



## 2011 ANNUAL MEETING HIGHLIGHTS FOR SENIOR OPHTHALMOLOGISTS.

### We hope to see you soon in Orlando for the 2011 Annual Meeting Oct. 22-25.

The Academy Senior Ophthalmologist Committee recommends the following meeting highlights:

#### Club Lounge

**Saturday, Oct. 22, to Tuesday, Oct. 25.** Open daily from 9 a.m. to 5 p.m. and on Tuesday 9 a.m. to 3 p.m.  
*Orange County Convention Center, Room 208c*

Lounge is free to Senior Ophthalmologists (members 60 years and over) who can receive assistance with Annual Meeting details, access computers, or just relax and enjoy light refreshments. Please note: Members must wear their "SO" Ribbon to

access the lounge. The Ribbon pick-up booth is located on Level 2, Hall A1.

#### Technology Courses

Instructed by Andrew P. Doan, MD, PhD  
**Saturday, Oct. 22**  
*Orange County Convention Center, Room W106; Tickets: \$150*

**SPE06: Selling and Purchasing on eBay, Craigslist and Other Mediums: How to Clean Your Office or Attic with Profit**  
*9 a.m. to 12 p.m.*

This course will offer an overview of how to shop, sell and make money on the Internet, as well as tips for protecting yourself from fraud and phishing schemes.

**SPE09: Use Blogging and Social Networking to Supercharge Your Website and Internet**

**Marketing** with guest presenter, Randall V. Wong, MD  
*1 to 4 p.m.*

This course provides hands-on, step-by-step instruction in how to construct your Internet blog and how to publish articles to use the power of search engines to attract people to your practice, website or business.

#### 2011 Breakfast with the Experts

*Orange County Convention Center, Hall A1*

**B603: Transitions in Practice Slowing Down and its Implications;** Moderated by W. Banks Anderson, MD, and Robert Wiggins, MD  
*Sunday, Oct. 23, 7:30 to 8:30 a.m.*

**B604: Stopping Surgery – When, Why and** *(Continued on page 2)*

## Orlando Meeting Highlights

(Continued from page 1)

### What it Means to Your Practice;

Moderated by William Tasman, MD, and Allan Jensen, MD  
Monday, Oct. 24, 7:30 to 8:30 a.m.

### NEW! “Safety Behind the Wheel – Should Miss Daisy Be Driving?” (SYM04)

Sunday, Oct. 23, 12:45 a.m. to 1:45 p.m.

Orange County Convention Center, Room W414cd

Jointly sponsored by Academy Committee on Aging, Senior Ophthalmologist Committee, Ethics Committee, American Geriatrics Society and the John A. Hartford Foundation: Section for Enhancing Geriatric Understanding and Education among Surgical and Medical Specialists.

**Summary:** As the population ages, we are challenged by the increasing number of older drivers requesting our approval to maintain their driver’s license. Is your patient competent to drive? Is this patient visually impaired? What is the effect of a field loss on the patient’s ability to drive? Is this patient cognitively impaired? What is the ophthalmologist’s role and legal obligation? How do you best break the news to the older driver that driving is no longer an option? This symposium will address the core competencies surrounding

the many complex issues related to elderly driving: medical knowledge, systems-based care, patient care, interpersonal and communications skills and professionalism.

### FREE! Senior Ophthalmologist Special Program and Reception (SPE42)

Monday, Oct. 24 from 2:30 to 4 p.m. Reception from 4 to 5 p.m.

Orange County Convention Center, Room 308abc

Presentations by: Geoffrey C. Tabin, MD “**Impossible Dreams- Everest and Eradicating World Blindness,**” Steven C. Schallhorn, MD “**NASA, Jet Pilots and LASIK.**” Following the presentation of the 2011 EnergyEYES Award, enjoy a complimentary reception and mingle with the speakers and members of the Academy Senior Ophthalmologist Committee\*.

For more information, please visit: <http://aao.org/careers/seniors/>

\*Academy Senior Ophthalmologist Committee

Harry A. Zink, MD – Chair

W. Banks Anderson, MD

Susan H. Day, MD

H. Dunbar Hoskins Jr., MD

Allan D. Jensen, MD

David W. Parke, MD

William S. Tasman, MD

Martin Wand, MD

## DEATH OF TRADITIONAL ADVERTISING & RISE OF INTERNET MARKETING

Andrew P. Doan, MD, PhD

We live in a digital era where our attention is constantly flooded with media and advertising. Businesses fight for our attention. Our brains have learned to screen out advertising. We all are limited to 24-hours per day, so most of us are highly selective about where we focus our attention.

