for organising fundraising events and also serves the added need of spreading knowledge of the Hospital. Guild activity has been spectacular in the last two years, generating funds and interest in the Hospital.
The work of the board is complicated by the "spread" of the business; the main Hospital is in Israeli controlled East Jerusalem; our static clinics are in Arab areas (the West Bank and Gaza); and we have an office in London.
In each of these areas there are complexities of finance (including taxation), employment, and audit as well as legal variation. These problems are not unusual in charities operating overseas but do make for a great deal more work, not only for the Hospital staff, but also for Board members (especially the financial and legal directors).

The Priories. The financial support (either cash donations or gifts in kind) given by the Priories to the Hospital varies considerably and is mainly dependent on the financial strength of the individual Priory and of the other financial demands within the Priory (usually ambulance work).
At my first Grand Council meeting in 2003 I got the distinct impression that some Priories were becoming cautious about supporting the Hospital, which was perceived to be at a low ebb. It is very gratifying to note that a sense of "ownership" of the Hospital by the Priories has been growing, especially when we started to put our affairs in order and to do "better"! Support for the Hospital both financial and in kind has increased steadily and all Priories now contribute to the Hospital (Appendix 2).
Keeping the Priories informed about Hospital activities is not only achieved as a result of the general communication strategy of the Hospital, but also via my annual report to Grand Council and my quarterly updates to Priory hospitallers based on the report of the CEO to the Board.
The relationship with some Priories does have a somewhat distant feel (and this is not just geographic), and I am, for example, disappointed that, in six years, I have only visited four Priories to speak about the Hospital. The culture of Priory support for the

Hospital, which is a manifestation of the growing sense of mutual responsibility within the St.John family has, however, improved: thus most Priories now have dedicated hospitallers, the majority of whom have visited the Hospital.
Contact with the two Commanderies (Ards and Western Australia) has been very slight, as their business is conducted through their adjacent Priories, but in both cases there is enthusiastic support.

The three *European Orders* of the Johanniterorden of Germany, the Crown Order of St.John in the Netherlands and the Crown Order of St.John in Sweden together with their associated Commanderies, and the Venerable Order constitute the Alliance Orders of St.John. The *Sovereign Military Order of Malta* (SMOM) is the other recognised Order.
The European Orders have continued to show interest in the Hospital, in addition to their own substantial charitable commitments. Collectively they make a donation to the Hospital each year and individual support has also been given. Thus, the Johanniterorden facilitated an application of the Hospital to the European Union which resulted in a generous grant to fund a second mobile outreach facility. This grant has been repeated year by year for the last four years. The Swedish Order has supported Swedish nationals either at the Hospital itself or to visit the Hospital in a medical capacity, and the Swiss Commandery has donated valuable equipment.
The Hospital very much values the interest and support of the European Orders and this support is fostered by the Secretary-General of the Alliance Orders, Robert Krehl who has been associated with, and has enthusiastically supported the Hospital, for many years.
The St.John Eye Hospital has close ties with the SMOM Holy Family Hospital whose work in Bethlehem is conducted in circumstances similar to our own. An outreach clinic of St.John concentrating on children is conducted there at regular intervals. I hope that, in time, greater co-operative efforts will be made; the field of paediatric ophthalmology would seem an obvious possibility.

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Establishing The Basics

Our Hospital in East Jerusalem has always existed to serve anybody who seeks its help, regardless of race, creed or ability to pay. This is still the guiding ethos of what we do to-day. At this moment in our history of 125 years, and constrained by political circumstances, we serve the Palestinian people of East Jerusalem (approximately 250,000) the West Bank (approximately 2.5 million) and Gaza. (approximately 1.5 million). This impoverished population, increased by about 1 million people in the last six years, and in whom there is a high incidence of blindness emphasises the need for our services and the continuing relevance of our mission.

We do not express any political view, but we do have to respond to the political environment in which we work: for example, the Hospital in Jerusalem is subject to Israeli law and an annual inspection is made by the Israeli ministry of Health before our licence to practice is renewed.

