based upon this confusion of roles would not be equipped to handle the complex managerial and contractual issues that the new system of matching resources to performance will demand."¹² It remains to be seen whether the expansion of the new management role of DHAs to include being champions of the people will restore this confusion of roles.

Members report that health authority meetings since the 1991 changes have been more comfortable and friendly and that decision making is easier,¹³ especially since they are increasingly held in private.¹⁴ But there has been little debate on the impact of membership on the new reforms or on the effect of large purchasing consortia and district mergers, which remove health authority members still further from their communities.¹⁴

The model of direct ministerial management of health care, with its focus on individual consultation, is a long way from the 1944 green paper, which originally intended that local authorities should run health services and special professional and technical guidance would be provided by local health services councils.¹⁵ Then, in rejecting the suggestion that experts should be included in local authority administration of health services, the government felt, "The risk of impairing the principle of public responsibility (accountability)—that effective decisions on policy must lie entirely with elected representatives answerable to the people for the decisions that they take—outweighs any advantages likely to accrue."

Recent research shows that local democracy does count.^{16 17} Regardless of their political opinions, people identify with and value the role of their local authorities in decision making. Many of the debates throughout the 1980s indicate that there is no reason to believe that they would not support a more democratic health service.^{18 19}

If the NHS Management Executive is having second

thoughts about whether the new district health authorities and their members can fulfil their management role and be champions of the people then it has to realise that market research models can never be a substitute for a democratic process and local accountability. Otherwise community consultation, consumerism, and participation in needs assessment, priority setting, and developing and monitoring service specifications are meaningless.

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Day surgery for cataracts

At least a fifth could be done this way

In England and Wales 8% of cataract operations are done as day case surgery¹; the corresponding proportion in the United States is more than 10 times this. Undoubtedly, there the impetus for day case surgery has come from insurance companies because it is cheaper, but its greater use has not been accompanied by claims of poorer surgical outcome or other disadvantages to patients. Purchasing authorities in Britain will probably demand a similar shift in health care policy.

Twenty years ago day case cataract surgery was virtually unknown in Britain, but over the past decade many places have reported favourably on its use.²⁻⁸ Its advantages include cost savings,^{4,5} a high level of satisfaction among patients,^{6,7} and complication rates that are comparable to those of inpatient surgery.^{6,8} Day case surgery is usually performed with local anaesthesia, which permits earlier ambulation and feeding and is associated with less nausea and vomiting, fewer coronary and embolic complications, and less need for post-operative nursing care—advantages reported over 30 years ago.⁹ Many patients unsuitable for general anaesthesia owing to conditions such as poorly controlled diabetes, chronic heart failure, or chronic asthma can have cataract surgery under local anaesthesia. Although some patients with conditions such as senile dementia or anxiety states are unsuitable for surgery under local anaesthesia, they may still be suitable for

day case treatment with short acting general anaesthesia.

Postoperative follow up should follow a clear protocol that usually entails patients returning to the hospital department, although some units have found that home visits by trained nurses are practical and acceptable.^{2,6} Patients should receive clear instructions to contact the ophthalmic department if problems arise—this ensures that the workload of family doctors and community nurses does not increase. Patients lacking social support at home are probably better treated as inpatients.

Ophthalmologists may be unwilling to embark on day case surgery for several reasons. Leaver believes that the ready availability of highly trained anaesthetic staff and easy access to high quality inpatient facilities has encouraged British ophthalmologists to rely on general anaesthesia for a larger proportion of cases than do their counterparts elsewhere.¹⁰ He suggests that ophthalmologists can no longer ignore opportunities for doing most types of eye surgery under local anaesthesia.

