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# EDITORIAL

## HOSPITAL-BASED PRIMARY CARE CENTRES IN OPHTHALMOLOGY

In the National Health Service the delivery of primary health care remains the responsibility of the general practitioner (GP). In specialities such as ophthalmology the generalist is faced with a low level of undergraduate training and postgraduate experience, with the resultant difficulty in assigning the correct degree of urgency to a patient's symptoms. Hospital ophthalmic outpatient departments have long waiting lists, sometimes up to 2 years, and so the only realistic option for a GP wishing to obtain an early opinion is to refer the patient as an emergency to the local eye department. As a result primary care in these specialities has traditionally been provided by accident and emergency (A&E) departments and this applies especially in ophthalmology.<sup>1,2</sup> However, the majority of the primary care visits are not appropriate to the A&E setting: a recent audit in our department revealed a true accident or emergency in only 15% of attenders. Great pressure is created in such units, with insufficient staff and space to deal with an ever-increasing referral base<sup>3</sup> resulting in consultation times often as short as 2 minutes with associated long waiting times.

It appears that there is a definite need for a system which can deal with non-urgent referrals to the specialist quickly and efficiently. Available options are to improve the undergraduate training in ophthalmology, to improve ophthalmological skills in the community-based primary care sector, consultant outreach clinics, rapid access secondary care clinics and community-based or hospital-based primary care centres.

Ophthalmic training for undergraduates usually comprises a short clinical attachment, rarely longer than 2 weeks, and at best can achieve only a basic understanding of the diseases and their detection. A large technological barrier prevents further progress in a speciality in which training is essentially postgraduate.

Many subspecialities, especially ophthalmology, have difficulty in attracting GP trainees and attempts at including ophthalmology in vocational training have not proved popular. In contrast 'career' posts in ophthalmology are oversubscribed, with many junior

doctors standing little or no chance of reaching consultant level as highlighted in a recent letter published in the *British Medical Journal*.<sup>4</sup> A reallocation of junior ophthalmology posts from career to GP training may be difficult to achieve but would resolve imbalances within the speciality and create a steady if gradual improvement in the quality of ophthalmic primary care delivered by GPs. The involvement of postgraduate deans in general practice would be essential.

Outreach clinics involve the hospital-based specialist team providing an outpatient diagnostic and treatment service in the primary care setting rather than in the hospital and have become increasingly common.<sup>5,6</sup> Most of the early initiatives were in psychiatry<sup>7</sup> but more recently other specialities including paediatrics,<sup>8</sup> obstetrics,<sup>9</sup> orthopaedics,<sup>10</sup> dermatology<sup>11</sup> and ophthalmology<sup>12</sup> have begun to develop outreach clinics. In view of the growing body of epidemiological evidence concerning the high prevalence of treatable eye disease in the community which does not present to the hospital outpatient department,<sup>13</sup> these outreach ophthalmic clinics seem a good idea. Potential disadvantages of outreach clinics include an adverse effect on the training of junior doctors, increased waiting time for hospital clinics and inefficient use of consultants' time. Patients may still require a visit to a hospital for special investigations and treatment and liaison with other hospital departments is lost.<sup>14</sup> From the hospital's point of view there is the real possibility of loss of referrals with consequent loss of revenue. The tendency for outreach clinics to contribute to a two-tier service because of the purchasing power of fundholding practices needs to be resisted.

The disadvantages of outreach clinics apply particularly to ophthalmology, in which expensive and often bulky instrumentation is required in addition to specific support services such as opticians, orthoptists, visual field assessment, photography, ultrasound and electrophysiology. Development of service models locally has indicated a minimum specification to provide for efficient use of consultant

and support team, and comprise three ophthalmologists with one optician providing refraction and low vision services, one orthoptist/field technician and at least one ophthalmic specialist nurse. This level of service specification would be impracticable in all but the largest GP health centres. However, such a service model becomes feasible and appropriate when sited within community hospitals located at some distance from the base hospital with the latter providing surgery and specialised outpatient services.

Pecker *et al.*<sup>15</sup> have reported the successful establishment of a rapid access secondary care clinic, with the waiting time for new outpatient appointments being reduced from 40 to 2 weeks. They also reported that 66% of patients seen in their clinic were diagnosed, treated, listed and discharged on their first visit, requiring no further follow-up. Patients' and GPs' satisfaction were reported to be high. This model does not address true emergency cases, which are still seen in the general A&E and can suffer the same disadvantages as outreach clinics in terms of training of future specialists.

A hospital-based primary care unit staffed by a specifically trained specialist team can provide a comprehensive service to cover accidents and emergencies as well as urgent and non-urgent GP referrals. The objective of the primary care ophthalmic clinic is a quick, efficient and comprehensive 'one stop shop' for ophthalmic diagnosis and management. The hospital location provides easy access to the necessary support services and avoids unnecessary revisits. Strict protocols ensure best practice, aid the assessment of individual conditions and ensure appropriate management. Specialist ophthalmic clinics within the eye unit provide necessary backup for the more complex problems. Improved access to these clinics should help prevent inappropriate 'recycling' of follow-up patients as occurs in the traditional A&E department.

The Liverpool ophthalmic primary care unit replaced the previous ophthalmic 'accident and emergency' department 2 years ago, providing a service for all ophthalmic accidents and emergencies and urgent and non-urgent GP referrals. Staffing is by a mix of trainees and permanent primary care specialists, including part-time GPs. The outpatient appointment waiting time has been reduced from 26 weeks to 6 weeks for all the eye clinics. There has also been a significant reduction in the number of patient revisits to the department.

The provision of a hospital-based primary care clinic offers rapid and easy access for GPs, many of whom feel uncomfortable regarding their level of ophthalmic expertise. Structured processing of routine ophthalmic conditions with appropriate investi-

gation and treatment and proper consultant support reduces the workload on the outpatient clinics and decreases the overall waiting times for patients. The opportunity for supervised training of GPs and ophthalmologists should improve the quality of postgraduate training and community expertise in the speciality. With tangible advantages for the patient, the GP and the hospital this type of innovative service can greatly enhance the provision of care in specialities such as ophthalmology.

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