During the last six years there has been no significant progress in settling Arab – Israeli differences, and one aspect of this stalemate is that the system of road blocks, worsened both by large Israeli conurbations surrounding East Jerusalem and the rapid progression of the security wall, has made travel to East Jerusalem much more difficult and expensive for a community which has become progressively impoverished.

Journey times to the Hospital have increased significantly for both patients and staff. The "wall" is not just a simple barrier between Israel and the West Bank but with a complex system of related roads (mainly to access enlarging Israeli settlements), has restricted movement within the West Bank itself. The borders between Gaza and Israel effectively seal in the population in Gaza and patients referred from our Gaza clinic for advanced care have difficulty in accessing the main hospital. We have limited access to our staff in Gaza and professional isolation is damaging and depressing.

Religious differences are invoked as being at least partially at the root of the regional disputes, but at the Hospital we have a mixture of Christian, Muslim and a few Jewish staff, looking after mainly Muslim patients. All are united in our humanitarian work.

Before we could start addressing and improving the way in which we delivered the two main parts of the charitable mission at the Hospital, namely *clinical services* and *teaching and training*, the urgent priority was to improve *management* and to address the dire *financial* position.

Starting with interim *management* in 2003 there has been a steady improvement in all aspects of the management of the affairs of the Hospital. Chief Executives (Steve James from 2004 to 2006 and Rod Bull from 2006) have been supported by the Directors of Nursing and Medicine (Jackie Jaidy and Jeanne Garth respectively) and together with a small executive team (Appendix 3) they have been responsible for a whole raft of management reforms. This has particularly improved the administration and finance departments and, through the Nursing and Medical directorates, has improved the clinical work of the Hospital. Inspection and recognition by the International Standards Organisation (ISO) of many aspects of Hospital activity has helped upgrade and maintain standards throughout the Hospital, but there is still much to do.

The Hospital is now run in a business-like way, and progressive improvement in all aspects of management, particularly financial, was the main reason why it was possible for a realistic three-year strategic plan to be constructed in 2005.

Our approach to improving our finances consisted of a three-tiered process of *establishing accurate information*, examining all aspects of *expenditure* and *increasing income*.

The first and most obvious problem was the lack of regular and accurate up to date financial information about the Hospital Company. This lack of information impaired decision-making at all levels up to and including the Board and was retarding the development of a business culture within the charity. Early in 2003, the then interim CEO, Bob Frost, as well as making some fundamental management improvements, advised that an interim Director of Finance be appointed at the Hospital (John Bradford). Together with additional training in the finance department, and, aided by a grant from the European Union to improve our financial software, this move started to yield results almost immediately. Accurate and regular information soon became the norm.

This was the start of a progression of steps resulting in the upgrade of the skills and abilities of the finance department at the Hospital which enabled the complete transfer of all accountancy matters to the Hospital in Jerusalem from the UK in 2005.

The management team (particularly the renewed administration department) has examined all areas of *expenditure* and has established measures to ensure that all expenditure is carefully measured and controlled. These measures have, for example, included issues such as purchasing policies and all matters related to Hospital supplies.

Our *income* is derived from three main sources, and in roughly equal proportions; firstly from the Hospital and its clinics; secondly from the Priories; thirdly from a wide range of other sources (individual donors, trusts, non government organisations, fundraising

events, and legacies etc). Income at the Hospital consists of fees received from patients treated, from the letting of some of our unused accommodation, and from local fundraising. The most important part of our patient generated income comes from the Palestinian Authority (the PA), established in 1994, which covers, in part, costs for treating their patients. Income from this source accounts for about 15% of our total income. The PA is completely reliant on outside aid (mainly from Europe and the USA) to meet its own needs, and payments to the Hospital are made only when funds are available; these payments are inconsistent and incomplete, and we have become used to having to carry significant PA debt. We also receive fees for treating Palestinians from East Jerusalem who are eligible for Israeli insurance and from UNRWA (United Nations Relief and Works Agency) for treating Palestinian refugees from some areas of the West Bank.