When a patient is reading the newspaper, for example, they have learned to screen out print ads and concentrate on the news content. Similarly, households have implemented digital video recorders to skip TV commercials. Being constantly bombarded with advertising has conditioned people to mentally avoid traditional advertising in newspapers, local print ads, phone books, radio, and television. Businesses are experiencing low return on investment (ROI) with traditional advertising in the digital age. Advertising companies are seeing a major shift in advertising dollars to online social media and search engine companies.

On the other hand, Internet advertising, particularly search engine advertising, is highly effective. Patients are using the Internet. According to the 2011 U.S. Census Bureau, 42% of people 65 and older use the Internet, 78% of people 50-64 use the Internet, and 87% of the people 30-49 use the Internet. Only 63% of individuals earning \$30,000/year or less have Internet access, but 95% of individuals earning \$75,000/year or more use the Internet regularly. Within Internet users, 87% of people use a search engine to find information, 61% of people use social media, and 32% of people rate products, services, or other





people. Individuals who utilize the Internet are a highly valuable and sought after patient group. Doctors who are not creating a large footprint on the Internet will be at a great disadvantage when attracting new patients to their practice.

The success of search engine advertising is based on the principle of “just in time learning.” Patients search the Internet when they need and seek information. The search engine and the medical provider who utilizes Internet advertising strategies and analytical tools know the information patients are searching and the key words that are most popular. When searching for information on the Internet, ads are offered by the search engines related to the topic of interest in the search. Internet advertising appears similar to information links rather than traditional ads, and patients are more likely to click on the ads. Successful Internet strategies employ linking Internet ads to website landing pages providing patient education, information about the medical provider, and contact forms for patients to request an appointment. Thus, patients are more likely to notice a medical provider’s service because they are seeking information rather than screening out advertising associated with traditional print, radio, and television advertising.

Patients are using the Internet to ask questions every day. The search engine provides incredible insight into the minds of patients. Doctors can use Google tools to determine what patients are searching and how often the terms are being searched. For instance, the term “medical exam” is searched 450,000 times monthly around the world and 165,000 times monthly in the United States. The term “High cholesterol” is searched 201,000 times monthly, “diabetes” is searched over 4 million times monthly, and “cancer” is searched over 13 million times monthly. Patients are seeking answers to medical questions through searching the Internet every day.

The most effective and economical method of promoting a medical practice is having web pages appearing in the organic search results, that is in the main search results generated by the search engine. Appearing on the first page of the search engine results require well designed strategies, search engine optimization techniques, and a large Internet footprint. Organic search results generate and refer new patients to the medical practice continually without the expense associated with pay-per-click advertising.

If a medical practice is unable to achieve first page position in the organic search result that is in the free placement area then it is cost-effective to pay for pay-per-click advertising. The medical practices in the sponsored links area at the top and right hand side are paying for specific medical terms. This type of advertising placement is highly effective because patients are thinking about this topic and actively searching for information. The links at the top and right hand side appear as information links. A doctor managing diabetes can pay on average \$3.49 per click to guide patients to their medical

practice website and a cardiologist pays on average \$1.91 per click to guide patients to their medical practice website. We have found that 20-30 pay-per-click visitors to a website will generate one new patient to the practice. One new patient will more than pay for the investment in the pay-per-click campaign. Search engine advertising has allowed small practices to compete effectively, using hundreds of dollars, with larger practices who have dominated print, radio, TV, and bill board advertising using tens of thousands of dollars.



