A PUBLIC OPHTHALMOLOGICAL SERVICE

SUGGESTED SCHEME TO INCLUDE MEDICAL PRACTITIONERS AND OPTICIANS*

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Considerable progress has been made during the last 20 years in the provision of ophthalmic services to the public of South Africa. But there is still much to do in this direction, and now would seem to be an appropriate time to take stock of the situation, and consider proposals to improve the position with the resources at present available or likely to be available in the foreseeable future.

Let it at once be said that it is no part of the object of this paper to level criticisms against sight-testing opticians, a body of men who, both here and in other countries, can carry out a considerable service to the community. But there are reasons why the present position, in which a majority of the refractions in this country are carried out by opticians, falls somewhat short of the ideal at which we should aim.

Let us consider first the amount of work to be done and the personnel available to do it.

There are some 77 ophthalmologists in active practice in this country to serve a population of about 2½ million. So that leaving aside for the moment the question of distribution, it is fair to estimate that there is one ophthalmologist to about 30,000 of the European population. It is worth recording that of this number rather more than 600,000 are over 45 years of age and consequently need more or less regular ophthalmic examination. This is not an altogether satisfactory position, even in existing conditions in which the majority of refractions are carried out by opticians. I do not know of any reliable figures in this connection, but I believe that not many years ago the proportion in Great Britain outside London was about one ophthalmologist to 20,000 population.

To this has to be added the vast imponderable of non-European practice, and here the position is likely to undergo considerable change in the fairly near future. At present, owing to illiteracy, comparatively few non-Europeans have to be provided with presbyopic spectacles, but this number must increase *pari passu* with the increase in Native education. So that leaving aside the Native's predilection for glasses as an adornment or a bringer of prestige (I would estimate that at least 90% of the glasses at present worn by non-Europeans of less than presbyopic age fulfil these functions only) the amount of work done in non-European refraction will shortly become a formidable problem.

One is thus led to the conclusion that even with optimum distribution there simply are not enough ophthalmologists at present to provide adequate ophthalmic services for the population of the Union without assistance. As any great increase in the number of ophthalmologists is likely to be a slow and dubious quantity, the need for assistance stands out.

Fig. 1 shows the towns in which ophthalmologists are known to be in practice in the Union. It is probably fairly complete. Fig. 2 is an attempt to give a comparative picture of the distribution of opticians, i.e. towns in which opticians are in practice. It is also probably fairly complete, though small inaccuracies certainly exist in both, which, however, are not likely to affect

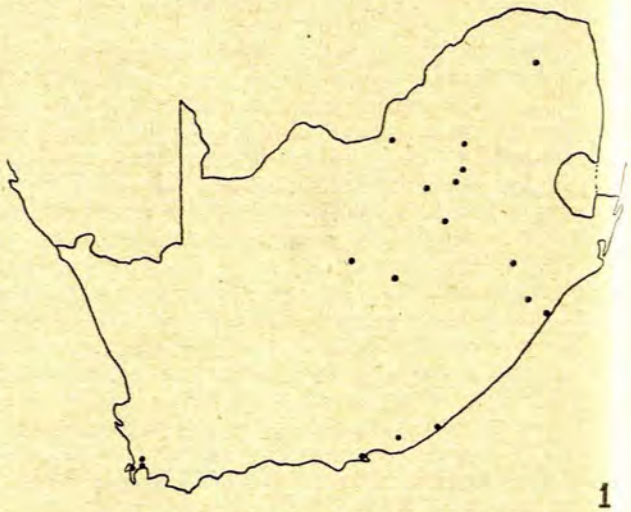

Fig. 1. Distribution of ophthalmologists.

the over-all picture. The first point which emerges is that while there are 77 ophthalmologists there are 337 opticians. In both cases there is a concentration in the more densely populated areas, and so the pattern of the two maps coincides to some extent, but of course there are many more opticians scattered in the country districts. Comparing Fig. 3, showing the Provincial hospitals,† however, it can be seen that there is a much wider spread of hospitals than there is of ophthalmologists, and one comparable with that of opticians. In Natal, for example, there are opticians in 8 towns and hospitals in 14. So that to meet the problem of distribution it is quite clear that the hospital is a most important factor, and it is on them that any scheme for organizing ophthalmic services must be based. It is realized of course that with the personnel at present available and the great geographical difficulties in some parts of the Union, a comprehensive plan is not yet possible. For example there is no ophthalmologist between Cape Town and Port Elizabeth to the East and Bloemfontein in the North-east apart from 2 close

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† Except those in the Transvaal, about which information was lacking.

