

Commentary

Ophthalmic medical assistants

The ophthalmic medical assistant (OMA) is a relatively new concept within the National Health Service in the United Kingdom. However, in the United States, OMAs have been recognised as important members of the eye team for some time. Neither nurse nor doctor, the OMA may perhaps best be described as a technician or doctor's assistant.

An OMA can undertake a number of tasks, including cataract preoperative counselling, clerking, biometry measurements, compilation of operating lists, postoperative examinations, and even discharge from clinic. Furthermore, their role need not be restricted to cataract surgery but can include all other aspects of ophthalmology. In some eye departments many of these tasks are already performed by extended role nurses or nurse practitioners. The major difference between the two roles is that an OMA is appointed to work with one particular consultant, whereas a nurse, by virtue of his or her mode of employment, will not be able to fulfil such a role.

Since an OMA is employed to work on a one to one basis with a consultant, the weekly timetable of the OMA can be designed to complement the work programme of that particular consultant. Nurses usually work in teams, often in a shift pattern, and communication can fail even in the best of teams. This can lead to missed or inappropriate admissions, suboptimal theatre timing, and other problems. However, with an OMA the same person sees the patient preoperatively, attends the ward round, makes up the operating list, deals with the patient perioperatively, and sees the patient postoperatively, thus eliminating the potential for failure of communication. An OMA offers continuity of care, which patients find reassuring.

Traditionally most of the OMA's tasks were performed by trainee ophthalmologists. However, changes in the working hours and training requirements of junior doctors mean that it is no longer possible for them to carry out all of these tasks. Individual OMAs will get to know their consultant's requirements and preferences. Investigations and instructions are less likely to be forgotten since the OMA has only one consultant's preferences to remember. With one person carrying out all the biometry for one surgeon, it is possible to produce an accurate personalised A-constant. One important difference between an OMA and a nurse is that the OMA is not bound by restrictive rules and regulations that seem to govern nursing practice. An OMA will generally be able to carry out any task his or her consultant requests, following appropriate training and assessment. Trust develops between an individual OMA and his or her consultant, enhancing the relationship and working practice.

In the United States, where the post received national recognition in the mid 1980s, the role is much wider than

that currently performed in the United Kingdom. The training programme for ophthalmic assistants' covers subjects such as basic anatomy of the eye, description of disease using ophthalmological terms, basic optics and principles of refraction, including subjective refraction, focimetry, and keratometry. Furthermore, the OMA is also trained in visual field testing and common pathologies, IOP measurement, spectacle dispensing, contact lens care, basic casualty assessment, common drugs, drug instillation, aseptic technique and sterilisation, and even fluorescein angiography using an orally administered dye.²

With such a wide training the OMA's post may be customised to complement the roles performed by existing members of the department and to fill any gaps where no specific personnel exist, such as in ophthalmic photography or ocular motility testing.³

The cost efficiency of the employment of OMAs is difficult to estimate. The salary of an OMA may be based on the nursing or technical pay scales, but would generally be less than a senior house officer. However, an OMA would probably see fewer patients per hour than a junior doctor. This alone makes it difficult to estimate which employee offers best value for money, but there are other, less tangible, matters to take into consideration. Less operating time is wasted through inappropriate theatre lists, and more problems are anticipated and sorted out prospectively leading to increased efficiency. Finally, one should also consider the intangible benefits of a smoothly running team and continuity of patient care.

This type of working pattern in the present NHS is novel. The introduction of an OMA into one's practice will require a degree of effort in overcoming the reluctance and inertia within each organisation. However, success provides each consultant with the benefits of an assistant who works flexibly and independently with them. The development of mutual trust will enable one's OMA to do more and more. At a time when the quality of working practice has deteriorated, the OMA can markedly improve the situation. Hospital trusts will generally encourage such posts when they realise there will be an increase in numbers of patients seen and operated on following the introduction of these posts.

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