We have relatively little influence on the amount or the timing of payments from any of these sources, and the consequent unpredictable cash flow makes budgetary predictions difficult.

The Priories. The need for and the duty of the Priories to support the Hospital is enshrined in the strategic plan of the Order. Each Priory decides on the level of support it wishes to give to the Hospital but these donations do not have any proscriptive pattern. In some Priories there is active fundraising for the Hospital, whereas in others a donation is made from the business activities of the Priory. Priory donations are either unrestricted or designated for specific purposes and, although we do all we can to encourage Priory activity (information, personal contacts etc), decisions about Hospital support lies entirely with the Priories themselves

We are particularly dependent on the United States Priory, where it is hoped that an even stronger operation to help both the Hospital and the Order will be further developed, and the English Priory, which is by far the biggest in terms of Order membership and has a long history of Hospital support.

We encourage the Priories and other donors to consider sponsorship of our staff for a three-year period as a method of giving, because to involve a donor with a specified member of staff is rewarding for both sponsor and staff member and creates many new friendships. About a third of our staff is supported in this way.

Other areas of giving include funds to acquire equipment or other items selected from our “needs list”.

Of our three main sources of income, we can do relatively little to influence either patient income at the Hospital or donations from the Priories. We have therefore concentrated on trying to boost all other sources of *voluntary* income**.**

2003 was the year in which the recovery phase of our activities really started and in the following two years our income went up by about £1million -the greater part of which was from increasing our *fundraising* activities.

The winning of a grant from the European Union (EU) to support a second outreach team was not only important in itself (and a real confidence booster) but, in view of stringent

EU regulations, provided proof and encouragement to other donors that the Hospital was robust enough to win and administer such a grant.

Although this was a good recovery, it was clear that we needed to make fundraising and marketing a major strand of Hospital Company policy. It was, therefore, decided to employ a consultancy (headed by Dr Christine Stokes) to assist in the process of fundraising, but equally important to leave us with the necessary skills and structure to support ourselves on a permanent basis. During the consultancy, posts were created to address specific tasks (e.g. trust applications and to establish a legacy policy) and to encourage both existing and new donors. A communication strategy has also been created and this included upgrading our regular newsletter Jerusalem Scene, which had been reintroduced in 2004; the production of an annual report, of an e-mail newsletter, the upgrading our website and the production of audio-visual material to tell the Hospital story.

The consultancy lasted until 2007, after which a permanent team of fundraising and marketing, led by Nicky Wynne was established, based in London and at the Hospital. Between 2002 and 2007 our annual income has risen from £2.9 to £4.5million, and our much-depleted reserves have been recharged.

Our fundraising and marketing initiatives will be extended into many new areas but the task is difficult. Fundraising for any charity has become very competitive and for one situated in a highly “difficult” region with a complicated mixture of politics, religion and with different ethnic groups, especially so. But, to some, these are the very features that make us attractive. These potential donors have to be sought out from our worldwide family (the Priories) and elsewhere. People and institutions can only help if they are asked.

The progress that was made in 2003 and 2004, particularly in achieving increasing financial stability, gave us the confidence to produce a strategic plan for the triennium ahead. The main purpose of the plan was, firstly, for the Hospital Company to take a detailed look at its present operation and to see in particular how we could increase our work in the prevailing political climate; secondly to send a message to our supporters that we were quite clear about what we were trying to achieve; and thirdly to meet the needs and perceptions of an increasingly sophisticated donor market.

The future ambitions of the Hospital were completely reliant on improving income and achieving stable financial management. That both aims were achieved, together with the enthusiasm and commitment of our staff, was the main reason why we were able to accomplish the major goals of the plan − increasing our services, improving teaching and training, and reinforcing and re-establishing our reputation as a centre of ophthalmic excellence.

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Meeting The Need

The main consequence of our improved finances was that we were able to do more work and, by investing in our staff, we did so by increasing our *clinical services* and our *teaching and training* programmes. In addition, we had to continue to refurbish our ageing main Hospital building, continue to reequip our clinical areas and to begin to develop a research facility.
As funding became available, there were three main factors influencing our ambitions to increase the delivery of services; *Firstly* restricted access of our patients to the main hospital as previously described and the political uncertainty of the future of East Jerusalem; *secondly* the particular characteristics of the population we serve; and *thirdly* our ability to increase the level of sustainable service by the recruitment of additional staff to ensure delivery of care of the highest standards.

