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American Academy of Ophthalmology
The Eye M.D. Association

Academy Seniors
To Honor, Serve and Represent Senior Ophthalmologists of the American Academy of Ophthalmology

SCOPE

The newsletter of the Academy Seniors

MENTORING: OUR LEGACY AND OUR REWARD

By Peter J. McDonnell, MD

In a previous university, I worked under a brilliant academician and scientist. "There are two kinds of senior academicians" he once told me. "One kind says 'look how great I was –when I retired, everything just kind of fell apart in my department.' The other kind says 'look at what a great job I did–when I retired, the group of junior people I left in place kept everything working great, if not better.'"

In many ways, we academic ophthalmologists are not so different from our counterparts in the world of business or private medical practice. Some senior partners seem to be constantly adding stellar young people to their groups, mentoring them and having them quickly develop into successful partners who are widely admired in their communities. The senior partner is perceived as a "first among equals" and his/her practice acquires the reputation for across-the-board excellence because the group has no "weak links." Other senior partners in other practices hire a succession of junior people who are not perceived as particularly well-trained. They stay with the practice for a while and then move on, without achieving a great deal of success. Or they stay for quite a while because they have no other options; sometimes people whisper that they were hired to make the senior person "look good by comparison," the way American presidents often seem to select their vice presidents. When the senior founding partner slows down or stops practicing, the practice fades away, as there was no group of dynamic junior ophthalmologists that had been recruited and mentored to keep the practice strong and growing.

In academics, it seems to me, things are pretty much the same.

> "Hire people who are better than you are, then leave them to get on with it. Look for people who will aim for the remarkable, who will not settle for the routine."
> *–David Ogilvy—Scottish born British military intelligence officer and later top advertising executive (1911–1999)*

Some senior faculty in an ophthalmology department delight in the recruitment of talented young assistant professors, who they carefully guide in ways that maximize the odds of success and minimize those of failure. Choosing a young colleague, like selecting a spouse, is risky, and no senior faculty mentor bats a thousand. But clearly there are examples in most, if not all departments of professors who have the ability to consistently identify and nurture talent, resulting in a list of trainees who have gone on to achieve recognition in their field.

But people are people, and there also exist examples of senior professors who never seem to have a younger colleague in their area that might be perceived, in one way or another, as superior or even comparable to the white-haired maven. This is the subset that, rather than delighting in the success of young people, fears junior colleagues who might be so successful as to threaten their self-perception as the ultimate authority. When this category of professor retires, the department typically has to rebuild from scratch by recruiting a successful replacement because there was no one in place and prepared to assume the leadership role.

Needless to say, as is probably the case with most department chairs I prefer the senior academic ophthalmologists who can proactively identify, nurture and retain talent. Those are, by and large, the people who lead large groups, have many exciting things going on in their areas, and attract the brightest residents into their fields of subspecialty. I feel sorry for the other group.

In my opinion, our current crop of senior *(Continued on page 2)*

Mentoring

(Continued from page 1)

ophthalmologists in this country (both within academics and in private practice) has a great deal to be proud of in this regard. By any measure, the current readers of *Scope*, this publication aimed at this cadre of senior ophthalmologists, have been remarkably successful stewards of ophthalmology. The changes that have been ushered in during their watch is impressive: greater efficiency, dramatically safer and better small incision cataract surgery, intraocular lenses, keratorefractive surgery, successful therapies for diabetic retinopathy and other retinal diseases – to name but a few. There is no question but that, by any measure, today's senior ophthalmologists have enhanced their field. They should feel proud.

The quality of medical students seeking ophthalmology residencies today never ceases to amaze me. It would be the understatement of the century to say that American medical students are not dumb, and their interactions with ophthalmologists, both full-time academics and those in private practice, convince our students that this is a fraternity (or sorority as the case may be) they should join. In short, they are impressed with and choose to emulate their ophthalmology teachers, many of whom are in the senior category.

The knowledge explosion in the last two decades or so has been remarkable. It can be a challenge, no doubt, to keep up with the explosion of knowledge in general, let alone in medicine. The immediate past president of my university, himself a physician, apologized to the graduating university class a few years ago, saying that half of what they had been taught during their four years was wrong. In medicine, I am told that the expansion of knowledge is so great that "facts" become "falsehoods" at an even greater rate. My medical school eschews the use of textbooks as teaching platforms, because so much of the content is demonstrably inaccurate or embarrassingly incomplete within a few short years of publication. When I tell my residents that my early days of training involved my admitting patients to the hospital for a few days so they could have cataract surgery, I am sure they must think dementia is setting in. As a resident, my former chairman declared that it would be "over his dead body" before he would risk a patient's vision by performing outpatient cataract surgery. Eventually he was willing and able to change when forced to by insurers, and when I finished my residency he was performing only outpatient surgery.

> "I've been blessed to find people who are smarter than I am, and they help me to execute the vision I have."
> *–Russell Simmons—Goals, employee.*

In academics, when we are surrounded by brilliant young medical students, fellows and junior faculty constantly challenging how we do things and adding new knowledge, it is a constant challenge to keep up. Fortunately, ophthalmologists love to learn and innovate. My belief is that this explains why ophthalmology, in general, is one of the specialties that rapidly embraces new technology and new therapeutic approaches. There is no opportunity to relax, as the young will quickly be able to tell when the professor is "blowing smoke." But my experience has been that senior ophthalmologists are like sponges, seemingly constantly on the prowl for better mousetraps. Many of my faculty tell me that it is the regular interaction with our trainees and their many questions and challenges of convention that makes their work fun and "keeps them young and in the game."