*Dr. Doan’s Technology Talks in Orlando:*

*Sat Oct 22, 9 – 12 a.m.  
(SPE06) Selling and Purchasing on eBay, Craigslist, and other Mediums: How to Clean your office with Profit*

*Sat Oct 22, 1 – 4p.m.  
(SPE09) Use Blogging and Social Networking to Super Charge Your Website and Internet Marketing. Guest presenter, Randall Wong, MD*

*Sat Oct 22, 4 – 5 p.m.  
Supercharge our Practice’s Internet Promotion (Tech Pavilion)*

*Sun Oct 23, 2 – 3 p.m.  
The Biggest 24: Harnessing Your Full Potential in the Digital Age (Tech Pavilion)*

*Mon Oct 24, 12:30 – 1:30 p.m.  
Free and Open Source Software for Your Practice (Tech Pavilion)*

*Mon Oct 24, 3:15 – 5:30 p.m.  
AAOE Course 433, Internet Marketing Strategies for Ophthalmology Practices*

## FROM THE EDITOR'S DESK

### A Humanistic Approach to Low Vision Rehabilitation

Low vision is a significant loss of visual capability resulting from disease, trauma, congenital or degenerative conditions which is not correctable with spectacles, contact lenses, medicine or surgery. Not long ago, the World Health Organization (WHO) and the International Association for the Prevention of Blindness (IAPB) developed a global motto: "The Right to Sight." They challenged ophthalmologists and other physicians to never say to a patient with low vision, "Nothing more can be done for you." This complemented Helen Keller's challenge to LIONS Clubs International in the early 1920s to become "Knights of the Blind." It is with these thoughts in mind that I chose to be involved in low vision rehabilitation after retirement from active practice.

Low vision ranks third among disabilities requiring assistance with activities of daily living (ADL). Only patients with arthritic and cardiovascular diseases more commonly require help. Often low vision patients also suffer from concomitant neurological, circulatory or muscular-skeletal problems which compound the need for, and challenges of, aid and rehabilitation.

Each individual has his/her own way of perceiving change in the visual world. Initially, most patients with visual disorders suffer some degree of grief, depression or even anger (Why me?) at the onset of visual loss. There is an underlying fear of loss of independence which can cause some to shy away from the help of family and friends. On the other hand, if rehabilitation is delayed, others may eventually learn to enjoy dependence on others and refuse help and aids. Also prolonged depression

inhibits attention span in the rehabilitation process.

It is difficult for many of us to imagine the psychosocial consequences of vision loss on ADL. Personal skills levels and physical and societal barriers in the environment can seem insurmountable obstacles to rehabilitation. Thus any rehabilitation program must be based on a humanistic approach as an attempt is made to reduce the functional impairment of a visual handicap. Efforts to alleviate anger, denial and/or depression must be made before any attempt to evaluate the potential for maximum use of residual vision will be successful. I believe that we as Eye MDs have greater ability to understand the physiology of vision and the pathology of disorders than other paraprofessionals who offer help to those with visual disabilities. We can approach the challenge with altruism, empathy, compassion, and exceptional clinical expertise. There is great satisfaction in helping low vision patients "see again."

At the AAO Annual Meeting in Orlando in October, there will be two topics of interest to ophthalmologists contemplating slowing down in practice and/or giving up surgery. These discussions will take place at Breakfast with the Experts. Slowing down, or retirement, requires planning. It is generally agreed that most physicians should have plans to fill the void. Hobbies may become an alternative, but if they



are purely physical in nature the passing of time may render them difficult. It is also felt that maintaining some interest in medicine is a healthy way to utilize in a worthwhile manner the years of continuing education and caring and curing that once was one's vocation.

For me, involvement in low vision rehabilitation has been most rewarding as golf, hiking, travel, fishing and hunting have become physically challenging. To offer help and hope to the visually disabled beats being a couch potato.



**AAO | 2011**  
**ORLANDO**  
**OCTOBER 22-25**

## WHERE IS EMILY POST WHEN YOU NEED HER?

William S. Tasman, M.D.

In 2011 the American Academy of Ophthalmology marks its 115th year. It has been 15 years since the AAO's Centennial celebration in 1996, and over that relatively short time much has happened. Everyone is now on the Internet. Wikipedia has replaced hard-copy encyclopedias, and card catalogues in libraries are rarely used by today's students. Newspapers and other print media are facing financial crises as Internet use grows. Submit an article to a journal and it's published online. And then there are the e-book readers, Kindle and Nook.

ter, "A rose by any other name would smell as sweet."\* And what has happened to handwritten thank-you notes? Are e-mail thank yous now de rigueur?

This summer's *SCOPE* had two excellent articles on changes and advancements in communications, one by Andrew Doan and another by Banks Anderson. Communication isn't what it used to be, which brings me to another pet peeve—phone manners. It seems to me that everyone is busy these days, yet when we call a doctor's office or place of business, we are greeted with a menu and several choices before we can reach a "real person."

