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A New Lens: Reflections on My Ophthalmology Elective in Sydney

REFLECTIONS

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During my final year at UCL, I completed a six-week ophthalmology elective at Westmead Hospital in Sydney, Australia. Being a final-year student made this placement feel like a rehearsal for professional life. I could try out new clinical responsibilities in a supervised setting. It also let me reflect on how ready I felt for foundation training and whether ophthalmology suited my developing clinical identity.

The elective was both informative and new to me. I had daily supervised access to advanced imaging, sustained surgical exposure, and active involvement in research within routine care. These opportunities are rarely available to UK medical students in a single placement. I had first encountered ophthalmology during a brief rotation at Moorfields, but the intensity and structure of the Westmead programme deepened my commitment and clarified why I might choose this specialty. Given that undergraduate ophthalmology teaching in the UK is increasingly optional, (1) in-depth electives like this offer a rare chance to experience how diagnostic technology, operative practice, and research interact in everyday decision-making.

I approached the elective with two aims: To consolidate practical eye-care skills and to compare how ophthalmic services are organised and delivered in Australia versus the UK.

Discovering the breadth of ophthalmology

Early in the placement, during a glaucoma clinic, I was asked to take a focused history from a patient with intermittent blurred vision. I measured visual acuity and intraocular pressure and performed a slit-lamp examination. The registrar supervised me closely and coached my technique throughout. The task required precise instrument alignment and a systematic search for subtle anterior segment signs. My immediate reaction was apprehension: the microscope felt unfamiliar and I was concerned about missing clinically significant findings. Repeating the examination with direct, task-specific feedback shifted that anxiety into competence, and I began to perform the same sequence of assessment with increasing independence.

This episode illustrates a structured learning sequence: observation, guided practise with formative feedback, and progressive autonomy. In educational terms, this is experiential learning - active acquisition of skill through repeated, supervised application rather than passive observation. In this setting, experiential learning meant turning theory into practice. I took the components of a basic eye examination and applied them repeatedly in real patients. With supervision and feedback, my performance became safer and more reliable until I could work more independently.

My stepwise progression from observer to active participant aligned with formal undergraduate expectations for ophthalmic competence. Current guidance from both the Royal College of Ophthalmologists (Level 1 undergraduate outcomes) and the General Medical Council (Outcomes for Graduates) sets clear expectations. Newly qualified doctors should be able to perform basic eye examinations. They should also recognise red-flag visual symptoms. Referencing these standards clarified that the skills I practised were not optional extras, but core competencies expected at graduation.

Critically, this emotional and practical arc altered my learning choices and mastery of these skills. Experiencing how deliberate scaffolding produced measurable competence led me to prioritise training environments that explicitly structure skill acquisition. In practice, this means choosing placements that allow repeated, supervised practice of core skills. These include measuring visual acuity, basic slit-lamp use, and pupil and motility assessment. Competence should be assessed formatively, with tasks becoming more complex as skills improve.

From the clinic to the theatre

Another highlight of my elective was exposure to surgery. I observed procedures from cataract extraction and glaucoma filtration to vitreoretinal repairs and paediatric strabismus operations. In the operating room, consultants narrated each step and invited questions. For example, during a phacoemulsification cataract surgery I was allowed to hold a speculum and briefly operate the irrigation under supervision. That brief hands-on involvement improved my understanding of ocular anatomy and the tactile aspects of microsurgery, converting abstract anatomical knowledge into practical surgical judgement. Participating even at this basic level improved my three-dimensional understanding of ocular anatomy and the tactile aspects of microsurgery, and it made surgical decision-making feel less abstract.