> "If we weren't still hiring great people and pushing ahead at full speed, it would be easy to be a mediocre company."
> *–Bill Gates—American entrepreneur and founder of Microsoft Co., b. 1955.*

In academic departments there is clearly a role for faculty who enjoy teaching, even when they no longer have the ability or stamina to see many patients or do a lot of surgery. For example, in my department our Grand Rounds is enhanced by the regular presence of a faculty member who has been in the department for over 50 years. When you consider how our approaches to ocular disease have dramatically evolved over the last few decades, you can readily imagine how interesting the insights and historical vignettes shared by this senior colleague must be. He is a treasure trove of information.

We have never in our history had better training in ophthalmology than we do now. Senior academicians find it a joy to work with the young medical students and residents, and have a great deal to offer, even when (or sometimes in part because) they are not seeing as many patients or doing as much surgery.

The presence of senior ophthalmologists enhances the educational environment of academic departments, and senior academic ophthalmologists can probably remain active on average much longer than their private practice colleagues who are expected to remain clinically highly-productive until they retire.

FROM THE EDITOR'S DESK

Give Up the Car Keys?

Ideally, I'd be an idealist, but reality keeps getting in the way. As we grow older and assume new responsibilities certain compromises must be made and dreams may have to be deferred or abandoned.

At the Low Vision Rehabilitation Center of the Yale School of Medicine Department of Ophthalmology and Visual Science where I practice, patients have four chief concerns: they want to be independent in their own homes, they want to manage their own finances, they want to be able to read comfortably, and they want to drive. For many, driving is the most important aspect of independence. Many patients are aware of their visual impairment and voluntarily give up driving, but too often I hear, "I just want to be able to drive to church, to the store, and to the bank." Many have already voluntarily stopped driving at night, in the rain, and in unfamiliar territory, but too often their solution to the problem is inadequate. Department of Motor Vehicle regulations vary from state to state. In Connecticut an unlimited driving license requires 20/40 vision, best corrected, in one eye and limited concentric field loss in that eye. Some states allow people to drive with 20/200 vision or with telescopic lenses.

In low vision rehabilitation it is often reasonable to improve independent living with aids and devices, to encourage use of large print checks or enhanced electronic devices to help with financial independence, and to greatly improve reading and computer capabilities with magnification, but it is difficult to improve on best corrected distance acuity without resorting to telescopic means which result in limited peripheral awareness. It is difficult to advise cessation of driving, particularly when the patient has no ready access to a driver or local transportation. In Connecticut we have no legal right to report a person with impaired vision directly to the Motor Vehicle Department. If they are "legally blind" we must report them to the Board of Education and Services for the Blind (BESB) which then can report to Motor Vehicles. When concerned families are in evidence they are usually appreciative of our advice and help their loved one to give up the car keys.

Personally, I believe that an otherwise healthy individual with 20/70 can manage limited driving in day time hours, but if they are involved in an accident, even if it's not their fault, and they're over 65, the media appends the adjective "elderly" to their account.

It is a tough decision for a patient to give up driving. Studies have shown that when seniors stop driving they are at higher risk for depression and decreased interest in socializing and leaving the house. Richard Marattoli, MD, a geriatrician with the Adler Geriatric Assessment Center, has been studying the problem of "giving up the car keys" for many years. His concerns and studies go far beyond vision, and embrace physiological and cognitive changes as well as ways to help seniors remain on the road safely. Recently he stated, "The majority of senior drivers are quite safe. What we hear about most often, however, is the minority who have problems." He believes that cognitive impairment and severe physiological problems, both motor and vascular, are probably of greater concern than moderate visual impairment.

At this fall's Annual Meeting in Orlando, the Academy's Committee on Aging, the Academy Seniors Committee and the Ethics Committee will co-sponsor a symposium, *"Safety behind the wheel—Should Miss Daisy be driving?"* This should be most interesting and I urge your attendance.

PAST PERFORMANCES

Editor's note

Since 1987, the Academy's Museum of Vision has been building the only known oral history collection focusing solely on our profession. In 2009 the Academy Seniors Committee in collaboration with the Academy Archives Committee, under the direction of Jenny Benjamin of the Museum of Vision, undertook the regular recording of the oral histories (The Oral History Project) of Academy members who have been prominent in the development of various aspects of ophthalmology over the years. SCOPE will reproduce interesting "snatches" of some of the comments of these members in successive issues. Usually two ophthalmologists talk together about aspects of our profession in which they have had similar interests. The recording sessions take about one hour each. The recordings are transcribed to allow an oral and written record of these conversations.

"When I was developing my medical career, it was a different era. I told my Chairman of Medicine at Beth Israel that I was going into ophthalmology. I figured he would go epileptic… and he said, 'Al, this is really good because ophthalmology needs some people who aren't interested specifically in surgery.' When he saw me about two weeks later on morning rounds he said, 'So, what have you done about ophthalmology?' Well, I actually hadn't done anything. It was still an idea that was percolating in my brain, so I said, 'Well, I haven't done anything quite yet.' Three days later I had a note in my mailbox from Howard Hyatt, and it said, 'I've just had a conference call with David Cogan and Ed Maumenee at Wilmer and we've decided that you will do your residency at Wilmer.' That doesn't happen anymore, but these were terrific people, they were supportive, and they told me what I was going to do with my life, and that's what I did."

