Two Steps Forward, this time

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As the first batch of optometrists successfully qualify for extended prescribing rights, Andrew Matheson recounts optometry's long-running struggle and offers advice for anyone thinking of specialising in therapeutics

Educate then legislate. How many times have I heard those words? As an optometrist keen to do more for his patients and to push the profession forward I have been eagerly awaiting the time when we would get further prescribing rights.

That moment finally arrived on April 5 this year when the first batch of candidates took the Common Final Assessment exams of the Specialist Qualifications in Therapeutics. Now we have access to a further armoury of drugs to help our patients.

There are two specialist qualifications, the DipTp AS – the Specialist Diploma in Therapeutics (Additional Supply), and DipTp SP, – the Specialist Diploma in Therapeutics (Supplementary Prescriber), the first giving a small extra group of drugs such as antibiotics and a NSAID so that we can directly treat our patients better, the second giving us access to any drug that an ophthalmologist allows us to co-manage his patients with.

Optometrists with the additional supply qualification will prescribe drugs via the pharmacist still using the signed order system, currently in use. Supplementary prescribers will get their own NHS prescription pad, as nurses with this qualification do.

Slow pace of change in UK

Unfortunately, because the wheels of legislation turn slowly, two of the antibiotics and an antihistamine on our approved additional supply list, have been discontinued before any of us

qualified. But that might be a blessing in disguise, if they are replaced with better products. Twenty years ago optometrists in the UK were ahead of their colleagues elsewhere in the world, being able to use diagnostic drugs, anaesthetics and some antibiotics, though admittedly in a fairly restricted framework of use.

In countries such as Australia, optometrists at this time were not even allowed to dilate their patients. How things have changed. State by state, US optometrists gained prescribing rights and now, in most states, they independently manage anterior eye pathology and chronic conditions such as glaucoma.

Slowly optometry in other civilised countries round the world followed suit, to a greater or lesser degree. For various reasons, therapeutic prescribing in the UK has been slow to arrive.

I, like several others became frustrated with the therapeutic education in the UK and joined the British Chapter of the American Academy of Optometry about 12 years ago. This organisation ran conferences in the UK and the speakers at the US conferences were second to none. Nobody nodded off in these lectures and workshops. The speakers are incredibly enthusiastic and the topics cutting edge teaching.
Here I learnt many of my new therapeutic skills. I did workshops in punctal plugs, cranial nerve work-ups, suturing, injection techniques, laser surgery and so on. Remember this was 1995. I passed the American Academy fellowship exams in 1996.

I started my three City University Ocular Therapeutics modules in 1996 and finally gained the College's higher qualification, the DipTp in 1999.
The profession had to establish that there was the necessary education in place to show that optometrists would be competent to undertake these new therapeutic tasks. To that end the universities started running therapeutic courses about nine years ago, the most well known being City University, which ran three modules in therapeutics. Each module represented three days of intense lectures and workshops, followed by competency exams.

Students successful in these three modules were given exemptions which enabled them to take the College examinations in therapeutics, A and B. To pass these you were required to submit 12 therapeutic case reports showing how you had managed these cases. You then sat a two-hour viva exam based on these reports. This was not easy. Not everyone was successful on the first sitting. But if you were, you gained the hallowed College Higher Diploma in Ocular Therapeutics, the DipTp.

A similar situation existed for the College qualification in glaucoma management. In all, 11 optometrists succeeded in gaining the DipTp. This was hoped to lead to our professional bodies being able to gain us therapeutic prescribing rights; we had educated, now we must legislate. If only it had been that easy. After the haggling was over, it was finally decided that DipTp was not enough. Further training was required.

Although in some ways this was disappointing for those optometrists who have taken the numerous university and College exams over the last decade, at least now there was a clearly defined path by which the new prescribing qualifications could be gained. To be honest, although we had had extensive practical therapeutic training and experience, we had not been trained to actually prescribe drugs, especially within the context of the NHS.

Pathways to therapeutics

For someone with no previous therapeutic training, there are currently two sets of foundation courses available, one at City University and one at the Institute of Optometry.
At City there are two courses, one is a course in the Principles of Therapeutics and one on the Principles of Prescribing. These currently cost £600 each. The Principles of Therapeutics is a distance learning programme, while the Principles of Prescribing is a more conventional three-day intensive course at City. Having passed the exams in these subjects you can then enrol with the College for the Common Final Assessment (CFA) process. This costs a further £700.