In planning to increase our *services* we had to take special note of the population we serve**.** In the rapidly expanding Palestinian population of the West Bank and Gaza, there is much poverty and unemployment. Consanguineous marriages are common (about 25% of marriages are between close relatives) and large families are the norm. Thus about 30% of the population is under ten years of age and there is high (but unquantified) incidence of genetically inherited ophthalmic disease (such as congenital glaucoma). School eye testing and screening for eye disease in children is very poorly developed, and therefore, care of *children* is a major need.
In the *adult* population there is a high incidence of *diabetes* (15-20%).Medical care, including screening and monitoring of this condition, is limited and many patients do not seek help until there is irreversible loss or reduction of sight in one or both eyes. This is a big area of need, as the disease must be treated as early as possible to prevent blindness.
As in many developing and underdeveloped countries our population has a high incidence of cataract and treatment of this condition forms a high proportion of our surgical workload.

Lid and corneal disease is common, but some conditions (e.g. age related macular degeneration) are seen much less frequently than in developed countries.

We have increased the size of the *staff* (Appendix 4) to meet the needs of our enlarging business and this increase depended on our ability to recruit additional professionals of the required standards and to ensure we could look after them properly. Most staff employed by the Hospital Company are based at the main Hospital in Jerusalem and smaller numbers are found at our outreach centres in the West Bank and Gaza and in our office in London. St.John is respected for its employment record and we continue to support the professional development of all staff as much as possible.

The *medical* staff, sadly depleted in 2002, has been gradually built up although the loss of two specialist surgeons, trained by St.John in corneal work and paediatric surgery respectively, was unfortunate. While the attraction and retention of medical staff has been one of the most difficult tasks of the last few years, a great effort has been made to upgrade the skills of our senior staff and to attract new highly qualified staff to ensure that our clinical practices are modern and expert. Although visiting doctors have played a vital part in training, it is our own staff upon whom we most rely and it is gratifying to see that some of our own trainees are now filling senior positions. From our weakened position in 2002 we now have ten ophthalmic consultants at the main hospital, (six of whom are expert cataract surgeons) and we have also been able to recruit additional staff to work in our new outreach centres.

Thanks to the excellence of standards at our Sir Stephen Miller School of *Nursing* we have not been short of trained nurses to help us to extend services. The policy of the School to train nurse practitioners, (there now are eight) skilled in examination and diagnosis has provided us with the extra nursing staff needed for our new centres. We much depend on the skills and performance of our nursing staff.

A key ambition of our strategic plan was to extend our activities at the *Hospital,* to access more patients in *Gaza* by increasing staff at our clinic, to increase our mobile outreach work in the West Bank, and to open new centres in Hebron and Anabta.

At the *Hospital,* our Outpatient work was much enhanced when we opened our new department in 2003 to give us a much better facility.

General outpatient work (including optometry, contact lens and prosthetic services.) is supplemented by sub-speciality clinics, which we have progressively upgraded and equipped. Thus we have clinics specialising in medical and surgical retina (supported by retinal investigative services), paediatric (including orthoptic work), cornea and oculoplastic disease. A recently established glaucoma service is in its infancy.

We have continued to equip and upgrade our two main operating theatres and the central sterile supply department to provide a fully up to date operating facility.

