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Residency is the time when young surgeons learn to operate. We start with the basics and progressively gain skills as we practice our future trade. We learn to “open and close,” we become experts at holding the sucker, we learn to sew in drains, and we learn to cut sutures and tie knots. At some point in our training, someone hands us the lauer and time stops. The lauer can go by many names — the right angle, negus forceps, etc. It is the key instrument used to guide the surgical assistant and is held by the primary surgeon. When the lauer is passed to you, the moment has finally come. You have been entrusted with this exceedingly important tool; to guide the person on the other side of the table to cauterize here or cauterize there. Trumpets sound. Doves are released. Euphoria ensues. All of which comes to a crashing halt when you hear, “What... are you doing?” from your beloved staff.

Happy Lauer Syndrome (HLS) is a condition in which the learner is given the primary surgical instrument and becomes so overcome with feelings of happiness that said learner is unable to proceed with the case. Sometimes he/she will stare at the lauer mutely, not knowing what to do next. Other times he/she may slow the progression of the case by nervously repeating a move the staff has just done, or make seemingly random moves that are not in keeping with the next logical step, which then must be safely corrected. This results in staff surgeon frustration and the inevitable “taking away of the lauer.” HLS was inadvertently coined by Dr. Robert Nam during the partial nephrectomy incident of 2018, where he suggested a resident (who shall remain nameless) may have this terrible condition. We now look to further explore this seemingly widespread malady.

Any surgical resident can develop this condition, but those at highest risk include the junior population (PGY1–3), senior residents with exposure to a new surgical procedure, learners with an unfounded high degree of confidence, or those in training programs where the resident does not reach the operating room (OR) until a late stage. HLS is very difficult to avoid altogether; the best one can hope for is to suffer a quick bout and move on unscarred. Those with lingering HLS are doomed to suffer the most. This is explored further in our proposed grading system (Table 1).

Table 1. HLS grading system

Low-grade	1–5 acute episodes of HLS, with no lasting side effects (i.e., the staff quickly forgets the resident’s happy lauer use)
Intermediate-grade	>5 episodes of HLS, or 1 lasting side effect (side effects may include ongoing staff recall about a previous particular lauer move, sadness from the knowledge that you are not performing well in the OR, muscle cramps from lauer death grip, etc.)
End-stage	This resident has unresolved HLS despite multiple attempts at correction. An unfortunate and serious condition with no known cure. It has been associated with “Staffman Syndrome”

With good staff mentorship, HLS can quickly dissipate, similar to an allergic reaction. Once the excitement is removed with repetitive exposure to the lauer, the learner will naturally become more thoughtful and show more controlled motions. You know you have been cured of HLS when you ask for the lauer yourself in a calm and controlled voice, and proceed to use the tool with precision and care. You may receive such

uplifting compliments as, “mm-hmm,” or “keep going,” or even “excellent!” At this point, the resident can rest assured he/she has made a full recovery.

A high rate of HLS seen in a surgical training program may indicate that the time has come to re-evaluate resident teaching. A combination of earlier exposure to the OR, increased guidance and communication from the primary surgeon, simulation models, and of course, preparation from the residents themselves, can facilitate a better and safer operating experience. Surgical teaching at a reasonable pace and volume (whenever possible) is needed. One promising move towards a cure is the introduction of Competency-By-Design (CBD). The CBD model for surgical training focuses on increased direct observation with assessments and more direct feedback. This allows for early identification of weaknesses and guidance for improvements of core competencies. In these times of highly prevalent HLS, we can look to such advancements in urological surgery education as a beacon of light.

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