Eye on Ophthalmic Educators

This quarter we talked with Dr. Lik Thai Lim, Professor and Head of Ophthalmology Department of the Universiti Malaysia Sarawak, UNIMAS in Malaysia regarding his thoughts on ophthalmic education. Dr. Lim teaches both medical students and residents in clinical and surgical settings.

Learn more about the ICO Ophthalmic Educators Group.

Contact us at educators@icoph.org.

1. Which groups (e.g. med students, residents, fellows) are you educating now and in what way?

Response: I have been educating mainly medical students and residents (specialist trainees) when I was in Scotland (working in the National Health Service (NHS), UK for 12 years), and currently, continuing my educating activities of the two main groups as mentioned above in my new place of work back in my home country, Malaysia (as Professor and Head of Ophthalmology Department of the Universiti Malaysia Sarawak, UNIMAS, since 26 February 2016).

For the medical students, the approach of teaching is two folds; clinical theory and clinical practice. For the clinical theory, I have designed and taught them by thematic presentations (e.g. The acute red eye; Painless sudden loss of vision etc), with the emphasis being from a practical aspect. It is through this method that I find that I can best engaged and interact and gain interest among the students in this subject, making them more directly aware of practical theoretical knowledge, which they can apply to real life cases (as oppose to rote learning the different clinical eye conditions without direct appreciation of the importance of each eye disease, without over-burdening them on less important trivia), highlighting the important and common eye conditions. This teaching is usually delivered in interactive group teaching with power point presentations with pictures and discussions, checking for understanding as the tutorial progresses.

From the clinical practice aspect, the students who had undergone the clinical theory teaching shall be exposed to real life clinical patients. It is here that the students are encouraged to apply practical theoretical knowledge that they had learnt, to real life patient scenarios. This will reinforce the basic knowledge and application of it to common ophthalmology cases expected of general doctors, once they passed their medical degrees.

In order to ensure a good standard, I am also involved in the assessment of the students, encouraging lateral thinking during my teaching and this being also reflected by the questions set in the assessment.

With the above described approach, the feedback I received from the medical students (both in the UK and in Malaysia) have been very positive, thus reinforcing my believe in
this approach to produce safe and competent doctors who can treat eye conditions to the level expected of them and to know their limitations and to know when and how soon to refer cases that is not in their competency areas, thereby giving patients in general the best quality of care possible by a general doctor.

For the residents (specialist trainees), the approach of teaching is also two folds; clinical practice and surgical practice. For the clinical practice, as specialist trainees, it is expected on their part to read and learn the clinical theories/knowledge from standard text. My role here is mainly to reinforce and make them appreciate more the theory that they had learnt, and put it to practical use. Supervision of trainees in clinics is vital, and it is through this supervision that the trainees will come and seek advice and help in cases that they are less familiar with, and through case based discussions that I reinforce their theoretical knowledge and encourage them to apply it into real life scenarios. With such application of knowledge into practice, the trainee will develop further in their training to be lateral thinking, empathetic eye specialists, with common sense and confidence.

From the surgical aspect, training trainees to be competent surgeons can be a challenge. For me, the main goals are as follows: 1. To develop competent basic and/or transferable surgical skills (including microsurgical skills); and with that good foundation, to then expand into other higher more complex surgical skills, the most common being cataract surgery (being the bread and butter of ophthalmology). 2. To then train them in more complex surgical skills emphasising on cataract surgery, with my approach being through analysing step-by-step surgical progress of the trainees and guide them to do better, with the help of videos of the surgery (with prior permission from the patients). My personal experience is that such approach will not only increase the rate of learning and progress in surgical skills, but also transform trainees into confident and competent surgeons.

My teaching approach to the specialist trainees described above ensures a high standard of both clinical and surgical practice, which will in turn ensure the best ophthalmic care that patients can get from them.

2. Do you have specific interests within education (e.g. assessments, teaching in the OR etc)?

Response: As an enthusiastic ophthalmology educator, with a passion to see ophthalmology practice standards grow from strength to strength internationally, both for general doctors and eye specialists, my interest within education is multi-fold, each with an intended passionate and clear objective, and can be broadly divided into three major components: teaching of practical ophthalmology knowledge and its application (at medical students and residents level)—the objective being to ensure that they can apply useful knowledge into practice for the benefit of their patients in a safe and appropriate manner; teaching of surgical skills and communication skills in the operating room (for residents)—the objective being to ensure that they become competent and confident eye surgeons with a good grasps of empathy towards patients and their concerns; and assessments (at medical students and residents level)—to ensure that those who passed at the intended level do indeed have the required knowledge and skills to
practice safely and competently and empathetically and ethically for the benefit of their patients.

I sincerely also hope that not only will my effort and passion above benefit more patients, but also that those students/trainees can in turn impart the knowledge and skills to their juniors in the hope that more and more patients can benefit from this. It is what I personally refer to as ‘augmented benefit’ to both patients and future ophthalmologists.

3. **What are your biggest challenges in being an educator?**

   **Response:** It is both an honour and privilege, and a heavy responsibility to be accorded the position as an ophthalmology educator. As the saying goes, 'heavy is the head that wears the crown'. It is with this responsibility that I identify the challenges that I face, when teaching medical students and residents, knowing that the end result is not just passing of the students, but the effect and impact that derive from their future practice on the welfare and standard of care of the patients in their charge. From my humble experience, the challenges faced by me are different for the different groups of students that I teach and train. For the medical students, the biggest challenges I face are: 1. Lack of interest: it is generally felt that ophthalmology is a hard subject at medical student level, and most medical curriculums only allocate a relatively short attachment time, thus making them feel the uphill task to master the subject to the level expected of them, and 2. Most have not been able, through their short stint in ophthalmology, to grasps the important concepts and application of knowledge at the level expected of them, to real life clinical situations. In order to satisfactorily address these challenges, I had adopted the approach described above (in Question 1), with good feedback and results.

   As for the residents (specialist trainees), the biggest challenges I face are: 1. Sometimes residents may have the theoretical ophthalmic knowledge but not able to apply this on a case by case basis combined with common sense and what is best for a particular patient’s condition or situation (clinically and surgically). Hence my approach used, as discussed above (in Question 1), to make them see a more practical side of decision making based on patients’ personal circumstances (tailor-made management plan based on individual cases, and at the same time applying clinical knowledge on case by case basis). 2. Surgical progress: Some residents/trainees may not be able to grasps the bigger picture of their weaknesses in ophthalmic surgery, especially surgical aptitude and knowing when and how to do certain manoeuvres on a case by case basis. This involves higher order as well as lateral thinking, and taking charge confidently when things do not go as initially planned, and be able to think on their toes of alternative surgical approach should the planned approach not go according to plan. In order to address this, I had adopted the approach described above (in Question 1) of getting basic transferable surgical skills, and then to embark on more challenging cases, encouraging lateral thinking through step-by-step analysis as the surgery progresses (with aid from the video recording of the surgery). This approach actually resulted in better surgical progress of residents, whom I hope will become competent and versatile eye surgeons to benefit more patients in the future.