A day in the life of an Ophthalmic trainee

I

"What do you think you would've done if you hadn't done eyes, doctor?"

I look up from my notes to the face smiling through the bars of my slit lamp. I have just diagnosed neovascular glaucoma in this lady, and I need to arrange urgent retinal laser for her. She has been very patient with me this morning during a busy eye casualty clinic. Of all the questions I could be asked in this clinic, I'm not expecting this one. She's caught me off-guard. My thoughts drift briefly to other things I enjoy: arts, crafts, music –

She's still smiling, swaying her head from side to side to make eye contact, as she waits for my response. I then realise I've left the microscope light on and it's dazzling her. That explains the bob-and-weave. I turn it off.

"That's a tricky question," I reply, as I roll the slit-lamp to one side so she can see me. "I've sometimes thought I would've liked to be a professional perfumer. I studied organic chemistry at university and I make perfumes as a side hobby…but to be honest I find being an ophthalmologist stimulating in many more ways at once."

She nods. I wonder what she's thinking, but I'm conscious of the need to press on with her care and to also see the other patients, so we move on to discussing the laser procedure. She returns to the waiting area while I step out to speak to another registrar about the chances of fitting her in to his laser list this afternoon. On the way, I tell my junior colleague that I will be gone briefly while he continues to see our patients. He gives me the thumbs up and carries on. It's nearly the end of the morning and fortunately we do not have many patients left to see. Finally, eye casualty is coming to an end.

Eye casualty. One can never predict how a session will unfold. Some days there are runs of straightforward cases: a corneal foreign body in a metal-worker who has attended many times and jokes about a loyalty card; a self-diagnosed flare-up of recurrent iritis in a patient who has become an expert at early detection; a posterior vitreous detachment in a retired schoolteacher anxious about retinal detachment, but easily reassured after a thorough examination. On other days, there are clues but no suspects, questions but no answers yet. It takes great skill to distil the signals from the noise when assessing such a patient within the constraints of a casualty appointment, and mastering this art is what specialty training really boils down to. Regardless of the case mix seen, at the start of the

session we have a waiting room full of patients with red eyes, black eyes, white eyes. Patients who can't open their eyes, patients who can't close their eyes. Some have lost vision, others are seeing two of everything. Each and every one of them is worried about what we might find, and what it could mean for their sight, their livelihood, their life. It is our job to listen to, investigate, treat, and reassure them with responsible plans by the end of the consultation. As I wait to speak to my colleague about the laser, I think about how I once found acute ophthalmology daunting. I remember sharing the same fears as my patients about what I might find and whether I would be able to help. Six years on, it is exactly this responsibility that gives my role meaning. I return to the unexpected question my patient posed a few moments earlier. No, I really don't think I can imagine myself in any other profession.

II

In the afternoon I am in a different world, upstairs in the operating theatres. I am currently part of an ocular motility and strabismus firm. Belonging to a firm: this is what makes ophthalmology training stand out from the rest. Since the Working Time Regulations came in, the traditional medical firm has all but disappeared. This has had an impact on the training experiences of junior doctors ever since. However, as ophthalmology trainees, we rotate from one subspecialty to the next, joining small subspecialist teams. There is a sense of pride that comes with this role. This identity, of representing a subspecialty, is also recognised by others in the workplace. Got an oculoplastic problem you're not sure about managing? Catch the oculoplastic registrar in the staff room and pick her brains. Having trouble examining a child in eye casualty? Ask the paediatric ophthalmology registrar next door if he can help. The current training structure certainly fosters a sense of belonging. I can't imagine working in a field where I wouldn't feel this connection.

Today our firm will be carrying out a list of squint operations. Before convening in the operating theatre, we complete the pre-operative round, where we address any questions our patients have and double check the surgical plans. With strabismus surgery, the proof is in the planning. Our patients have been reviewed by us and our orthoptist colleagues a few times in outpatients so that we can plan their operations with more confidence. The star of this afternoon's list is the Harada-Ito procedure, which is performed on the superior oblique muscle to help reduce the symptoms of torsional (tilted) double

vision. I am rather excited about this because, although I have read a lot about it, I have only ever seen it demonstrated on cadaveric tissue. This is the first real-life case I will witness, a stepping stone to assisting in and ultimately performing this procedure myself one day. After I complete the more straightforward squint cases on the list, our subspecialty fellow and consultant prepare to perform the Harada-Ito together.

