ABC of Ophthalmology

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OPHTHALMIC SERVICES IN THE NHS

Ophthalmologists and opticians

The ophthalmic services are broadly divided into two groups: the hospital-based services and the General Ophthalmic Service (GOS), which provides a service limited to sight testing (refraction) outside hospital. There is also special provision for schoolchildren, which is now under the community health services.

Specialists dealing with the care of eyes also fall into two distinct groups: those with medical qualifications and those without—ophthalmologists and opticians respectively.

Consultants in ophthalmology have to possess surgical qualifications. Most eye disorders, however, do not need purely surgical treatment, and many are part of diseases of a general medical or neurological nature. The consultant's professional life is therefore generally a blend of surgery, medicine, and refraction. Refraction is important because abnormalities obstruct normal function and its assessment.

There are also many other doctors practising full-time or part-time ophthalmology who have limited their activities by excluding surgery. The GOS, however, recognises only their ability to diagnose and does not permit them to treat outside hospital, except by prescribing glasses. Treatment other than glasses cannot be obtained under the GOS, though the general practitioner may, of course, treat eye disorders medically, with or without advice from an ophthalmologist. The result is that many patients with quite simple medical eye conditions are forced to visit hospital for treatment.

General Ophthalmic Service

The GOS is essentially a sight-testing service and a system whereby the many people who self-diagnose the need for glasses can get confirmation that this is so or whether disease is present. It is manned by ophthalmologists who are often consultants doing part-time work outside hospital and by opticians who are either ophthalmic (sight testing) or dispensing.

A sight-testing optician's training is basically restricted to the optical functions of the eye and its disorders. Obviously this demands some knowledge of whether the eye is otherwise normal, but opticians are not qualified to diagnose or treat eye conditions. Their function is to improve acuity by providing glasses. If they suspect other abnormalities or cannot improve defective vision they must refer the patient to their general practitioner.

It is often extremely difficult for doctors to identify a condition from the patient's complaints of discomfort. And it may be equally difficult for an optician to differentiate between an optometric condition and a medical condition which may represent a serious threat to eyesight. In addition patients are generally reluctant to tell opticians about their general health. Any information that passes either way is likely to be garbled by the patient. Comparatively few ophthalmic opticians are to be found in the hospital service or in community clinic work outside hospital.

School eye service

Dispensing opticians are qualified only to make and fit glasses to someone else's prescription. This skill is very important because inadequate fitting may itself undo any good the glasses were prescribed for—even to the extent of producing double vision, for example. Dispensing opticians often work in liaison with ophthalmologists and provide consulting rooms for them. These establishments are known as medical eye centres, where ophthalmic medical practitioners perform the refraction rather than sight-testing opticians, in many cases providing an indirect personal link with the hospital service.

The school eye service was originally set up by local authorities to deal with the fact that neither children nor their parents notice or necessarily report their eye defects. Screening schoolchildren showed that many had poor vision and were unlikely to have anything done for them unless it was made easy. Clinics manned by ophthalmologists were therefore set up outside hospital, to which children were referred by the school doctor with the parents' agreement. These clinics opened the way to better medical treatment for squints, including the employment of orthoptists, and to the provision of medical opinion on the need for glasses and the role of eyesight in poor performance at school. (Prescriptions are issued under the hospital eye service, not the GOS.)

It gradually became apparent that screening at school entry was not early enough, so that children's eye services developed in some areas drawing patients from infant welfare clinics as well as from schools. Now community physicians have taken over the school medical service from local authority medical officers of health. Community physicians may have a greater role to play in catering for the diverse needs of the population for ophthalmic care, perhaps with the opening of developmental and geriatric clinics. Paediatric assessment centres, for example, often need ophthalmic opinions. The school eye service is excellent for detecting all children's visual defects by screening and following them up, neither of which is systematically dealt with by the hospital eye service or the GOS.

