The Royal College of Ophthalmologists
Primary Care Subcommittee

Paper for Discussion

Primary Care Ophthalmology as a Career

Background

Ophthalmology in the UK has traditionally been a hospital-based specialty with all but the most minor eye conditions being referred to the Hospital Eye Service (HES). Ophthalmology figures fleetingly in the undergraduate curriculum of most British medical schools, and not at all in the case of four medical schools. Most GPs and even specialists in Accident and Emergency (A&E) Medicine feel poorly equipped to deal with eye problems and, as a consequence, most HES units devote a considerable amount of resource (both human and financial) to providing an ophthalmic A&E or urgent referral service. However, a significant proportion of referrals to the HES (both urgent and elective) do not result in admission to hospital or surgical intervention, do not require special investigations, present no major diagnostic or therapeutic dilemmas, and can be concluded in one or two consultations[1]. In fields of medicine such as paediatrics, dermatology and gynaecology, many conditions of comparable complexity fall well within the remit of general practice. What, then would be required for this part of the HES workload to take place safely and effectively in the primary care arena as envisaged in the NHS Plan[2]?

There are some GPs who have had some training in ophthalmology and who maintain a special interest in ophthalmology within general practice. They are not numerous and the demands of general practice can make it difficult for them to devote more than a small proportion of the working week to ophthalmology. A case has been made for community optometrists rather than GPs to be the primary providers of ophthalmic care outside the HES. Although not medically qualified, optometrists have access to equipment for ophthalmological examination and have more knowledge of clinical ophthalmology than the average GP. There are approximately 7,000 registered optometrists in the UK, most of whom work in community practice.

The terms “primary care” and “secondary care” have become somewhat confused when applied to ophthalmology. To restrict the remit of ophthalmic primary care to the range of eye conditions that GPs or optometrists would be happy to manage with current levels of training would still result in many relatively minor conditions still being referred routinely to the HES. We have argued elsewhere[3] that, if the term “primary care” is to be applied to ophthalmology, it should be defined in terms of a process (ie the characteristics of the consultation and its outcome) rather than the environment in which it takes place (community / general practice versus the hospital).

It may be helpful at this point to define eye care services in terms of levels or tiers (an idea originally proposed by Mr Trevor Warburton, a community optometrist), in order to avoid the semantic confusion of the terms primary, secondary and tertiary care. The purpose of this is not to indicate a hierarchy of importance, but rather to provide a framework from which to make some observations about the skill-mix and training of the professionals who might contribute to each tier of the service. From the patient’s perspective, the purpose of

this terminology is not to introduce an esoteric maze of triage levels, but to help to ensure that "care pathways" are designed to take the patient to the right level for their particular condition with as few intermediate steps as possible.

A scheme of six levels is set out in Table 1. There may be discussion about whether the distinction between levels 4 and 5 is artificial, or about whether certain activities belong in one level or another, but the main focus of the remainder of this paper will be on level 3. Having introduced some clarity of terminology, we are now going to have to muddy the waters slightly by calling level 3 "Ophthalmic Primary Care (OPC)" – partly because the term has been used in the same context in an earlier paper[2], and partly because no-one has yet come up with a better term for it. Similar terms have also been used elsewhere to describe "Level 2" services, which would include regional schemes involving specialist optometrists such as those in South Wales (the Primary Eyecare Acute Referral Scheme) and Glasgow (the Glasgow Integrated Eye-care Service). For the purposes of this paper, we refer to level 2 as "Enhanced Community Eye Care".

Our earlier paper entitled "The Future of Ophthalmic Primary Care" is an attempt to describe the characteristics of a "Level 3" service in this scheme. We draw attention to the fact that there are already many services in different locations in the UK which have these characteristics. Some are based within hospitals (eg the primary care services at Moorfields Eye Hospital and the Oxford Eye Hospital). Some are community based outreach services from hospital eye departments (eg Warrington[4]). Some are based on general practice or primary care trusts. It is notable that many of the ophthalmologists who have devoted themselves to setting up these services have had to forge their own, sometimes rather unconventional career pathways, which may explain to some extent the wide variety of settings in which they take place.

Before considering the benefits of a formal career structure for ophthalmologists who wish to develop an interest in OPC, it is necessary to explain why a level 3 service, as described in "The Future of Ophthalmic Primary Care" differs from the traditional outpatient and ophthalmic A&E services provided by a typical hospital eye department.