Alfred Sommer, MD, MHS; Oral History Project, October15, 2010

"I had a six-week elective in my senior year in medical school and I signed up for ophthalmology. I had already accepted a position as a path resident. But it was love at first sight; I just fell in love with the eye. I thought that looking at the fundus was just one of the more exquisite things I had ever seen. And I guess that (Harold) Shea appreciated the chemistry that was going on, and at the end of the six weeks he called me into his office and he said, 'You know you should really retain your interest in pathology, but do it through ophthalmology. We have wonderful models with tumors, and you can do everything you want in pathology, but you can combine it with your love of the eye.' And then he called in his secretary, Miss Bueber, and said, 'Dan's going to dictate an acceptance to the residency program. Type it up and have him sign it.' And when I went home that day and when my wife and I sat down to dinner, I said, 'I have something to tell you.' I had left that morning headed for pathology, and now I said, 'No, we have to make a detour, I accepted an ophthalmology residency.'"

Daniel Albert, MD; Oral History Project, October 15, 2010

"My father was a prominent plastic surgeon so my interest was in plastic surgery from childhood. I began looking at things that were near the surface of the body because burns and cosmetic disfigurement are often skin or soft tissue problems. So I wrote (my first) paper as a first-year medical student. And then, with my father, I wrote another paper discussing the cartilage of the nose because I thought rhinoplasty would be a great career. I remember going to Atlantic City, New Jersey to deliver this paper at a meeting of The American Association of Plastic and Reconstructive Surgery. I arrived, feeling very important. I got into a taxicab and casually said, 'What's happening here?' The driver said, 'Not much. Just a bunch of plasterers in town.' True story. With that I fell right back down to earth."

"I went to medical school at Yale, and was in my senior year (feeling) torn between ophthalmology and plastic surgery, uncertain about which field I would like to go into after I graduated from medical school. My father offered to arrange for me to spend one day with the Chairman of Ophthalmology at Harvard and one day with the Chairman of Plastic Surgery at Harvard. Dr. Edwin Dunfey and Dr. Kazanjian, Professor of Plastic Surgery, respectively. And that's exactly what I did. After those two one-day experiences at the nearby city of Boston and the Harvard medical system, I concluded that there were greater opportunities for investigation and research and intellectual excitement in ophthalmology. My training became my pathway indirectly to the Academy, because as an ophthalmologist I (was able) to develop a wonderful relationship with Dr. Algernon Reese, who was President of the American Academy of Ophthalmology and Otolaryngology. He became one of my really critical mentors. I had a fellowship with him after medical school before going into the military service and worked with him when I returned to Columbia University as an ophthalmology resident. Dr. Reese became a very fine role model, friend and mentor to me for a number of years."

Bradley Straatsma, MD; Oral History Project, October 25, 2009

UV LIGHT AND BACTERIA

W. Banks Anderson, Jr., MD

Pathogenic operating room bacteria have been a concern since Lister. Ultraviolet light will kill bacterial cells. Deryl Hart, MD, the first chair of the Duke Department of Surgery, was interested in this effect. In 1936 he directed that ultraviolet emitting light fixtures should be installed in the Duke University Hospital operating rooms. Accordingly high up around the walls of the OR suites long purple tubes about the size of fluorescents were installed. He was able to demonstrate lower postoperative infection rates when cases were done in the rooms with these UV lights. I was first exposed to them in 1956 after arriving at Duke for a surgical internship. In addition to the customary OR surgical attire, staff in the Duke ORs wore visors and/or clear plastic glasses with side shields that were opaque to most of the UV radiation. Such eye protection would not look out of place in any of today's ORs where staff protect their eyes from HIV with such shields. In those days however there was considerable grumbling about the required visors. The ultraviolet lights remained on between cases while the orderlies scrubbed the floors with their mops. Those multiuse OR mops being an excellent bacterial disseminator, there probably was real benefit in reducing postoperative infections although at the time this was disputed. For example one study using air sampling noted that once the humidity exceeded 60%, there was a large decrease in the bacteriocidal effectiveness of the UV lights.

Snow blindness is the term usually applied to the keratitis resulting from high levels of ocular ultraviolet exposure. Characteristically the tearing and pain have a latency of several hours after the peak exposure and those affected become blind because they have difficulty opening their eyes. When they do manage to open them in spite of the pain, their copious tearing interferes with their sight. Time is the only effective cure and the use of topical anesthetics to reduce the associated pain has resulted in permanent loss of sight from corneal ulceration, infection, and scarring. The corneal epithelium recovers rapidly and within six hours or so, depending upon exposure, normality usually returns.

When I returned to Duke in 1959 as an ophthalmology resident, one of my duties was to handle the middle of the night calls and emergency visits from OR staff that had neglected their eye protection for one reason or another. Even with visors, the reflection from the large shiny retractors holding up the liver during abdominal surgery could circumvent the protection that they afforded. Usually one bout of snow blindness made believers out of those affected. For such surgeries they learned to wear the protective spectacles in addition to their visors. But the pain involved in this learning experience only increased the general level of surgical staff rumbling and whining associated with the use of ultraviolet. One of the common rationalizations was that the lights were useless because any sort of liquid film would be protective to pathogenic bacteria. Such statements were pompously delivered as fact even by those who had experienced the painful penetration of their corneal tear films by those "ineffective" ultraviolet lights. Dr. Hart's successor had most of the lights removed and I never learned if any increase in postoperative infections occurred or whether comparative data were collected or analyzed.

I keep some lovely Koi carp in my back yard pool. Green water interferes with admiring them.

