Modern practice options for UK ophthalmologists

BY ROMESH ANGUNAWELA

When I spoke on setting up private practice at the annual United Kingdom & Ireland Society of Cataract & Refractive Surgeons (UKISCRS) meeting in November '23 there was a lot of interest in different types of practice models. If we had run this session 20 years ago, I would wager that the speakers would all have been NHS consultants who did some private practice for additional income. The ophthalmic healthscape in 2024 is a vastly different ecosystem. The NHS is no longer the monopoly career path and the speakers at this session represented the diverse options now available to ophthalmologists in the UK. So what options are there for young ophthalmologists at the end of training or even the mid-career consultant?

As emotive as it may be, some 50% of routine NHS cataract surgeries are now provided by independent treatment centres, which have responded to criticism and now even undertake surgical training of junior ophthalmologists [1]. These providers are backed by private equity and other investors with deep pockets that see rich investment cases in an NHS under strain and a growing ageing population [2]. Separately, and for similar reasons, a greater number of people are now paying for private medical insurance and this trend is predicted to rise [3]. The failure of consultant salaries keeping track with inflation isn't unique to the NHS. Insurers such as BUPA and AXA lowered their fees to doctors some years ago and have also failed to keep track with inflation [4].

> "Consultants no longer see their job as lifelong and will move for a better job, location or for personal reasons"

The traditional path for the ophthalmologist has been to take an NHS consultant job somewhere, stay there for the rest of their career and supplement their income with private practice at the local private hospital. Consultants no longer see their job as lifelong and will move for a better job, location or for personal reasons. A newer generation of doctors may want a greater say in how they work (full, flexi, part), be more aware of work-life balance, have a more egalitarian share of childcare or have priorities other than work [5].

Opportunities for employment as an ophthalmologist have evolved and there is now more choice than ever before. The different practice options now available to UK ophthalmologists as I see it are as follows:

- Traditional NHS hospital job – no private practice
- Traditional NHS hospital job + independent private practice
- Work for an independent treatment centre or provider, e.g. Spa Medica, Optegra, CHEC, Optical Express
- Invest and become a surgeon shareholder in a corporate healthcare provider, i.e. Newmedica (owned by Specsavers)
- Create your own brand and clinic, e.g. OCL Vision, Vision Scotland, Cathedral Clinic
- Practise only in a private hospital, such as Nuffield, Spire, OCL Vision, or Vision Scotland.

Interestingly these options aren't fixed and can be mixed and matched. One could start in an NHS consultant job and then decide later in one's career to pick another option because you might simply want to work 2–3 days a week, or you might find that your NHS Trust is not sympathetic to dropping sessions and you still want / need to maintain a good income whilst spending more time with family or on other pursuits. The reverse pathway from private to NHS isn't well tested and one might find oneself deskilled. The future of what care the NHS provides will also certainly be very different and past opportunities are not indicative of future options (glaucoma, ARMD and diabetic retinopathy care are all beginning to be provided by independent providers and advances in AI-guided diagnostics and treatment nomograms will be transformative at a public health level).

Each work model has its pros, cons, risks, rewards, opportunities, opportunity costs and time commitments. Beyond financial considerations, professional fulfilment through a consultant career that typically lasts three decades warrants careful thought.

There is no doubt that the pure commercial perspective would focus on 2–3 high-ticket, high-margin surgeries and do these at scale on a salaried or per case basis – usually high-volume cataract or laser refractive surgery. An advantage of this model is the undoubted simplicity of a plug-and-play, high-income job without the need to develop a private practice or spend on patient acquisition (marketing). One could in theory do this a few days a week combined with a part-time NHS job. But what of those that are solely based at high-volume providers? Does this bring professional satisfaction?

A recent conversation from a busy surgeon at an independent treatment provider had him describe his job (25 cataracts a day, five days a week) as being like a factory worker. He felt he'd lost his previous specialist skills in corneal surgery, but he did enjoy the absence of departmental politics, the efficient teamwork and a predictable high income.

This is a personal choice that requires careful thought. Can doing 20–30 cataract surgeries per list as required by some of these models be physically sustainable and fulfilling over many years? Do you really have the indisputable surgical skills required to perform surgery at this level? Should you lose the niche skills you've acquired early in your career, or is it better to consider this later? What are the options when you decide you want more diversity in your professional practice? Is it easy to get back to a job where you can use more specialist skills or will you be deskilled? Who would employ you?

For those that balked at the idea of being paid £100 per cataract surgery, some did the math (£100 x 25 cases / day x 4–5 days a week = 10–12.5k per week), swallowed their pride and decided this wasn't such a bitter pill after all!

The traditional model of an NHS job combined with independent private practice at your local private hospital has its own challenges for new starters. Typically one would see patients in the evening or at times when you weren't working in your NHS day job. These hospitals may not market or prioritise ophthalmology in terms of equipment and theatre allocation, and prefer higher-value in-patient procedural specialties such as orthopaedics and gastro-intestinal surgery. Low insurance fees for cataract surgery are an unfortunate reality and many insurers are moving to assured cataract pathway fees with chosen facilities. The Independent Practitioner calculates that an ophthalmologist will keep only 30–40% of income after tax and expenses [6].

