Comprehensive ophthalmology at the Last Chance Saloon

Let me let you into a secret. No one is in charge. No one knows what’s going on.

I don’t know how it is in your specialty, but in mine there is one man at the Department of Health who is supposed to know what’s going on. He is a one man band in charge of “optical services.” That’s 7000 optometrists and 1000 consultant ophthalmologists. My 100 colleagues in paediatric ophthalmology rate a few civil service digits.

The government of the day thinks in soundbites and spin. The soundbite for ophthalmology is waiting lists, cataracts, and private practice. That’s not to say that cataracts are not important. The reason cataract surgery is the most commonly performed surgical procedure in the NHS is that it is the commonest cause of blindness worldwide. Unlike in sub-Saharan Africa, in Newcastle corteges of blind people with their hands on the shoulders of the person in front are not a common sight. And waiting lists were a problem that the government paid good money to sort out. And it wasn’t the independent sector that did it. Of 301 656 cataract operations done in the United Kingdom last year, only about 10 000 were done in independent sector treatment centres.

But there is more to ophthalmology than cataracts. The health department knows little about services for children with eye disease, services for retinal detachment, corneal transplantation, uveitis, and all the rest. We’ve quite proud of these services. Ophthalmology has always been quietly in the background of medicine. Cataracts were crouched by the ancient Egyptians. The first disease in humans in which a genetic linkage was identified was X linked retinitis pigmentosa. The 100th anniversary of the first successful organ transplantation is celebrated this year. You’ve guessed it: it was a cornea. Diabetic patients used to have their pituitaries removed for retinopathy—but went blind anyway. Lasers and vitrectomy surgery changed all that. The blind schools used to be thriving institutions.

Under the second wave of the independent sector treatment centres programme, primary care trusts will be forced to contract with the centres for thousands of cataract operations and other unspecified surgical procedures and thousands of outpatient appointments. The doctors staffing the centres, from Hungary and South Africa, will, it is hoped, be able to churn through these procedures and appointments free of the terrorsome requirements for appraisal, revalidation, and continuing medical education. Optometrists, who have MPs and professional lobbyists among their number, tell the government they can see most of the patients traditionally seen in eye clinics for less money. I wonder.

The effects of these changes are already being felt. New and replacement consultant appointments are on hold, and those appointments that are advertised are for rolling, one year locum contracts. Primary care trusts are telling ophthalmic units to reduce their return outpatients by 50% to 70%. Where these patients will go—and what kind of care they will receive—is anybody’s guess. And consultants, who find their units crumbling beneath their feet, have a choice. They can either hold out for retirement or join in with the chaos, banding together in chambers. Ultimately they will become alternative providers themselves and, like dentists before them, contract out of the NHS altogether. And when that happens, although the streets of Newcastle may not feature corteges of the blind, I wish you all luck in finding someone to fix your retinal detachment or your child’s glaucoma.

Moorfields Eye Hospital is opening Debenham’s style health boutiques (www.guardian.co.uk/uk_news/story/0,1590909,00.htm). Welcome to the brave new world of ophthalmology. I’m off to have my pituitary removed.

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Lanyards

How many have you got? I’ve got a tatty white one with my university ID on it, and a bright blue one with the NHS logo that came with my honorary contract. I have a green one from Cathay Pacific that I found in a bag with a pair of woolly socks and a fold-up toothbrush on a long-haul flight (apparently you can attach the toothbrush to the lanyard with a little clip, though I’m not sure why you’d want to). And I’ve got a whole car’s cradle of conference ones (Bournemouth 2001, Blackpool 2003) sitting at the back of my knicker drawer waiting for the next clearout.

How do you wear yours? I’ve never been sufficiently well endowed to tuck it in my cleavage, and letting it hang loose like a Garland brings out the dyspraxic in me. In busy clinics I’ve been known to place my swipe card, rather than the bell or the diaphragm, on a patient’s bare chest. So now I tie it through a belt hook in a granny knot, though this is probably against the rules.

Ribbon development

What’s your most outrageous one? Last week I was sent two, unsolicited, in the post, one maroon and one purple, with “widening participation” in bold capitals as the text repeat. At more than an inch thick, they are the widest I’ve ever seen. If I take underprivileged schoolchildren on campus tours, I am apparently required to wear one of these to ensure that they (and I) retain clear focus and orientation on the experience.

What do you hate most about them? The assumption of a greater allegiance to corporate values than you would otherwise have signed up to? The mugshot that makes you look like an identikit reconstruction of an escaped paedophile? Finding that you’re sitting in a restaurant with it still round your neck? Or the knowledge that your employer has succumbed to a trend which, like luncheon vouchers and teambuilding awaydays, will in a short space of time be consigned to the scrap heap of passing organisational fads and fashions?

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