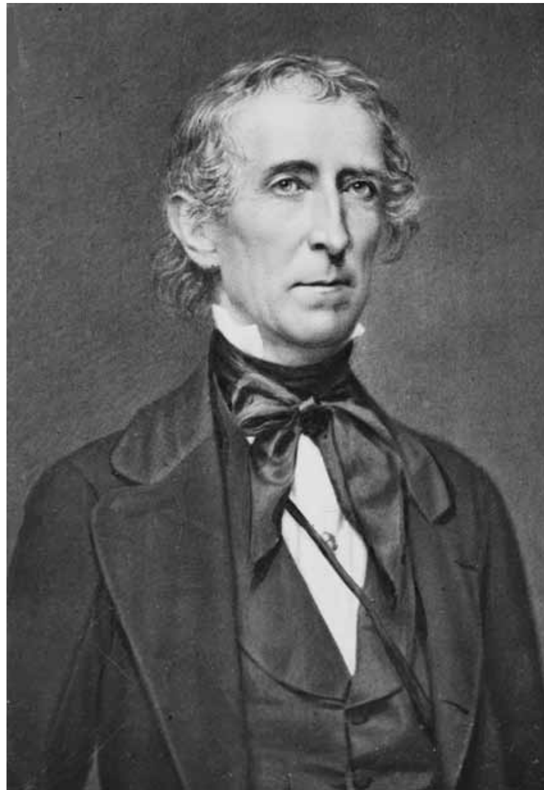
Algal cells are small enough to pass most filters but they can be cleared out by pumping the pond water through tubes containing ultraviolet lights. In spite of the water, most algal cells die an ultraviolet death. As I turn on my pool pump, I often wonder if patients have died because of the lack of those ultraviolet OR lights. Since all surgical staff now wear eye protection without grumbling, perhaps the time has come to do a randomized prospective study to find out. Deryl Hart would be pleased.

ARE YOU SERIOUS? JOHN TYLER'S GRANDSON IS STILL ALIVE?

William Tasman, MD

John Tyler, the 10th President of the United States, served from 1841 to 1845. He was Vice President when President William Henry Harrison died of pneumonia just 32 days after his inauguration. Both men were born in Virginia. Harrison had studied medicine at the University of Pennsylvania, but when his father died, he no longer had money for tuition. Governor Henry Lee of Virginia, who knew the family, suggested that he join the army, and there Harrison soon rose to the rank of general. He gained fame at the Battle of Tippecanoe in Ohio against the Tecumseh and the Shawnees and in the War of 1812 at the Battle of the Thames near London, Ontario, during the invasion of Canada.

In 1840, when Harrison became the Whig candidate for President, John Tyler was his running mate. Together they ran under the slogan "Tippecanoe and Tyler Too." Harrison served the shortest term of any President, and upon his death, Tyler assumed the Presidency, the first to gain the position after the death of his predecessor.



John Tyler

Letitia Tyler

Tyler secured his place in history by having more children than any other President: 15 in all with two wives. His first wife, Letitia Christian Tyler gave birth to eight, but she died in the White House in 1842. Tyler's second wife, Julia Gardiner, was only 24 when she became First Lady in 1844. Ealier that year she had joined Tyler on a cruise on the Potomac aboard the USS Princeton, which had been built at the Philadelphia Naval Yard. Several dignitaries were on board, including Julia's father, Representative David Gardiner of New York, Secretary of the Navy Thomas Gilmer, Secretary of State Abel Upshur, and Representative Virgil Maxey of Maryland. A ceremonial firing of the two main deck guns, the "Oregon" (originally called the "Orator") and the "Peacemaker," led to tragedy when the "Peacemaker" blew up killing the four men.

Julia, who was below deck, fainted into the President's arms upon hearing of her father's death. Romance blossomed, and the two were married on June 26, 1844. The bride's sister, Margaret, and brother, Alexander, were bridesmaid and best man. John Tyler III, was the only Tyler family member at the wedding. Tyler was concerned about secrecy and had not told his other children about the nuptials. The Tyler daughters were surprised and hurt. After all, the bride was 30 years younger than the groom; she was 24 and he was 54. The eldest daughter, Mary, had to adjust to a stepmother five years younger than

Julia Tyler

herself. Julia and the President had seven children together.

Tyler's 13th child, Lyon Gardiner Tyler, was born when Tyler was 63, and the 15th child was born when he was 70. Not to be outdone by dear old dad, Lyon had his last child at the age of 75 in 1929. That child, Harrison Tyler, a chemical engineer graduate of Virginia Polytechnic Institute, is now 81 years old and appears to be in good health. It has been my good fortune to meet and speak with him on two occasions. The first was in 1994 at the Retina Society meeting in Williamsburg, Virginia, where the Tyler ancestral home, Sherwood Forrest, is located and where Harrison lives today. The second time was in Washington, DC, at a meeting of the Colonial Dames of America, of which my

Harrison Tyler

wife is a member. Harrison was the guest of honor and spoke at length about Pocahontas, the daughter of Chief Powhatan. The story of her rescuing John Smith from execution by Indians has often been told. It is questionable whether there was a romance between the two, but in the end she married a tobacco planter, John Rolfe. They traveled to England, but on the return trip while still on the River Thames, Pocahontas became ill and died ashore at Gravesend where a life-size bronze statue honors her memory.

So, President John Tyler's grandson is alive. In fact, there has been a member of the Tyler family alive over the span of all U.S. Presidents, from number 1 through number 44.