In the last fifteen years, there has been a steady trend towards sub-specialisation within ophthalmology, with at least seven recognised sub-specialties. Some larger departments have become specialised to the point where consultants work almost exclusively within their sub-specialty. Even within the smallest departments, there is usually some degree of sub-specialisation and it is rare to see a consultant ophthalmologist post advertised without some reference to a sub-specialty interest. College inspections of training posts generally favour sub-specialisation because it tends to make the curriculum for basic and higher specialty training easier to deliver, with a greater likelihood of systematic exposure to complex and rare eye conditions. Clinical Governance favours sub-specialisation because it tends to result in a concentration of highly skilled personnel, specialist investigations and specialised surgical procedures.

Although, with a degree of ingenuity, any eye condition could be assigned to a sub-specialty service, many referrals to eye departments are for common conditions which do not require high degrees of specialist expertise or complex diagnostic facilities. Such conditions are often seen either in general ophthalmology clinics or ophthalmic A&E departments, depending on the degree of urgency of the referral. General ophthalmology

clinics and ophthalmic A&E departments therefore tend to contain a mixture of level 3, level 4 and level 5 clinical problems.

Ophthalmic A&E departments are often staffed by junior ophthalmologists with little direct senior supervision. Some departments have attempted to regulate demand by operating a strict appointment system, but most departments remain over-subscribed and ophthalmic A&E sessions tend to be regarded by trainees more as a survival challenge than as a useful learning environment. Although most referrals to ophthalmic A&E departments are not true emergencies, many are relatively acute ocular problems which merit attention within a day or two. As such, they are appropriate referrals in the sense that most departments do not have any alternative provision for making appointments within that time frame. Hospital eye departments usually also have very limited provision in outpatient clinics for accommodating short-notice follow-up appointments from A&E visits, with the result that follow-ups are frequently seen in A&E, often by another (or even the same) junior trainee. There is a consistent inverse relationship between the seniority of the doctor and the propensity for requesting follow up appointments.

In contrast, a level 3 OPC service as envisaged in "The Future of Ophthalmic Primary Care" will have the following characteristics:

1. There is direct senior (consultant or senior staff / associate specialist level) supervision. Lack of availability of a senior opinion should never be a reason for bringing a patient back.
2. The service is built around the philosophy that any clinical problem that can reasonably be resolved within a single consultation, should be resolved at that consultation. This implies access to basic diagnostic facilities such as perimetry.
3. Clinical problems which have not been resolved after one follow up visit should usually be referred directly to another tier of the service.
4. Referrals which are clearly destined for a different tier of the service should not be accepted (eg cataract, suspected choroidal neovascularisation).
5. Access times should be maintained at a level where it is possible to offer appointments based on clinical priority. The service in Warrington has succeeded in maintaining a maximum wait of two weeks for routine referrals for over ten years (M Wishart, personal communication).

OPC as a sub-specialty of ophthalmology

There is a popular misconception within ophthalmology that OPC is like what is left of the Christmas turkey after the breast meat, legs and wings have been eaten and the rib cage has been removed to boil up for soup – an unappealing residue of minor ailments and non-specific symptoms.

Not so!

OPC deserves the status of a sub-specialty of ophthalmology, not because it focuses on a particular range of pathology or treatment, but because it focuses on the "patient-centred consultation" and because it is a particularly rich educational environment. The vocabulary in the last sentence has been borrowed from general practice, and deliberately so because, whether OPC services are based physically within hospitals or elsewhere, OPC has much in common with general practice in its philosophy and processes.

Designating OPC as a sub-specialty of ophthalmology implies that it must have a training programme capable of delivering ophthalmologists who are both excellent clinicians and excellent trainers. It cannot simply be a fall-back option for ophthalmologists whose careers have stalled in other fields of ophthalmology. Although it will omit some parts of the core curriculum of the ophthalmic surgical training programme, it will need to include some additional modules, and may need to take some aspects of the ophthalmic surgical curriculum to a higher level.

A training curriculum for OPC

We propose the following:

1. OPC should have a single run-through training grade leading to its own Certificate of Completion of Training (CCT).
2. The training programme should include exposure to the other ophthalmic sub-specialties, but should not include practical surgical training.
3. The training programme should include exposure to emergency ophthalmology.
4. The training programme should include exposure to general practice.
5. The training programme should include exposure to optometry and orthoptics
6. The training programme should include formal training in teaching and assessment method.
7. Optional modules might include: further training in other ophthalmic sub-specialties (eg diabetic eye disease, glaucoma), public health, ophthalmic epidemiology, health service leadership, audit method and research.
8. There should be an exit assessment, equivalent to, but distinct from the exit assessment for the run-through training grade in surgical ophthalmology. The Part I MRCOphth should be common to both programmes. There should also be structured in-training assessment of competence.
9. There should be flexibility within the training programme to allow trainees to move to and from related training programmes (eg the ophthalmic surgical training programme, the medical ophthalmology training programme and vocational training for general practice).
10. There should be provision for assessing eligibility for exemption from parts of the training programme on the grounds of previous relevant experience. This should not just be a “grandfather rights” clause, but should include a fair and transparent mechanism for assessing applications for entry to the specialist register under Article 14 of the General Medical Practice and Specialist Medical Education, Training and Qualifications Order 2003.