As we wait for the patient to arrive, I am asked to explain the operation to the medical student on our firm. She is very keen and knows her anatomy and cranial nerves by heart, but is puzzled by the superior oblique muscle. "I've read that it helps you look down and in, but that it also turns the eye inwards – I'm not sure I understand it." By some serendipitous coincidence I have, in my bag, a teaching model I've made from a foam ball and fabric tape, simulating the anatomy of the superior oblique muscle. I let her play with it so that she can see, in three dimensions, how the action of the muscle depends on the position of the eyeball. Her eyes widen.

"Wow! I have never been able to visualise it before from diagrams or lectures! I don't think I'll forget it now," she says excitedly.

"I guess my work is done then," I say, as I usher her back into theatre in time for us to watch the procedure. She now has a cognitive scaffold on which to hang her observations as our colleagues proceed with the case. It feels good to have helped her iron out this crease in her learning. The question my patient asked me in eye casualty earlier echoes between my ears. No, I don't think I can imagine myself in a profession where I would not experience sharing knowledge in this way.

At the end of the list we have a cataract operation, filling in for a cancellation. I have done hundreds of these before. It was initially a steep learning curve, but then, with deliberate practice and a lot of patience, it came together in my third year, when all the steps coalesced into a single, seamless performance. Before I knew it, I was doing case after case with fluidity, in the same way that I could play pieces on my guitar without needing to constantly count frets or check my sheet music. On my current placement I am aiming to build the same expertise in squint surgery, so it has been a few months since my last cataract operation.

"You ok to do this one?" asks the senior fellow.

"Yes of course, although I'd like you to be here just in case, as it's been a while since I was doing regular lists of these." He smiles knowingly, but reassuringly.

“Don’t worry, I’m here.”

As I scrub up I mentally rehearse the sequence of cataract surgery and remind myself of the potential pitfalls in this particular case. The team checks that we have the correct patient, correct eye, and correct lens implant and I proceed to prepare the patient’s eye for surgery, explaining what he may see or feel during the case. I reach for the microscope. Using an operating microscope in theatre feels very different, psychologically, from using the slit lamp in clinic. In theatre, it is not just the patient’s eye that I am observing. I am watching myself as well, performing microsurgery. Every decision, every manoeuvre, under high magnification.

As I adjust my focus on to the cloudy lens, I go through the steps in my mind once more, a small part of me wondering whether the instruments will feel alien in my hands after so many weeks. The scrub nurse passes me tool after tool, the sounds of my surroundings fading into the background as I focus my attention entirely on the eye in front of me. Suddenly, it is as if the instruments are an extension of me. I am back in my element, neatly performing my microsurgical ballet. After just a few minutes, I am cleaning up and removing the drape, meeting the gaze of my patient. “Was that it? That is nothing like how I’d imagined it, doctor! I didn’t feel a thing, but I saw the most beautiful things.”

It hits me right then that they almost always say that. Patients frequently describe seeing patterns and colours, skies and sunsets, swirls and rainbows during cataract surgery.

“Well I’m glad you enjoyed the performance,” I joke, “I suppose that’s why they call it theatre.”

“You couldn’t see the colours then, could you doctor?” he asks as my colleague helps him sit up.

“No sir, that was all in your eye.”

“Beautiful,” he says as he shuffles out of the theatre, eager for the hot cup of tea and biscuits that await him on the ward.

As I wave goodbye, I think about how I will probably never see what he saw. This makes me aware of how there must be so many experiences and perspectives our patients have that we cannot directly appreciate; they are the only ones who can enlighten us about them. Ultimately, how would we ever recognise characteristic patterns in patients’ symptom histories – photophobia, metamorphopsia, jaw claudication – if it weren’t for their descriptions in the first place?

III

Finally, the day has come to a close. I take the lift down to the exit level. At the main entrance, I find the lady from my morning eye casualty waiting for a taxi.

"Your lovely colleague has done my laser, doctor. He was so kind to me."

"I'm pleased we could get it done for you today," I reply, unsure how much to say to her here in the outside world.

"Doctor, you said you like to make perfume? I've been stuck on a crossword, I'm not sure if you can help, but I might as well ask. What is that stuff that comes from whales, nine letters?"

"Ambergris."

"Ah, thank you! I do like a good crossword but I've been stuck on that one for ages."

"Well, let's get you better so that you can enjoy doing them again."

She winks and shows me her crossed fingers. I feel like I have more to say to her.

"You asked me this morning about what I would've done if I hadn't done eyes. I've been thinking about that a lot today, since you asked me. To be quite honest with you, I really don't think I could do anything else."

Words (excluding title)- 1980