

# Rosa Braga-Mele, MD

Dr. Braga-Mele explains how her experiences as a clinician and teacher make her a better surgeon.



**One of your major research interests is improving the techniques for cataract surgery. How do you overcome the challenge of small eyes?**

When I operate on small eyes that have shallow anterior chambers, I concentrate on giving myself more room in which to work, usually by injecting a viscoadaptive viscoelastic into the eye. If I still feel like I need more room to create a main incision or capsulorhexis, I will likely perform a posterior vitrectomy to remove some vitreous from the patient's eye. I usually enter the posterior segment 3.5 to 4.0mm behind the limbus and will point the vitrector toward the optic nerve with visualization. I want to avoid the posterior capsule at all costs. The anterior chamber will deepen as vitreous is removed. I can create even more space by injecting additional viscoelastic, after which I can proceed as I would in a normal eye.

**In 2002, you published a report examining gender equity in academic medicine. Do you think academic ophthalmology has since become less of a "boy's club"?**

I have noticed a shift toward more equity in academic medicine, in part because men are more involved with their families than in the past and they are beginning to understand the boundaries and roles that women face. Personally, I have received tremendous support from my male colleagues. Although more women are entering surgical subspecialties, I think this area of ophthalmology, which requires a greater time commitment than general medical specialties, still suffers from inequity. The situation has evolved greatly, however. If the glass ceiling is not disappearing, it is at least getting a little higher as men become more accepting and more active promoters of women in academic

medicine. I may revisit the topic in about 5 years to see how much progress has been made.

**In 2003, you were chosen by the residents graduating from the University of Toronto to receive the Silver Needle Award, which is traditionally given to the best surgical teacher. What do you like best about teaching residents?** Teaching is a privilege and, at times, a punishment. My job is wonderful because it forces me to keep up with the state-of-the-art developments in cataract surgery, but it also can be hard on my coronary arteries.

I do a lot of wet labs with my residents, which gives them a chance to become familiar with the phaco technology and learn the nuances of different surgical techniques.

It is important to me that the residents not only know how to make a capsulorexis and remove a nucleus, but that they also understand the physics behind these procedures. The residents start by operating on cadaveric eyes, and eventually they progress to treating live human eyes in the OR.

Teaching residents to perform cataract surgery is a great responsibility and requires a lot of patience, but I would never give it up. I feel like I am helping patients by teaching my residents to be better doctors. Every day is not easy, but it is always rewarding.

**Besides surgical proficiency, what other skills do you think are important for residents to learn?**

As the Director of Communications and Collaborations for the Department of Ophthalmology at the University of Toronto, I teach a course on building communication skills. We emphasize using nonmedical terms when talking to patients, using sensitivity and empathy when breaking bad news, and interacting with support staff and other medical colleagues effectively.

**What is the current focus of your research?** I am investigating patients' satisfaction with and the side effects of currently available multifocal and accommodating IOLs. My other area of interest is optimizing the parameters of microincisional cataract surgery as well as developing IOLs that can be inserted through smaller incisions. I think the technology of IOLs is the future of ophthalmology, and I want to learn as much about it as I can. ■