Subject: RE: Public consultation on amendments to Guidelines for use of Scheduled Medicines
Date: Monday, 14 January 2013 5:47:47 PM

Dear Mr Colin Waldron,

My name is Jack Phu, and I am a currently-practicing, therapeutic-endorsed optometrist working in Cabramatta NSW. I am writing in response to the proposed amendments to the guidelines.

Firstly, my background is working in a very high-volume and disease-based practice. I see many cases of glaucoma daily and frequently have patients with advanced glaucoma. My patient based is primarily elderly South-East Asian, with a particularly high proportion of migrants who don't speak English well. Because of their poor socioeconomic background and language barriers, many of them are unable to visit ophthalmologists for treatment of glaucoma. As such, they end up losing a large proportion of their sight. Our practice has imaging, does routine dilation and applanation tonometry - all of which are essential for the diagnosis of glaucoma.

My opinion is that optometrists should have the option of initiating treatment in patients with glaucoma, or in those with high risk of developing glaucoma (e.g. ocular hypertension, angle closure suspects). There are many patients who would benefit from the optometrists' ability to initiate treatment. Two recent cases of mine which highlight this situation include:

1) An elderly Vietnamese man who cannot afford to go to the ophthalmologist. As you know, a visit to the ophthalmologist is very expensive, particularly when they have to do many additional tests to confirm the diagnosis. He didn't go when he was referred 4 years ago. He ended up losing half the vision in his left eye because no treatment was instituted.

2) An elderly Chinese woman was diagnosed by another optometrist (without therapeutics) and was referred to a public hospital for treatment (due to being unable to afford a private ophthalmologist). She had advanced glaucoma but the hospital couldn't see her immediately and put her on a 6-month waiting list.

Both of those exceptional cases illustrate the consequences of inaction. Were an optometrist able to prescribe initial treatment, vision loss may well be prevented.

There are concerns that optometrists may simply take over some cases altogether and this may antagonise ophthalmologists. Many of the ophthalmologists that we comanage with are very busy already and cannot afford to frequently review the typical glaucoma patient - particularly in those who have no field loss, or early stage, which may be pointless. Our optometry training is adequate in helping us understand our depth of knowledge and there is no doubt that we would refer those patients we deem complicated or suspicious for ophthalmology opinion.

My opinion is that having the option adds another weapon to our arsenal to take better care of our patients. The benefits of this proposal for our patients far outweighs the drawbacks.

Kind regards,

Dr Jack Phu
Optometrist
NSW