Whither ophthalmic pathology in the UK: why not wither and whemmie?

MICHAEL ANDREW PARSONS

Last year, Professor Gordon K. Klintworth delivered the third Ashton Lecture, 'Ophthalmic pathology from its beginning to the high technology of this millennium', the text of which is published in this edition of *Eye*.[1] The start of the third millennium, as he indicates, provides a good opportunity to sit back and reflect on the current position of ophthalmic pathology in the UK, and on what may happen to it in the future. This has been a matter of some concern for many years, if only, and not unnaturally, to the small number of UK ophthalmic pathologists.

Gordon Klintworth's lecture reflects on the major role of the late Professor Norman Ashton in the development of ophthalmic pathology in the UK, and his successor Professor Alec Garner charted his role in the foundation and development of the European Ophthalmic Pathology Society.[2] In the UK, the concern in the 1970s and 1980s about the future of ophthalmic pathology led to the foundation of the British Association for Ocular Pathology (BAOP). This Society has performed a sterling service in bringing together 'full-time' ophthalmic pathologists (i.e. those who practice ophthalmic pathology to the exclusion of all other branches of histopathology) and pathologists 'with an interest' in ophthalmic pathology (i.e. those whose practice includes general pathology and/or sub-specialties of histopathology, such as neuropathology). Yearly meetings of around 30 members, which originally centred around a 'microscope slide/case conference' format, now include research presentations and 'External Quality Assessment' of ophthalmic pathology reporting – of which more anon.

The 1990s were somewhat traumatic for ophthalmic pathology, or at least for dedicated ophthalmic pathology posts in the UK. As members of the 'old guard' of pathologists retired – in Manchester, Birmingham, London and Glasgow – their full-time specialist posts outside London were either changed into posts with additional general and neuropathology (Manchester), or were abolished entirely (Birmingham, Glasgow). This was mainly because 'local' hospitals did not want to pay for 'national' services, under the prevailing cost-sensitive conditions. Tragically, Dr Alison McCartney, an outstanding ophthalmic pathologist and a vital 'link' between the 'old guard' and 'new pretenders', died during this period. However, the news was not all bad, as two new academic ophthalmic pathology posts were established in Liverpool and Sheffield (although the NHS did not fund these posts). The net effect of this series of retirements was that, at one time in the 1990s, only two of the 'full-time' ophthalmic pathology posts in the UK were staffed with ophthalmic pathologists who had more than five years of specialist experience! Fortunately, the BAOP members reporting ophthalmic pathology as part of a more general practice performed an important role in supporting the specialty, a role which is also vital today. However, the lack of strategic planning for ophthalmic pathology had been almost disastrous.

Towards the end of the 1990s, not wishing a similar problem to recur in the future, ophthalmic pathologists persuaded the Royal College of Ophthalmologists and the Royal College of Pathologists to establish a Joint Working Party on Ophthalmic Pathology, to conduct a major review of the specialty. The result was a Report which stated the requirement for strategic planning and action to establish a core of national ophthalmic pathology laboratories, with permanent posts which could not be abolished at the whim of local hospitals or other authorities. The Report reflected many of the points made by Professor Gordon Klintworth's lecture – that the increasing specialisation within ophthalmology, and developments in science and medicine, were placing increasing demands on ophthalmic pathology. The Report was 'submitted upwards' into the National Health Service, and a two year wait began.

On 1 April 2000 the National Specialist Ophthalmic Pathology Service (NSOPS) was 'officially designated' by the National Specialist Commissioning Advisory Group (NSCAG) of the National Health Service. NSOPS is co-ordinated as a single functional

Dr M.A. Parsons ✉
Ophthalmic Sciences Unit
Royal Hallamshire Hospital
(Floor O)
Glossop Road
Sheffield S10 2JF, UK

To whemmie (verb):
to overturn; to turn upside down; to throw into a state of disorder or agitation (*Chambers English Dictionary*, 1989)

referral service, currently provided by a group of five full-time ophthalmic pathologists operating from four designated laboratories in Liverpool, London, Manchester and Sheffield (a fifth designated laboratory in Birmingham is not yet functioning). Although NSOPS has been established to provide, co-ordinate and regulate the provision of specialist ophthalmic pathology services in England, it is currently operating (at some level) within the context of the UK as a whole. However, as yet there is no funding for NSOPS, although funding will be required if the Service is to fulfil its envisaged role.

The aim of NSOPS is to secure a specialist core of full-time ophthalmic pathology posts as a national diagnostic resource, on the basis of a long-term national requirement for such a service, with provision for a small number of trainees to ensure the future of the sub-speciality. NSOPS will function as a single national reference service for ophthalmic pathology in the UK, but it will also co-ordinate and liaise with other pathologists providing local ophthalmic pathology services at individual hospitals throughout the country (many of whom are members of the BAOP).

