

## Newsdesk

### Clinical performance in the NHS

The British government has unveiled its plans to introduce new indicators of clinical performance (NHS Executive Document: *Quality and Performance in the NHS: High Level Performance Indicators and Clinical Indicators*, June 1999). As the authors state, this document heralds "the sustained national drive to continually monitor and improve standards of care for NHS patients". The indicators are aimed at NHS trusts, health authorities, and primary care groups to ensure uniformity of standards across the NHS. Secretary of State for Health, Frank Dobson, is quoted as saying "Standards matter to patients and to doctors and nurses. The government is determined to raise standards . . .". Thus, in the continuing fallout in the wake of the Bristol affair (see Newsdesk, *BJO* 1998;82:861), Dobson admits that it is not possible to raise standards in the absence of good information (evidence); much of this relates to clinical outcomes of treatment and effectiveness of care, in addition to efficient use of resources which has been the main focus of performance assessment until now. Dobson goes on "This is a step away from the former crude league tables which were not concerned with clinical outcomes". Use of the 47 indicators, jointly developed with the Joint Consultants Committee of the British Medical Association, as published will allow NHS organisations to perform inter-trust comparisons, identify areas for improvements and possible action, share information and good practice to achieve best results for patients, and keep an informed local public. There are three elements to the package: setting standards through organisations such as National Service Frameworks and the National Institute for Clinical Excellence (NICE), already established under the leadership of Professor Sir Geoffrey Rawlins; introduction of a statutory duty of quality based observance of clinical governance plus lifelong learning and professional self regulation; and ensuring that monitoring arrangements are in place. The statutory element of these proposals, under the control of the Commission for Health Improvement, are likely to generate the most debate at several levels including the funding and time consuming nature of aspects such as "lifelong learning". Guidelines on minimal requirements may need to be provided and advice from the professional colleges will be welcomed.

### Towards good publication practice

The Committee on Publication Ethics (COPE) (see Newsdesk, *BJO* 1998;82:1230) has revised its guidelines for "good publication practice" which will be published in full in the autumn. The committee was set up in 1997 to provide a forum for editors concerned about misconduct in research and publi-

cation. Problems relate not merely to the review and selection of papers for publication but also to their ethical background and study design. This latter aspect is quite innovative in that the advice produced by COPE attempts to cover aspects such as how to design good clinical and laboratory research, with the emphasis being on well thought out protocols even for pilot studies, and for research being hypothesis driven. The varying regulations between countries for the use of animals in research is highlighted as a potential problem. In addition, the lack of supervision for all types of research and of full and transparent data analysis with appropriate statistics and power calculations is considered "unethical". Clear guidelines on authorship with the recommendation to disclose in the publication the precise role of each author are provided. The thorny issue of open peer review has not yet been resolved but some journals have already moved towards this practice.

Several other issues are dealt with including the obvious ones of plagiarism and redundant publication. Several recommendations are also provided to ensure the good behaviour of editors, especially in relation to the use of sanctions by editors when faced with scientific misconduct, and the correct use of the mass media.

While COPE is an advisory, voluntary, and "relatively informal" group, its members believe that its promulgations are to be welcomed in the context of the need to publicise and educate in the manner of "good publication practice".

### British Association of Ophthalmic Pathologists

The annual meeting of the British Association for Ocular Pathology was hosted by the Department of Pathology at the Institute of Ophthalmology, London, at the High Leigh Conference Centre, Hoddesdon, Hertfordshire, as a two day residential meeting in April 1999. This meeting consisted of a mixture of clinical and pathological case presentations and research presentations. The cases discussed included a de-differentiated parosteal osteosarcoma of the orbit (Luthert, London), an illustration of autosomal recessive congenital hereditary endothelial dystrophy (CHED) and molecular genetic research on this disease (Kennedy, Dublin), Thiel-Benke's corneal dystrophy (Snead, Coventry), and a demonstration of expert intraocular lymphoma cytological diagnosis (Smith, Liverpool). The research presentations included a report on the use of a mushroom derived lectin to study retinal pigment epithelial cell (RPE) adhesion (Hiscott, Liverpool) and contraction in vitreous scarring and a whole session on research into retinal disease including detachment, diabetic retinopathy, silicone oil in retinal surgery, and retinoblastoma. The plenary lecture

entitled "Trauma Pot Pourri. Anecdotes" was delivered by Dr R Jean Campbell (Mayo Clinic, USA) while Dr McCarthy (South Shields) gave an eye opening account of the role of the pathologist in the work of the International Tribunal for War Crimes in the former Yugoslavia.

The association also discussed the future of ophthalmic pathology in the UK and the future of the association itself. In view of the perceived difficulties faced by ophthalmic pathology and indeed pathology in general in the UK, the members agreed to investigate the process of formally preparing a constitution and aims which broadly would be "to further the art and science of ophthalmic pathology . . .". Ian Cree (London) agreed to act as an interim coordinator until next year's meeting while the association draws up a constitution and prepares to elect office bearers. The year 2000 meeting will be hosted by Susan Kennedy (Dublin, 13-14 April) to coincide with the meeting of the Ophthalmic Branch of the Royal Academy of Ireland.

### Successful treatment of retinal arterial occlusion with recombinant tissue plasminogen activator

In the April issue of the journal *Ophthalmology*, Richard *et al* report the remarkable resolution of retinal arterial occlusions using recombinant tissue plasminogen activator (rTPA) (1999;106:768-73). Fifty three patients with central (n= 46) or branch (n=7) retinal arterial occlusion were treated using a transfemoral approach to directly cannulate the ophthalmic artery and infuse 10-20 mg of rTPA in a volume of 50 ml saline per hour for a maximum of 3 hours. Improvement in visual acuity occurred in 66% of patients, with nearly 50% showing an improvement of two lines or more. Arterial occlusion time before therapy varied from 3 to 14 hours and no correlation was observed between this time period and eventual visual improvement. Complications were few with only one patient suffering a transient hemiplegia during catheterisation and a second experiencing a hypertensive crisis during infusion of the drug. While fibrinolysis in retinal vascular occlusion is not a new concept, most previous attempts have floundered on the excessive complication rate owing to the difficulties in delivering the drug directly to the site of occlusion thus requiring high systemic doses to achieve local fibrinolysis. The results of this new study are highly encouraging and merit further investigation in a prospective study which would include a placebo or at least a conventionally treated group, since the natural history of recent arterial occlusion is somewhat variable depending on whether the embolus "passes on" (transient ischaemic attack).



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