Training the trainers

Learning phakoemulsification is a psychologically demanding process. Every ophthalmologist passing through the UK training system will almost certainly have many stories to tell of difficulties faced along the way; hideous disasters where lessons were learnt, as well as glorious triumphs where inevitable failure was averted at the last minute by skill, cunning or, more commonly, luck.

Those supervising trainees during their early years, the first 50 cases in particular, are also absolutely instrumental to how a trainee experiences phako. I remember stories told of consultants who would shout, scream, get annoyed and tut-tut all the time. While this certainly had a profound effect on those being trained there were also stories of the best bosses around. Those heroic souls who would fill their trainees with confidence, offer advice in a friendly manner during the operation and eventually walk out to the coffee room while the trainee operated independently for the first time. Yes, everybody wanted a boss like that.

But the most feared boss was the nervous boss. The consultant who was so fearful of letting trainees loose on their patients that they would seemingly have a million excuses ready as to why every phako on the list was in some way unsuitable. Those consultants the trainees pitied. Pity, of course, was much worse than fear, as we would usually ascribe our failure to progress at their hands to their own probable lack of surgical skill and overall confidence. Trainees can be so cruel behind closed doors.

As my surgical numbers increased the pre-eminence of the trainer receded into the background more and more and such thoughts were forgotten until I found myself sharing a theatre list with a new ST1. The consultant in charge of the list, a super-competent paediatric ophthalmologist that had trained me during my first rotation through Singleton, was pleased.

"You can teach him how to do the incisions this week Gwyn," he said. I was uneasy. I had just about managed to learn phako without the crushing fear that sometimes accompanied the cataract list and this was some new challenge. I thought of myself as a Hippocratic doctor though who is duty bound to teach others and accepted. I talked him through the process using the white board in theatre as an aid and, suitably prepared, was scrubbed alongside him while he did the incisions. As much as I tried to guide him I was a little perturbed at how clumsy his movements were and after the wound was constructed there was such a large leak of fluid that the anterior chamber was unstable for my part of the operation and required a suture at the end. The second case, despite me reiterating the instructions on the board, ended up the same. For the remaining cases it turned out that there were co-morbidities present that meant the gallant ST1 was unable to form more incisions. Which was a terrible shame indeed, I thought.

The following week my consultant and mentor said that cracking might be a good skill too for the junior trainee to learn, and then he went off to the theatre office to sort something out. I was pleased the incisions would be left to me and overall felt it was easier to teach cracking than making the initial incisions and again drew lots of nice drawings on the theatre whiteboard. I could tell the ST1 was impressed as my explanation must have been so detailed he had no comment at all to make at the end of my lengthy tutorial.

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The stage was set and after forming what I considered a nice groove I vacated my seat and allowed the ST1 into position. He struggled somewhat getting the second instrument into the eye and my gentle explanations about hand positioning did not seem to make any difference to the angle of approach. After distorting the cornea unbelievably the second instrument was finally inside the eye and the phako probe placed in the groove. "Too shallow," I said, my bowels tightening. My brain felt the subconscious scream of nature that seemed to me to be zonules creaking and groaning as the ST1 then moved the second instrument into the groove and then seemingly leant his entire body weight against it. Breathlessly I told him to stop and before I could calm my beating heart I saw the anterior chamber shallow to nothing as he accidently switched the inflow off with his foot. Gasping for air I made guttural noises to the scrub nurse who thankfully worked out quickly what I wanted and switched the flow back on. Happily no zonules were broken, though no nucleus was cracked either, and I took over and finished the case. The second case had a slightly smallish pupil and I determined in the interests of the ST1 it would be best if he did not take part in that operation, or the next one, or indeed any more on that list.

The third week my heroic mentor did the teaching and as it turned out there were many more suitable cases for the ST1 during that list. A few days later I entered the theatre coffee room and both the ST1 and the consultant were debriefing after a list. "Well done on the incision there," the ST1 was told. "You need more confidence that is all." The ST1 was grateful. "Thanks. There aren't many cases I can do on Tuesday's list when the reg is there." That was my list with him. He did not know that I was in the coffee room but I recognised the gravity of his statement instantly. I had used the same mocking tone when I felt I wasn't being given enough cataract work by that most despised of trainers, the nervous boss. I then realised that I had become that which I had mocked all those years ago, and clumsily knocked the kettle over.

The ST1 turned around at the noise, saw me, and in an embarrassed tone informed the consultant that I had let him do two incisions the other day. Pity. I felt it like a blow to the colon and wondered if my old bosses felt likewise when they caught people talking about them like this. I smiled weakly as I realised that phako is in fact a more psychologically demanding process for the trainer than the trainee and the real challenge in learning phako was in fact only just beginning for me.

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