Case Report (Open access)

A study of provision of Facilities and Fallacies of Eye Camps in India

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ABSTRACT- There are various diseases, that are preventable and one of the high priority amongst them is blindness. Owing to insufficient ophthalmological healthcare facilities in the peripheral setup, the concept of camp surgery came into existence for the developing nations so that maximum cases could be treated at a single sitting within a nominal expenditure. Unfortunately, if something goes wrong during mass surgery, many people have to pay the price for it in terms of permanent loss of vision. Hence it was of utmost importance that when so many people are getting operated for a particular operation, there should not be any compromise in quality of care and standards of delivery of health services.

Key words- Cataract, Blindness, NPCB, Sterilization

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INTRODUCTION

As of 2012 there were 285 million visually impaired people in the world, of which 246 million had low vision and 39 million were blind [1]. The majorities of people with poor vision are in the developing world and are over the age of 50 years. Cataract contributes significantly to this burden of blindness across the world, but can be treated effectively [4]. Of the estimated 40 million blind people located around the world, vision of 70%–80% can restore partially or fully through treatment hence the term coined for such a state is avoidable blindness [2].

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The 12th five year plan has earmarked the budget of 2506.90 crores for the National programme for control of blindness in India. [3] The amount has been sanctioned for the implementation of the programme for reducing the prevalence of blindness to 0.3% by 2020. This allocated fund has to be used from the districts to the sub center level. The revised guidelines of the programmes have also been circulated. Thus the target to be achieved stresses the need for increasing cataract surgery rate, increasing the coverage for providing assistance for treatment of other eye diseases, strengthening of existing eye care infrastructure and developing new eye care infrastructure by involvement of human resources through community including panchayats and voluntary organizations etc. [7,8]

Further the funds to be utilized are to be channeled in performing 33 million cataract surgeries, out of which 95% will be intraocular lens implantations. The non government

organizations (NGO) are to be assisted and the funds are to be utilized for maintenance of ophthalmic equipments supplied to various centers. The strengthening of training activities for eye care personal to modern eye care techniques has been stressed along with monitoring of the same through MIS. The collection of 250 thousand donated eyes is to be done for corneal transplantations along with strengthening of the existing eye banks and construction of eye wards. The recruitment of ophthalmic officers and supporting staff on contractual basis is to be done. The help of the private practitioners to be taken along with the government staff with the aim towards better eye care.

The work related to the blindness control has to be routed through state programmed office/ joint director NPCB. The appraisal of the programme will be given to the Director Health Services by the state programme officer, who in turn will intimate this to the Director General Health government of India.

Implementation at ground level

As with all programmes of centre Government there is always the problem of implementation for variety of reasons, one of them is lack of continuous evaluation and monitoring based on the difficulty faced by implementing personnel. The answerable authority just acts as reporting agencies to the central offices to achieve particular target. They simply pass on their order and are forced to submit reports of the work being done, which is partially or sometimes fully cooked. The real issues on the ground for implementation are not addressed or a formality of doing so is done.

Guidelines given by NPCB to carry out an eye camp are

Camp Site– Necessary permission from authority and all credentials of organizers, hospital with working OT, all equipments and instruments for surgery, duration of camp- minimum 4 days.

Hygiene– Safe water supply with bleaching of water and tank checking**,** Face and hand washing of patients, cleanliness ward and bed sheets, antibiotics schedule, local & systemic medication**.**

Sterilization- 2 fumigations of OT, one OT table should have 3 sets of instruments, OT dresses for all, autoclaving of blunt instruments and cidex for sharp with minimum 10 minutes sterilization between surgeries.

Surgery and medication- Maximum operation in one day–50, Maximum operations in one OT 100, no complicated patient to be operated, drug, which is used at base hospital should be used, a sample should be tested for microbes before, emergency drug tray.

Back up support– Anesthetist and physician, referral servicers.

Discharge and follow up– Discharge patient after 2 dressings (2 days), 1st follow up on 5th day and 2nd at one month, patients with decreased vision is taken to hospital, do's and don't message explained in written in patient language, discharge slips, record of patients is kept.

Based on these parameters a checklist should be prepared and submitted before starting and after completion of camp. The shortcoming of the camp should be recorded, so that the same could be improved in the next camp. A responsible committee of persons should be made well in advance for proper evaluation of these reports; so that suitable measures are taken before organizing the next camp. The responsibility of rectifying them should be fixed on the concerned authority before the next session of camp and the measure of evaluation should be implemented. The objection raising committee works with more zeal, as the objections are rectified for the next camp.