Here is a situation: Dr. A calls Dr. B to consult about a patient, but when Dr. B picks up the phone to answer, he hears a feminine voice on the other end say, "Just a minute, I'll get Dr. A." Shouldn't Dr. A be on the line when the call is placed?

Now many will say I'm a relic from the 20th century (some would place me in the 19th century), and I don't deny it. For the record, I do value the Internet and the many technological changes now available, but I'm not sure the associated changes in some of the social graces are for the better.

\*Apologies to Shakespeare and Romeo and Juliet

## AS I REMEMBER IT

### Who Says That Ophthalmology Has No Crossover With Other Specialties?

In the course of an average day in the office, I reviewed the new patient's chart outside of the exam room and noted that she was a woman in her 30's with absolutely no complaint regarding her eyes. A living view of her person revealed a nice looking, well spoken young woman whose face took on an unexpected turn at my first question: "How are your eyes."

I was not alert enough to pick up on her first look so I pushed on to the second question: "Do you wear glasses?"

At that point we seemed to be getting into dangerous territory because her face was showing exasperation. She did not wait for the third question but parried with one of her own: "What kind of an exam are you going to do?"

Now it was my turn to show her a face in question. "An eye exam" I said.

"An eye exam?" she said.

"What kind of an exam were you expecting" I said.

"A pap test" she asserted.

By now our two faces were beginning to light up to a level of glow-in-the-dark. My recovery was slow but when it came I mustered: "So sorry. Do not know how this happened... this is an ophthalmology office... let me escort you out the back door... the gynecologist is down the hall... I am so sorry" etc.

By the time we were passing out of the door the glow was waning and we started to giggle. Her parting shot (Continued on page 9)



My wife, Alice Lea, and I received e-mail invitations to a relative's wedding. I thought that was over the line (no pun intended). Our daughter corrected me, pointing out that these are Evites. No mat-



## HUNGER

David W. Parke, M.D

In this issue of *SCOPE* the Academy Foundation and its Museum announce the introduction of a curriculum, *Healthy Eyes, Healthy Body* aimed at teaching people, especially children, about the association of childhood obesity and its threat to visual health if they become diabetic. It also stresses the importance of a proper diet, with essential vitamins and minerals, as being eye healthy. The Foundation's involvement in this area is most commendable, but it also makes me think of the years I've spent on the board of a non-profit agency with a soup kitchen and food bank aimed at alleviating hunger. How can one in three children in the United States be obese when, according to the USDA, more than 20% of the children live in poverty and "food insecure households"? One obvious answer is the amount of junk food often found in children's diets across our economic spectrum.

Recent television programs and other news media have emphasized the terrible problems of starving people in Somalia, Kenya, Tanzania and other African countries, especially the deaths of so many skeletal infants and children. A recent report, *World Hunger*, shows that in Asian, African and Latin Ameri-

can countries over 500 million people are living in what the World Bank has called "absolute poverty" and that every year 15 million children die of hunger. The Indian subcontinent has nearly half of the world's hungry, the rest of Asia and the African continent account for another 40%. The World Health Organization estimates that one-third of the world is well-fed, one-third is under-fed, and one-third is starving. In the time you have spent reading this article thus far;



at least 200 people have died of starvation.

We are being exhorted to contribute to organizations involved in alleviating world hunger and I hope that all of you have heeded the call. Also we must remember that there is hunger in America. In these times of economic stress in our country millions of people may not know when they next will have a nutritious meal. Being hungry doesn't always mean being poor. Over 50% of food-insecure households do not qualify for SNAP benefits (food stamps) or other government nutrition assistance programs according to the *Map of the Meal Gap* study released by Feeding America, the nation's largest hunger-relief organization. Unemployment, reduction in work hours, the onset of chronic illness, or the rapid rise in food and gas prices on already stretched budgets of many senior citizens can force our neighbors to turn to food banks for help.

The almost empty shelves of many food banks testify to the need for financial and volunteer help.

Most food kitchens and food banks attempt to assure that recipients of help are truly in need. Unfortunately we sometimes discover that in many poor households there is no knowledge of healthy nutrition. Food stamps and WIC benefits often go toward shopping carts full of candy, potato chips, cheese puffs and soft drinks; often no vegeta-

bles or fruits are found. This underscores the need for education and the Academy Foundation's *Healthy Eyes, Healthy Body* program which is aimed at coming-of-

age children who can bring home some knowledge of food values and better nutrition.

