

Commentaries

Shared care for glaucoma

The term 'shared care' has become an ophthalmic buzz word to describe the sharing of clinical management responsibilities. It has most frequently been applied to the management of outpatients with chronic glaucoma, but could equally well be applied to any other category of outpatient which the clinic head feels has grown too populous for his staff to handle. I will set out some reasons for the development of the concept and current attempts at administering it as well as problems it can cause.

Primary care for ophthalmic outpatients is provided by ophthalmologists. Any patient with an incurable eye disease, such as glaucoma, will require lifelong supervision within the outpatient department. Constant new referrals without discharges mean an ever increasing number of outpatients with this disease, hence the disproportionately large number of patients with chronic glaucoma in any general outpatient clinic. Without an increase in staffing levels to meet demand, the extra numbers are only managed by reducing the intervals between visits or by squeezing out (discharging) other categories of outpatient. This approach suffices for a while but sooner or later the attention available for each patient is reduced, patient care suffers, and 'quality' falls. Often charter standards fail to be met as well. There is, therefore, a major incentive for ophthalmologists to try and lighten this outpatient load.

One option would be to depute paramedical personnel either within the eye department or outside it to manage some of these patients. Such an approach to the management of chronic ophthalmic disease can be called 'shared care'.

Shared care has, on the face of it, much to recommend it; relief for the hard pressed ophthalmic outpatient clinic, better and more economical throughput of patients, maintenance of charter standards, and greater cooperation with our paramedical colleagues. It has also definite problems including legal responsibility for patient care and safety of the patient. Therefore, it is worth looking at the experimental models under way or in the pipeline.

The MRC is funding a pilot study at Bristol whereby the management of chronic glaucoma by ophthalmologists in the eye clinic is being compared with that given by community optometrists. The efficacy, practicality and, eventually, success of the experiment is awaited with interest.

In Sheffield, Glasgow, and other centres shared care is confined to the hospital (a method preferred by a majority of ophthalmologists surveyed by our royal college

recently). Here optometrists, orthoptists, and nurses work alongside clinicians in a semiautonomous unit, adhering to protocols of management and asking for advice when problems are identified. The safety and efficacy of this approach will be compared with the 'outreach' Bristol approach in a study to be embarked upon by Richard Wormald at Moorfields Eye Hospital.

If neither 'experiment' works, perhaps because of poor disease control, a legal difficulty, or patient/ophthalmologist unhappiness, then two options remain – either to assign more staff to outpatient management of chronic disease or to allow this patient group to suffer a decline in clinical standards as more and more patients attend for treatment. The former might be justified under the current contracting system with resources following patients, although there is little sign of it at present. The latter will be associated with a rise in patient complaints and litigation, as well as decreasing job satisfaction for the luckless practitioner.

Assuming that a model of shared care works, should it be adopted nationally? To do so would overcome the problems outlined above. Who would participate? Primary care physicians (general practitioners) will not acquire the necessary skills in the foreseeable future. There are few clinical assistants remaining nationwide. Almost by default for the community this leaves the optometrists, while in hospital the choice is wider. Would optometrists in the community want to participate? To judge by recent discussions, many are prepared to do so. With suitable controls concerning the legal position, examination skills, and treatment protocols their profession would fulfil current needs. Care would need to be taken to erect 'Chinese walls' to prevent temptation by the treating optometrist from becoming the selling optometrist as well. With these provisos the optometrist in the community could join in 'shared care' schemes and assist in the management of our chronic ophthalmic diseases such as glaucoma. It will be up to our respective colleges to establish guidelines. Any community care scheme can only function with the cooperation of all the participants, both medical and administrative. We would have to avoid the American experience of having 'shared care' imposed without prior testing for efficacy or safety or considering its effect on other community eye health.

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