

OPERATING ON COLLEAGUES AND OTHER SURGEONS



The high visual demands of an eye surgeon's career are unavoidably top of mind.

BY ALLON BARSAM, MD, MA, FRCOPHTH

I have operated on many colleagues throughout my career, including other consultant eye surgeons, optometrists, and surgeons and physicians from disciplines outside of ophthalmic care. I would say that, most weeks, I operate on another doctor (see the accompanying sidebar for one example). I approach certain aspects of these procedures differently than I do when treating a patient who is not a health care practitioner.

LIFESTYLE CONSIDERATIONS

When operating on other surgeons, especially other eye surgeons, I am hyperaware of the highly visually demanding nature of their work. As a surgeon who has undergone laser vision correction myself that improved my quality of vision in all activities, I also know firsthand how much of a positive impact it can have on one's ability to see for work. Before my laser vision correction procedure, I was losing vision

while operating due to dryness from contact lenses.

In my opinion, eye surgeons are likely to be intolerant of any amount of hyperopia, but they may tolerate tiny amounts of myopia. So I adjust my target slightly. I would usually target approximately +0.10 D, depending on the accommodative amplitude of patients younger than 35 years of age. For an eye surgeon or other microsurgeon, however, I target plano. In patients older than 35 years of age who may be approaching presbyopia, I may deliberately leave the nondominant eye slightly myopic—usually around -0.12 or -0.25 D, depending on how presbyopic the patient is for their age.

PSYCHOLOGICAL PRESSURE

I'd be lying if I said it isn't on some levels more nerve-racking to operate on a fellow surgeon than on someone who works a desk job. When I treat a patient who has a highly visually demanding

job, I feel more pressure because tiny imperfections in this patient's visual system or refractive outcome are going to be more noticeable to them. In a way, it does demand more perfection.

Having said that, I strive to achieve perfection for every single patient I operate on, so it's not a hugely different approach. I have an obsessive personality, I'm uncompromising, I'm hard on myself, and there's no complacency or lack of focus during surgery—ever. You inevitably have more awareness of who the patient is that you're operating on, however; you can't ignore when you've got a colleague under the drape or anyone else with high-level visual requirements, including military aviators and commercial pilots. There are many careers in which the vision requirements are extremely high, and this puts more pressure on the surgeon to achieve an excellent visual result.

CONCLUSION

When operating on a colleague, there is extra motivation and pressure to do the surgery as perfectly and efficiently as possible. It's the highest honor for me to have a fellow surgeon or ophthalmic colleague come to me for surgery in the first place because they have the choice of pretty much anyone else in this specialty, so I see it as a privilege; that's something that I try to respect and work hard to live up to as this individual's surgeon. ■

CASE EXAMPLE

One colleague I operated on also happened to be a former professional sports player who continues to compete at a high level today. Therefore, I was aware of pressure in terms of visual outcome on two levels with this patient. I would also describe this individual as a *perfectionist*—a term I would use to describe at least half of all ophthalmologists.

Preoperative examination. BCVA was 20/16 OU with a refraction of -5.25 -1.50 x 10° OD and -5.25 -1.50 x 170° OS. There was no sign of presbyopia or pre-presbyopia. We pretreated the patient's ocular surface because he had some mild meibomian gland dysfunction. The treatment included hot compresses, oral flaxseed oil, and fluorometholone ophthalmic suspension 0.1%

(FML, Allergan), one drop instilled once a day for 1 month in both eyes.

Surgery. I performed advanced wavefront-optimized LASIK with flap customization using a 100- μ m flap with diameter of 8.4 mm. Excimer ablation was carried out with an optical zone of 6.3 mm and a transition zone extending to 8.1 mm. The surgeries were uneventful.

Outcome. UCVA was 20/10 OU on postoperative day 1. Because the patient had no presbyopia, I had targeted plano in each eye. The patient was over the moon with the outcome with regard to his ability to carry out complex intraocular surgery and laser procedures and to continue playing sports in his spare time.

ALLON BARSAM, MD, MA, FRCOPHTH

- Director and Founding Partner, Ophthalmic Consultants of London
- Member, *CRST Europe* Editorial Board
- allon@oclvision.com; www.oclvision.com
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