We responsible ophthalmologists can support the efforts to encourage better knowledge of good nutrition by contributing to the Foundation of the American Academy of Ophthalmology and by helping those less fortunate by contributing to local food banks. Skip a few dinners out and a day a week of your regular latte or coffee and donate now.



## PAST PERFORMANCES

*Note: This is continued publication of some of the remarks of senior ophthalmologists as presented to the Academy Museum's "Oral History Project."*

*Bradley Straatsma, M.D.  
taped October 25, 2009*

"Jules Stein was extremely brilliant. The story of his career from being a musician to becoming an ophthalmologist and then being torn between pursuing ophthalmic practice with Dr. Harry Gradle in Chicago and continuing to book musical groups as a band leader was a thing he struggled with for more than a year. Actually, he described refracting patients while he was also working on the telephone to book a band for the weekend affairs. Finally he decided to take a leave from ophthalmic practice, and it was a leave of absence, not a termination.

He was walking down Michigan Avenue in Chicago and he passed a sign that said, 'Radio Corporation of America' which later became RCA. He said to himself, 'That's a great name.' He was on his way to incorporate a company which was called, 'Music Corporation of America' which became known as MCA, the largest entertainment conglomerate in its era.

*Dr. Jules Stein (center)*



*Headquarters of the American Academy of Ophthalmology in San Francisco, CA.*

When he entered the business world he changed his name from Dr. Jules Stein to Mr. Jules Stein. He did that because he said, 'No one in business would respect a doctor.' I recall many, many years later walking into a hospital room with Mr. Jules Stein, and he walked to the bedside of a patient and suddenly said, 'I'm Dr. Jules Stein'— after more than 30 years of being Mr. Jules Stein. That one patient interface was crucial to his decision to return to medicine. It's a wonderful story and absolutely genuine to my knowledge."

*David Noonan, former Deputy  
EVP of the Academy,  
taped October 25, 2009.*

The most difficult day of my entire professional life was when the division of the American Academy of Otolaryngology and Ophthalmology was decided and Dr. Bruce Spivey and I prepared a 34-page report to the Board

of Trustees of the Academy on why the Academy should not be located in Chicago and also why it should not be located in Washington, D.C. We stated why the Academy's best home would be in San Francisco. Don't

forget that the Board wanted Dr. Spivey to have the position of Executive Vice President; he was already in San Francisco. I think that had he been in Alaska, the headquarters offices would have been in Alaska. We wrote a fairly convincing paper to tell the Board that there was a wonderful opportunity for a revitalized staff in a marvelous community and that the communication tools available to us and the growing opportunities for even better communication tools were an option indicating that we could relocate on the West Coast.

When the decision was made, I had to tell 44 people who were on the staff of the AAOO that there would not be a position for them in the new office, because the otolaryngologists had decided that they were moving their office to Washington, D.C., also out of Rochester, Minnesota.

To the leadership's credit, they said, "David, we will not leave until every one of the 44 people have a job of equal or better stature in the city." So we put advertisements in the local newspapers and the Mayo Clinic being located in Rochester provided a wonderful base from which a lot of people interested in medicine and medical education could find a home. And I can say of those 44 people, every one had a job at equal or better pay and responsibility in the city before we left Rochester on May 19, 1979.

## OPHTHALMIC HISTORY

David W. Parke, M.D.

Ophthalmic historians of today, such as members of the Cogan Ophthalmic History Society, like to encourage our members to realize that history is no more a listing of names and dates, but rather that it is a long story of which the present is just the most recent chapter. Also the Academy Museum's "Oral History Project" is trying to assure that the vivid memories of many leading senior ophthalmologists are recorded and transcribed for future reference. Not to know what or who came before is like trying to read a book which we have just opened in the middle.

Some of us are discouraged that today many high school students don't know whether the Civil War came in the first or second half of the 19th century or why the First World War was felt to be the "war to end all wars." Many medical students have never heard of Osler or Cushing; many ophthalmology residents know nothing of the work of earlier giants in our specialty. When I visited the Allgemeines Krankenhaus in Vienna a few years ago I found the site of Semmelweis's First Obstetrical Clinic by searching out a plaque on a wall. When I told several medical students and house officers

*Sir William Osler, 1849–1919*



for what I was searching, it was apparent that they had never heard of Semmelweis and had never noticed the plaque.