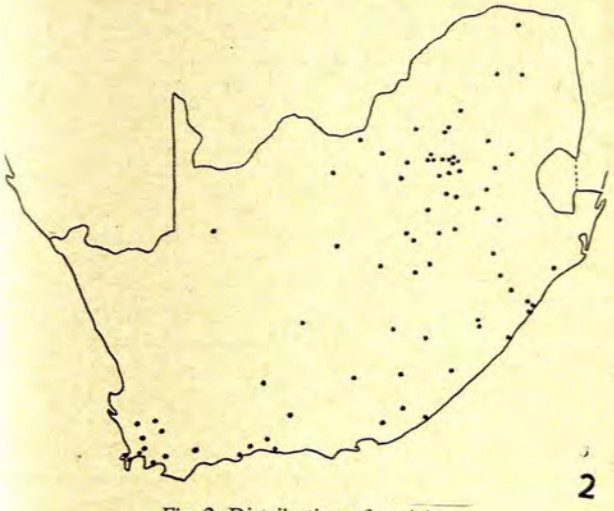

Fig. 2. Distribution of opticians.

to Cape Town. Much of this area must be served by opticians while this state of affairs exists. But there is no reason why one should not look into a future in which there may be a larger number and better distribution of ophthalmologists. Already in Natal and on the Reef the scheme to be described could be put into operation with very little, if any, addition to existing personnel.

From these maps then emerges the glimmerings of a possible plan—a plan that cannot, obviously, be introduced without much preliminary organization and scheming; and a plan that is perhaps Utopian because it depends for its success upon cooperation and give-and-take between two bodies of men (ophthalmologists and opticians) who have not so far been remarkable for an ability to see eye to eye, and because a certain amount of sacrifice, both of income and of convenience, may be necessary, at all events in the early stages, from those operating the scheme. However, it could work. There is no reason why it should not.

Fig. 3. Distribution of Provincial hospitals.

PROPOSED SCHEME

Briefly, the proposals envisage a series of integrated ophthalmic clinics based on the main Provincial hospitals but with antennae connecting with the smaller hospitals, and manned by one or more ophthalmologists, who would be the responsible people in charge of the clinics, plus an appropriate number of refractionists.

This seems a suitable place to mention part-time ophthalmologists. The services of such persons, who carry out a certain amount of eye work, including refractions, in addition to general practice, are fairly extensively used in some provincial areas in Great Britain. There are no specific minimum qualifications laid down. Some of them have a D.O.M.S., others have merely spent a sufficient time working in the ophthalmic department of a teaching hospital to acquire a reasonable proficiency.

Admittedly, it might be more difficult to arrange the necessary instruction for such practitioners in South Africa, where there are relatively few teaching hospitals at which such facilities could be made available. On the other hand the number requiring instruction would be correspondingly less.

For a postgraduate an adequate knowledge could probably be acquired in 6 months. A deep knowledge of the subject is of course not necessary. He should know 3 things:

1. How to cope with refractions en masse.
2. How to deal with the commoner eye diseases, or at all events how to institute treatment.
3. His own limitations.

He need know little of ophthalmic surgery other than of the minor procedures. (These are simply observations on minimum requirements, and are not to be taken as in any way restrictive.) Such a practitioner could be used in one of two ways—either as assistant to an ophthalmologist in charge of a large central clinic, or as the medical officer in charge of one of the smaller peripheral clinics with power to refer to the central clinic cases requiring special attention.

