**Make it to the Podium: Why Investment in Therapeutic Training is a Must**

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Description:

This course will explain what is needed to become an independent prescriber by understanding the balance between investment in your education and return for your patient. The course also will explore the future in prescribing.

Course Learning Objectives:

1. What you need to do to become an independent prescriber
2. Understanding the balance between investment in your education and return for your patient
3. Compare and understand the development of therapeutic legislation in different jurisdictions
4. Scope the future of UK prescribing optometric practice

1. Introduction

Whatever you may feel about your own personal involvement in optometric therapeutics it is an absolute given that no jurisdiction that has granted optometrists the right to treat ocular disease has ever rescinded this. Further in every jurisdiction that has developed this scope of practice optometrists has risen to be more valued and more involved in the clinical care of patients.

2. History

The aspiration and politics that got us started, against medical and our own professional bodies opposition.

3. Purpose

To present a case discussion describing the progression of a registered optometrist to full independent prescribing status in just about one year. To remind delegates that ocular

therapeutics and independent prescribing is fundamentally about improving the access and quality of ophthalmic diagnosis and treatment at lower cost. Whilst HES optometrists have been amongst the first to embrace IP as logical extension of their extended scope of practice this is very much is secondary care and does not provide the numbers required to alter the perception of optometry.

4. Global position

The WCO Global Competency Based Model of Scope of Practice in Optometry has addressed the diversity in optometric qualifications by establishing a four step ladder of qualification, starting with dispensing optics with refractive and investigative functions and gradually increasing the scope of practice through to Level 4 which fully encompasses the working definition of full scope optometry.

Unique amongst optometrists in Europe, UK optometrists had access to diagnostic drugs which predated the registration of optometry in 1958, and this exemption from limiting access to medically qualified professionals was maintained when the consolidating Medicines Act was passed in 1968. Despite this access, the use of ophthalmic drugs by optometrists was limited in its practical use to anaesthetics (mainly for tonometry and contact lens fitting) and cycloplegia. Until the 1990’s there was very little onward development in this area.

From the 1970’s onwards optometrists in the USA campaigned on a state by state basis, acquiring previously unheard of access to both diagnostic and therapeutic agents and were seen worldwide as the standard bearers for the development of an enhanced scope of optometric practice. Australia began its move towards therapeutic prescribing in the mid 1980’s and achieved this status in Victoria in less than ten years.

This paper will describe the clinical, educational, political and regulatory history of the development of optometric prescribing in the UK to the point where there are now at least three postgraduate courses in optometric prescribing and almost 100 optometrists qualified as independent prescribers. The UK is the first country of the EU that has reached level 4 of the WCO. Whilst the UK remains some way away from an at-registration level of competence the number of experienced qualified optometrist Independent Prescribers joining the specialist register has now reached 150 and has just about doubled each year since legislation was enacted in 2009.

This presentation will also include an update on the development and enacting of therapeutic capability amongst optometrists in other advanced societies, namely Australia and New Zealand and compare and contrast with the UK and the USA.

5. The Initiation

So what is the hot topic in my practice life at the moment, well, for me, I think I can say that after July 2011, clinical practice will never be the same. On 4th July, after 30 years in practice and some 25 since I last worked in a hospital eye unit, I began my clinical placement in the lead up to becoming an Independent Prescriber.

This is building up to the culmination of an aspiration I have had for nearly all of my professional career. I was first exposed to the scope of therapeutic practice in the USA in 1983 when Lou Catania taught a brief two day “scope of US practice” course at the Victorian College of Optometry, Melbourne, where I was studying for my MSc. Following my return to the UK in the early eighties I have held up therapeutic practice as the ultimate optometric aspiration. While not all of us may do it, and many legitimately specialise in other areas such as learning difficulties, contact lenses etc., I believe therapeutic practice thrusts optometrists right into the forefront of clinical practice.

Like many optometrists I have been advising patients and GP’s on diagnoses of conditions manageable without HES involvement and this scope of my practice has risen with every change in accessible medicine from the only antibiotic when I qualified (sulfacetamide) to the wider range of antibiotics, lubricants and anti-allergy now available on the General Sales List or as Pharmacy medicines optometrists are now allowed to supply. Prescribing is nothing more than a logical extension of this.

Through my work initially on the AOP/College Joint Steering Group and latterly on the GOC I have been involved with steering optometric prescribing into legislation. From that perspective I decided that I would wait until the full scope of Independent Prescribing became available rather than adopt a stepwise approach through Additional Supply and Supplementary Prescribing. There was after all a strong possibility that courses taught and attended prior to enacted legislation would not attract the requisite Accreditation of Prior Experiential Learning (APEL).