Providing sight tests and glasses

Sight tests are free under the NHS and can be obtained by anyone from birth onwards without medical advice or referral. If they are requested more than once a year by adults special circumstances must justify the test. A doctor's letter is usually accepted by the administration but referral for a second eye test is not desirable as a means of obtaining a second opinion, which is better obtained privately or by a hospital consultation under the NHS.

Children's sight may change within short intervals—3 to 6 months—and special regulations apply to their eye tests.

The accepted practice of having an eye test every two years is not medically inspired. Any adult with a sudden new visual disturbance should seek advice within days and those with a gradual increasing disturbance within weeks. Those who are satisfied that each eye is performing normally without change can wait indefinitely in safety unless there is a strong family history of visual defect and disease.

Schoolchildren get glasses at special rates, but charges in general depend on the source of the prescription. Prescriptions issued from hospital for spare pairs of glasses, toughened lenses for children, and magnifiers of any sort are honoured by the NHS but not so if written by the same practitioner in the GOS. The best buy is therefore a hospital prescription. Glasses prescribed for hospital inpatients are totally free, but elderly people often have to pay considerable sums for their glasses after surgery—for example, for cataracts—because they are no longer in hospital when the glasses are ordered.

The GOS is therefore an effective organisation where healthy people can obtain sight tests and glasses, but it is not as useful as it might be for diagnosis and treatment. It has special limitations in respect of the handicapped and housebound.

The orthoptist

The orthoptist's work is similar to that of a physiotherapist: she is concerned with movements of the eye, in particular abnormal movements, which are mainly squints. Since squints are correlated with the development of visual acuity she is responsible, under an ophthalmologist, for supervising the treatment of children's eyes that are reluctant to play their full part in visual acuity or binocular vision. About 90% of the orthoptist's work is with children, mostly those aged under 7, but she has a useful role in the management of any disorder of binocular vision at any age. Such conditions include palsies or muscle imbalance, whether or not they are caused by trauma.

A newly squinting eye in an infant can lose its acuity in a few weeks, become conditioned to the abnormality, and build up secondary abnormalities in a few months that may take months or years to undo. Here the orthoptist has a valuable part to play in monitoring progress as well as in instituting actual treatment.

In most clinics orthoptists see only cases delegated for specific procedures, though in some areas they perform primary screening of children on behalf of the consultant and in others they see all doubtful cases of squint referred by GPs or from infant welfare clinics. Many combine hospital and school clinic work. Many attendances at orthoptic clinics over months or years are often necessary. Therefore this dispersal of the clinics is a boon to mothers who would otherwise default.

Health visitors and social workers

Both health visitors and social workers may be a great help to the visually handicapped. Health visitors, for example, are more likely to be asked about broken glasses or arranging a visit to an optician than doctors, and conversely, a health visitor can take an active role on her visits to the housebound. She may either ask direct questions about eyesight or do a simple reading test; the small print in the radio programmes is as good a test as any for reading difficulties.

Opticians have little inducement to visit people at home, which means there is a large gap in the services for the handicapped and housebound, though the general practitioner can always request a domiciliary visit from a consultant. The GOS rules apply to an optician's visit, but the more generous provisions of the hospital eye service are available through a consultant's visit.

Recent surveys in geriatric wards and at home have shown that not only do the elderly handicapped include many with defective vision but also that about 25% of the rational elderly are not getting theoretically easily obtainable remedies that would make life easier for them. This includes even some registered blind.

Social workers too should look out for visual problems and provide advice on help and aids. There are all sorts of aids for visually handicapped people. These include magnifying glasses, braille watches, extra illumination, telephone attachments, attachments for cooker dials, and so on. Problems to do with schooling and work often need sorting out.

Visual problems arise more often in children with other handicaps (physical or mental) than they do in normal children, and the social worker can legitimately inquire about eyesight at all ages and how any problems are being tackled. Social workers should not only be on the alert for people with visual handicap but also know whom to appeal to for practical and diagnostic aid. This is hard on the generic social worker, as the subject is so specialised.

Alarm clock supplied by the Royal National Institute for the Blind

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Eventually this series will be collected into a book and hence no reprints will be available.

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