Revalidation and Retinal Detachment

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Key Words

Outcome • Case mix • Dataset • Audit • Revalidation

Abstract

Proposed changes in the medical regulatory environment in the UK will shortly introduce a system of revalidation of individual doctors, and this will include the regular and mandatory collection of treatment outcomes. Comparison of such outcomes requires an agreed set of items (a dataset) as well as an efficient method of collecting it, preferably electronically. Such a dataset must be large enough to encompass details on case mix to make comparisons valid, but small enough to be practical. There are considerable benefits of pooling outcome data for improved clinical care, research and education.

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In the late 1990s the medical establishment and the public in the UK were rocked by a high-profile scandal involving paediatric cardiac surgery. The essence of the problem was the lack of an effective system of either detecting or dealing with poor surgical outcomes, even though informally the profession and the hospital in-

involved were aware of the issue. Following major investigations, including a public enquiry, significant changes were made, and cardiac surgery now leads the field in both the collection and reporting of outcomes, so that referring doctors, regulatory authorities and the public can be reassured. For some time now, the complication rates for individual cardiac surgeons have been published for all to see on the Internet. Despite these advances, most other specialties have been slow to catch up, but in the UK change in the regulatory environment is about to provide an important boost to efforts to collect and report outcomes. The General Medical Council is introducing a system of revalidation for doctors which will most likely involve the submission of several individual outcome audits during each 5-year cycle. This has provided a powerful incentive for surgeons to adopt electronic data entry.

One advantage the cardiac surgeons have is that a major point of interest (patient death) is recorded as part of a set of 400 items routinely collected by all UK hospitals and submitted centrally. Unfortunately, none of these 400 items is of any relevance to ophthalmology, which makes similar exercises in our own field more challenging. One solution to this problem is the Eurequo project [1], which seeks to create an anonymised database of cataract and refractive surgical outcomes. Data can be entered online

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or via paper forms on a voluntary basis. However, to avoid duplication and ascertainment bias, the ideal solution would be to have full integration with an electronic patient record (EPR), so that only one data entry is required, and all operated patients are included. The power of this approach can be seen in a groundbreaking audit of cataract surgery on more than 55,000 patients whose data were collected using an EPR [2].

The collection of outcomes is equally important in the field of retina, and the BEAVRS has embarked on a programme to develop outcome data and collection methods for rhegmatogenous retinal detachment. This now has a European dimension, with EURETINA agreeing to provide support for a pilot project in 4 centres across Europe. In order to successfully collect and compare outcome data, an agreed 'dataset' is vital. A dataset comprises a set of defined variables representing clinical information about a patient with a given condition, and its importance is twofold. Firstly it allows surgeons in different centres and using different systems of data collection to pool results. Secondly it allows the collection of sufficient qualitative information to set the results in context. This is particularly important in retinal detachment, where the primary outcome (anatomical success with a single operation) is very dependent on the complexity of the detachment. Without these additional data, there is a theoretical risk that if surgical results are published, some sur-

geons might decline to operate on complex cases to avoid reducing their published success rates. It is encouraging that this phenomenon has not been observed in cardiac surgery.

I look forward to a time when efficient and user-friendly EPR collect full sets of clinical information as a simple by-product of routine practice. Sharing datasets agreed on a European and international basis will allow surgeons to regularly and effortlessly check their outcomes against their peers. The potential for improved clinical care, research and education is enormous. There is a long road to travel to attain this particular nirvana, but the first steps have definitely been taken.

Disclosure Statement

The author has no conflicts of interest in the presented material.

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