

Commentary

Ophthalmic services for children

The report of the joint working party of the Royal College of Ophthalmologists and the British Paediatric Association, released in December 1994, points the way to providing optimal eye care for children, both in hospital and in the community. Aspects of patient care are covered in the first five chapters, with the important issue of training coming in chapter 6 and followed by 'Recommendations'.

As one would expect from a predominantly hospital based group (Dr S Stewart-Brown is the only member of the group representing the non-hospital community) the recommendations for screening (of premature babies, children with diabetes and juvenile chronic arthritis, etc) are excellent. Similarly, chapters 2 and 3 covering the provision of appropriate outpatient and inpatient services are helpful, and correctly establish the child as the overriding priority to be considered in such provision.

However, the question of community screening, considered in the first chapter, raises some difficult issues and while seeking to define optimal care patterns, it runs the risk of failing to acknowledge the practical difficulties that may arise.

In the current climate, health care providers have at least to consider the intentions of the 'purchasers' without whom no service can exist. These purchasers need guidance as to what clinicians feel is best practice, but that guidance must consider cost implications. It is in this context that the screening recommendations seem to demand further discussion.

For example, who will be members of the proposed community screening team? Medical staff are significantly more expensive than orthoptists and optometrists. Will the team be adequate if there is no medical member? Certainly these two professional groups are fully capable of performing the screening tests, but if a community team is thus constituted, then some means of achieving rapid access to the hospital based medical services is an essential support element. The team of orthoptists and optometrists might also undertake treatment programmes in the community, which would greatly ease problems for families requiring frequent review and hopefully lead to greater compliance with, for example, amblyopia therapy. However, a community based service demands that the supervising clinician accept the responsibility for drawing up clinical protocols and ensuring a uniformity of care for all children whether in hospital or in the community. Auditing of the service is not adequate on its own.

The recommended programme for visual screening outlined in chapter 1 of the document makes some unexpected suggestions. Reliance on the parents' assessment of vision at 6 weeks is surely not right. Parents provide important

information, but some effort to evaluate fixation should be carried out by the examining doctor.

It is also unclear why screening at 7–8 months should be performed by health visitors, particularly since it is acknowledged that orthoptists are more effective. It is also disappointing to see that the choice of whether or not to screen is left entirely to district health authorities. Guidance from this body will influence policy decisions by health authorities, while the absence of such guidance may allow finance to be a prime determinant in the decision making. Later in the document, the school nurse is recommended as the primary screener at school entry, though ophthalmologists are aware that vision tests performed in the poor conditions, which may prevail in school, and by less experienced personnel can give dangerously misleading results.

Finally, as a community, ophthalmologists should question the continuance of tests at the ages of 8 and 11 years. By this age, the risk of amblyopia has almost disappeared, and the potential for successful intervention similarly gone. Should the responsibility at these ages fall on the family and the local optical services?

Other points in the document deserve some further consideration. For instance, the maximum waiting time for surgery is deemed to be 6 months, but that too must be subject to input from the purchaser. For non-urgent surgery the waiting time is inevitably dependent on the level of activity purchased, and the clinician must identify, realistically, those children with strabismus (and possibly ptosis) where correction is likely to have functional significance.

The document might also have benefited from recommendations regarding educational input. In the United Kingdom, we are fortunate to have an active visiting teaching service which requests information about all children with vision of 6/18 or less. Many children will not require registration and yet will still benefit from early educational assessment and input. Perhaps when the next draft is produced, educationalists might be invited to comment.

I am conscious that this commentary seems roundly critical of the report of the joint working party. In fact, the report is a valuable document and should serve as an important guide to best practice. However, before it achieves that goal a period of open discussion within the medical and teaching professions would be useful. If that process leads to redrafting and the production of a more authoritative and widely agreed document, then so much the better.

H E WILLSHAW

Children's Hospital,
Ladywood,
Birmingham