Outpatients The number of patients now being seen in our various outpatient departments at the Hospital, by our mobile outreach service and in our static clinics has increased steadily. In 2002, 45,000 patients were seen and by 2007 this had risen to

83,000. Thanks to the efforts of our paediatric department, the number of children seen has risen from 15,000 in 2004 to 25,000 in 2007. The establishment of nurse orthoptists, an idea promoted by our head orthoptist, Judith Mussallam, to help particularly with the screening of young children, is an innovative response to the huge numbers of children who need assessment and care.
We now have laser facilities, for the treatment of the retinal complications of diabetes, in all of our clinical areas including our mobile outreach service, and the number of patients treated has risen from 1,000 in 2004 to 2,600 in 2007.
Operations. The increase in the number of trained surgeons and the adoption of modern techniques, particularly for cataract surgery, has resulted in a big increase in surgical output, with a progressive transfer to day-case work. 1700 major operations were performed in 2002 and 3,300 in 2007. Surgical effort has been facilitated by nursing skills of the highest calibre in the operating theatres.
The recruitment of well-trained retinal surgeons has always been a problem as their training is longer and more complicated than with any other form of eye surgery. At the present time, we are fortunate to have in this field not only an expatriate retinal surgeon but also the additional services of an Israeli retinal surgeon.
We are, in addition, well served by cataract, oculoplastic, and squint expertise and are developing the same for corneal work. Although, at the moment, we have no dedicated paediatric surgeon we have been wonderfully supported in this work by surgeons from Moorfields Eye Hospital in London.

There is no part of the St.John operation that better exemplifies the spirit of our mission than our clinic in *Gaza*, which has been functioning since 1992. Regular political upheavals, both civil and military, in this strip of land, cause much disruption, but throughout all of this, our clinic there continues to serve the local community, which has become progressively impoverished and less healthy.
We have, by the addition of a further surgeon in 2007, increased the amount of work done in Gaza − especially in our performance of modern day- case cataract surgery.
Although I paid a memorable visit to the clinic to meet Dr Jom'a and all his staff in 2008, it has been a great disappointment that, like other members of staff I have been unable to visit our Gaza clinic more often, as the borders are frequently sealed. These closures also make it difficult for patients in need of special treatment to come to the Hospital. We do everything we can to reduce this isolation, but it remains. There is a real need to expand our premises and our activities in Gaza and we will do so whenever possible.
It was a fitting recognition for the nurses at our clinic in Gaza to be awarded a "Human rights in Nursing" award by the International Centre for Nursing Ethics in 2005.

Our *mobile* outreach service was established 25 years ago as a primary care facility to reach those who could not easily access the Hospital in East Jerusalem. Over the years

the working of this service has become progressively more sophisticated. The team consists of an ophthalmologist and a nurse practitioner, together with supporting nursing and ancillary staff. Even though this is an expensive care model, the need has become more pressing and was the main reason for further developing and extending this work.
We established a second mobile outreach team in 2004, as a result of a grant from the European Union, in the application for which we were greatly assisted by the German Order. Both teams are based at the main Hospital. One team goes out every day and as a result, the number of patients seen has increased considerably.
An important objective of the EU grant, which has been renewed in successive years, was to concentrate on the detection and treatment of the ophthalmic complications of diabetes. In many instances, we have been able to treat patients with a portable laser facility but more advanced cases, requiring surgery, were referred to the main Hospital.
Our mobile outreach teams, a vital link to those most in need, and, often working in arduous circumstances have also been used as an important way of disseminating a programme of health care education.
In 2005 we decided to rent part of a building in *Hebron* and to establish a St.John centre. We chose the city of Hebron, which is about 20 miles south of Jerusalem, because it had a large urban population (about 500,000 people) and has very limited ophthalmic services. The clinic has so far been very successful, not only seeing large numbers of out patients, but also with the introduction of secondary care services to concentrate on day-case cataract surgery. It is likely that our presence in Hebron will be of increasing importance to the evolving mission of the Hospital.
Anabta is a small town situated about 40 miles from Jerusalem, just west of Nablus in the northern part of the West Bank. We opened a centre there in 2007, forming a partnership with the Palestinian Red Crescent Society and even though there are ophthalmic services in Nablus, there are a number of neighbouring communities which are impoverished and isolated. Our work in Anabta has, thus far, been at a primary care level, concentrating on the treatment of the ophthalmic complications of diabetes. We intend to develop a surgical facility in due course.
The centres at Hebron and Anabta are integrated with the main Hospital-there is an interchange of staff and support personnel (e.g. medical staff from Jerusalem visit to operate and participate in special clinics). This is necessary both to prevent isolation and to maintain standards.
The remarkable overall *increase in clinical output* between 2002-2007 is summarised in Appendix 5.
The *teaching and training* of our staff is an integral part of the mission of the Hospital in order to deliver care and to build up ophthalmic skills in the community. The main focus of our efforts is for the benefit of the medical and nursing departments, but other staff are also involved in the process.
A Director of Medical Education was appointed at the Hospital (Dr Nick Sargent) and together with the Medical Director has put much effort into the teaching programme.

