

After having qualified as an optometrist in the UK, **Rabiah Narband** moved to Australia. Here she describes the structure of the profession Down Under and what she had to do in order to practise there



# Looking to Australia

**T**he UK practitioner who wants to apply to be recognised as an optometrist in Australia must hold a listed qualification – BSc or BSc (Hons) in optometry or ophthalmic optics from one of the schools of optometry in the UK: Aston, Bradford, Cardiff, City, Glasgow Caledonian, APU, Manchester or Ulster.

The applicant must also have passed the PQE or its equivalent within a four-year degree and must have passed an

examination, or examinations as specified by the board.

Optometrists who have not graduated in Australia or New Zealand are required to pass an exam before being registered.

This exam is conducted by the Optometry Council of Australia and New Zealand (OCANZ) and is accepted in all jurisdictions. The candidate is required to pass two three-hour exams in clinical science. Hence, the applicant's background knowledge in basic biomedical, vision, optical and clinical science

and the ability to apply the knowledge clinically. The candidate is then eligible to sit one two-hour exam in diagnosis and management.

This exam consists of up to 20 photographs of clinical conditions and test findings accompanied by case histories where appropriate. This tests the candidate's assessment, diagnosis and management knowledge. Having sat this set of exams myself, the time given is very little for the content of the exams, although only 50 per cent is the required

## The long view

Before 1905 opticians in Australia lacked professional identity and were seen only as retailers. Australians in the 19th century received their vision care from bizarre sources, such as jewellers, watchmakers and travelling hawkers, these were known as sight testing opticians.

The Australian Optometrical Association (which in 1998 became the Optometrists Association Australia – OAA) was formed as a national body in 1918. As in the UK, the profession agreed codes of behaviour and educational standards required for opticians. The first aim of the profession was for opticians to be registered – hence, government recognition of the professional status.

The first optometry course was established at the Institute of Ophthalmic Opticians of Queensland in 1909. By 1920 opticians began to call themselves optometrists, following their American counterparts.

In 1913, Tasmania became the first state to have legislation

enacted where registration as an optometrist was required; it had taken another 20 years for all the other states to follow. (The world's first registration of optometrists occurred in Minnesota in the US in 1901. UK optometrists were not registered until 1958.)

Over the following years, the optometric profession faced restricted progress due to organised ophthalmology. Ophthalmologists claimed optometric educational standards were inadequate, yet they were not willing to help teach.

The National Health Scheme (Medicare) in Australia was first introduced in 1952. However, optometric patients were unable to benefit. After a struggle, the OAA was able to overturn the government's decision to remove Medicare benefits for most optometric consultations.

As in the UK, optometrists can employ diagnostic drugs (Table 2). In the 1990s the Australian profession concentrated on the prescribing of therapeutic substances by optometrists. In 1999, Victoria became the first state to enact this legislation. Other states are to follow.

pass rate. Subjects covered range from visual perception to practical optometry.

The majority of questions are based around real-life situations, where experience proves more beneficial than book work.

On passing these examinations, the candidate is then eligible to sit the clinical skills assessment. This is a stations exam, comprising of seven stations on specific diagnostic and information-gaining techniques.

Finally, on passing this exam, the candidate is assessed on four patient examinations. This exhausting process takes from four to six weeks in total.

**EDUCATION**

Surprisingly, there are only three institutes in Australia conducting optometric courses – the University of New South Wales, the University of Melbourne and Queensland University of Technology.

Not every state in Australia conducts the optometric course, thereby registration of an optometrist in one state automatically confirms registration in all states. Each course is four to five years, leading to a bachelor degree.

This academic year (ending in December 2005) will produce no optometrist graduates as the course has increased by one year due to the therapeutic legislative changes. The prerequisite of graduation is a demonstrated competence in clinical skills (so no PQEs).

**EMPLOYMENT**

Approximately 16 per cent of Australians make use of optometric services and over 75 per cent make use of all vision-care services in Australia.