These proposals will need input from those with expertise in curriculum design, assessment and workforce planning. They will need to be discussed with the Royal College of General Practitioners, the Medical Ophthalmology Subcommittee and the Postgraduate Deans. An approach has already been made to the Department of Health regarding the proposals.

From where might OPC draw its recruits?

First and foremost, we believe that OPC will draw from the same pool of applicants as ophthalmic surgery. Ophthalmology has been heavily over-subscribed for many years and

the number of SHO posts will reduce from about 420 to just under 200 in the next three years to balance with numbers of SpR posts as the grades merge into a unified training grade for ophthalmic surgery. Many of the 220-odd "surplus" posts are at risk of being lost to ophthalmology altogether, or becoming "trust grade" posts. OPC offers a means of keeping some of these posts within ophthalmology as training posts. Providing that OPC offers a good training curriculum leading to interesting and attractive posts, there is no reason for it to be a second-class alternative to surgical ophthalmology or medical ophthalmology.

OPC will also draw from a pool of ophthalmologists who are effectively already working in this field. Some have been appointed with a specific brief for OPC, while others have developed an interest while working in staff grade, associate specialist or similar posts. It is important to make specific mention of Ophthalmic Medical Practitioners (OMPs) in this context. OMPs are, in a sense the archetypal providers of OPC in the community. They are ophthalmologists who are contracted to the General Ophthalmic Services and there are about 662 OMPs in active practice in the UK, probably equating to about 265 whole-time equivalents. A recent postal survey of OMPs (Smith R, Bhagey J, data not yet published) suggests that the constraints of working within the General Ophthalmic Services (eg the inability to issue NHS prescriptions for drugs) result in their skills being considerably under-utilised. It is uncertain what proportion of OMPs would wish to move into posts in OPC as envisaged in "The Future of Ophthalmic Primary Care[3]", particularly if they are nearing retirement.

It is anticipated that some doctors will wish to combine a career in general practice with OPC, and this is to be encouraged. Some GPs already do this, either by undertaking hospital sessions as clinical assistants / hospital practitioners, or by providing an ophthalmology service from within their general practice. The Royal College of General Practitioners (RCGP) has encouraged the development of special interests within general practice by introducing an additional optional fourth year into GP Vocational Training. This is known as the General Practitioner with a Specialist Interest (GPSI) programme[5]. Ophthalmology is on the list of disciplines for which a GPSI programme will be available, but plans for this are still at an early stage. The GPSI programme in ENT is at a more advanced stage, with an established diploma course, through which considerable numbers of GPs have passed.

In the Aylesbury area, seven GPs have completed the training programme in ENT, but only one of these has continued to provide an ENT service within general practice (I Bottrill, personal communication). The reason for this high attrition rate seems to be the pressure of main-stream GP work. Clearly, the same danger exists for ophthalmology, and the responses from the postal survey of OMPs confirm that GPs find it difficult to maintain the time and space in which to practise ophthalmology. Requirements for continuing professional development and revalidation in both areas of practice create a further burden. These are issues which general practice as a specialty will need to address if GPSIs are to become a common part of general practice.

To facilitate the participation of GPs in OPC, there should be flexibility within the training programme to accommodate different levels of engagement with ophthalmology. Some GPs might wish to undertake a full training programme in OPC to CCT, while others may wish to have shorter training and work in OPC in a supporting role.

The professions allied to ophthalmology

Specialist nurses and nurse-practitioners have provided an invaluable supporting role within the hospital eye service for many years, undertaking a wide variety of clinical tasks. There is clear potential for developing their role further in OPC.

There are just under 1000 registered orthoptists in the UK. Many work partly within the hospital eye service and partly in community health services. Many have already been trained for tasks beyond their core areas of expertise and their skills could be developed further in OPC. However, orthoptics is a shortage specialty, and there may be limited scope at the present time for broadening the role of orthoptists without compromising their key role in paediatric vision testing and assessment of ocular motility problems.