We cannot blame students and ophthalmology residents for our failing the responsibility to pass on to them the stories and traditions of our past. This has always been the duty and privilege of elders in every tribe to assure the continuity of cultural memory and provide some reality to the illusory present. It is certain that without memories there could be no consciousness as we understand it. If each present moment were forgotten as it passed, we would be little more than robots. The briefer the memory the more constricted would be the cognizance.

Individual memory must in some way be likened to historical memory. As it declines, a community, profession, or even the human race must suffer from a shrinking awareness and a deterioration of wisdom. Art and architecture have been records of earlier times, but today buildings seem to be replaced after a generation or two. Traces of our past and traditions have been stored in libraries. Modern libraries serve us better than ever; our enhanced ability to handle and store information, thanks to ever-advancing new technology, has revolutionized the study of history. Historians

*Vienna, Allgemeines Krankenhaus*

write and speak mostly to one another. Such exchanges are essential among scholars to help put events in order, but if our students and residents never hear of it, they are hardly adding to historical memory.

History must be told as a story initially, a story that begins in the imaginable past and proceeds to the experienced present. *History* and *story* derive from the same Latin word, *historia*. In German they are the same word, *geschichte*. An historian once said that 'some like it hot, some like it cold:' two ways of writing history. For young ophthalmologists and students for whom history is not of primary importance, it is probably better hot; cold "facts" can come later if they find the subject interesting. Interest will be there if the story is well told.

To turn young people into good amateur historians requires telling a good story well; we can count on bright minds to take the hot story to the cold facts. For that fortunate group, history, and ophthalmic history, opens a new road to wisdom.

*Dedicated to Gregory Mahony, a rising student of medicine who majored in the history of science at Yale and with whom I've enjoyed bits of ophthalmic history.*

## WHO WAS FUCHS

Robert M. Feibel, MD

The name of Ernst Fuchs (1851–1930) is well known to us from his descriptions of Fuchs' corneal dystrophy, Fuchs' heterochromic iridocyclitis, and Forster-Fuchs' spot in degenerative myopia.

According to Spencer Thornton's *Ophthalmic Eponyms*, there are five other disease entities associated with him. Other diseases that he described or studied included sympathetic ophthalmia, chalazion, pterygium, disciform keratitis, and choroidal detachment.

Fuchs was the professor of ophthalmology in the Second Eye Clinic at the Vienna Medical School during the zenith of its importance (1885–1915). He developed a huge collection of 40,000 histologic specimens related to all types of ocular disease and used them to support his clinical studies.

His greatest contribution to our specialty was in the teaching and dissemination of knowledge.

*Allgemeine Krankenhaus, 1930s*



*Ernst Fuchs*

Physicians came from all over the world to study in his clinic and it was the Mecca for budding ophthalmologists.

Fuchs was fluent in several languages and traveled all over the world lecturing on ophthalmology; he made three extensive tours to the United States. His "Textbook on Eye Diseases" was for many decades the most extensively used reference in the world. First published in 1889, it ran into 12 German editions and was translated into many languages, including an American edition in 1892. Certainly his influence on ophthalmology in the 19th century was second only to Albrecht von Graefe.

Fuchs was one of the giants on whose shoulders rests much of the success of our specialty.

## As I Remember It

*(Continued from page 5)*

was this: "You know, while I was waiting for you to come in the room, I was asking myself just how is he going to do this? I could see the heel of my left leg in that little depression where those white papers are (slit lamp) but I could not for the life of me figure out where I was going to put my right leg..."

*Robert L. Slavens MD  
Syracuse NY*

## Verhoeff Anecdote

Dr. Frederick Verhoeff, the first Professor of Pathology and the first full time Professor and Chairman of the Department of Ophthalmology at The Massachusetts Eye & Ear infirmary (MEEI), was an unusually talented and productive scientist. In addition to his brilliance he was known to be cantankerous and intellectually vain. From the stories I heard and what I saw of him at the end of his career it was a reputation which was well earned.