This process was much helped when in 2006 the clinical adviser to the board (John Talbot) together with a Past President of the Royal College of Ophthalmologists, carried out a constructive review of the medical department and its teaching practices.
Although the main thrust of our teaching and training is directed at our resident medical staff all medical staff are involved in the process. We have a close and cooperative relationship with Hadassah (The Israeli Hospital complex in West Jerusalem) and presence of a previous Chairman of Hadassah (Professor Saul Merin), an inspiring teacher, is of great benefit. The improvement in the standard of the training of our staff is noteworthy as indeed is the intrinsic quality of the residents themselves. Library facilities have been updated (courtesy of the Scottish Priory), and wet laboratory facilities, for surgical training, have been developed.
Of the resident staff we have five doctors at the main Hospital and a further two at Hadassah. Our resident staff are subject to regular review and appraisal.
Our four-year training scheme for residents conforms to the Palestinian and Jordanian training requirements and some residents also take the Israeli qualification examinations.
Further training in the form of fellowships can be pursued after the residency period, either in the region (at Hadassah or at our own Hospital) or abroad, but it is getting progressively more difficult to obtain clinical fellowships at reputable centres abroad.
Our ambition is to continue to train those who will remain in the region for the benefit of the Palestinian people − it is heartening that at the beginning of 2008, we were able to promote three of our trainees to consultant level.
We teach the medical students from Al-Quds University (Jerusalem) with a course of lectures and clinical instruction. This exposure (much more than in most UK medical schools) is building up the infrastructure of ophthalmic knowledge in the medical community, as well as attracting new recruits into ophthalmology.

Our *nursing* school (linked to Thames Valley University in the UK) continues to train new staff on our annual course, and to upgrade the skills of our nurses upon whom we so much depend.
In 2007, two senior nurses from Moorfields Eye Hospital in London reviewed the department of nursing. The review process, which our Matron has embraced with enthusiasm, will have a profound effect not only on the nursing but also on the medical and general management of the Hospital. This process has begun.

Medical *visitors* to the Hospital have always had, and they continue to have, an important role to play in our teaching and training programme. They do so by bringing clinical knowledge, but more importantly, exemplify how good medicine should be practiced. Some of our visitors have been coming for years and in return for the service they give they have the gratitude and friendship of us all. Our visitors are predominantly from the UK but also from the USA, Europe, and Australia. It is very rewarding to see how these

visits can bear fruit − for example we now have an oculoplastic surgeon at the Hospital who owes a great deal of his training to UK and USA visitors in this field.
Our paediatric services have been strengthened by visits from UK orthoptists and surgeons to strengthen our thinly spread permanent staff. This has boosted our service to children at the Hospital and throughout our outreach work..
At the present time the Hospital is largely clinically orientated and there is little emphasis on *research*. As we become stronger we will hopefully develop a more comprehensive research facility.
At the moment we are undergoing a genetic study of Behcet's disease (a joint study with Hadassah and St.Thomas' Hospital in London), and are just completing an epidemiological study into the causes of adult blindness amongst Palestinians. This will lead to an update of information that was first gathered by the Hospital twenty years ago. Since that time there has been much change, and the present survey will reveal much useful information which, as well as being a significant piece of work in its own right, will have an important impact on the planning of our future services.
From 2002-2008 we have had to undertake *major refurbishment work* at the main Hospital, which was built in 1960. We have built a new outpatients department, and have refurbished the wards, the Nurses' home, the Sisters' house, and the medical accommodation. Replacement of equipment in outpatient, ward and theatre areas has continued both at the main Hospital and at our outreach centres. All this has been accomplished on top of a great deal of routine maintenance of an aging building to give us a top class facility of which we are proud.