Standard operating procedures

Under the norms of service delivery in eye camps it has been emphasized that a deputy chief medical officer or medical officer should inspect the eye camp during operative session along with the power to grant permission

for holding an eye camp.

However there is no stipulated time fixed for taking the permission before conducting the camp. If any time frame is fixed for the same the permission number can be put in the advertisement made for the eye camp in which the authenticity of the camp can be proved.

Further the professional responsibility of planning and supervision is given to the eye surgeon regarding the technical component of the eye camp.

The proper details of the size of the operation theatres should be furnished to the eye surgeon along with the number of tables to be used and even the size of the other rooms. There should be specifications regarding the fumigation facilities in the camp and further as to who will get the procedure done and there should be specific details of the sterilization process for the instruments and there should also be a proper performa for the same in which the concerned expert has to only mention yes or no for the protocol followed.

The component regarding the sterilization of the instruments has not been stressed properly and an elaborate data should be prepared for the same. The postoperative infections can be caused by a contaminated environment, unsterile equipment, contaminated surfaces and infected personnel as well as contaminated disinfectants and can jeopardize the hard work done by the surgeon.

A better idea will be given by a microbiologist and he can take the precautionary samples, which can be sent to laboratory for microbial evaluation. This phase should not be a mere eye wash, but every detail should be brought to book. The responsibility of the surgeon should only be limited to the surgery and the health of the patient as this involves lots of concentration. The name of the general physician and the anesthetist should be clearly specified and they should be available at the camp itself.

The eye camps are usually organized by a non government organization, which gets an amount of 1000 rupees per case for motivating, getting the patient to the camp and getting a cataract surgery done.

The leading reasons identified as to why the patient opt for camp surgery are, monetary constraints (18.8%), transport difficulty (17.4%), lack of awareness about cataract in the eyes (17.4%) and lack of escort (14.5%).[5] Often the patients are brought by the NGO for the camps to achieve their target, number of surgeries justify their social work and get the government aid, or if the camp is done by the health department the prime motive is to achieve the target rather than quality of surgery which is most vital for the patient. Patients under pressure of poverty had no other choice but subject to the mercy of the system, because they are not aware of their rights. [6]

A proper counseling of the patients regarding the premedication, surgery, beddings and discharge should be done by the specific person so that the patient has full faith and confidence in the procedure. There should be a Performa for the same so that the patients should not have an element of anxiety or fear in them. The doctor who has operated on the patient with proper standards of care and has the qualification, skill and expertise towards his work should not be immediately written off by the media judgment. In the famous Jacob Mathew v/s state of Punjab case in which Honorable Supreme Court of India gave a landmark judgment and three important rights were bestowed on doctors and they are:

1. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice, which can normally be expected to give an impartial and unbiased opinion applying the Bolams test to the facts collected in the investigation.
2. A private complaint may not be entertained unless the complainant has produced prima facie evidence

before the court at the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.

3. A doctor accused of rashness or negligence, may not be arrested in a routine manner. Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make him available to face the prosecution unless arrested, the arrest may be withheld.

It is sad to know that the doctors have to run for cover for seeking bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge, but the loss which he has suffered in his reputation cannot be compensated by any standards.

Though the government of India is trying to eradicate blindness through its policies, the finer and minutest of details have to be worked out so that policy of maximum delivery should be followed.

1. There should be standardized monitoring in hospitals after collecting information that will help to answer the questions about the functioning of the organization and find practical solutions to the needs. National indicators for routine monitoring of quality of health services should be followed and the progress of the project should be evaluated periodically.
2. The microbiological evaluation of various parameters in ophthalmic operating rooms should be calculated. The detailing should be more elaborate on the preparation of the eye camp with elaborate detailing on the number of instruments used including the detail of the standard of sterilization. To do this, the right indicators are to identified and monitored, so that an insight into the performance of the existing service is measured. Standard protocols, which are very important way to ensure good outcome through proper monitoring should be adopted. This will help to highlight the areas of concern rather than beating the chest in the end when the possibilities of correction are remote.
3. Monitoring is the process of being aware of the procedure to know the correct process to follow. The benchmarks help us to know where we are in comparison to the best. Tools used in monitoring can be used and its practicality and application should be evaluated for each setting. Clinical auditing to monitor the quality in eye care delivery to be done.

The other side of the coin also should be noticed that since it is a free camp it does not give one a license to practice negligently, while doing a particular procedure sufficient man power/ infrastructure should be readily present if any complication arises and the solicity of the patient is not allowed as per ethics and should not be done.

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