

THE HISTORY OF PRESBYOPIA

By David G. Harper, MD

Presbyopia is undoubtedly as old as humanity itself. Aristotle referred to his fellow sufferers as “presbyters,” a Greek reference to old men. Cicero, Nepos, and Suetonius also referred to the condition. Older scholars in those days probably hired younger colleagues to read to them.

Today, many reading this newsletter do so thanks to corrective lenses. The use of convex lenses for reading probably dates to the end of the first millennium. It was at that time that Ibn Sahl wrote *On Burning Mirrors and Lenses*, in which he puts forth (according to some authorities, for the first time) a precursor to the sine law of refraction, now called Snell’s law (after Willebrord Snellius, who, with Descartes, would develop the principle more than six hundred years later).

During the next several hundred years, the manufacture of spectacles with convex lenses spread quickly among monks and monasteries and among the cultured, rich minority of Europe. This happened first in Germany, where the glass manufacturing industry was quite advanced. It is a reasonable assumption that the use of spectacles for presbyopia, by prolonging the active professional life of many intellectuals and artisans, contributed to the scientific, artistic, and social explosion of the Renaissance.



Franklin-type split bifocals, circa 1850.

By the 16th century, research on presbyopia, not to mention hyperopia and myopia, was well under way. In the 1520s, Francesco Maurólico, an Italian monk, proposed the existence of an accommodative mechanism and believed that presbyopia was caused by a flattening of the convex crystalline lens—a theory that Descartes and others would also describe.

English physician Henry W. Pemberton may have been the first to use the term accommodation (in his dissertation of 1719), and he agreed with Descartes and Maurólico that it resulted from changes in crystalline lens curvature. Experiments proving that, however, would have to wait

until the 19th century.

In the meantime, Benjamin Franklin famously commissioned the manufacture of the first pair of bifocals in 1784. This was during the end of his stay in Paris as United States ambassador to the French Court, where he was responsible for bringing bifocals into fashion, especially in aristocratic circles. It was about this time that 51-year-old General George Washington, in an emotional moment with his rebellious troops (they had not been paid for several years), admitted his own personal frailties by donating a pair of reading glasses, thus regaining their sympathy and support.

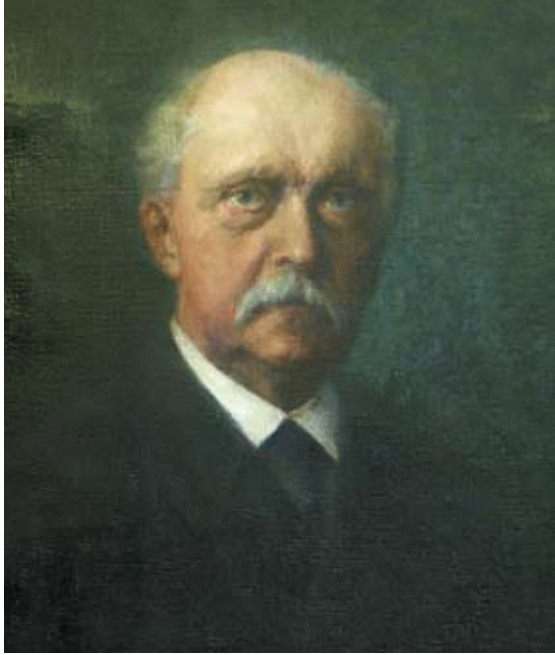
By the middle of the 19th century, the ciliary muscle had been discovered, and in 1853, Hermann von Helmholtz, inventor of the ophthalmoscope, published a theory of accommodation that would remain the domi- (Continued on page 2)

Benjamin Franklin Bifocal Sesquicentennial Commemorative Medal, 1934.



History of Presbyopia

(Continued from page 1)



Hermann von Helmholtz

nant theory into our own time. Helmholtz's theory held that in accommodation for nearby objects, the contraction of the ciliary muscle allows a relaxation of the zonular fibers and, consequently, a bulging of the crystalline lens because of its own elasticity.

Meanwhile, researchers continued to look for alternative explanations for the mechanism of accommodation. Most investigators had a hard time accepting the idea that the tightening of a muscle (in the ciliary body) would result in the relaxation of something else (the zonules) and in turn lead to another tissue (the lens) rounding up from its own intrinsic elasticity. If this were true it would be the only such example in the entire world of muscle physiology.