After enrolling for the CFA, the next stage is to examine patients under ophthalmological supervision within the Hospital Eye Service. These need to be therapeutic cases, typically seen

in casualty. You need to attend for five full days to be eligible for Additional Supply (DipTp AS) and 12 full days for Supplementary Prescriber (DipTp SP) assessment.

You have to keep at least eight contemporaneous record cards per day of the patients you have examined. Next you need to select patients from all those you have seen to write up extended case reports on (eight for Additional Supply and 12 if you are also taking Supplementary Prescribing). The extra four extended case reports should be cases that show conditions amenable to supplementary prescribing, which realistically, in the hospital setting, means glaucoma and iritis. You are expected to pay the hospital approximately £100 per day for their help with this training.
If you are not in too much of a rush to do this experience, you can spread your hospital visits out so they have less effect on your practice's financial well-being.

Hospital experience

Your hospital experience should be relevant. Submitting cataract, retinal detachment and diabetic retinopathy patients would not be appropriate. The extended case reports should be written to discuss the case management with relevant research on the conditions treated. References should be included.

You have to work hard to get individual ophthalmologists to help you get this experience. It is a significant sacrifice for them during their normally busy clinic schedules.

I would advise anyone taking the theory training to nurture relationships with local optom-friendly ophthalmologists early on so they are in a frame of mind to accept you when the time comes that you need their help. Taking part in local shared care and co-management schemes and doing hospital low vision work is the sort of thing that may make them more amenable to the idea. Make sure they know you are not just an ordinary 'refractionist', but have a special interest early on. Using your therapeutic qualifications in medical correspondence helps. Doing presentations to GPs, health visitors and nurses helps get your foot in the door.

If you are unable to set up a local hospital scheme, Moorfields is running one for the Additional Supply experience requirement, although the additional glaucoma clinical experience sessions required for Supplementary Prescriber status have not been set up yet, but I am sure they will follow soon.

Being already involved in ophthalmology co-management, especially in the glaucoma field, I am more excited to have the second qualification, as this will enable us to modify a patient's drug regime, as necessary, within agreed protocols, rather than clogging up the system by re-referring the patient back to the ophthalmologist for treatment change. The two conditions most amenable to this arrangement are recurrent iritis and chronic glaucoma.

As I understand it, there is no reason why we should not set up a similar relationship with GP independent prescribers to manage less severe conditions such as recurrent conjunctivitis in the immuno-compromised or allergic conjunctivitis. This would enable us to write NHS prescriptions for medications that at present we can only write signed orders for, making the treatment more affordable, especially for the elderly and those on benefits.

I am currently talking to both types of independent prescribers, and the PCTs involved. Not surprisingly, all this is new to them, so may take a while to put in place.

This may all seem a bit daunting, but it is a fraction of the training required to get the original DipTp. The emphasis is as much on patient care, drug knowledge and prescribing in context than your ability to perform complex clinical procedures. This is really how it should be so that the optometrist is assessed to see if he or she is knowledgeable and safe enough to do the task in question, rather than an expert in the field. This must be the case or like the original DipTp qualification, there will not be enough people gaining the qualification to make therapeutic prescribing a reality for UK optometry. I will be encouraging and assisting the optometrists in my company who have an interest in gaining these qualifications. Two of them have already enrolled on the necessary courses.

The way ahead

Many of the ‘cannon-fodder’ optometrists who have taken the numerous university and College exams over the last decade, are dismayed that the earlier qualifications taken did not give them prescribing rights on their own. We seem to have been taking one step forward and two back for ages, so I sympathise with this feeling. I feel we must press on, now that we finally have the legislation in place.

Because the relevant professional bodies have put so much time and thought into setting up therapeutic prescribing in the UK, ophthalmology and optometry will be able to continue to co-manage their patients without the inter-professional friction seen in places such as North America.
Until a couple of years ago, optometrists were able to attend the American Academy of Ophthalmology conferences each year. I used to attend these regularly and learnt much from them. Unfortunately, due to the animosity between US ophthalmologists and optometrists, the Academy of Ophthalmology now bans optometrists from attending as it is seen as ‘training the enemy’. This is a great loss as I learnt much there, especially in the workshops, which were excellent.

Next year should see the arrival of true independent prescribing rights for optometry, as in the US. This will presumably add the qualification DipTp IP, to the already humorous, DipTp AS and DipTp SP. Hopefully, now the wheels are in motion, this next major stride forward will be taken, without any further obstacles appearing to block its path.

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