Epilogue

I believe that the progress that the Hospital has made during the last few years has re-confirmed our position as a centre of excellence in the region and has, at the same time, emphasised the long-established role of the Order in providing eye care.
The Order has, in its Vision statement, indicated the wish to be an International Humanitarian Organisation— and, building on the work of its Hospital in Jerusalem, development and progressive internationalisation of sustainable ophthalmic work, for which there is great need, would seem to be an ideal way of doing just that.
There is much to do.

Acknowledgements

My sincere thanks are due to Mr Hugh Peppiatt and Miss Georgina Chignell who were kind enough to read the text and give invaluable advise on content and corrections.

Appendix 1

The Board of the Hospital Company

THE LORD VESTEY	Chairman
ANTOINE MATTAR	Deputy Chairman and Business
ANTHONY CHIGNELL	Order Hospitaller
HAROLD CLIMENHAGA	Ophthalmology
PHILIP HARDAKER	Finance
ROBERT KREHL	Finance
RICHARD MAKEPEACE	UK Consul-General in Jerusalem
LAIRD MORTIMER	Business
NICHOLAS RIDLEY	Insurance, Property and Audit.
MICHAEL STEWART	Law
JOHN TALBOT	Ophthalmology
ALISTAIR WOOD	Governance

Secretary to the board: Mrs S.Holmes

June 2008

Appendix 2

Priory Donations

Priory Donations (£)	2002	2003	2004	2005	2006	2007
Australia	7,663	7,498	25,402	25,550	25,844	40,165
Canada	64,861	60,553	51,376	47,546	69,199	57,142
England	265,309	302,863	433,442	358,752	352,175	430,567
New Zealand	35,376	25,426	32,206	28,057	170,199	65,768
Scotland	61,800	65,800	87,000	90,335	92,485	81,000
South Africa	0	0	0	0	0	7,500
United States	406,659	304,001	271,285	439,355	420,252	373,304
Wales	2,921	8,614	12,741	17,542	22,638	40,000
Total	**844,591**	**774,757**	**913,455**	**1,007,137**	**1,152,791**	**£1,095,446**

Appendix 3

The Executive Team

ROD BULL	Chief Executive Officer
JACKIE JAIDY	Matron and Director of Nursing
JEANNE GARTH	Medical Director
REEM SALAMEH	Administration Manager
GEORGE AKROUSH	Development and External Relations Executive
GHASSAN ISAAC	Financial Controller
SYLVIA HOLMES	Executive officer in London
NICKY WYNNE	Head of Fundraising and Marketing

June 2008

Appendix 4

Staffing Levels

(Full-time equivalents)	2005	2006	2007
Doctors	24	23	28
Other Medical	10	11	11
Nursing	89	89	93
Management, Admin & Finance	59	60	66
Total Staff (Jerusalem + Clinics)	**181**	**183**	**198**

Appendix 5

Clinical Activity 2002-7

	2002	2003	2004	2005	2006	2007
Outpatients seen at Hospital	32,317	32,362	34,732	40,171	35,181	38,160
Outpatients seen at Gaza	9,146	10,785	8,942	11,751	13,358	17,005
Outpatients seen at Hebron	-	-	-	788	10,733	13,842
Outpatients seen at Anabta	-	-	-	-	-	4,531
Outpatients seen on 'Outreach'	4,458	5,728	7,553	11,982	10,625	9,763
Total Outpatients	**45,921**	**48,875**	**51,227**	**64,692**	**70,077**	**83,301**
Major operations in Gaza	110	131	98	186	350	447
Major operations at Hebron	-	-	-	-	220	451
Major operations in Jerusalem	1,615	1,885	1,686	1,625	2532	2401
Total Major Operations	**1,725**	**2,016**	**2,784**	**2,811**	**3,102**	**3,299**