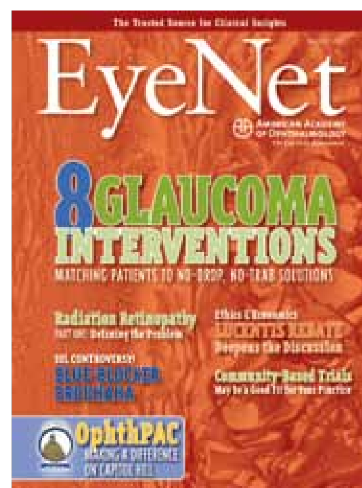
USE IT WHILE IT STILL WORKS

W. Banks Anderson, Jr., MD

Use this new treatment early while it still works. All of us in medicine know how pervasive magical thinking is in medicine but few of us realize how powerfully it can influence even randomized "controlled" scientific investigations. Richard Mills' opinion piece in our Academy companion publication, *EyeNet*, was the stimulus for this article. He references Bob Shaffer's "use it now" dictum and "Scott's Parabola" which graphs the rise and fall in the popularity of surgical procedures. In glaucoma where a new variant filtering procedure seems to find a place in every month's journal, this graph is perhaps particularly apt.

Some other examples recently in the news include the failure of axillary node dissection to prevent breast cancer recurrence as effectively now as it seemed to do in the earlier studies and the recent loss of the incremental benefit of second generation antipsychotic drugs as compared with the less expensive earlier ones. Some antidepressant medications also seem to be losing their effectiveness. In ophthalmology using the latest "dry eye" drop early on is certainly critical as we all know it will not be long before the new one will join the hundreds, if not thousands, of other such preparations that have been reformulated or withdrawn from the market.

Also in the March *EyeNet* was a summary of an article appearing in the *Archives of Ophthalmology* detailing the effectiveness of acupuncture in the treatment of amblyopic Chinese children. A Canadian, Richard Palmer, looked at published reports on acupuncture treatments between 1966 and 1995. All 47 reports originating in China, Taiwan,



and Japan reported beneficial results. During the same period of the 94 reports from the US, UK, and Sweden, only 56% reported any benefit, this in spite of the "publication bias" to report only positive results. Jonah Lehrer in his article "The Truth Wears Off" in the *New Yorker Magazine* cites this study as evidence of the pervasive bias in medical publications. He addresses some of the difficulties in replicating biological data in even meticulously crafted experimental designs. Lehrer posits that bias creeps in and that the spectrum of biologic variability is so wide and so high that finding the truth is difficult. John Ioannidis is even more direct, entitling one of his publications: "Why Most Published Research Findings Are False." He states that: "for many current scientific fields, claimed research findings may often be simply accurate measures of the prevailing bias." As one example of the small probability of truth, he cites a study of 432 molecular genetic papers concerning disease risk differences between men and women of which only one report he says has been consistently replicated. A.W. Chan et al. have looked at randomized trials and detected some instances of bias by comparing trial protocols with the resulting published articles. As a result of these and similar findings there is a national effort to be more transparent concerning *(Continued on page 8)*

ORLANDO 2011

Join the Academy in Orlando for our 115th Annual Meeting. The meeting will take place at the Orange County Convention Center, October 22–25, 2011. It will be preceded by the Subspecialty Day program, October 21 and 22.

What's new in Orlando?

Since the Academy last met in Orlando in 2002, 2,400 new hotel rooms have been added within five minutes of the convention center, including a new Westin Hotel, Hilton Hotels and a massive expansion at the Peabody Hotel. There are also new world-class restaurants at Pointe Orlando, which is within 10-15 minutes walking distance or a short cab ride away along Sand Lake Road. The area has seen a huge improvement in the traffic around the convention center. The new Universal Boulevard alleviates traffic on International Drive and connects the convention center area to both the freeway and Universal Studios.

Your Annual Meeting experience will not be complete without a visit to the **Academy Seniors Club Lounge**, located in the Orange County Convention Center, **Room 208C**. Hours are: Saturday, Oct. 22, to Monday, Oct. 24, 9 a.m. to 5 p.m. and on Tuesday, Oct 25: 9 a.m. to 3 p.m. Remember, the Club Lounge is free for all Academy members over 60 and you must wear your "SO" ribbon to access the lounge. This member benefit allows you to enjoy light refreshments, internet access, meet colleagues and take a break in a quiet relaxing environment.

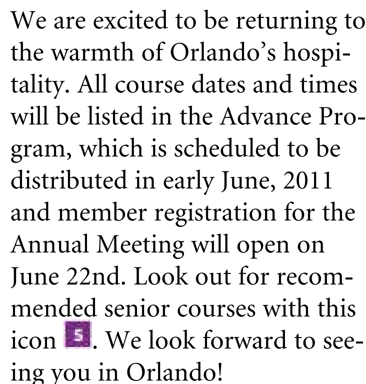
Don't miss the following Academy Seniors Events in Orlando

Two new **2011 Breakfast with the Experts** courses geared towards Academy Senior members: *"Transitions in Practice –Slowing Down and Its Implications"* and *"Stopping Surgery–When, Why and What It Means to Your Practice."*

For a second year, the symposium co-sponsored with the Committee on Aging, Academy Seniors Committee and Ethics Committee will cover a new hot topic: *"Safety behind the wheel–Should Miss Daisy be Driving?"*

Two Technology Courses instructed by Andrew P. Doan, MD, PhD: *"Selling and Purchasing on eBay, Craigslist, and other Mediums: How to Clean Your Office or Attic with Profit,"* and *"Use Blogging and Social Networking to Super Charge Your Website and Internet Marketing"* with guest presenter Randall Wong, MD.