6. Becoming an optometrist prescriber

Before considering undertaking an IP course I strongly suggest you access the College of Optometrists[1] website which has an extensive area devoted to the subject, in particular the starter document “Is optometrist prescribing for me ?” which details first steps and lists a number of individual case studies, albeit thus far only Additional Supply or Supplementary Prescribers. College; please update ! The starter document is a bit daunting at first and perhaps significantly slanted towards NHS work, possibly because most Independent Prescribers have aimed or are likely to aim at this sector. However, if your aim is to Rx in the private sector and prove your worth and capability there it is essentially the same process.

Personally I feel that the guidance could be more enthusiastic and confidence building, if all you did was read this documentation it is possible you may feel it simply too daunting. Therapeutic prescribing is within the capability of all optometrists and is of course now a fundamental part of the at registration training of optometrists in the USA, Canada, Australia and New Zealand.

7. The Course

Although there are courses available from both City and Glasgow, practicality, distance and accessibility dictated the new joint Aston/Manchester would be my choice. This course consists of the following components, but as they all comply with the GOC Course Handbooks, they are necessarily very similar.

a) Application and Acceptance. There is a protocol to demonstrate that the interested optometrist has an appropriate level of experience and has the support of an ophthalmologist mentor. Experience is not just assessed by time in practice (minimum of two years registered is clearly defined) but also by any previous courses completed or clinical experience acquired. Candidates are also required to demonstrate that they have financial support (even if ultimately it is their own).

b) Distance Learning. There are two modules of distance learning delivered on-line each lasting around 4 months with on average an exercise per week following requisite reading, study and didactic material delivered in the now familiar PowerPoint style. Additionally various other components are introduced e.g. case records, essay and critique. Each course is worth 20 credits in the scale of higher education currency. The two courses are:
    a.
        OP4OT1; Ocular Pharmacology and therapeutics

        OP4OT2; Prescribing for disorders of the eye.

    b. Each module of the course costs £811.00.

c) Clinical Competency. Prior to starting the clinical placement the candidate is required to demonstrate clinical competence in slit lamp assessment of the anterior eye including staining and lid eversion, slip lamp binocular indirect ophthalmoscopy andcontact tonometry. It remains an interesting aspect that ten years after all of the above was enshrined in the entry-level competencies, prescribing courses and, for that matter enhanced services contracts, insist on evaluating this competence. This either says something about the perceived rigour with which it is tested or the perceived use to which these skills are put in practice ?

d) Clinical Placement Independent prescribing requires a period of mentored learning and practice. This is determined to be a minimum of twelve days practical training in the form of a clinical placement in conjunction with an Independent Prescriber (hitherto an ophthalmologist in a hospital eye department).

e) Log Book. Candidates submit a log book of cases seen in their clinical placement and are asked to indicate those patients they actually saw and managed themselves, as opposed to observed.

f) Common Final Assessment. Run by the College of Optometrists this is the common hurdle required to become IP. Candidates have to have completed the theoretical components and clinical placement period and enter for the examination with the log book of their placement experience. The fee for the CFA examination is £395.00. Interestingly the fee for IP is significantly lower than that for either AS or SP (£566 each) presumably because, unlike the aforementioned there is no formal viva process for the IP CFA. Instead the examination is a

computer-based key features examination completed simultaneously with all other candidates at two venues. Final Examination

The sign off examination allowing access to independent prescribing rights amongst UK optometrists is, at present, granted to the College of Optometrists, principally for political reasons of presenting a united front to what was at the time some anticipated entrenched medical positions. Thankfully the opposition has been largely passive and based around a legitimate and real lack of placement opportunities in what are already hard pressed ophthalmic units around the country.

g) The role and nature of the sign off examination known as the Common Final Assessment will be discussed in the context of a continued process of development alongside guidance and the evidence base.

h) Specialty Registration with the GOC. This is a key feature of prescribing legislation, prescribing optometrists become registered on the GOC specialty register, on production of the evidence of completion of the theoretical and practical components. At this point the candidate also declares a defined scope of practice e.g. glaucoma, primary care and pays the requisite registration fee of £30.00, it is not clear what one does if one declares both, or conceivably an alternative area.

Thus far I am at stage 5, fee paid, log book submitted and awaiting the CFA examination with some trepidation.

8. My Experience so far

So what's it been like ? First of all I have been afforded every courtesy by the local ophthalmology team starting with my acceptance by my mentor Steve Scotcher, clinical lead ophthalmologist at the Hereford Victoria Eye Unit.

Secondly, the course modules themselves were, for a full-time 53 year old optometrist with a busy professional and family life, a bit of a slog, but eminently doable. For an experienced practitioner the components relating to disease recognition and likely management are somewhat more familiar than delving into the finer points of pharmacology. If I had to criticize I would suggest that the course is thinnest on the formulation of management plans and in particular prescribing menus (i.e. choice of drug, dosage and length of treatment). Clearly this is something one is intended to absorb within the clinical placement working alongside the doctors.