One of my favorite stories which demonstrated these qualities involved his testimony as an expert witness at a court trial late in his professional life. His daughter, who took care of him at the time, drove him to court and they were on their way home after his testimony. He turned to her and said "What seems to be the problem? You appear to be upset about something." She responded "I was so upset by your behavior in the court room I wanted to get up and leave. When the attorney asked you if it was fair to say that you were the most outstanding ophthalmologist in Boston you didn't even hesitate when you said 'Yes.' Then when he asked if it was true that you were one of the most respected and accomplished ophthalmologists in the country and probably *(Continued on page 12)*

# Cogan

OPHTHALMIC HISTORY SOCIETY



The Cogan Ophthalmic History Society will mark its 25th anniversary at the National Library of Medicine, Bethesda, Maryland, on March 30, 2012. This presents an opportunity to present an interesting talk on a favorite piece of ophthalmic history or to discuss the history of ophthalmology. Detailed information is on line at [www.cogansociety.org](http://www.cogansociety.org).

### Only in America

A DC airline ticket agent who deals primarily with government people offers some examples of 'why' our country has troubles: (the editor has elected not to print the actual names, but has them on file.)

1. A New Hampshire congresswoman asked for an aisle seat so that her hair wouldn't get messed up by being near a window.
2. A staffer for a Kansas Congressman wanted to book a flight to Capetown. I started to explain the length of the flight and passport information when he interrupted with, "I'm not trying to make you look stupid, but Capetown is in Massachusetts."
3. A Massachusetts senator's aide called to inquire about a trip to Hawaii. After giving all the cost info, she asked, "Would it be cheaper to fly to California and take the train to Hawaii?" (OMG)
4. A California senator called and said, "I need to fly to Pepsi-Cola, Florida. Do I have to get on one of those little computer planes?"

I asked if she meant Pensacola on a commuter plane.

She said, "Yeah, whatever, smarty."

5. A Louisiana senator inquired about documents needed to fly to China. After discussing passports and shots I mentioned the need for a visa. The senator replied, "I don't need one; I didn't have one the last time I went to China."

So, I doubled checked and then repeated that a visa was required.

"Look, I've been



there before and they accepted my American Express."

They are in politics, walk among us, and continue to breed.

### The Fisherman

A 72 year old man who loved to fish was sitting in his boat when he heard a voice say, "Pick me up." He looked around but couldn't see anyone. He thought he was dreaming when he again heard the voice say, "Pick me up." He looked around and all he could see was a frog floating in the water.

The fisherman warily said to the frog, "Are you talking to me?"

The frog answered, "Yes, I'm talking to you. Pick me up and then kiss me and I'll turn into the most beautiful woman you have ever seen. I'll make sure that all your friends are envious because I will be your bride." The man looked at the frog for a short time and then reached over the side of the boat, picked up the amphibian and put it in his side pocket. The frog protested and cried, "Are you nuts? Didn't you hear what I said? You must kiss me and I'll be your beautiful soul mate forever."

The man opened his pocket, looked at the frog and then said, "Nah, at my age I'd rather have a talking frog."

With age comes wisdom!

### The Longest Password

During a recent password audit, it was found that a young lady who didn't have the brightest lights in the harbor was using the following password: "Mick

eyMinniePlutoHueyLouieDewey-DonaldGoofyWashington" When asked why she had such a long password she told them it had to be at least 8 characters long and include at least one capital.

### Whacky Labels

On a Sears hairdryer: "Do not use when sleeping."

On a bag of Fritos: "You could be a winner! No purchase necessary. Details inside."



On some Swanson frozen food dinners: "Serving suggestion: Defrost."

On Tesco's Tiramisu dessert (printed on bottom): "Do not turn upside down."

On Nytol Sleep Aid: "Warning: May cause drowsiness."

On a Swedish chain saw: "Do not attempt to stop saw with your hands or genitals."



# NEWS

from the  
Academy Foundation

 THE FOUNDATION  
OF THE AMERICAN ACADEMY  
OF OPHTHALMOLOGY  
Advancing Lifelong Ophthalmic Education

## HEALTHY EYES, HEALTHY BODY

Over the past three decades, childhood obesity rates in America have tripled, and today, nearly one in three children in America are overweight or obese. Obesity affects a child's overall health. In fact, if this trend continues, one third of all children born in 2000 or later will suffer from diabetes at some point in their lives.