What of the reality that most doctors following this traditional model build no asset value in their private practice over their lifetime? Income falls off a cliff at retirement. Where a retiring doctor's practice might once have sold on some intangible goodwill valuation where the retiring doctor would write a letter of recommendation to their key referrers, does this even apply in a digital world where patients now search for their surgeon online and where you can present yourself to them through targeted pay-per-click advertising (which is arguably a better investment of capital). Specsavers-owned Newmedica goes some way to addressing this issue through a model that offers an equity buy into the local business unit and a share of dividends. Newmedica will even lend a surgeon the money they need to buy in, and Newmedica largely service NHS cataract requirements, guaranteeing a regular flow of patients. Of course there are some unknowns in this model as equity exit valuations remain to be tested, and a non-voting share has little power in case the business were to be sold on.

Budding 'Ophthalpreneurs' might choose to follow in the footsteps of surgeon-owned private clinic groups such as OCL Vision, Vision Scotland, the Cathedral Clinic and others in setting up their own surgical facilities. This option comes with much greater involvement, risk, time, and financial capital outlay, but does reward the entrepreneurial spirit with autonomy, direct engagement with insurers, ability to deliver one's own vision of patient care, choice of which equipment to use, response to emerging opportunities and growing value in a tangible asset. The Ophthalpreneur wears many C-suite hats – surgeon, CEO, COO, chief marketing officer, governance lead, HR lead, etc. – one must ask oneself whether this personally interests you. How do you cope with stress? Are you good at multitasking? Do you have the time? Can you inspire and build a team? What kind of leader are you? Can you delegate? Do you have an understanding partner that believes in your vision?

Returning to the theme of professional fulfilment, when Allon Barsam, Ali Mearza and I set up OCL Vision (OCLvision.com) we were keen to continue to offer full-spectrum anterior segment surgery ranging from vision correction to corneal transplant surgery for which we were all dual fellowship trained as we didn't want to lose these skills. We were the first independent surgeon-owned clinic in Harley Street to have an HTA import license for corneal tissue. This took effort and expense but remained true to our desire to preserve our specialist skill set. We were also keen to deliver a comprehensive ophthalmic service with consultants in glaucoma, medical retina, Vitreo-retinal surgery and oculoplastics, which is enriched through cross-referral, peer engagement and case discussion.

The challenge, and privilege, of independent surgeon-owned clinics such as OCL Vision is to identify, nurture and grow the practices of young consultant associates through mentorship, marketing, and complete practice support in a collaborative environment. A path to equity is also an attraction as young practices grow, and essential for long-term commitment and shared interest. Groups such as Vision Scotland, the Cathedral Clinic, and others offer other incentives and it is fair to say that these models are evolving.

Variety remains one of the best parts of my practice. This was a deliberate choice that maintained my skills, knowledge, and interest not only in private practice but also in my NHS job.

I have remained in my NHS consultant job at Moorfields Eye Hospital. My NHS role keeps me clinically and surgically challenged and allows me to continue to teach fellows. I am grateful to my NHS Trust for allowing me to fulfil my professional ambitions and hope that other Trusts evolve to realise the importance of flexibility as opportunities for employment outside the NHS increase. NHS jobs still provide a greater scope of clinical practice and opportunities for professional growth, teaching, training, research, a grounding in clinical governance, peer interaction, and vocational fulfilment in the practice of medicine, amongst other benefits.

Touching briefly on the final option of private-only practice, it is reasonable to say that this experience may be a slow burn for a new consultant without an NHS job working at their traditional private hospital such as a Nuffield, Spire or Ramsay, and is perhaps better suited to mid-career or senior consultants with established practices. The experience is different even for fresh consultants at new generation, surgeon-owned, mentorship-based private clinic groups such as OCL Vision and others.

The healthcare landscape of 2024 and the future will offer far greater work options for ophthalmologists than ever before. Choices now available allow you to be fully NHS, private, or hybrid private-NHS. My key takeaway would be to spend time reflecting on what individual factors are important to you as a person – your role as a doctor, NHS work, professional fulfilment, financial needs, available time, family, attitudes to risks, ability to work within and lead teams, etc., when considering which model might work best for each person.

The aphorism 'first know thyself' is perhaps never truer. It's a long career. Prepare to evolve and choose wisely.

References

1. Changes in NHS cataract surgery in England 2016-2021: an analysis of national, regional and independent sector trends. *RCOphth*. https://www.rcophth.ac.uk/wp-content/uploads/2022/08/Cataract-Sector-Data-Report.pdf
2. Investors eye opportunities in Labour pledge to boost private health sector. *Financial Times*. https://www.ft.com/content/80056593-1949-4732-828a-9e68835bf69a
3. NHS strains set to drive private health insurance growth. *Financial Times*. https://www.ft.com/content/611fbbb5-9f68-40b0-b8b9-3992a04d2c8c
4. Bupa faces UK doctors' rebellion over private healthcare fees. *Financial Times*. https://www.ft.com/content/0c15b7d8-fd19-4180-aea4-8d571e43969a
5. Ferreira T, Collins AM, Feng O, et al. Career intentions of medical students in the UK: a national, cross-sectional study (AIMS study). *BMJ Open* 2023;**13**:e075598.
6. Stride R. Warning of tough era for private practice. *Independent Practitioner Today*. https://www.independent-practitioner-today.co.uk/2023/01/warning-of-tough-era-for-private-practice/

[All links last accessed September 2024]

AUTHOR

Romesh Angunawela, BM, MD, FRCOphth, FRCSEd, FWCRS, Cert LRS, PCEO,

Consultant Ophthalmic Surgeon, Moorfields Eye Hospital; Founding Partner, OCL Vision. He completed the Physician CEO Executive Education Programme at the Kellogg School of Management.

Declaration of competing interests:
Romesh Angunawela is a founding partner of OCL Vision Ltd.