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Cataract surgery

Auditing cataract surgery nationwide

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Ultimately, good data are the best protection for patients and doctors

The Royal College of Ophthalmologists has been urging the Department of Health to fund a prospective national cataract audit for some time. The ongoing House of Commons Health Committee inquiry into independent sector treatment centres (ISTCs) highlighted the need for good quality information.¹ Large sums of government money have been spent on independent sector procurement and questions are being asked as to whether they represent good value for money and, perhaps more importantly, whether it threatens the funding of local hospitals.

COMPARE LIKE WITH LIKE

The health committee wanted to know about the complication rates of surgery carried out in ISTCs and how they compared with those performed under the NHS. There is an amazing lack of information. Ophthalmology at least came out reasonably well as there are good data in some NHS units. Some 25 NHS trust hospitals now have facilities for prospective ongoing audits. The amalgamated data are sizable and provide the benchmark.² To compare like with like, however, any audit should be national and involve both independent and the public sector. A number of cases with serious complications have been highlighted by the media such that there is a genuine need to build public confidence in teams working in ISTCs.

WHY IS CATARACT SPECIAL?

Audit for outcomes in many surgical specialties is limited to re-admission rates, recording of complications, or crude measurements of patient satisfaction. In ophthalmology, structure and function are closely related and can readily be measured. A well chosen and executed incision can reduce astigmatism.³⁻⁴ Patients undergoing surgery with complications tend to see worse than those without.⁵⁻⁶ The surgery is "predictable" and it has been demonstrated that it is possible to stratify patients in terms of their risk of complications.⁷ We seem to be able to recognise a straightforward case (or not) when we see one.

PAY AS YOU GO

The Royal College of Ophthalmologists' audit initiative has the support of the Department of Health in principle. Monies that were identified last year dissipated this year as the NHS faces a large overspend of £800 million. This deficit has to be recouped in the next two years, so it does not look likely that a large capital expenditure will be forthcoming in the near future. There may however be another way forward. The sheer volume of surgery gives us leverage. Cataract operation is the commonest surgical procedure performed by the NHS, accounting for some 300 000 cases a year. Even if a single pound was paid for each patient operated on, towards audit as part of the national tariff, the recurrent and year on year accumulated sum will amount to large total. Software companies are willing to invest and put in place the software and infrastructure support on "per case basis" so that we can capture every cataract episode nationally whether it is done in large or small units, in independent sector or on the NHS.

BIG BROTHER CHANGING OUR PRACTICE

Does an individual surgeon have anything to fear? If the Department of Health has access and control of the audit data, primary care trusts and hospital trusts can access information on each doctor's "productivity" and performance. Can we stop unfair comparisons being made? Cataract surgery is only a small part of many ophthalmologists' preoccupation. How do we prevent cataract surgery becoming yet again the single currency for measuring our contribution to the NHS? Audit has in the past led to change in practice.⁸ Will a national comprehensive audit lead to some "occasional cataract surgeons" giving up this surgery? Will doctors avoid difficult cases because they do not want to have a high complication rate? Information can be a two edged sword.

STATISTICS AND INSIGHT

But if the truth is out there, it can also be measured and counted; statistics is said to be the art of quantitative reasoning.⁹ As a

direct result of the higher surgical training programme, all UK surgeons would have completed 300 cataracts and audited 50 consecutive cases before gaining access to the specialist register. Any surgeon with an insight into his or her ability should have no cause for concern. Indeed, audit on one hand will enable them to demonstrate that their skills compare favourably internationally and on the other hand enable them to "validate" their continued fitness to practice.

STANDARDS AND CHOICE

There is, however, a part for the Royal College of Ophthalmologists to play in interpreting the data and promoting excellence. In the United Kingdom, we have never had the kind of information that is available in the United States from insurance companies. The large numbers of a national audit would give accurate complication rates and facilitate epidemiological studies¹⁰ (for example, role of intracameral antibiotics/intraocular lens safety). In the meantime, there is still some work to be done in validating the national cataract dataset. Ultimately, good data are the best protection for patients and doctors. The NHS will be increasingly driven by choice. Choice can only be arbitrary if it is not informed. The ISTC inquiry has already highlighted that choice based simply on waiting times may not best serve the patients in the long run.

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