Two speakers will be featured at this year's Academy Seniors Special Program and Reception: Geoffrey Tabin, MD will present on *"Mountain Climbing"* and Steven Schallhorn, MD will talk on *"Vision and Flying."* Following the two presentations, members of the Young Ophthalmologist Committee will recognize and honor the 2011 EnergEYES Awardee. The **EnergEYES Award** was created in 2009 to recognize and honor a senior ophthalmologist who demonstrates exemplary leadership skills by energizing others to improve ophthalmology. This individual is one who mentors young ophthalmologists, serves as a strong role model, and displays high energy that motivates others to get involved.



We are excited to be returning to the warmth of Orlando's hospitality. All course dates and times will be listed in the Advance Program, which is scheduled to be distributed in early June, 2011 and member registration for the Annual Meeting will open on June 22nd. Look out for recommended senior courses with this icon S. We look forward to seeing you in Orlando!

Use It While It Still Works

(Continued from page 7)

trials and their sponsors' control and financial relationships with investigators and institutions. Also there is now a listing of US registered trials and a report of their status available at [Clinical Trials.gov](ClinicalTrials.gov).

All of us that are trained in science know that the beliefs of today may be modified by the observations and experiments of tomorrow. Einstein amended Newton's laws. Early 1950s textbooks claimed the wrong number of human chromosomes. Seeing what we expected to see, thousands of us miscounted and discounted what we observed. In spite of such bias, better techniques in the hands of careful and competent investigators will advance the science and close in on the truth. What is conventional wisdom today may be discarded next year with repeated and careful study and this does not surprise us. It is what science is all about. So, if you are planning on taking vitamins for a healthier macula, better take them now while they are still effective.

AS I REMEMBER IT

Too Clear

G. Thomas Reavell, MD
Bellevue, Washington

Zen masters don't always look like monks; occasionally they can resemble bag ladies. Maybe it is because we are too young or perhaps too busy with "life" to see clearly, but there definitely are times when we don't recognize the wisdom in the moment. Such was the case for me, a recently discharged Vietnam-era veteran who was beginning his Ophthalmology residency in 1972 in Seattle at Harborview Medical Center, the hospital that cared for the homeless, the schizophrenics and the down-and-out souls who live on the margins of our society.

Alice was wearing all of her sweaters, all three of them, the pink one was on the top and the blue and yellow ones were buttoned to each other in an odd pattern. The remainders of her earthly belongings were safely deposited in a shopping cart which was parked in the lobby. She was not wearing her new spectacles. Instead they were tightly clutched in her fingers, fingers that protruded from her fingerless mittens. She slowly shook her head from side to side. I was in trouble.

"Too clear," she said emphatically.
–"I'm sorry," I said, hardly believing my ears, "I guess I don't understand what you mean by

too clear."
–"Too clear," she repeated. "Before the world was beautiful… but now I see gum wrappers and cigarette butts on the street." The street she referred to was her home on Pioneer Square at the end of Skid Road.
–"I see," I said,—but I really wasn't seeing at all because my eyes were rolled up to the heavens. My nurse had charted her visual acuity at 20/20+ in each eye. Slowly I put her refraction into the phoropter and gently pushed it in front of her unsmiling face. "Let's try this," I suggested, as I twirled the big wheels of the phoropter downwards, "click, click, click"

The +.75 over-correction brought a smile to her face.
–"F...Z...B...D...E," she responded approvingly, "It has a nice softness."

My senior resident had threatened to take my cross-cylinder away. He had once told me, "Tom… you can't make 20/20 glasses for 20/40 brains!" Maybe he was right. I wrote a brief explanation to the optician and Alice left happily with her new prescription—into her fuzzy world.

Arthur Schopenhauer railed against the newspapers of his time. He called them the second hand of history, and journalists he likened to yapping dogs who alert us to too much detail. What would he say about our "Information Age:" 24 hr cable news, reality TV, smart phones, the internet, Facebook and Twitter?

"Click…Click…Click" are the sounds of my electronics going off-line. The silence does have a nice 20/40 softness. Now that my hair has turned gray, nearly 40 years later, I think I might understand what Alice was trying to tell me—about cigarettes and gum-wrappers.

I see it all too clearly.

Corneal Foreign Body

Johan T. Zwaan, MD,
San Antonio, TX

I had been doing research for over a decade when I started my ophthalmology residency and had not seen a patient, let alone an eye patient, in that time. Being on first call was an anxiety-riddled experience. Part of my duties included covering the emergency room. Thus when my beeper went off, I was instructed to go to the emergency room. A patient was complaining of eye pain after something had blown into his eye. I was only too glad to accept the help of my second year backup in learning how to remove a corneal foreign body. He questioned me about the best way to tackle the problem and I suggested using a spud. He told me that I was all wrong; there was a much better way.

He then took a tuberculin syringe from the drawer. After instilling topical anesthesia and with the patient positioned in the slit-lamp, he approached the eye with the syringe delicately held between his thumb and index finger, like a dart. He then placed the needle firmly in the patient's nose!

Needless to say, the patient jumped and yelled. Immediately I had second thoughts about my colleague's capabilities. Without missing a beat he said, "Hey, I was just testing the sharpness of the needle."