In 1894, Danish ophthalmologist Marius Hans Erik Tscherning published his own theory of accommodation, which differed from Helmholtz's theory in two basic ways: 1. When the ciliary muscle contracts, the zonule—instead of relaxing—tightens,

causing the anterior face of the crystalline lens to increase its curvature in the form of a central lenticonus, along with a flattening of the periphery; and 2. accommodative contraction of the pupil covers the flattened lens periphery, thereby reducing spherical aberration.

Tscherning's theory provoked a storm of controversy that persists to this day, and the first half

of the 20th century saw the appearance of several

additional theories of accommodation. One of the most interesting theories came from Swedish ophthalmologist Allvar Gullstrand, who

proposed that a third of accommodation was due to the lens fibers themselves increasing their refractive index in the center of the lens. If this theory were true, presbyopia would of course result from a failure of this refractive index change. Neither this nor any other new theory gained much acceptance.

During the latter half of the 20th century, investigators began to focus efforts on the biochemistry of lenticular aging. Two factors common to the aging of all tissues are water loss and increased tissue calcium content. But no one has found any relationship between crystalline lens water content or lenticular calcium levels and the age of the lens.

It is also notable that the lens is the only tissue in the human body that changes uniformly in a linear fashion over time in every member of the species worldwide, and it is highly unlikely that this could be due solely to age-related changes in lens biochemistry. Besides, the decline in accommodative function begins around age 15—before maturity, let alone the onset of old age.

Recently, Ronald A. Schachar, an ophthalmologist and physiologist at the University of Texas, published a theory of accommodation that is similar to Tscherning's. Building on his theory, Schachar has proposed that the cause of presbyopia is a continuous age-related increase in the equatorial diameter of the lens with a subsequent decrease in the effective working distance of the ciliary muscle. Tests in the

last decade of his scleral expansion surgery have shown promise—as have the unrelated development of accommodating and multifocal lenses, designed to correct presbyopia at the time of cataract surgery.

Meanwhile, eyeglasses remain the mainstay of presbyopia correction—as they have been since the time of the Renaissance. It seems that no other phenomenon in human physiology and aging has so thoroughly resisted complete elucidation of the underlying cause and mechanism but is so readily compensated for by something as simple and safe as reading lenses.

Presented at Cogan History Society Meeting, 2009.



E-Books

In the Summer, 2007 issue of SCOPE there was an article, *Bells Toll for American Newspapers*. We are now hearing predictions of the death of printed books and bookstores. In recent years many of us have witnessed the closure of locally owned bookstores. My favorite was the town's "Book Vault"; so named because it was housed in an old bank building. It, and many stores like it, could not compete with the mass purchasing powers of chain book stores and supermarkets or with the likes of Amazon, now the world's largest "bookstore".



In 1997, Joseph Jacobson, a professor at MIT, developed E-Ink Corporation. Paper-flat E-Ink displays are a great reading medium. It was soon realized that, with some tech-tweaking, they could be turned into computerized books. Jeff Bezos, who founded Amazon, had already turned it into the bookstore giant, as well as developing the concept of internet shopping.

He realized that the "book business" was in trouble due to high production costs and low profits. He was also aware of the potential for computer-



ized books and started the Kindle e-books.

At present there are two Kindles. The DX model's screen is the size of a sheet of letter paper. The Kindle 2 has a paper-book page size screen. Both are about as thick as a weekly news magazine. The Kindles use a wireless service connected to their bookstore where over 300,000 books are \$9.99 each and some classics are free. They can be plugged into a computer, but can be used as a stand-alone device which affords the reader more mobility. For many, Kindle makes for easy reading with greater speed. Print size can be changed in the DX model, which may be of benefit to my moderately impaired low vision patients.

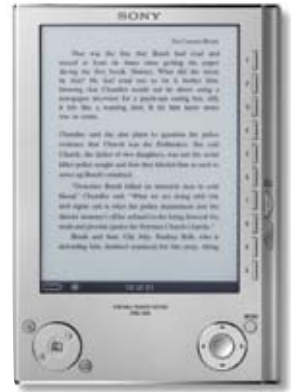
Sony has two e-book readers that must be plugged into a computer. Their touch screens, also made by E-Ink, are glossy and hard to read in bright light, but are enjoyed by many tech-tinkers.