Unlike the UK, most Australian optometrists are self-employed or partners in private practice. Remaining optometrists work as employees of other optometrists. In contrast to many other countries, optometrists are not employed to any great extent by hospital eye services or related institutions.

Domiciliary visits are occasional and not as widespread as those in the UK. Most optometrists are located in practices in or near shopping areas. This is the same for Australian doctors or dentists.

**SCOPE OF CLINICAL PRACTICE**

The Australian optometric profession is well established and highly developed. The scope of practice, the legislative framework and social status of the profession are seen as comparable to that

experienced by optometrists in the UK and Canada.

The basic range of clinical skills are just as those in the UK: refraction, binocular vision, ophthalmoscopy, slit-lamp biomicroscopy, tonometry, contact lens patients and the supply and management of spectacles.

Gonioscopy is a clinical test used commonly in areas of Australia. As therapeutic management of patients, such as those suffering from glaucoma, increases across the country, gonioscopy is being employed by more practitioners. Table 1 lists the drugs available to optometrists.

**OPTOMETRISTS ASSOCIATION AUSTRALIA**

The Optometrists Association Australia is the professional association for optometrists. Membership is open to all registered optometrists who practise optometry in any state or territory of Australia.

Membership fees are set by each state division (of which there are six). This is because the services provided to members by each of the state divisions vary. Fees also vary on a membership level which is based on the amount of time spent in practice per week, so part-time optometrists generally pay lower membership fees.

Services provided by the association include representation of members and their interests to the government and other bodies. The OAA provides resources and publications to assist optometrists in practice. The public is also provided with information and other services.

**‘Optometrists who have not graduated in Australia or New Zealand are required to pass an exam before being registered’**

**TABLE 1. Use of diagnostic drugs**

**The diagnostic drugs which optometrists are legally authorised to use in all states and territories of Australia are:**

**Anaesthetics:**  
Oxybuprocaine HCl 0.4%  
Proxymetacaine HCl 0.5%

**Mydriatics:**  
Tropicamide 1.0%  
Cyclopentolate 1.0%

**Cycloplegics:**  
Tropicamide 1.0%  
Cyclopentolate 1.0%

*The concentrations given are the maximums allowable*

**In addition, a number of other drugs can be used in some states, but not others. These are:**

**Anaesthetics:**  
Amethocaine 0.5% (NSW & Victoria)  
Other ‘synthetic cocaine substitutes’ 0.5% (Victoria)

**Mydriatics:**  
Eucatropine HCl 2.0% (NSW)  
Ephedrine HCl 5.0% (NSW)  
Phenylephrine HCl 2.5% (NSW)

**Miotics:**  
Physostigmine 0.05% (NSW & Victoria)  
Pilocarpine 2.0% (NSW, Qld & Victoria)  
Thymoxamine 1.0% (NSW)

**Cycloplegics:**  
Homatropine HBr 2.0% (NSW)

**Vasoconstrictors:**  
Tetrahydrozoline HCl 0.05% (NSW)  
Phenylephrine 0.125% (NSW)  
Adrenaline 0.1% (NSW)

**TABLE 2. OAA code of ethics**

**It shall be the ideal, the resolve, and the duty of the members of the Optometrists Association Australia to:**

- ◆ Keep the visual welfare of the patient upper-most at all times
- ◆ Promote in every possible way in collaboration with the association their educational and technical proficiency to the end that their patients shall receive the benefits of all acknowledged improvements in vision care
- ◆ Hold in professional confidence all information concerning a patient and to use such data only for the benefit of the patient
- ◆ Advise patients whenever consultation with an optometric colleague or other professional care seems advisable
- ◆ See that no person shall lack for visual care
- ◆ Conduct themselves as exemplary citizens
- ◆ Maintain practices in keeping with professional standards
- ◆ Never advertise or suggest that in any way their qualifications, equipment or techniques are superior
- ◆ Maintain and promote cordial and useful mutual relationships with members of their own profession and of other professions, for the interchanging of information for the advantage of their patients



OAA members are required to practise in line with the association's code of ethics (Table 2).

