A foundation year post in ophthalmology

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"Jobs are scarce but they offer a totally unique FY2 posting"

Ophthalmology is a unique specialty. Success requires combining the diagnostic and therapeutic interventions of a physician with the technical skills of a microsurgeon. The result is a varied and fascinating mix of medicine and surgery with frequent opportunities to make sight saving interventions.

Choosing a foundation post in ophthalmology is a very beneficial first step in achieving this goal. On offer is the chance to learn the basics of ophthalmology, both by participating in outpatient clinics and also with dedicated time set aside for theatre sessions. Ophthalmology is a heavily outpatient based specialty and as a foundation doctor my first role was to familiarise myself with the clinic setup. Initially, I was asked to sit with a registrar or consultant with the aim of gaining a basic understanding of the slit lamp microscope along with examination techniques and the management of basic ocular conditions.

After this initiation period, I began to see patients by myself. Initially asking for a senior review of every patient, I later gained the confidence to manage patients I was comfortable with. This included basic glaucoma follow ups, simple lumps and bumps, and other common cases such as conjunctivitis and allergy. I also gained confidence in listing and consenting suitable patients for cataract surgery.

Ophthalmology clinics are very varied in nature. A usual department will run many different clinics, often simultaneously. My weekly timetable involved taking part in general ophthalmology clinics along with paediatric, emergency, medical retina and glaucoma clinics. There were also dedicated cataract clinics. The usual protocol was for an

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initial nurse led assessment to record visual acuities for each eye. Depending on the clinic type, one of several things then took place: For glaucoma clinics, the patient often had a visual field test done by the orthoptist along with a retina scan. For paediatric clinics, patients often had a full orthoptist consultation (to quantify squint, subjective refraction etc) before seeing the doctor. In cataract clinics, new patients had biometry measurements taken and pupil dilation. I found that clinics ran very smoothly and, as the last person seeing the patient, the doctor would have the privilege of putting everything together to formulate a management plan, be it a medical or surgical one.

As a FY2 with no ophthalmology experience from medical school, I was initially quite intimated by the sheer technicality involved in an everyday ophthalmology clinic. However, I soon found myself confidently managing cases of allergic conjunctivitis and listing and consenting patients for cataract removal, as well as discharging patients following successful surgery. Since my registrar and consultant were always next door, I could ask them if I felt unsure of anything. They were always approachable and keen to teach.

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During my post, I was quickly expected to achieve a basic competency with a lot of the equipment found in clinic. For people like myself with a strong fondness of gadgets, this proved to be no bad thing! First and foremost, this involved the key piece of equipment: the slit lamp microscope. You will need to try and master its use fairly early on as there is not much that can be done in ophthalmology without it! Fundoscopy is another key skill that takes some practice, along with Goldmann's applanation tonometry. For the first twenty or thirty intraocular pressures I measured, I asked my registrar to verify my values until I became confident of my ability and accuracy. The same applied to fundoscopy. It took approximately three weeks for me to become comfortable and reliably get a good view of the fundus: I realised that it took a combination of correct posture of the patient, correct setting of the incident light and a steady hand with the lens. The confirmation from the consultant of any abnormality I found at the fundus was always confidence inspiring. Other instruments used in clinics include keratometers in cornea clinics, IOL masters in cataract clinics, pachymeters in glaucoma clinics, and last but not least, the humble direct ophthalmoscope. The direct ophthalmoscope is not just used in OSCEs for fifth year finals! It is often used along with the slit lamp microscope in medical retina clinics, offering a superior field of view along with greater magnification of the fundus. A four month post is usually more than enough to gain a reasonable competency in all of these areas.

You may get the feeling at this point that working in ophthalmology primarily includes the management of chronic ocular disease. Although this is largely true, there is a significant acute workload, differing according to the hospital you find yourself working in. My FY2 post was in a District General Hospital (DGH) and thus, there was no dedicated eye ward. However, I remember plenty of times that the registrar, during clinic, received acute ward referrals. These were patients who would either come down to be seen at the end of clinic or, if too unwell, would be seen on the ward. I would often accompany the registrar and we would take with us a portable slit lamp and a direct ophthalmoscope along with eye drops and other essentials. Cases I remember included seeing severe exposure keratopathy in ITU patients, infected eczema herpeticum of the face encroaching the eyes and severe thyroid eye disease. Acute patients would also be found in the realms of an everyday outpatient clinic: I remember several patients who came for glaucoma follow up

who were found to have alarmingly high intraocular pressures in one or both eyes. These patients would require cannulation (usually by me!) to be given IV drugs to lower the pressure and then sent to a regional centre for further assessment or admission.

As an FY2, I also attended teaching for trainees. This is usually a weekly regional session where trainees in the deanery gather for central teaching. Often, Ophthalmic Specialty Trainees (OST) will present cases for discussion and teaching. However, there is an opportunity for FY2s to also present. This may be an interesting case you came across, an audit you've been working on or even an area of research. This would count as a regional presentation and would no doubt benefit your CV! Other CV boosting activities to be getting on with during your post include taking part in a departmental audit and clinical research. I would also try and book onto a microsurgical skills course, run by the Royal College of Ophthalmologists. I also attended a Basic Surgical Skills course, and found both courses helpful in increasing my confidence in basic surgical techniques and principles. There is also a yearly Edinburgh 'FOCUS' course. This covers basic ophthalmology skills . All of these courses are very popular, with places on the microsurgical skills course filling up incredibly quickly. The FRCOphth Part 1 exam was also something which I did during my FY2 post. Having clinical exposure whilst revising for the exam was no doubt very beneficial.

I found my FY2 post in Ophthalmology extremely enjoyable. Being supernumerary, I benefitted from the sudden liberation of my weekends and evenings, which gave me room to focus on extracurricular activities as well work to boost my CV. Bear in mind that not all foundation posts in ophthalmology are supernumerary with some FY2s put on the ophthalmology on-call rota. However, this comes with added support from seniors and, just like I experienced when starting, there is an initiation period of shadowing to give you a chance to absorb basic ophthalmology without losing your hair on call!

I would wholeheartedly recommend trainees interested in a career in ophthalmology to try and get an FY2 job in the specialty. The jobs are scarce but they offer a totally unique FY2 posting where you can take a step back and focus on some fundi, as well as an area of medicine that really interests you. ■