Some ophthalmologists may also be reluctant to do more surgery because this inevitably leads to more demand for post-operative follow up in already overbooked outpatient clinics. The pressure of work and inadequate facilities probably discourage many surgeons who would otherwise consider setting up day case units. Day case cataract surgery is

unsuitable for training junior ophthalmologists, although a recent wide ranging review of staffing in ophthalmology suggested that use of specially trained clinical assistants or long term senior house officers for surgery and outpatient follow up should be considered.¹¹

The Audit Commission has noted how widely the rates of day case cataract surgery vary in Britain, with many districts doing none and others treating more than 40% of their cataracts this way.¹² It has therefore recommended 20% as an optimistic target for the proportion of cataracts to be treated by day case surgery. With adequately resourced units this target seems achievable. To tackle the backlog of cataract surgery (about 65 000 cases in 1991) other measures such as local initiatives may also be required.¹³

The demands for ophthalmic services will continue to rise as the number of elderly people increases, the threshold for surgical intervention falls,¹⁴ and developments such as refractive surgery and complex vitreoretinal surgery occur in other aspects of treatment. More ophthalmologists need appointing: the number of ophthalmologists per head in Britain is among the lowest in Europe and much lower than that in the United States. The College of Ophthalmologists has recommended the creation of 200 new consultant posts if Britain is to have a proper hospital eye service.¹⁵ The college has taken a positive attitude to day case surgery and better integration with primary care, and this positive approach should be matched by the provision of adequate resources in provider units.

Cataract surgery with intraocular lens implantation is probably the most successful microsurgical procedure in modern medicine. We owe it to our elderly population to make it more widely available.

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Liver fibrosis

Better understanding may help diagnosis and treatment

Hepatic fibrosis is a common sequel to most forms of chronic liver disease and an essential component in the development of cirrhosis. Even without cirrhosis, fibrosis may disrupt intrahepatic blood flow and produce portal hypertension. Recent interest in the basic cellular and molecular mechanisms of fibrogenesis is beginning to pay dividends in clinical hepatology, suggesting new approaches to diagnosis and treatment.

Far from being a passive aggregation of "reticulin",¹ fibrosis is now seen to be a dynamic process, resulting in the accumulation of several distinct proteins in the extracellular matrix.² The effect of this accumulation is not simply to create a space occupying mass; by changing the composition of the extracellular matrix, fibrosis may directly alter hepatocyte function via cellular integrins. These proteins act as trans-membrane linkers through which the extracellular matrix may influence cell movement, polarity, and gene expression. Changes either in the relative amounts of matrix proteins surrounding hepatocytes² or in the expression of integrins by these cells³ may therefore have profound functional effects.

Matrix proteins accumulate not only because of increased synthesis but also through altered degradation rates.⁴ The principal enzymes concerned in remodelling the matrix are collectively termed metalloproteinases, of which there are three broad groups: interstitial collagenases, stromelysins, and type IV collagenases-gelatinases. Although the last group may have a role in early liver disease, altered interstitial collagenase activity is more likely to contribute to progressive fibrosis. Activity may diminish either because expression of

the active enzyme is reduced or because the expression of metalloproteinase inhibitors such as TIMP-1 is increased.⁵

The liver contains few fibroblasts, and until recently the cellular origin of the matrix proteins was uncertain. In vitro culture systems,^{6,7} immunoelectromicroscopy,⁸ and in situ hybridisation⁹ have all been used to show that although hepatocytes can synthesise some matrix proteins,¹⁰ the main cells concerned are the perisinusoidal cells.¹¹ These cells (also referred to as fat storing cells, Ito cells, or lipocytes) lie in the perisinusoidal space of Disse and contain abundant cytoplasmic retinoids. They proliferate in response to liver injury¹² and undergo phenotypic changes with loss of retinyl esters and hypertrophy of the endoplasmic reticulum. This phenotypic modulation towards myofibroblast-like cells is accompanied by expression of proteins associated with smooth muscle^{13,14} and by increased synthesis of matrix proteins.⁶ In most forms of necroinflammatory liver disease activation is mediated by a complex interplay of growth factors, released by Kupffer cells (and possibly platelets).^{14,15} Activated perisinusoidal cells may themselves synthesise and secrete some of these peptides, leading to additional autocrine stimulation.¹⁵ Other mechanisms, however, may be implicated: acetaldehyde, the toxic metabolite of alcohol, can directly stimulate collagen synthesis in cultured perisinusoidal cells.¹⁶

Knowledge of the structure and metabolism of the extracellular matrix has led to the development of serum assays which offer a non-invasive approach to assessing hepatic fibrosis.¹⁷ Concentrations of serum aminoterminal propeptide