## MEDICARE

The structure of the Australian government is unique in that some matters are governed by federal legislation, whereas others are state-controlled. The Commonwealth of Australia comprises of six states (New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia – see map) and two territories (the Australian Capital Territory and the Northern Territory). With this structure, the country is governed by both a Federal Parliament and the independent Parliaments of States and Territories.

It is the state and territorial governments that are responsible for the control of optometric practice and registrations. The Australian national health programme is governed by the federal government – this provides benefits for consultations with optometrists to all Australians.

Medicare is the Federal Government National Health scheme, in effect all Australian optometrists have agreed to participate as providers of optometric care for Medicare.

Optometrists in the UK are bound by contractual terms with the ophthalmic terms of service to be on the ophthalmic list. Similarly, Australian optometrists are required to achieve the Medicare standards of practice.

The Australian version of the ophthalmic list application is called the Common Form of Undertaking (CFU). This is a legal agreement between an individual optometrist and the Federal Minister for Health and Ageing.

The CFU specifies the conditions under which an optometrist needs to operate in order to access Medicare benefits. The contents of the CFU are comparable to the ophthalmic terms of service, such as details on prescriptions, recalls, record-keeping and advertising. Upon signing the CFU, optometrists are given a 'provider' number – the Australian ophthalmic list number.

## CONTINUING PROFESSIONAL DEVELOPMENT

As with CET, CPD is an essential part of optometry to maintain and improve the standard of care provided to patients and to advance the interests of optometrists. If you practise in Australia and want to stay on the GOC list, accumulated CET points can be transferred as long as proof has been provided.

◆ *Rabiah Narband is an optometrist now based in Australia and was winner of the OPTICIAN/City University Dissertation Prize in 2002*

# The Ocular Fundus from Findings to Diagnosis

Professor Robert Fletcher looks at a recently published text which successfully adopts an interesting and helpful format

PRODUCED WITH 309 illustrations, including excellent coloured plates to Thieme's high standard, much of this text is based on Aachen ophthalmic clinic material.

The layout is unusual yet very helpful; rather than a limited approach to fundus examination, a wide range of methods is presented and this should be particularly helpful to students. Brief historical introductions concentrate on European classical and post-1950 techniques, embracing the bare bones of objective methods from photography, tomography, Doppler measurements, interferometry to angiography, as well as electrophysiological studies and ultrasound. Thus, a broad introductory sweep can be enjoyed. References are somewhat biased towards continental papers and aspects of subjective assessments are somewhat curtailed. Readers should not look askance at the presentation of visual field plots strictly in Goldmann modes – there is often an advantage in viewing isopter plots in this way, as in Figure 3.19, where sector defects of retinohoroiditis juxtapapillaris are shown.

There are suitable chapters in 'appearances' of fundus disorders, under different headings. Here are descriptions of an extensive variety of macular conditions, very well illustrated, backed by listed causes, comments on symptoms and indications of treatments. The section on areas of exudative retinopathy extends over nine pages and embraces one of the frequent tables, this one on risk factors for CRA occlusion.

Chapter 4 deals with the appearances of vascular disorders, emphasising the 78D lens and slit-lamp observation. Here the reader should appreciate the interplay between illustrations, concise and explanatory text and the emphasis provided in page-edge columns. The design is a pedagogic success.

Vitreous diseases are approached in Chapter 5, giving a good balance between symptoms and a variety of examination methods. Further chapters introduce optic nerve disorders, alongside physiological features and 'disorders with no conspicuous fundus changes', with several aspects given rather short shrift. In addition to a very full index the authors have thoughtfully added several pages of systemic classification (with page numbers) and a list of abbreviations, a fitting finale to a most valuable book.

*Wolf, S, Kirchof, B, and Reim, M (2006) Stuttgart, Thieme. ISBN 3-13-139371-8 – 234pp. €119.95*

◆ *Robert Fletcher is Emeritus Professor at City University, London*