Phacogeddon

A trainee shortly to rotate to my firm was unhappy at the fact that she had only one phaco list in her timetable. She was a final year trainee with more than five hundred cataract extractions to her name so would be fine but her situation made me realise that there is a problem ahead. More junior trainees have much more limited training opportunities than even I did, and that wasn't so long ago, and the situation is getting tighter.

There aren't enough consultant ophthalmologists on this island, and certainly in Wales, to do the work needed. We don't produce enough and have always been reliant on an influx of ophthalmologists from overseas; initially the Indian subcontinent, then the EU and especially Greece until Brexit put paid to that, and now the Middle East. Whenever we advertise a new job in this region, the vast majority of candidates (if there are any that is) are from Syria, Iraq, Egypt or various other countries we see quite regularly on the news. One day the internal strife in these places will hopefully die down but that would then inevitably mean a reduction in the associated brain drain from those regions. It is always dangerous, as well as being somewhat immoral, to rely on other countries to train our ophthalmologists for us. So there is constant pressure from above, the sides and the bottom to increase training places here at home. This in itself is tricky because of our own lack of consultants but the numbers are rising and rising consistently.

My colleague here who acts as the college tutor is tasked with producing timetables for our trainees, considering accommodation constraints, retired colleagues and theatre issues. Trainees and specialty doctors go to him to ask for specific firms, timetables and swaps with varied and conflicting demands. His office is off the main hospital corridor and sometimes as I pass by I fancy I hear the soft muffled moans of anguished crying through the chipped windowless wooden door. His task is an utterly impossible one and with each passing year it gets worse. The theatre issue is the most difficult to solve. Due to Jeremy Hunt altering some complicated tax rule in Westminster our anaesthetists variously received gigantic tax bills that left them reeling. In this way their industry was rewarded by the so-called pro-work Conservative government in London. The Welsh Government tried to fix this London meddling by sending a letter promising they'd cover such bills but trust was broken and it has been the equivalent of us losing 40% of our anaesthetists over a very short space of time. Our cataract capacity collapsed.

I had two lists and now I reliably have one. Many of my colleagues also lost lists, sometimes specific ones each week, but more commonly random ones just to keep us on our toes. The waiting list grew longer and outsourcing became standard, such that the complexity of remaining cataracts increased. Trainees had to be redistributed and where I did have two lists each with a single trainee I now have one list full of horrible cataracts with two to three trainees. This is where we are now and there is no sign of this changing. The anaesthetic department presumably have the same trouble recruiting as we do as they have had interviews for newly created posts, but the trouble remains. I also worry that if I give away too many cases I might atrophy, so I always do two on a list which means the trainees do a maximum of two each, unless one is away, and with the best will in the world it is impossible to train that way. Sure, simulators are one way forward, but can a simulator emulate an elderly COPD sufferer who occasionally has the need to tell you about the pretty pictures they're seeing during the operation as you are struggling to crack a rock hard lens? Made extra hard by the fact that the waiting list is now longer than a human lifetime. So the trainees have complications born of not doing enough cataracts and the cataracts they do are not training cataracts. Because of this, the more junior trainees will struggle to reach their 350 and will be more nervous, stressed consultants as a result, so what will happen when they in turn have umpteen trainees all wanting a piece of the action on their only list of the week, which in fact only has one six-slot patient on it that will be cancelled for twenty different medical reasons? The situation worsens and deepens.

The NHS seems incapable of keeping up with cataract demand in its current form. In my opinion, the days of cottage industry ophthalmology is over. Almost every ophthalmologist operating is a recipe for disaster. It's impossible to train so many surgeons reliably for the amount of work needed, and forcing everyone to struggle through five or six slot cataract lists of difficult cases with training demands is not the way to break the backlog. I believe only a portion of ophthalmologists should do cataracts, on multiple lists a week in a high throughput centre. Patients only need a maximum of two cataract extractions in their lifetimes and should be expected to travel to have this done for free on the NHS. It should not be expected that every hospital in the land can do this highly complicated technology-heavy and disposable-heavy operation and that every ophthalmologist of every sub-specialty is able to perform it. It is not efficient and it is not safe. In Wales, for example, we could do with one in North Wales and two in South Wales where patients travel to have highly efficient surgery performed by highly trained and experienced staff and surgeons who made a conscious decision to concentrate on phaco surgery. Trainees wishing to become cataract surgeons could spend time at these dedicated cataract hospitals to learn on a spectrum of cases. In this wonderland there would be no long and highly variable region-based waiting lists, as the new lists will be highly efficient. Gone would be the requirement that all trainees have to struggle through rivers of sweat, stress and vitreous to reach their 350 so that they can immediately drop all lists on becoming a consultant. In Europe and most of the rest of the world, most ophthalmologists are not also cataract surgeons.

For now, the situation is unsustainable and something needs to be done. I feel a bit like the character played by Stanley Tucci in the movie *Margin Call*, who thinks the company balance sheet is a bit ropey then works through a few models and discovers that complete bankruptcy is actually just around the corner. He tries to highlight this and is immediately sacked, but hopefully that won't happen. Besides, I think many people have come to this conclusion as well all over Britain. I think that the time has come to bite the bullet and Europeanise our practice, or we are at risk of phacogeddon. The number of trainees complaining will be such that there won't be a single college tutor left in the land; a situation that will only be matched by the number of patients and VR surgeons complaining about the increasing tide of vitreous threatening to submerge our island in a Thunbergian deluge from which we might never recover. *Written pre-COVID and now truer than ever.*

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