Commentary (*Series editor: David Taylor*)

Ophthalmologists and optometrists—interesting times?

As the ancient proverb entreats, "May you live in interesting times." We do. The relation between the two professions has never been in greater flux. We have, in the United Kingdom, moved from conflict and intolerance to (relative) harmony and cooperation in a very few generations. We are all contending with changes to the climate in which we work, compounded by changes in legislation, enacted or threatened.

There are references in the literature to "turf battles" and "strained relations" especially in the United States.[1 2] In general, in the UK we are fortunate to have a relatively peaceful alliance which more often than not is mutually beneficial. The services offered by the two professions are complementary and any animosities that used to exist should be consigned to history. In looking to the future it seems that there is potential for both hospital and community based optometrists to become involved in some aspects of ophthalmological care. With an ageing population, and therefore increasing prevalence of eye disease, it would appear essential to have an extended workforce undertaking screening for and monitoring of eye disease. This is particularly relevant to the UK in which the organisation of ophthalmic care is different from most other countries in the developed world. Why should each group be defensive towards the other or afraid that their work will be usurped or negated? Clearly, there is plenty of work for all of us.

In order to encourage cooperation, communication and mutual respect are essential. Teamwork is of course much easier in the setting of the hospital where communication and feedback are part of daily routine. Interaction across different environments is more challenging and even with the revision of the referral form GOS18, non-communication between hospital and community based professionals remains a problem.[3] The issue of consent should be no barrier to the free and full exchange of information between ophthalmologists and optometrists. Without feedback the optometrist has no opportunity to learn, and without improvement in referrals the ophthalmologist remains dissatisfied with the quality of those referrals. Such lack of union begs the question—did we go wrong in 1948 when the optical profession remained in the high street rather than being fully integrated into hospitals?

Consultants no longer perform the range of tasks that they used to. Specialisation now means that the "general" ophthalmologist must have regard to the limits of his skill. Professional indemnity is not a blanket cover nor carte blanche to work outside the limits of training or experience. How soon will it be before the ability of an ophthalmologist to refract will be questioned in a case of dispute? An optometrist may perform 75 or more refractions each week and an ophthalmologist from none to a small fraction of that number. Optometrists' primary skills involve the science of optics, about which they should know much more than many ophthalmologists, and the practice of refraction, at which they are likely to be more skilled than many of the new generation of consultants. The consultant who has always prescribed spectacles for postoperative patients requiring them might argue that the skill is essential—maybe everyone should be proficient at refraction. However, is this the best way to use his/her time and skills?

Traditionally, hospital optometrists have been required to undertake much of the refraction generated in that environment—until now they were usually interpreting a challenging retinoscopy reflex from a corneal graft or coping with a difficult paediatric refraction. More recently, some consultants are recognising the value of adding an experienced optometrist to their clinical team. In this "extended role" a trained optometrist can contribute to relieving the burden of overstretched clinical resources. In the right environment they can work with some autonomy and yet offer a satisfactory standard of service.[4 5]

Many optometrists wish to undertake new work and while talk of surgery or laser treatment has been heard, there are many more realistic options currently open to them that make better use of their skills. Shared care schemes involving glaucoma, diabetes, cataract, and low vision as well as primary care are working well in many parts of the country. Glaucoma and diabetic screening in particular are relatively well developed with shared care schemes in operation both in the community and hospital setting. Very much depends at the moment on the enthusiasm and goodwill of individuals but always the ultimate responsibility for the patient remains with the consultant.

Much heat is generated by the suggestion that optometrists might become more involved in the management of cataract patients. The General Optical Council's rules for the referral of patients to a registered medical practitioner have recently been changed.[6] No longer is it obligatory for optometrists to refer all lens opacities regardless of the visual requirements or performance of the patient. This state of affairs recognises the current practice of the majority of optometrists and a rationalisation of the use of existing skills. It is a notable but small step for the optometrist to suggest that the patient may be suitable for cataract surgery. The first visit to hospital could be for examination, confirmation of the diagnosis, performance of the necessary measurements, the obtaining of informed consent, and arranging the date for surgery. Those yearning to exercise professional discretion will have far more satisfaction in their work, but they will have to be able to justify their actions if these are called into question. Of course the ultimate questions are asked in the disciplinary process after something has gone wrong. This process is itself under review but must always remain in some form as a last resort. But who should judge an optometrist in this process? Traditionally, ophthalmologists have rightly given expert views and opinions. Questions have been raised as to the appropriateness of one profession judging another.[7] Is peer judgment more appropriate or is this too cosy?

Training is perhaps the key to success in the "skills mix" evolution. In order to undertake specific roles, it is probably no more difficult to educate optometrists than doctors. The initial training for optometrists consists of a 3 year undergraduate course followed by a "preregistration" year, where experience is gained practising under supervision. A substantial portion of their knowledge is not used in standard practice. That they have insufficient training to meet the demands of shared care/extended role is at least in part related to the reluctance of the medical profession

to take students into their already busy clinics in which there is no time to devote to the required one to one teaching. Training of optometrists by optometrists alone is also a problem and it is projected that there will be a severe shortage of preregistration posts for the 2001 output of the optometric schools.

If we were able to look ahead several years what would we like to see? An appropriately trained optometrist would be offering a limited primary care service to patients who would be referred by general practitioners or who walk into the practice, be it in hospital or the high street. There might be medical personnel present on site but, if not, an opinion might be sought readily by telemedicine or on the "net" or the patient referred to hospital by normal routes or some agreed "fast track." Optometrists would make diagnoses and prescribe from a limited list of drugs, but work within strict protocols, referring on anything outside their remit. They would be certified by ophthalmologists as competent to work within those protocols and the ultimate responsibility for the welfare of the patient would remain firmly with the consultant. There are many driving forces to change including the NHS plan, the Crown Review,[8] *Action on Cataracts*,[9] and the College of Optometrists' "guidelines."[10]

The main objective of these developments would be to take full advantage of the UK's 8600 registered optometrists in order to help cope with the ever increasing burden of eye health care. It would reduce waiting by patients who would be seen conveniently near their home or place of work, relieve eye department outpatient clinics of the simpler problems leaving them better able to cope with the complex problems for which they are ideally suited, and provide the NHS with an economically sensible model of care with no worse standard of care. A radical change to the training of optometrists would be required to meet this objective. Courses should increase their practical clinical content, there should be progressive integration with current services, and dialogue at all levels. The thorny issues of funding and remuneration need to be resolved. In addition, there is the requirement to investigate the new model of care to ensure that it is cost effective and safe for patients.

There is no room in today's world for conflict—there is sufficient work for all as territorial boundaries become more blurred. Surely it is more constructive to debate and to define roles and responsibilities, and thereby encourage and develop a harmonious alliance between ophthalmology and optometry.

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