The competency element also sent me mixed messages. The IP optometrist has to demonstrate a level of experience and prior knowledge before starting the course, however, those competencies required are basic entry-level competencies for all optometrists. Of course some optometrists may not have been assessed or grown used to slit lamp biomicroscopy or applanation tonometry. As previously discussed, the need for such an assessment says much about current basic competency in practice, unfortunately. One aspect that I do think is unfortunately omitted is gonioscopy. Even if an IP optometrist is not planning on working within the scope of practice of glaucoma, the recognition of glaucoma and diagnosis of the types of glaucoma in primary care is vital. This, in my opinion s very

hard to do at a satisfactory standard without the ability to assess the anterior chamber angle and depth, and, as recognized by NICE, this cannot be done without gonioscopy. I think at the review of the course gonioscopy needs to become one of the competences to be assessed and if not competent, acquired.

9. Clinical Placement

The clinical placement has been the absolute highlight   First I must say I am bowled over by the respect and help accorded to me by all of the staff at all levels of Hereford's Victoria Eye Unit. Secondly, that it is very much a team with coherent clearly defined roles and an ethos that is wholly patient centred. They just do things like appointments differently to the private sector. I chose to ask to do my placement here because I would like to think that I have built up a rapport over many years of practice locally and know the care they afford their patients, I expected nothing else but it is impressive to see it borne out.

It's mutual too because you can feel the respect and gratitude felt by the patients who undoubtedly come from all walks of local life. Stay in Casualty long enough and all life certainly passes through ! It was also interesting to test my memory as I regularly bumped into patients who also come to our practice.

I'd like to think I have been able to contribute practically outside of the mentoring and training I received. I undertook the odd OCT or fields and even completed a refraction on a child admitted with head injury and reduced VA (turned out to be anisometropic amblyopia !) I suspect my greatest contribution was but also helping the Cas Doc's keep on top of the clinics. In fact the only day we actually finished late was my birthday !

The one area I do think HES ophthalmology (especially a department without staff optometrists) misses out on is on contact lens practice. Although I have seen one or two microbial keratitis (serious enough to need g. Ofloxacin hourly and immediate follow-up, but, interestingly neither swabbed nor admitted) there have been relatively few other CL patients and many aspects of modern CL practice (the advantages of silicon hydrogels, disposability, solutions compatibility etc. have not filtered through to the HES, perhaps there's a training opportunity here.

So how does it work ? Well I have been working in casualty, taking alternate patients off the pile, occasionally this has dropped to none and we can break for a cup of tea, but at worst there have been five or six waiting with a good few dilating at any one time. I have a well equipped clinical station with Haag-Streit 900, Goldman tonometer, diagnostic drugs etc. Each patient is assessed by the nurse (e.g. visions, visual acuities taken) and if necessary (e.g. floaters) they are dilated before they are seen. Once I completed an examination the case wass discussed with the Cas Doc and occasionally both of us would take it to a registrar or consultant. The patients vary from new presentations of minor trauma, or specific symptoms such as red eye or flashes and floaters alongside 1st post-op assessments for surgery completed elsewhere and eye related examinations requested from A&E or a ward. If a prescription is needed the Cas Doc will fill it out unless its available as a P and is cheaper over the counter than via an NHS Rx charge. The hospital pharmacy

does not fill the casualty prescriptions.

From my perspective the principle learning has been the difference between making definitive clinical decisions over diagnosis and management against simply recognising abnormality and referring. I am used to making decisions and managing things without immediate recourse to topical treatments, but then I've engineered the way my practice works to give myself and the optometrists I work with, the time (probably more important than equipment and training) and fee charging to examine as thoroughly as necessary. We do not use the GOS Sight Test for symptoms based needs assessment unless circumstances are exceptional. The GOS Sight Test has never been a needs based contract geared up to deal with symptomatic presentation. I wonder if the Department of Health realizes this, which is a non-economic reason behind the fee being allowed to shrink year on year.

Obviously, apart from self-referral, casualty attendees can come from any source and a number of these referrals are initiated by optometrists. Occasionally the optometrist or practice phones ahead to advise the casualty unit of the patient they have in front of them. As a general rule, other doctors, such as GP's do this more than optometrists. This is extremely useful as very often the nurse can give a good indication of the best time for the patient to arrive and less frequently the Dr can offer advise on diagnosis or action. You do have to cultivate the relationship though (good diagnoses, clear and succinct letters with full data set and identifiable referring practice and optometrist).