According to the National Eye Institute, between 40 to 45 percent of Americans diagnosed with diabetes have some stage of diabetic retinopathy, a leading cause of blindness in the United States. That is why the Museum of Vision, a public service program of the Foundation of the American Academy of Ophthalmology, has teamed up with the *Let's Move! Museums and Gardens* campaign. As a part of this national effort, the Museum is offering free curriculum guides for parents, grandparents, and educators to teach young people about the connection between healthy eyes and a healthy body.

Launched in May 2011, *Let's Move! Museums and Gardens* is the museum component of First Lady Michelle Obama's national initiative dedicated to solving the challenge of childhood obesity within a generation. One of the objectives of the campaign is to ensure that every family has access to affordable education about being healthy.

The Museum of Vision supports and encourages teaching children about living a healthy lifestyle. To that end, the Museum has

composed a curriculum guide for parents and teachers to use, when teaching their children the importance of maintaining a healthy body. The curriculum guide, *Healthy Eyes, Healthy Body*, is free and can be downloaded at [www.museumofvision.org/education](http://www.museumofvision.org/education).

The *Healthy Eyes, Healthy Body* curriculum is designed for multiple uses, including classrooms and home schools. While the concepts in this curriculum can be appreciated by children of all ages, it is targeted to students in the 6th, 7th and 8th grades. These children will be best able to grasp the concepts of life science, health and environment.

The first chapter of this curriculum, an introduction to the eye and the human visual system, will teach children about the parts of the eye and how they function together to allow them to see. The following two chapters focus on eating right and exercise. In these chapters, students will learn about the important vitamins and minerals in eye-healthy foods like strawberries, sunflower seeds and of course... carrots! Each chapter contains fun demonstrations and



activities designed to help students understand these concepts with hands-on learning.

The Museum of Vision has partnered with the *American Association for Pediatric Ophthalmology and Strabismus* and the *National Association of School Nurses* to help distribute the guides.

### About the Museum of Vision

The Museum of Vision is an educational program of The Foundation of the American Academy of Ophthalmology. It is the only institution in the United States whose sole purpose is to preserve the history of ophthalmology and celebrate its unique contributions to science and health. The Museum of Vision strives to inspire an appreciation of vision science, the ophthalmic professions and contributions made toward preventing blindness. If you would like more information, please visit [www.museumofvision.org](http://www.museumofvision.org) or contact Jenny E. Benjamin, MA, Director, Museum of Vision & Stanley M. Truhlsen, MD, Director of Ophthalmic Heritage at (415) 561-8502 or [jbenjamin@aao.org](mailto:jbenjamin@aao.org). Thank you.

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## As I Remember It

(Continued from page 9)

in the world you immediately responded ‘That’s true.’ You were totally lacking in humility and it was embarrassing.” He turned to her and responded, “What did you expect me to say? I was under oath.”

*George E. Garcia, M.D.*

## MEEI & Lasers

During my senior year in medical school (1960-61) I arranged to take a one month elective in Ophthalmology at the Massachusetts Eye & Ear Infirmary (MEEI.) During rounds with Dr. Blake Dunfey, the Chief of Ophthalmology, one day he proudly took us to see their latest acquisition – a Xenon arc photocoagulator. It was the first one in

the United States, very expensive, about the size of a small closet with a direct ophthalmoscope on an articulated arm and offered the opportunity to explore new therapies for ocular vascular diseases.

About two years later, having been accepted for a residency, I was doing a preclinical research fellowship at the Howe Laboratories. Dr. David Cogan had instituted the custom of having “brown bag” lunches on a regular basis to discuss current events and research that was ongoing in the laboratories and elsewhere in Boston and in the world at large.

One day at one of our lunches a visitor was present from M.I.T. He had a small attaché case with him and at the end of the lunch he requested a few minutes to make a presentation. He opened his attaché case and took out a ruby laser. He stated that they had been “fooling around with it” but hadn’t found a practical use for it yet and he wondered if maybe it might be useful to ophthalmologists in some way since the eye was largely transparent.

A wonderful example of serendipity and the value of cross-fertilization in research. It didn’t take too many years before the Xenon arc photocoagulator was relegated to a back room!

*George E. Garcia, M.D.*

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## 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 500 words or less.

Send submissions to [scope@aaopt.org](mailto:scope@aaopt.org)

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## SCOPE

Newsletter of the Academy Seniors

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