Barnes & Noble, in conjunction with a company called Plastic Logic, are in the process of entering the e-book domain. Of great interest to all fans who embrace the e-book is the proposed device(s) now very secretly in production by Apple and called "iTablet", part iPod and part reader. All manufacturers are appealing to avid readers and the usability of their product.

Thus, many predict the demise of the written book. Some school texts are already in the e-book format. Just a week ago I read of a highly regarded prep school which has cleared its library shelves of printed books and requires all students to use e-books.

But not so fast! Many bibliophiles are not sold on the idea of e-books. Some just enjoy collecting books and others because

they truly feel more at home and comfortable curled up with a book. At Thanksgiving dinner our table was graced with the



presence of two college-student grandsons, and two college-student grand nephews. Although my daughter had placed a moratorium on iPhones and similar devices during the meal, all four agreed, in a discussion on e-books, that they preferred texts in book form. They cherished the ability to write comments in the margins and to underline words of importance. They also liked to retain the ability to crease the corner of a page to which they would refer during preparation for exams and paper writing.

At this point I prefer books. With time, things may change.

DWP



OPTIMIZING YOUR EXPERIENCE WITH THE ACADEMY'S NEW PROFESSIONAL NETWORKING TOOL

Andrew P. Doan, MD PhD

Social networking sites like Facebook and Twitter are attracting users by the hundreds of millions. The social networking buzz is infectious, and the American Academy of Ophthalmology has implemented software solutions to facilitate online communication among members. This new software solution is the American Academy of Ophthalmology's professional networking solution and adds exciting functionality to the Academy's website.

Do you want to connect with colleagues? Would you like to collaborate on business, academic or personal opportunities with like-minded individuals? Would you like to share your opinion about ophthalmic news headlines and the Academy's educational materials? Would you like to create a personal profile so that colleagues can find out more about your ophthalmic practice, academic interests, or personal hobbies? If any of these opportunities seem interesting to you, then I encourage you to explore professional networking on the Academy's website: www.aaopt.org.

The American Academy of Ophthalmology developed a professional networking solution that facilitates online interactions between the Academy's members. The Academy's professional network uses software to allow online interactions between Academy members. This article will give you tips on how to get started and maximize your experience with the Academy's professional network.

Creating your professional network profile is easy on www.aaopt.org.

On the www.aaopt.org website, log in with your Academy login and password. After logging in, you will see your name above the right hand side panel. Click on your name to view your Academy's professional network profile.

Editing your professional network profile allows you to upload your photograph, post information about your practice and interests, and specify other personal information if desired.

Your professional network inbox allows communication with other Academy colleagues via electronic mail. This works similar to email, but you do not need to know your colleague's email address. Sending electronic mail is as easy as clicking on your colleague's name in your network or by searching for their name.

Adding colleagues to your "friends network" is accomplished through the View/Find Friends link. On the View/Find Friends page, you may add people to your network and view people currently in your network.

The Academy's professional network interfaces with Twitter and Facebook via the Facebook/Twitter tab on your profile page. The Twitter and Facebook interfaces will automatically publish your comments on the www.aaopt.org website directly to your personal Facebook and Twitter accounts.

Recommending colleagues on the Academy's professional network allows you to provide a public vote of confidence for specific individuals. On the Academy members' profile pages, clicking on "recommend" link registers your recommendation for the individual.

At the bottom of articles, comments are entered in the text

boxes titled "What do you think?" You may type in your comments and click on "Post My Comment." You may also post a reference to your comment on your Facebook and Twitter pages by clicking a box.

Recommending articles is accomplished by clicking on the "recommend" link at the top of the article. As a community, we can cast our votes for the best articles and educational materials on the Academy's website.



Replying to others' comments on articles and educational materials may be done in the panel next to the comment. In this panel, you may reply, agree with the comment (thumbs up), disagree with the comment (thumbs down), send to a friend via email, link to the article, send to other social networking sites, and report abuse if comments are inappropriate or self-promotional.

For people who enjoy competition, the AAO Community Leaderboard keeps track of your contributions and recommendations on the www.aaopt.org. You will see a score in your user profile and your current ranking on the Leaderboard.

