Ophthalmic mentors: Professor Carrie MacEwen

Caroline (Carrie) MacEwen is a Consultant Ophthalmologist at Ninewells Hospital and Medical School, Dundee, and Head of the Ophthalmology Department at the University of Dundee (Honorary Professor). She trained in Glasgow, Dundee and London. Carrie took over as President of The Royal College of Ophthalmologists in May 2014.

What is it like for you being College President and a consultant ophthalmologist at the same time?

It's an extremely exciting and challenging time for the College. Being a consultant ophthalmologist and president of the Royal College of Ophthalmologists at the same time involves an interesting balance. I think it is important to be a practising ophthalmologist to be a credible president in order to understand the current clinical pressures. The presidential work is extremely busy, but I have been very fortunate at Ninewells in that my colleagues have been really supportive, as have the management. I am now working clinically about two days per week, and am able to devote two or three days to College responsibilities, which I hope is going to make my duties as president feasible and possible.

Have you set any achievement targets for your three-year term as president?

I would certainly like the College to become more engaged with the membership, totalling around 3,500, and external organisations, a more outward-focused and externalised approach.

Since I became president in May 2014 we've completed our first ever membership survey, undertaken in order to gauge what our members feel about the College as an organisation. The message we got back was that the members consider that the College is very good at assessment, training, education and professional guidance, but there is a feeling that perhaps it should be slightly better at engaging both with the members and with external policy- and decision-making bodies.

We have set a programme designed to get more members involved in College activities in order to get as much expertise and opinion involved in the decision and implementation processes as we possibly can. In addition, the membership survey indicated that we should be looking at engaging more proactively with external bodies, becoming the recognised voice of the profession. This is an area that the College is actively reviewing. We are aiming to improve our policy development and interaction with policy makers, government and the various different other organisations and charities within the eye healthcare community.

The main drive is patient care. Ophthalmologists are increasingly busy people and it has been repeatedly recognised that capacity is an issue. Hospitals need to capture ongoing data on the capacity and demand to identify those areas where ophthalmology departments are overloaded, where patients are not being seen within timeframes that are considered safe, to ensure appropriate action is taken such as additional or multidisciplinary staffing and better ways of working together across the whole ophthalmic sector both in hospitals and in the community.

What's in the strategic plan?

Following the membership survey and meetings of Council members and staff, a strategic plan has been drawn up for the next five years which aims to focus College activities better. This entails three essential strands:

- Continue to deliver and strengthen our core business of professional assessment, training, education and professional guidance and standards.
- More proactive and effective approaches to influencing and upholding standards in eye health through leadership and expertise in the field of ophthalmology – and that is for the ultimate benefit of our patients.
- Develop and sustain an appropriate organisational infrastructure to support these two main strategic drivers that we have in place for the next five years, ensure full support and broader participation from the membership.

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Therefore, in this proposed strategy the College will continue to do what it does well and will, in addition, adopt a more proactive role in policy development. Lastly, it will encourage open and inclusive mechanisms to maximise on the experience and expertise of all members in College activities. The RCOphth should be recognised as the

body which represents ophthalmology and our patients.

I'd like to see many more trainees involved with the College so they can then see the bigger picture. For example, in curriculum development, surgical skills, simulation and IT skills. I want to make sure that the College works closely with trainees so that they have a role to play in developing the best training possible to become better ophthalmologists of tomorrow. For the same reasons I would like to ensure that the College engages better with newly-appointed consultants.

Do you see a need for a greater number of ophthalmologists per head going forward?

There has been limited new money in the Hospital Eye Service (HES) for some time. There has, however, been an increase in activity due to more long-term conditions being managed successfully, such as repeated treatments for age-related macular degeneration (AMD) and diabetic retinopathy. Over the past five years in the HES, the number of outpatient appointments in England has increased by 30% and the number of ophthalmic operations carried out has risen by 25%. This has been achieved with very little additional medical resources being made available – much of this increased activity has been secured by remodeling work practices and the upskilling of nurses, optometrists, orthoptists and technicians.

Discussion about funding tends to lead to recommendations for restructuring, arguing that more money is not the answer. There is also the notion that more community-based ophthalmic service delivery might cut costs and prove more cost-effective. However, there is no evidence to suggest that by moving work into the community, services become cheaper. There is quite considerable evidence that it might make things more expensive, with wasteful duplication. So these changes need to be managed carefully.

By running a dedicated hospital-based eye health service with high levels of skill, there is economy of size and operation that is very efficient. Better working across primary and secondary care sectors, with the development of appropriate pathways and measured outcomes is nonetheless invaluable and needed in order to address the capacity issues within ophthalmology services.

Arbitrary tariffs tend to reward new referrals. What needs to be done to redress the apparent disincentives for effective ongoing follow-up care?