One of the main reasons for establishing NSOPS was to ensure excellence in the provision of a national ophthalmic pathology service, with full access to specialist ophthalmic pathology reporting from anywhere in the country. In line with 'clinical governance' requirements, NSCAG required NSOPS to develop National Guidelines for Ophthalmic Pathology Reporting, and a means to co-ordinate quality assurance and audit of ophthalmic pathology reporting at all sites in the UK. At the same time, NSOPS needed to find out what was the national 'load' of ophthalmic pathology specimens, and how this load was being reported. Such information is important when determining the need for specialist ophthalmic pathology posts, and (eventually!) the need for specialist ophthalmic pathologists and the central funding to support them. A survey was required, and the Royal College of Ophthalmologists conducted a survey of members to determine where ophthalmic pathology was being reported in the UK.

The results of the survey indicate that around half the specialist ophthalmic pathology reporting in the UK is done either by 'full-time' specialist ophthalmic pathologists or pathologists 'with an interest' in ophthalmic pathology; both these groups undertake an External Quality Assessment yearly. However, around half the specialist ophthalmic pathology specimens are reported by pathologists outside this grouping, who are not subject to specialist External Quality Assessment. Herein lies the problem for the future.

The requirement for a high national standard of ophthalmic pathology reporting is absolute, and should be (and is) our primary aim. To achieve this aim, a standard must be set, and performance should be measured against this standard. Hence the development by NSOPS of 'National Guidelines for the Reporting of Ophthalmic Pathology'. Draft Guidelines are in existence, and have been submitted to the Royal Colleges of Ophthalmologists and Pathologists for comment and approval. The main requirement which has been proposed is that specialist ophthalmic pathology must be reported by pathologists who have attained an appropriate standard in an External Quality Assessment scheme – this is the best way to ensure competence of reporting in histopathology specialties. However, many general histopathologists have to undertake many such assessments in the many branches of pathology required by their practice. The indications are that they may choose not to undertake 'yet another quality assessment scheme', in a sub-specialty which covers a tiny fraction of their general pathological practice. If they are then 'not allowed' to report ophthalmic pathology, the work would have to be referred to a specialist service – perhaps all of it to NSOPS. The problem is that NSOPS is working at capacity now, and there are currently no ophthalmic pathology trainees in the system, even if funding for new ophthalmic pathology Consultants were provided today.

There is another problem, this time potentially for the Home Office: the increasing recognition that fatal non-accidental injury to infants (in shaking/impact injury) often results in the need for a specialist ophthalmic pathology assessment of eyes, as part of a wider forensic pathological assessment. This time-consuming work is an increasing part of the ophthalmic pathologist's work load. This already leads to a delay in preparing reports for Child Placement Proceedings in the civil courts, and for criminal proceedings, in the context of a national political requirement for a more rapid judicial process. Has this been funded? No, it hasn't!

So back to the original title of this editorial: 'Whither ophthalmic pathology in the UK: why not wither and whemmie?' Implementation of any National Guidelines for Ophthalmic Pathology Reporting may reduce the numbers of pathologists 'with an interest' (and assessed expertise) in ophthalmic pathology – a 'withering' effect. There is no capacity in the current NSOPS system to take up the resulting increase in work load, and it could take a minimum of three years to start to increase this capacity. Therefore strict implementation of the Guidelines might well 'whemmie' ophthalmic pathology reporting in the UK, that is, it might 'overturn; turn upside down; and throw the whole system into a state of disorder or agitation'.

At this early stage of assessment and redevelopment of the national ophthalmic pathology services there are no additional resources for NSOPS (although these are now promised), and the laboratories at the individual sites have as yet no additional capacity to absorb more ophthalmic pathology cases. For this reason, *there must be no change to current case referral policy until further notice*, as NSOPS laboratories could easily become overwhelmed by an additional case load before specific provision has been made to respond to increased demand. This in turn could have a potentially deleterious effect on the quality of reporting. What is more, it could have a devastating effect on the lives of ophthalmic pathologists! As an ophthalmic pathologist, this worries me.

Clearly, ophthalmologists need a service for their patients which includes all the current specialist 'full-time' ophthalmic pathologists, and the vitally important other pathologists 'with an interest' in ophthalmic pathology. It is likely that new National Guidelines for ophthalmic pathology reporting will be agreed. However, full implementation of national guidelines must be seen as an eventual goal, and an evolutionary process must be started, and not a revolutionary one. Professor Gordon Klintworth has given us a picture of a potentially great and exciting future for ophthalmic pathology, but we must not 'whemmie' ophthalmic pathology now, or this future could be just a dream.

Addendum: 7 September 2001

UK ophthalmic pathologists have just heard that our number is very soon to decrease to a total of four in the UK, with the imminent departure of one of our number into Industry. This leaves the Institute of Ophthalmology/Moorfields Eye Hospital in London with only one Professor/Consultant (from a full complement of three Consultants 2 years ago). As yet there has been no funding confirmed from NSCAG for the National Specialist Ophthalmic Pathology Service. We live in interesting times!

References

1. Klintworth GK. Ashton lecture. Ophthalmic pathology from its beginning to the high technology of this millennium. Eye 2001;15:569–77.
2. Garner A. The European Ophthalmic Pathology Society. A brief history. Int Ophthalmol 1997;21:107–11.