

The efficacy of a nurse-led preoperative cataract assessment and postoperative care clinic

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TO THE EDITOR: We believe the study by Kirkwood et al,¹ investigating the use of nurse-led perioperative cataract clinics, contains flaws, and their conclusions are premature.

The authors do not explain the reduction in elective surgery waiting times. Use of a nurse-led clinic should not affect surgical throughput, which is dictated by surgeon and theatre availability.

The rate of postoperative complications with cataract surgery is very low.^{2,3} An assessment of the concordance in management between the nurse practitioner and ophthalmologist would therefore only be possible if a large number of patients were compared, not just the 18 used in the study.

The authors do not justify the statements “a nurse practitioner might be more... experienced in managing patients with ophthalmic conditions” [than a junior registrar] and “the experienced nurse practitioner might be more efficient in use of consumables and investigations” by reference to their own clinic or the literature. In our opinion, a medical practitioner is best placed to understand and make these decisions.

In Queensland, registrars perform or observe most cataract operations done in public hospitals. It is important for their training to see these patients both before and after surgery,⁴ making the presence of a nurse practitioner unnecessary.

If the authors are interested in increasing the efficiency of the process, they could reduce unnecessary clinic visits, which is very relevant here in Australia given that patients may have to travel great distances for operations.

The two preoperative visits proposed in the authors' model could be replaced by one. Standardised referral forms can be used for screening, and facilities can be put into place so that all necessary tests can be performed on the same visit for eligible patients. The 4-week visit can be eliminated if the patient's dispensing optometrist is aware of the expected postoperative visual acuity and can readily refer back if there are any concerns.

Although the model outlined by Kirkwood et al has merits, the conclusions are

misleading. Health care providers and governments must find ways to deliver high quality care during this period of workforce shortages. This should be achieved by increasing efficiency, while preserving doctor training opportunities, rather than through role substitution.

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1. Kirkwood BJ, Pesudovs K, Latimer P, Coster DJ. The efficacy of a nurse-led preoperative cataract assessment and postoperative care clinic. *Med J Aust* 2006; 184: 278-281.
2. Kamalarajah S, Silvestri G, Sharma N, et al. Surveillance of endophthalmitis following cataract surgery in the UK. *Eye* 2004; 18: 580-587.
3. Muhtaseb M, Kalhor A, Ionides A. A system for preoperative stratification of cataract patients according to risk of intraoperative complications: a prospective analysis of 1441 cases. *Br J Ophthalmol* 2004; 88: 1242-1246.
4. Ormonde SE. Ophthalmic microsurgical training: are we approaching a crisis point? *Clin Experiment Ophthalmol* 2005; 33: 453-454. □

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IN REPLY: The points made by McKee and Gole are valid.

However, the demand for eye-care services is outstripping the ophthalmological workforce. Some task substitution is necessary. The effect of the nurse-led cataract

clinic has been largely to increase patient access to outpatient appointments — it helps deal with a large hidden waiting list (time to first clinic appointment), and frees up ophthalmologists to spend more time in the operating room.

Registrars in training are not likely to cope with an increasing demand for services. The number of trainees is determined by the Royal Australian and New Zealand College of Ophthalmologists. Flinders Medical Centre sees 15 000 eye outpatients a year and does 1500 elective procedures — and has been allocated one first-year trainee. The nurse practitioner is more experienced and does not rotate to another hospital every few months.

Nurse practitioners may not be the preferred substitute for ophthalmologists. The employment conditions of nurses can be restrictive, and senior nurses are expensive to employ compared with other professionals, such as orthoptists and optometrists. Perhaps McKee and Gole are more comfortable with the use of professionals other than nurses, as they advocate the involvement of optometrists to decrease the load on outpatient clinics.

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