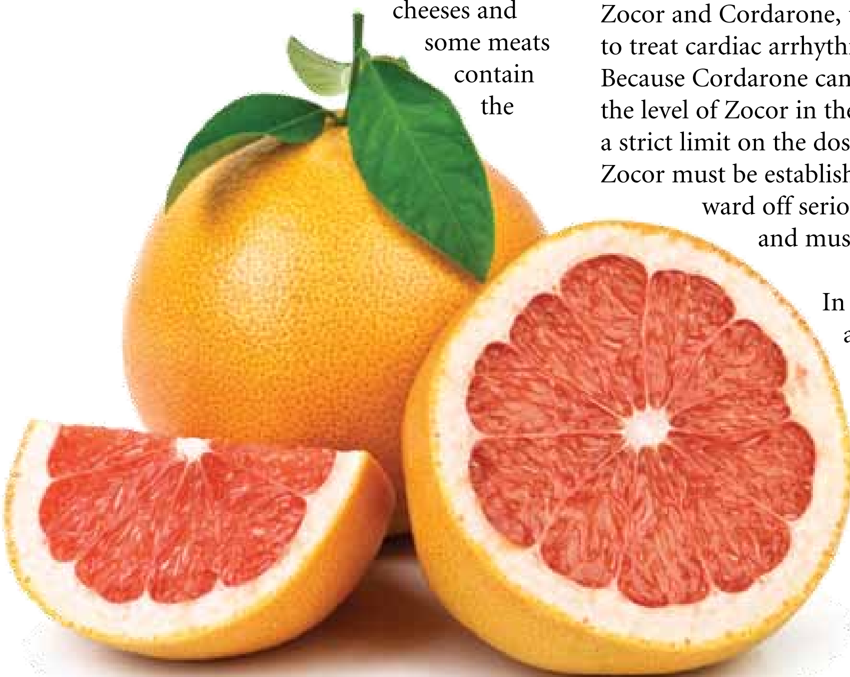
FOOD FOR THOUGHT

When foods and medications don't mix

Sometimes perfectly good medications take a bad turn at the dinner table. From milk to grapefruit, broccoli to beer, everyday foods can interact with some medications. In an ever-changing medical world new medications come to the fore along with highly advertised dietary supplements and "cure-alls." Each of them has the potential to interact with food, alcohol and other drugs.

Interactions are not always of the same sort. For example, caffeine-containing foods such as chocolate sometimes negate the effects of the drug Ritalin already being taken to reduce hyperactivity in attention deficit hyperactivity disorder by exciting hyperactivity. That same chocolate may decrease the sedative effect of the sleep medication, Ambien. Or consider the combination of milk and dairy products and anti-infection medications such as Cipro or tetracycline. Milk and dairy products significantly reduce the absorption of these drugs.

Beer, wine, avocados, certain cheeses and some meats contain the amino acid, tyramine. When taken with monoamine oxidase inhibitors they can cause dangerous hypertension, or even death. Alcohol can cause severe drowsiness when taken with antidepressants.



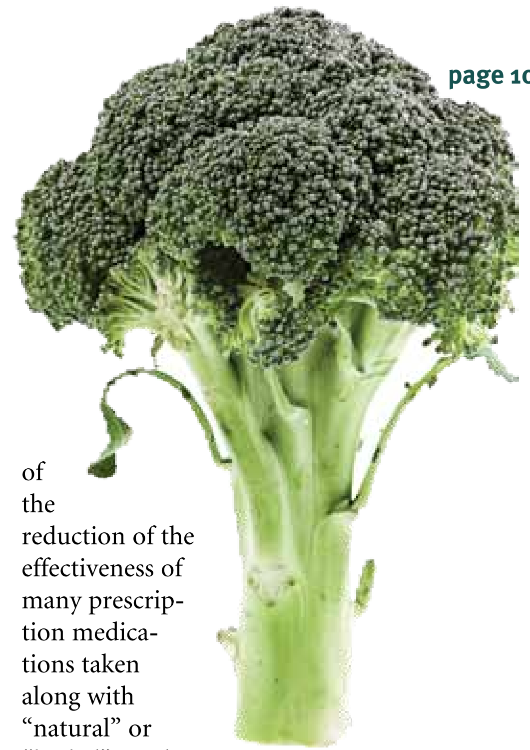
One of the most common negative interactions occurs with the anticoagulant, Coumadin, a drug taken by many with coronary artery disease and thrombotic phenomena. Eating more than the "normal" amount of Vitamin K-rich foods like spinach, kale and broccoli produces an interaction that can lower the anticoagulant effect of Coumadin.

Grapefruit and grapefruit juice can also have potential interactions with common cholesterol-lowering drugs, with calcium channel blockers, with anti-anxiety drugs, and with other drugs such as Viagra, and Allegra. The reactions differ from increasing the blood level of some drugs or decreasing the absorption of others, rendering them ineffective.

It is important that patients keep records of all drugs taken and of their potential for side effects.

Another area of concern is the effect of one drug upon another. A prime example is the relationship of cholesterol-lowering Zocor and Cordarone, used to treat cardiac arrhythmias. Because Cordarone can raise the level of Zocor in the body, a strict limit on the dosage of Zocor must be established to ward off serious cardiac and muscle injury.

In the new age of dietary supplements there are numerous examples of the reduction of the effectiveness of many prescription medications taken along with "natural" or "herbal" products. Many over-the-counter antihistamines combined with prescription sedatives have resulted in severe drowsiness and accidents.