So what's my perspective on high street optometry from this position as a casualty optometrist, well I can clearly see the ophthalmological point of view and I have to say there is significant inconsistency in diagnostic and managerial capability. It is not possible to say definitively if this is an issue of competence, experience or the fact that the UK (English ?) business model for optometry in many practices is a long way from a needs based system. By this I mean that the business model for very many practices and, it has to be said most corporates, is simply not geared up to repeat or follow-up visits to hone a diagnosis or management. It is quite clear that some optometrists are simply not covering basic ground and many of the decisions appear an excuse to move the patient on from expensive chair time.

What do the ophthalmologists think. Well fundamentally they absolutely realize the difference in capability especially in refraction and contact lens work and I have not come across any ophthalmologist recently who would proclaim the confidence that was often there amongst OMP's thirty years ago. There is, however, a realisation that their learning curve with regard to disease recognition is exponential compared to ours and that many optometrists have simply not seen the numbers of disease cases to appreciate the variability in presentation let alone management. I think that whilst the large numbers of patients with dry eye and blepharitis who self present are on the whole managed well (and no longer advised to use baby shampoo !) there is an air of resignation with regard to those who are sent in by their optometrist or optician where the condition is certainly manageable in primary care. Referring off basis cases like this sends a signal to patient and ophthalmologist alike that this optometrist/practice is not competent or interested in me and my condition.

There were no barn door misdiagnoses apart from a post holiday flight patient referred in with ocular pain ? acute angle closure (it was blepharitis).

There are some key differences in a casualty unit. First of all the entire world walks through at one

time, so its an eye opener if your practice is not used to less fortunate embers of society. Additionally, you are far more likely to see sick people, i.e. people who are really ill with perhaps advanced dementia, arteritis, herpes zoster than we are in practice. Some optometric patients struggle in when very sick but most would cancel, they don't cancel casualty and especially not if they are sent down off the ward.

10. Patient summary

I saw 162 patients in twenty-four sessions spread over 18 days (some half days). Two sessions were spent entirely in observation; an anti VEGf injection clinic and a minor surgical clinic (removal of basal cell carcinoma, cauterization of skins tags etc).

Any tips ? Well the level of supervisory support needed in a mentored placement is quite high and you need to know what you are doing. Therefore, the more experienced you are before you start the better. You also need the local respect of ophthalmological colleagues if you are to persuade them that their investment in your training is mutually beneficial and not a one-way street. How do you do this ? I think it hinges on behaviour around the referral and escaping from the "refer all disease" that the GOC consigned to the bin in 2000.

Personally, I would cease using GOS18's and use headed notepaper, if possible getting onto *NHSnet* as a prime means of communication. I'd try and make myself the best I could at diagnosis and ensure that my communications with HES and GP were concise, succinct and accurate and above all typed ! Good luck and go for it, its fun, and you will be a better optometrist for it !

So am I there yet, am I an independent prescriber. Well as I await my examination on March 23rd you sill simply have to wait and see. One way or another the presentation at SECO-AOP Destination London 2012 will synthesize all of the stages and components in a frank and open discussion that will challenge some beliefs and offer pointer to the future.

11. Future Planning and a call to arms

I can also see that, although the potential exists, the actuality of optometric clinical decision making in prescribing won't be there until there are a significant number of IP optometrists and in my opinion this needs to expand rapidly. It would seem that the corporate sector has unrivalled resources for advertising, perhaps the major players could make a point of training up a cohort of their optometrists as Independent Prescribers. We certainly need action on the farcical classification of optometry as a non-clinical discipline divorced from the NHS training funds available to orthoptists, physiotherapists and pharmacists, let alone doctors and nurses.

Several things need to happen before the common sense of optometric prescribing occupies mainstream optometry although they will not necessarily happen in any particular order. These points are raised to stimulate debate and challenge our current thinking.

At some point the undergraduate syllabus must upskill to enable all of the theory and fundamental diagnostic competence to be achieved at registration with therapeutic prescribing arising out of some sort of ongoing internship to what will become the second tier of optometric practice and so rather than splitting on a type or mode of practice delivery model, the profession will develop into tiers.

There needs to be a recognition that at some stage the IP mentor will be experienced IP optometrists themselves working in primary care teams and it will not solely be the province of ophthalmology.

A significant proportion of A&E cases and cases bothering pharmacy and the GP are contact lens related. Rarely is this appropriate in the first instance and in many cases it is counter-productive and inaccurate. The optical industry creates these cases and it has a public health and public protection responsibility to provide the education, training and placement opportunities for optometrists to "heal themselves". This will involve multiple optical businesses upskilling their key clinical to take responsibility for the actions of their staff.

1. http://www.college-optometrists.org/en/professional-development/Therapeutics/index.cfm
2. http://www1.aston.ac.uk/lhs/cpd/courses/optometry/independent-prescribing-for-optometrists/
3. http://www.optical.org/en/our_work/Education/Specialty_qualifications/Therapeutic_Prescribing_Specialties.cfm