Pooled cataract waiting lists: views of hospital consultants, general practitioners and patients

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SUMMARY

In the National Health Service general practitioners (GPs) usually refer patients to named consultants; thus, waiting times for a particular procedure can vary greatly even within a single centre. An alternative is to pool the waiting list, with patients treated in turn by the consultant available. We sought opinions on this strategy, from patients, GPs, and consultants, in relation to cataract surgery. Questionnaires were sent to 776 consultant ophthalmologists; telephone interviews were conducted with 50 randomly selected Birmingham GPs; and 85 Birmingham patients listed for cataract surgery were asked whether they would change consultant to be operated on sooner. 503 (64%) of the consultants responded.

Of consultants, 30% favoured pooled lists and 67% were against. Of patients, 82% favoured pooled lists and 18% were against. Of GPs, 92% favoured pooled lists and 8% were against. Some consultants thought that pooled lists were suitable for routine cases but not for more complex cases. 82% of patients expressed willingness to change consultant in order to get an earlier operation.

In units with surgeons whose cataract-surgery practices are similar, pooled lists are one way to maximize theatre use and equalize waiting times for routine cases. The model could be applied to other routine surgical procedures such as hip replacement, herniorrhaphy and prostatectomy.

INTRODUCTION

The National Health Service (NHS) is under pressure to improve efficiency. In ophthalmology the waiting time for cataract surgery, from referral to treatment, often exceeds the specified target maximum of six months. The average wait is seven months though some services achieve two to three. The Government document *Action on Cataracts*[1] indicates that pathways towards cataract surgery have clinical commonality: patients are treated under the same protocol and the same system. It also suggests that hospitals need to make sure that waiting times for different consultants are even. It does not, however, mention the use of pooled waiting lists. Little has been published on this model—whereby patients are treated in turn by the first available surgeon—though pooling has been used successfully in organ transplantation[2]. We investigated the views of consultant ophthalmologists, general practitioners (GPs) and patients.

METHODS

For consultants we conducted a postal survey. The questionnaire was sent to a database of 776 consultant ophthalmologists in the UK. Of these 752 were still practising.

Every tenth GP from a list of 501 in Birmingham was contacted to participate in a telephone interview. In 6 instances the designated GP was unable to participate, and the eleventh for that position on the list was taken instead.

85 consecutive patients were interviewed prospectively by a nurse at listing for cataract surgery and all agreed to participate in the survey. They were recruited from general ophthalmology outpatient clinics rather than specialist clinics and were thus representative of general ophthalmology patients undergoing cataract surgery at the Birmingham and Midland Eye Centre. The questions were asked before they were given any information regarding their waiting time.

The full questionnaires are available on request. None of the participants were identifiable by the authors.

RESULTS

The consultants' questionnaire yielded 479 completed replies (64%). 420 of the respondents had individual cataract waiting lists. Only 7.5% used pooled lists but 73% said that patients were moved between consultants if a list became excessive. 30% were in favour of pooled lists and 67% against. Some consultants in both groups felt that

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pooled lists were suitable only for routine cases. Reasons for opposing pooled lists were loss of responsibility for care, devaluation of the doctor–patient relationship, and loss of consultant control (Table 1).

40% of GPs referred cataract patients to a named consultant and 56% to the department in general; the remaining 4% might do either. 92% of GPs were happy for their patients to be transferred to an equally experienced surgeon if the operation would be done sooner. If the hypothetical waiting time was seven months and waiting time would be cut by one month, 88% would favour transfer; 4% would not switch unless the waiting time would come down by two or three months; and the remaining 8% would wish their patient to stay with the same surgeon whatever the wait (citing continuity of care, doctor–patient relationship and variation in surgical skills).

Of the 85 patients 55 were women and 30 men, mean age 75.7 years (range 50–93). 51 were Caucasian, 27 Asian and 7 African-Caribbean. When asked whether they would want their operation to be done sooner if performed by a surgeon of equal ability, 82% of patients said yes. If the waiting time was seven months then 79% would change consultant for a month's reduction in waiting time. 18% would not wish to change consultant at all. It is noteworthy that 73% of patients did not know the name of their designated consultant.

Table 2 summarizes opinions for and against pooling.

DISCUSSION

The NHS already uses pooling strategies. Planned outpatient clinic pooling occurs when trusts encourage GPs to refer generically rather than to a named individual. Surgical pooling is used in crises to achieve waiting-list targets; the work is often done by non consultant grades, and sometimes cases are removed to an external provider in

Table 1 **Consultants' comments regarding pooled lists**

Comment	*No.*
Technical problem	49
Complex cases are unsuitable for pooling; routine are	26
Different operating technique/standard of surgeons	16
Different listing criteria	7
Alternative strategy	27
Referrals to consultant with shortest wait	6
Find cause of disparity/proper finance/other procedures more important	6
Use pooled staff-grade lists for long waiters	7
Flexible sessions, clinic *vs* theatre	1
Pool referrals	4
Prioritize individuals on need	2
Pool new cases only	1
Devalues operation/operator	14
Increases disparity in workload (encourages lazy surgeons)	13
General practitioners or patients say in matter	11
Complaints/medicolegal	9
Suitability to particular unit/no need	8
Inefficiency (increases clinic visits/time elsewhere to see patient)	6
Reduced standard of care	2
Miscellaneous	9
I do more complex cases for some of my colleagues	1
Lead to competition to corner the cataract market	1
Patient care compromised, so only if waiting list long	1
Patients should be given the choice	1
Undermine patients' confidence by seeing different doctor	1
I've never understood the waiting list	1
Large geographic areas, not practical	1
Consultants could abdicate responsibility for patients in a pool	1
Lack of continuity of care	1

Table 2 **Results, for and against pooled waiting lists**

Group	For pooled lists (%)	Against pooled lists (%)	Don't know (%)
Consultants	29.9	66.8	3.3
General practitioners	92	8	0
Patients	82.4	17.6	0

another trust or to the private sector. Currently the Government is planning to use European medical teams to reduce waiting times.

A limitation of this study is the small sample sizes for patients and GPs, but a national survey would have been logistically very difficult. The views of inner-city GPs and patients may not represent those in more rural locations with less busy hospitals. Another weakness is the low response rate (64%) in the consultant survey: we cannot know whether the views of non-responders were similar or different. This incomplete sample, however, seems to us preferable to a local survey of the 23 consultants who serve our centre.

Despite its limitations this survey does suggest that most consultant ophthalmologists are against pooling whereas most GPs favour it. Why the discrepancy? From comments appended to the questionnaire it seems that consultants, once they have seen a patient, feel strongly that their team should complete the treatment episode. Not to do so, they think, likens them to a technician on a production line. Also some reckon that if they have worked hard to reduce their own waiting list, pooling could paradoxically encourage lazy surgeons. For most patients, as for GPs, the main considerations are that the operation should be good and done soon. Most patients did not know their consultant's name—probably because, for cataract surgery, contact with the consultant is short term. Consultants could find themselves isolated if they opposed pooling of waiting lists, as management drives forward greater throughput and efficiency. What we have found with cataract surgery could well be true of other routine operations such as hip replacement, herniorrhaphy and prostatectomy.

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