PASSING THE TORCH

As I conclude my tenure as chief medical editor, I am grateful for how rewarding this role has been and how much I have learned from the giants in whose footsteps I followed—mentors such as John F. Doane, MD; Eric D. Donnenfeld, MD; Steven J. Dell, MD; Stephen G. Slade, MD, FACS; and David F. Chang, MD. My work on *CRST* has sharpened my thinking and deepened my appreciation for the generosity of our community. The time has come for me to pass the torch to two dear friends and remarkably talented colleagues in whom I have full confidence, George O. Waring IV, MD, and Kendall Donaldson, MD.

In the spirit of transition, I want to address what I see as one of the greatest challenges—and opportunities—in cataract and refractive surgery today: training. Patient expectations have risen, technologies have multiplied, and the skill set required to deliver consistent refractive outcomes now extends well beyond what most residents can reasonably master during residency alone.

I have watched my own mentors Vance Thompson, MD; Richard L. Lindstrom, MD; Dr. Donnenfeld; and Dr. Slade, build apprenticeship-style training in their private practices during the LASIK boom and beyond. About a decade ago, William F. Wiley, MD, and I decided it was time to formalize that experience. We launched a fellowship in cataract, refractive, and anterior segment surgery to meet the trajectory of rapid innovation, evolving patient expectations, and an increasingly complex decision tree. Although this pathway has largely flown under the radar, momentum is building. More residents now recognize an alternative to traditional cornea or glaucoma fellowships for advanced refractive and cataract expertise.

Recently, Bill and I also started an organization to validate and broaden residents' exposure to this subspecialty, creating a mechanism for them to discover programs—both academic and private—that deliver the full spectrum of modern cataract and refractive surgery. The goal is simple: bridge the gap between where we train and where we ultimately practice. The response has been telling. Interest among residents has far exceeded the number of true cataract refractive fellowship positions; perhaps only 20 to 30 offer the comprehensive experience I am describing. Meanwhile, some academic colleagues have expressed resistance, which, to me, indicates that we are pressing on a meaningful pressure point in the system.

I urge you to consider starting a fellowship in your practice. It essentially consists of bringing on a junior associate for a defined year and committing to teach that person everything you can—surgical judgment, diagnostics, patient communication, the business side, and the "why" behind the "what." Give a young surgeon the scaffolding to make good decisions and let them learn from your mistakes without having to repeat all of them. This is better for patients. Cataract and refractive surgery can appear straightforward, but complexity emerges with target setting, lifestyle goals, ocular surface optimization, biometry nuances, IOL selection, and contingency planning for when outcomes miss. Mastery today means being comfortable across the spectrum from LASIK and PRK to keratorefractive lenticule extraction and from limbal relaxing incisions and toric IOL alignment to the use of multifocal and adjustable lenses. No one acquires that breadth of experience in residency alone, and few can assemble it without intentional mentorship.

There are practical benefits to fellowship training as well. A fellow can take on day-to-day tasks such as seeing postoperative patients, helping with weekend care or call, and assisting with IOL selection and surgical planning, freeing the senior surgeon to focus where it will have a greater impact and increasing the practice's bandwidth. It is a win-win-win for the fellow, the practice, and the patients.

We ophthalmologists must invest in training models that match the complexity of modern refractive cataract care and build them where we work. I am confident that, together, we can create the fellowships that will elevate the next generation of surgeons so that they enter practice not just ready to operate but also ready to deliver refractive outcomes with consistency, good judgment, and heart. *CRST* has always stood for state-of-the-art thinking in cataract and refractive surgery, and I am proud to leave this publication in the hands of Dr. Donaldson, Dr. Waring, and Chief Medical Editor Cathleen M. McCabe, MD. ■

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