Eye (2003) 17, 7–8

www.nature.com/eye

EDITORIAL

'Non-medical' prescribing in glaucoma

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Eye (2003) **17,** 7–8. doi:10.1038/sj.eye.6700182

In an ideal world all glaucoma patients and suspects would have regular reviews with a glaucoma specialist, who would have enough time and resources to provide the patient with an informed choice of management. An ageing population with a tendency to present with glaucoma at lower IOPs than in the 1980s,[1,2] together with ophthalmic sub-specialisation has resulted in expanding glaucoma clinics for those consultants who supervise them. Over the last few years shared care (SC) schemes have been developed in order to compensate for the relative shortage of ophthalmologists in the UK. Many schemes have utilised the expertise of professions allied to ophthalmology such as optometrists and nurses. Audits examining agreement between trained shared care personnel (optometrists) and ophthalmologists have indicated that decision-making in the management of continued care of the diagnosed patient can be devolved, provided a second opinion is available.[3,4]

The next obvious move forward in glaucoma management is to sanction prescribing rights, thus permitting SC personnel to treat glaucoma medically. Such a concept often provokes serious reservations from ophthalmologists with little experience of working in a shared care environment. 'Who is responsible for any sub-optimal outcomes?' one hears, whilst others fear a loss of control of their patients and an erosion of the quality of care in glaucoma. Similar reservations exist from ophthalmologists in the USA, but at the time of writing, 45 US states permit optometrists to manage glaucoma, including prescribing topical medications.[5]

The paper in this issue of *Eye* from Newcastle describes a system of triage of glaucoma suspects by trained nurses, including the commencement of topical medications for those found to have 'high pressure' glaucoma (defined as IOP >21 mmHg, visual field loss and cupped discs). Can this approach be justified on ethical grounds? Providing medical treatment as first-line therapy continues to be the norm, I believe, provided certain criteria have been met:

(a) The diagnosis should be unequivocal (the addition of an objective method of optic disc assessment such as the Heidelberg Retina Tomograph II[6,7] and the addition of gonioscopy would probably help here to ensure clinical governance issues were satisfied).
(b) The patient is an active participant in the decision to treat and the choice of agent.
(c) The first follow-up visit is with an ophthalmologist who would then agree a management strategy with the patient for their future care.
(d) The system is underwritten by regular audit.

The value of the Newcastle system is increased when there are long waiting times for an appointment with an ophthalmologist as treatment can be commenced quickly for those most at risk of rapid progression. Alternative strategies using SC personnel for identifying those with glaucoma from those referred from community optometrists may also result in an improvement in service without an increase in the numbers of ophthalmologists.

Initial therapy is probably the most appropriate stage at which to trial SC staff prescribing, as outcomes are relatively easy to measure being mainly short-term, but should the principle of prescribing by non-medical staff stop there? In an established system such as the Nottingham scheme where optometrists with additional glaucoma training work in parallel with ophthalmologists in the glaucoma clinic, much time is wasted by both parties as, at present, initiating or changing medication must be sanctioned by medical staff. Our experience

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is that the ophthalmologist almost always agrees with an experienced optometrist's management plan and that limited prescribing rights for 'trusted' SC personnel would clearly streamline the clinic. The introduction of topical antiglaucoma agents with improved systemic and local side-effect profiles have strengthened the argument in favour of the introduction prescribing rights for SC personnel.

Electronic patient management systems with in-built prompts to warn of previous allergies/drug interactions will support SC staff prescribing whilst enabling the consultant to monitor his/her patients' progress without the recourse to a retrospective casenote audit. Such a system, with its in-built audit trail, will permit a 'silent' audit of SC decision-making, something that should reassure those sceptical of the principles and practice of shared care. A sophisticated system is under trial in certain centres, including Nottingham, and the outcome of studies associated with its use is awaited with interest. In the meantime ophthalmologists should continue to gather evidence concerning the efficacy (or lack of the same) of their shared care schemes, including some measure of patient satisfaction.

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