Arbitrary tariffs and financial incentives around new patient referral ratios are powerful influencing tools, but frequently act as barriers to effective clinical care in the management of chronic eye conditions. The new referral to return appointment ratio in glaucoma is about one to 21, in AMD it was one to 15 but is probably rising as life expectancy extends. How can one work effectively in a hospital that says you have to work to a new patient referral ratio of one to two for such eye conditions?

The clinical constraints faced by ophthalmologists need to be better understood as it is very difficult to achieve long-term management for patients with chronic eye conditions if return appointments are discouraged.

In addition, working on ways to develop protocols to safely discharge patients or to share care in a community setting are essential to make sure that patients do not attend hospital unnecessarily.

What's the position with regard to off-label prescribing?

We have a drug regulatory framework and licensing network in place that is there to protect patients, and we must respect these fundamental regulatory principles, as well as the legal and medical obligations governing treatment decisions by medical practitioners.

The College has raised the issue of off-label prescribing and specifically the use of intravitreal bevacizumab for AMD, to make sure people are aware that this drug is not licensed for use in the eye and therefore its use is off-label. Because of the substantial price difference between intravitreal bevacizumab and licensed anti-vascular endothelial growth factor (VEGF) agents approved by the National Institute for Health and Care Excellence (NICE) for the treatment of AMD and other retinal conditions, a great deal of work has been done to evaluate comparative efficacy and safety. There is now a huge amount of data available to indicate that bevacizumab is safe and effective for neovascular AMD, an indication that falls outside of its licensed terms of use.

Practitioners must comply with regulatory drug licensing arrangements as well as NICE guidance. When clinically appropriate and available, licensed products should always be prescribed and dispensed in preference to unlicensed products. What must not happen, is that any individual doctor is put at risk of contravening guidance from the General Medical Council or breaching regulatory licensing practice. The College recommends that UK regulatory bodies appraise the use of intravitreal bevacizumab for AMD and agree a sensible way forward that might extend the range of approved treatment options available to ophthalmologists.

If you had wet AMD, were frail and had several comorbidities, how would you like to be treated, ideally?

Ideally I would like to be spoken to by the doctor who is treating me, and allowed the opportunity to discuss the advantages and disadvantages of any treatment and support that was available at that time, particularly for vulnerable patients.

The first question to answer is whether I would want treatment, and the consequences of not having treatment. One of the issues impacting clinic capacity is patients not showing up for appointments and we really need to be clear about the importance of on-going treatment.

No matter what, it is important to have that open discussion to ensure informed consent. As a patient, I would want to be assured that treatments are safe and effective but also aware of any risks. The ophthalmologist should work with the patient to be able to consider such things as the dosing frequency with available treatment options, with as few repeat injections or clinic visits as possible.

We are all hoping for the development of effective new treatment modalities or drug delivery technologies that may not require frequently repeated intravitreal delivery. The implications for service delivery are enormous in terms of time, effort and resource currently devoted to injection clinics. That said, increased workload is a small price to pay for

proven treatment that allows people to retain vision who previously only faced a potential route to losing their central vision.

What makes a good ophthalmologist?

A good ophthalmologist is a good doctor. That means identifying the patient's problems and responding appropriately to them. It is important that ophthalmologists listen carefully to patients, examine them thoroughly, and are clear about the best plan of management for them in a full and open discussion.

We are living in a time of huge change, driven largely by technology and continuing advances in ophthalmic medical and surgical practice. A lot of the changes that are going to take place will be in clinical areas that are facing rising patient demand, such as treatment for AMD and retinal vascular disease, focusing on innovative management approaches to address the large patient population involved, newer approaches involving virtual clinics and strengthened IT / data management systems. While achieving these changes, ophthalmologists need to make sure that patients feel that their views are important and that care is being delivered to them as an individual person.

While we may have to embrace different ways of working, we must make sure that the patient is kept completely at the centre of everything.

Any tips on securing a work-life balance?

One of the important issues about work-life balance is that it is recognised and accepted as a matter which warrants attention. People get more job satisfaction, perform better and are more likely to become engaged if they have a good work-life balance. The work environment is important in making work less stressful and enjoyable. Ophthalmologists have very rewarding jobs and careers, although it can be frustrating when clinicians feel that they may not get the interaction with management that they would like in order to deliver the best care.

Cautionary forward-looking statement?

Ophthalmology is a busy, high volume specialty, which is involved in assessing and treating large numbers of patients annually. I would like the challenges of high demand with limited clinical capacity that face our specialty to be recognised and addressed for the overall benefit of existing and future patients. I would like to see eye care recognised as a national health priority as its success impacts effectively on people's overall health.

Ophthalmology is a fantastic specialty with recognised high levels of satisfaction which are entirely justified. Our College is the only single surgical specialty college in the UK, which gives us a huge mandate to meet the needs of our members and our patients. I am very optimistic about the future of ophthalmology and I look forward to my remaining term as president of the RCOphth.

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