Optometrists have shown considerable interest in contributing to OPC in recent years. Many hospital-based optometrists already undertake clinical tasks well beyond their traditional work of refraction, contact lens fitting and low vision assessment. Their extended roles include visual electrophysiology, ophthalmic imaging and monitoring of ocular hypertension. Many community optometric practices are very well equipped and there are approximately 7000 registered optometrists in the UK. There are a number of projects underway in various locations across Britain where accredited community optometrists treat a range of eye conditions according to locally agreed protocols with the aim that only conditions which fall outside the protocols are referred into the Hospital Eye Service. Some, such as the Primary Eye-care Acute Referral Scheme (PEARS) in South Wales involve a large number of optometrists who have undertaken a small amount of additional training, whereas others, such as the Glasgow Integrated Eye-care Service (GIES) involve a smaller number of optometrists who have undertaken more substantial additional training. These projects have started relatively recently and, at present there is limited audit data on their impact on demand for local hospital eye service facilities. These projects, along with a number of co-management schemes involving community optometrist fall into “Level 2” as defined in Table 1.

We have suggested in “The Future of Ophthalmic Primary Care”[3] that optometrists, orthoptists and nurse practitioners, following additional training might treat patients alongside ophthalmologists within a “Level 3” service. This might only appeal to a small proportion of optometrists, as the maintenance of skills at this level would require a fairly substantial time commitment.

The relationship between OPC and General Practice

One of the particular strengths of the NHS is the pivotal role of the general practitioner in the coordination and integration of the healthcare of patients. Many ophthalmic conditions have systemic associations and the general medical and social aspects of the patient’s health often impinge on the management of ocular conditions, so it is very important that innovations in the way in which eye care is provided continue to involve the GP and do not allow primary care to become fragmented. The RCGP is in the process of reviewing the core skills and competencies required of all GPs and is keen to include ophthalmology as one component of the requirements (M Lakhani, personal communication, 2004). This is a development this College strongly supports. It is recognised that the majority of GPs will wish to remain generalists and not develop ophthalmology skills beyond the core requirements. The development of a more formal career structure in OPC should facilitate

the involvement of GPs either as generalists or specialists, particularly where OPC takes place in, or close to general practice.

OPC as a training environment

We believe that one of the most compelling justifications for a properly structured service at Level 3 is its potential as a training environment. Although there will be a tendency for some eye conditions to be filtered out at level 2, there is likely to be a reasonable concentration of common and acute eye problems.

For trainees new to ophthalmology (either as part of a Foundation Year 2 rotation, or as a first module in the specialty training programme), there will be opportunity to learn to manage these conditions safely under senior supervision. Trainees in A & E medicine might find it useful to undertake a short attachment in OPC. For medical students, it could provide a good grounding in basic ophthalmology, even within the constraints of the small time allotted to ophthalmology in most undergraduate curricula.

There is likely to be an increasing demand for clinical placements for GPs, optometrists, nurses and orthoptists as part of postgraduate courses or diplomas in ophthalmology. The postgraduate diploma in ophthalmology run by Rila in association with Middlesex University[6] is aimed at all these professional groups and lasts about 8 months. A number of postgraduate courses on ocular therapeutics for optometrists have recently been launched. All such courses require some level of practical exposure to clinical ophthalmology. The Hospital Eye Service as it stands has limited additional training capacity to support clinical placements. Clinical placements, if they are to deliver the intended learning objectives require physical space, equipment and trainer's time. All are expensive to provide. Many professionals who enrol for postgraduate courses do so at their own expense, so it is important that time spent in clinical placements is spent well. This implies that they should be appropriately supervised (ie not just sent to sit in casualty with an inexperienced SHO who is too busy to teach) and the content of the attachment should be relevant to the area in which they intend to use their new skills (ie not excessively specialised).

A level 3 service as envisaged in "The Future of Ophthalmic Primary Care"[3] could provide both the right level of supervision and exposure to a suitable range of clinical conditions to train those who wished to practise either at level 2 or level 3.

OPC services should build in training capacity by entering into funded contracts with course providers, similar to the Service Increment for Teaching (SIFT) which funds clinical placements for medical students. One way to ensure that service and training are not in conflict is to ensure that one is not subsidising the other.

Summary

Riad, Dart and Cooling, in their comprehensive article on Ophthalmic Primary Care[7] lay down the following challenge:

"Ophthalmic primary care, as a structured discipline, remains underdeveloped, borrowing identity from other specialties, despite the presence of clinical ophthalmology at the heart of its services, with abundant relevant ophthalmic expertise. This may be because of the

lack of [perceived] glamour in what is a highly technical and surgically oriented profession, but ophthalmic primary care is a rich and rewarding subject awaiting recognition by ophthalmology's leaders."

Perhaps now is the time to take up that challenge.

References

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