The exact manner in which clinics would be organized will of course depend upon geographical considerations, available personnel, and the distribution of hospitals within the area. The central clinics would be served by one or more units consisting of an ophthalmologist, one or more part-time specialists if available, and an appropriate number of refractionists. Some, or even many, of the peripheral clinics would have a part-time man at their head. If personnel permits of more than one unit, then the number of weekly sessions held would be divided amongst the units available.

SCHEME FOR NATAL

It is perhaps easiest to describe the proposed scheme in terms of a specific area, and although it is realized that each area will have its own particular problems, it should be possible to adjust the scheme to any given area. As I am naturally most familiar with local conditions I propose to demonstrate with the aid of the diagram in Fig. 4 how the scheme would operate in Natal. The diagram shows the available Provincial

hospitals (of which Addington, Wentworth, King Edward VIII, Grey's and Edendale are major hospitals). Ophthalmologists are available in Durban (6), Maritzburg (2), and Ladysmith (1).* There are also some 36

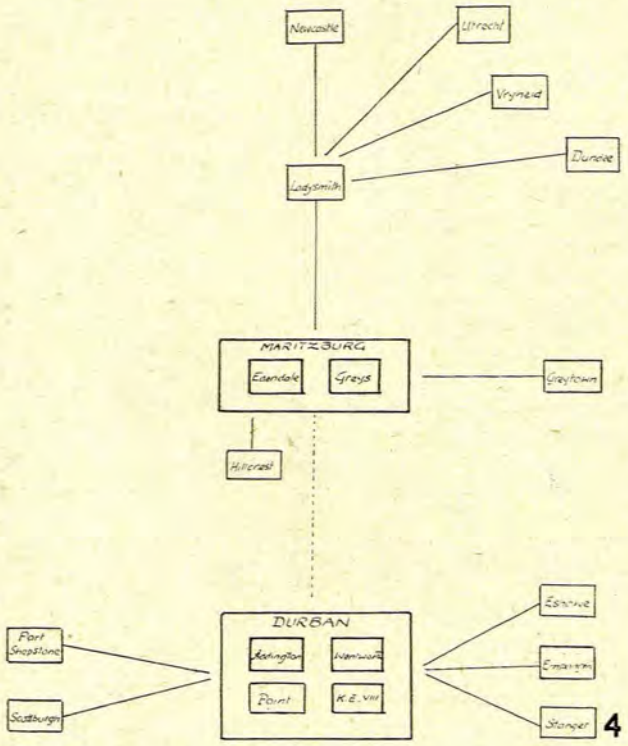

Fig. 4.

opticians in practice in Natal. Many—even most—of these might not at first join the scheme, but it is likely that as time passes and its advantages become apparent an increasing number of the public will fall into the habit of attending the clinics rather than the optician, and optician recruits will probably increase in number. Fig. 4 is self-explanatory, and shows how the main and subsidiary hospitals could be linked up. It is envisaged that at the main hospitals two or three clinics per week might be needed initially, plus one operating session. The provision of these facilities would of course be the responsibility of the Provincial Health Services.

The ophthalmologists staffing the clinics would be remunerated on a sessional basis. The refractionists might be paid a sessional fee for their attendance at clinics, but the major part of their income would derive from the provision of spectacles for clinic patients. The price of glasses for such patients would be controlled, but a full range of frames would be available.

The everyday working of the clinics would largely be the concern of the ophthalmologist in charge, but in general each patient would be seen in turn by him and he would deal with 'medical' and treatment cases, setting aside the refractions for the attention of the refractionist and/or himself as can best be fitted in.

All prescriptions for glasses would be initialled by the ophthalmologist before dispensing.