Finally it is important to heed warnings about the manner in which medications are consumed. The Physicians' Desk Reference (PDR) has a section on "Drugs That Should Not Be Crushed." We as ophthalmologists should also be fully aware of possible systemic side effects of ophthalmic medications on bodily systems as well as the possible effects of systemic medications on the eyes.

DWP

As I Remember It

Vignettes of the days of training and early practice.

SCOPE solicits interesting and entertaining vignettes of readers' days of training and early practice. Please limit your submission to less than 500 words.

Send submissions to scope@aao.org

NEWS from the Academy Foundation

The Foundation of the American Academy of Ophthalmology
Advancing Lifelong Ophthalmic Education

A note from Janice Di Natale, Director of Development

"To see things in the seed is genius." *–Lao Tzu*

Since its founding in 1896, the Academy has thrived and remains critical to ophthalmology today because of the dedication, loyalty and spirit of volunteerism among its leadership and members.

The Academy is its members—and today it is nearly 30,000 strong not only within the United States, but in over 100 countries, including places as diverse as Argentina, Japan, the United Kingdom, Croatia, Netherlands, India, Nigeria, China, Pakistan, Jordan, and others.

Because of the involvement of members like you, the Academy helps ensure that the field of ophthalmology flourishes and that Academy members everywhere have access to state-of-the-art continuing medical education resources.

As Alice R. McPherson, MD, in the most recent Annual Report of the Academy Foundation, spoke of the honor of being an ophthalmologist when she said: "...ophthalmology is an ideal specialty…to be able to prevent blindness and help people regain their vision is a great gift of service…it is a privilege to work in this field."

Likewise, it is an honor, for those of us who work with Academy Foundation volunteers, to highlight the Academy's important and unique contributions to potential philanthropic communities. It is an honor to represent the organization that has grown to become our planet's most significant resource in continuing ophthalmic education and in helping the profession to better care for patients.

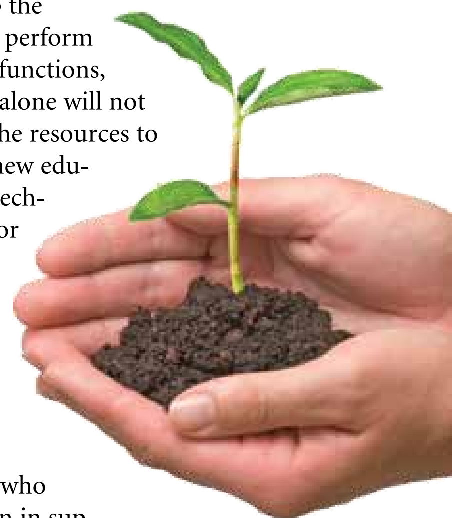
Philanthropy is more important to your Academy than at any point in its history. And, with a fragile global economy, individuals and foundations are giving less and are increasingly (and appropriately) more methodical and focused in their approach to the giving process. They seek to partner not simply with organizations with a noble cause, but with organizations that can demonstrate the capacity to have a substantive, measureable impact. Additionally, the success of any organization's development program is contingent upon the giving levels and percent of participation in giving from its leadership and from its members. Put another way, the organization must demonstrate internal support for its success before a foundation or individual philanthropist will commit to make a grant.

It is therefore the rule that external benefactors (whether individuals or those from private, family or corporate foundations) who are considering significant investments in the Academy will inquire about contributions from the membership and from those who serve on the leadership boards of the Academy and its Foundation.

You may be interested to know that the Foundation Advisory Board (under the leadership of Mr. Tony McClellan, President, and Dr. Tom Hutchinson, Chair) recently all gave substantial individual contributions to the Foundation to demonstrate this type of personal partnership. Likewise, the Academy's Board of Trustees each personally contributed to the Foundation this past year.

Imagine if each member of the Academy gave a gift this year! What a message that would send to potential external donors about the membership's appreciation for the Academy, its educational programs, its public service programs like EyeCare America, and its impact on the delivery of high quality patient care. In the fundraising world, percent participation is as important as total dollars given.

Your support is needed and will ensure that the work of the Academy continues for generations to come. Yes, membership dues help the Academy perform its many functions, but dues alone will not provide the resources to develop new educational technologies or to help reach underserved communities.



To those who have given in support of the Academy and the Foundation—a most sincere 'thank you'. And to those who have not, I hope you will consider a gift recognizing the value of the Academy in your professional life and in the future of the profession and of the patients you serve.

AN OPHTHALMOLOGIST WINDS DOWN

By J. Kemper Campbell, MD, Lincoln, Nebraska

"I've seen things you people wouldn't believe…"

–Rutger Hauer as the dying replicant in Blade Runner.

Protected by latex free gauntlets and starched green armor
I descended through the rabbit hole
Into a hidden world backlit by the orange glow
Of a full summer moon.

Machines would buzz, beep, and hum
As snatches of conversation and bits of music echoed
in the background
And invisible structures expanded enormously.
Droplets of blood became tsunamis
And imperceptible tremors became earthquakes.
I gently teased membranes more diaphanous than
Queen Mab's veil,
Careful not to unleash the quivering jelly beneath.

Time would either rapidly evaporate in the pleasant anticipation
Of certain gratitude, freely granted for the use of familiar skill
Or would stop as my raising heartbeat and rapid breathing
Heralded unexpected, but ever lurking, difficulties.

My consciousness of each moment was never purer,
My vision never clearer, my movements never more precise.
Then suddenly as the mysterious universe had appeared,
It was gone.

SCOPE
Newsletter of the Academy Seniors

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