Within surgical lists, differences between UK and Australian practice emerged. Surgical consent processes at Westmead were longer and often included more detailed discussion of post-operative rehabilitation and longer-term outcomes. Post-operative care pathways also differed, reminding me that healthcare delivery involves systems-level choices as well as clinical skill. Observing these consent and follow-up practices prompted a critical reflection on communication: more structured consent conversations can set realistic expectations and may influence adherence to post-operative care, which in turn affects recovery and outcomes. Noticing these differences made me reflect on consent discussions and follow-up pathways. I saw how they shape patient expectations and surgical outcomes. This experience changed how I think about explaining risk and recovery to patients. This aligns with literature showing that well-structured electives provide learning about health systems and determinants of care. (2)

Integrating research and practice

Beyond clinical work, I attended weekly research seminars at The Westmead Institute for Medical Research. These meetings showcased advances such as gene therapy trials for inherited retinal diseases, AI analysis of retinal images for diagnosis and prognosis of age-related macular degeneration, and new pharmacological strategies. Watching clinicians discuss ongoing trials showed me how research feeds into everyday decisions. It made clear why staying engaged in research matters. It shortens the gap between discovery and patient benefit and helps clinicians judge new technologies before adopting them. Seeing clinicians discuss cutting-edge research alongside their patient cases emphasised that academic inquiry directly shapes clinical options and that engaging with research can improve bedside practice. This is why I intend to pursue opportunities that combine clinical work with research; to contribute to evidence generation and ensure my clinical decisions are informed by current data.

Cultural and systemic learning

Comparing healthcare systems was one of my original aims. Both the UK's National Health Service and Australia's Medicare aim for universal coverage, but they operate differently. Australia's hybrid system provides universal care through Medicare while many people purchase private insurance for quicker access and specialist choice. In practice I met patients whose private coverage allowed faster scheduling of elective surgery. Recent national reports show that public patients wait significantly longer for cataract surgery compared with privately insured patients. (3)

Witnessing this contrast made me think concretely about equity. I considered how waiting times influence quality of life and surgical outcomes, and how resource allocation decisions translate into real patient differences. These observations challenged me to consider how

equity and efficiency are balanced in different systems and how clinicians can advocate for patients within those systems. These system-level differences reinforced an important lesson for me. Clinical skill and health policy awareness go hand in hand. Doctors who understand system constraints are better able to push for changes that improve access and outcomes.

Personal and professional growth

Spending six weeks in a different healthcare environment broadened my perspective and developed my confidence. I learned to adapt to new settings, navigate unfamiliar systems, and communicate with professionals from different training backgrounds. There were moments of vulnerability such as misunderstanding terminology or hesitating with unfamiliar equipment, but these became key moments of growth.

I was particularly inspired by the teaching culture at Westmead. The team's openness and mentorship encouraged me to ask questions and think critically. They went beyond surface explanations and shared their reasoning. This gave me not just knowledge, but real insight, and it inspired me to teach in the future. Practically, the placement produced two concrete commitments for my future practice: (1) prioritise structured, explanatory teaching when supervising others; and (2) seek roles that combine procedural practice with clinical reasoning and research. These experiences also highlighted changes I want to make in my own practice. I aim to prioritise clear, explanatory teaching when supervising others. I also want to seek roles that combine procedures with diagnostic reasoning. These outcomes are consistent with evidence that overseas clinical experiences foster substantial personal and professional growth. (2)

Conclusion

This elective confirmed ophthalmology as the specialty that I wish to pursue. It clarified the value in clinical practice: precision, analytical reasoning, and ongoing scholarly engagement. Revealing how system-level factors influence care delivery and why reflective teaching practices are vital to effective training. I learnt that research was particularly important as it connected innovation to patient outcomes, enabling clinicians to critically appraise new technologies before adoption. In the future, I hope to contribute to this process by combining clinical practice with research to improve diagnostic accuracy and equity of access in ophthalmology.

For students considering a similar elective, I suggest three practical steps. Choose placements with supervised, hands-on experience. Look for teams who explain the thinking behind management decisions. Finally, reflect on how system structures shape patient outcomes. These experiences not only clarify career direction but also strengthen transferable competencies that extend beyond ophthalmology.

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