It must be emphasized that these clinics are primarily intended to meet the requirements of that section of the community who cannot afford the services of a private ophthalmologist, and who are not covered by any form of Medical Aid. There is however, a considerable section of the population in the lower and middle income group who either dislike the idea of attending a hospital clinic, or who cannot afford the time to wait their turn. It is suggested that to cater for such persons a scheme similar to the British N.O.T.B. should be instituted. There should be an income ceiling for participation in such a scheme and, for this, and indeed for the proper functioning of the hospital clinics, an adequate system of almonership would be essential. These patients would pay a reduced fee—an amount bearing a realistic relationship to their income. They would attend within specified times, either at the ophthalmologist's rooms or at the hospital, and each would be given an appointment time, so that the ophthalmologist would be able to deal with a number at each session. At least one such session per week should be held after normal office working hours. These patients would be expected to get their glasses from the optician-refractionists employed by the Service.

It would be a fairly simple matter to dovetail normal practice and Medical Aid work into the framework of the scheme, and no particular comment in this connection seems to be necessary.

The problem of the registration of opticians now falls easily into place. There would be a register of optician-refractionists who would carry out no refractions outside the clinic work, and who would be accorded the status of Medical Auxiliaries. Those opticians electing to remain outside the scheme would have no such status, and no register.

DISCUSSION

The above proposals would not of course eliminate some of the undesirable features which many see in the service at present offered by opticians, for there would still be opticians operating outside the service. There are two ways of circumventing these difficulties. One is to legislate against them and the other is to offer a more attractive alternative.

The majority of people who patronize opticians do so because (1) they do not consider that sight-testing is a medical service, or (2) they feel they cannot afford the ophthlamologist's fee. Both these considerations are fallacious for the following reasons:

1. Refraction should be only a part of a routine ophthalmic examination. The mechanics of sight-testing may very well be carried out as effectively by an optician as by an ophthalmologist—hence the proposed employment of the optician in the clinics above described—but in bringing to bear professional judgment on the findings the ophthalmologist is probably a good deal more reliable. Furthermore the ophthal-

* Since this was written it has been learnt that the ophthalmologist at Ladysmith has retired.

mologist can bring to bear on the problem a balanced judgment unbiassed by the financial consideration of whether or not glasses should be prescribed in a particular case. This brings one to the most fundamental statement of policy which ophthalmologists should uphold in any proposed scheme. No person who is financially interested in the supply of spectacles should be the final arbiter in a decision to prescribe them.

2. It is extremely questionable whether an ametropic person habitually attending an ophthalmologist will in fact pay more over a longish period than one attending an optician. Experience shows that the latter, over a period of time, tends to acquire a larger number of pairs of spectacles than the former, and what is gained in one direction is probably lost in another.

Legislation in medical and allied matters is always to be avoided if possible—there are always those who see discrimination in every provision. I believe that given time and conscientious service from the participants such a scheme as the above would gradually resolve the problem of the sight-testing optician so as to make any form of legislation unnecessary.

Education of the public and a certain amount of propaganda, in which our general-practitioner colleagues and in particular school medical officers could help us a good deal, would contribute greatly to the success of the proposed scheme.

Two further points deserve mention. Firstly, any ophthalmologist who wished to have no part in the scheme could continue in ordinary private practice as at present. It is unlikely that his income would be affected to any serious extent.

Secondly, the institution of the scheme would not preclude legislation at some later date in respect of opticians outside the scheme if their numbers remained considerable and the relative problems persisted. One has in mind such questions as price-control of spectacles, the activities of intinerant opticians, the use of drugs, and the examination of children.

Ophthalmologists are in a singular position *vis à vis* other medical practitioners in that they have to contend with organized non-medical competition. There are naturally two opinions whether this competition is beneficial to the general public. Whether or not it is beneficial to the competitors should not of course be a considerable factor.

More often than not the medical profession tends to get a 'bad press'. Therefore let us avoid any accusation, even by uninformed persons, of sectarianism. Let us offer to the optician some measure of cooperation, and thus to the public the best of both worlds, in a combined attempt to give them a comprehensive service of which they will be happy to take advantage.

SUMMARY

After a statement of the problem a suggested scheme is outlined for the provision of ophthalmological services (including refractions) in which both medical practitioners and opticians might participate. Details are given indicating how the suggested scheme might be applied in Natal.