There is incredible potential with the newly released Academy's professional network. This is only the beginning of several exciting internet tools planned for release in 2010!

W. Banks Anderson, Jr.

I have no problem with labeling cars “clunkers” as in “cash for clunkers”. Like “old fogey”, “clunker” can be said with great affection. But was it really necessary to put them down with engine poison? Didn’t that give you a twinge? It certainly gave me a pang. A clunker was my first car. It had carted our family on treadbare tires all during the second war. During those years anything new with wheels and an engine went to the military. After that war there was this pent up demand for new cars. That meant that the only vehicle available for a newly minted driver was the prewar family Chevy. Did I love that clunker? You better believe I did.

As a goal, breathing probably ranked first but getting the keys to that car was a close second. Once in possession, keeping it rolling became a high priority. Imagine or remember how, upon lifting the hood and looking down you could see past the engine to the pavement. If you dropped your spark plug wrench while cleaning and gapping, it would fall straight down and bounce off the asphalt. Nothing impeded its descent; no air conditioner compressor, no windshield washer tank, no pollution control hoses and manifolds, no pressurized cooling system reservoir, no power steering booster. The plugs needed frequent cleaning because she burned oil. These days, if you are even able to find your car’s dip stick without reading the manual, you will discover that it must be a meter long just to reach the sump and then only the very tip manages to get there. My clunker’s dip stick stuck out prominently from the side of the engine. The “full” mark was an inch or two up the foot long steel ribbon.



On summer trips from North Carolina to Cape Cod adding oil every few hundred miles was a routine. My brother and I bought it in gallon cans.

These clunkers had six volt batteries. If the battery was sick, you just parked on a hill. If she wouldn’t start, you let off the brake, coasted down the hill, and when you got really rolling with her in gear you would let out the clutch, the engine would turn over and with a lurch she would start. Then there was that wide front bench seat, so much better than buckets for mutual explorations of anatomical differences. On cooler evenings windshield fog would add to one’s privacy. That clunker was a refuge from sibs and parents and that driver’s license, the declaration of independence. For today’s teens, clunkers clash with their image. Communicating electronically, they live independently in isolated

suites with attached baths and flat panel displays. Parents contact them on their iPhones to invite them down for dinner. The sportier their cars the better they like them. Twin front buckets with the shift lever between them and, oh yeah man, it’s OK



to poison those clunkers.

My wife came with a clunker as her dowry. Seeing the pavement through a rusted out hole near the clutch pedal and worrying about carbon monoxide, I bolted a shiny cookie sheet onto the floor pan. A neighbor down the street had one that he called “the green machine.” The name was inspired by one of the paint jobs used to cover its myriad dermatoses and not associated with energy efficiency although you did have to roll its windows up and down by hand. He obviously had a deep affection for his clunker, and a tolerant wife, for it graced his driveways for decades.

As an old clunker myself I certainly understand how others of the breed might imagine that like these cars, the government might subsidize scrapping us.

Actually there is little left to imagine since rabid commentators have described in detail how committees under the health bill would select clunkers for end-of-life junking. But

most of us don’t worry about this fiction. We are surrounded by those who also share our real affection for clunkers. We count on them to help keep us running or at least walking or rolling and to tell us when we stray over the center line.

THE MEASURE OF CHANGE

Change is inevitable. The course of history has been a chronicle of change. In recent months many Americans have been mesmerized by the promise of change. The pace of change varies, but in our lifetimes we've witnessed all manner of changes in social conscience, in ethical and moral behavior, in the ways in which business and politics are conducted, in major and minor global conflicts and power shifts, in education, in technology, and, most personal to physicians, in advances in our ability to diagnose and treat diseases. As a corollary to the latter, there has been the realization that some sort of well-reasoned universal medical care at a reasonable cost is needed in our country.

As a most senior of senior ophthalmologists I've witnessed more technological and patient-physician relationship changes than most. I've also witnessed private entrepreneurial and government involvement and intrusion into the transformation of our profession from one of curing and caring to one heavily laden with business requirements and regulatory dictates. I've learned that unity among the members of the medical profession and personal involvement in the legislative and regulatory processes are important parts of reality.

In 1959, just new in practice, I was appointed by the Section on Ophthalmology (now the Connecticut Society of Eye Physicians—CSEP) of the Connecticut State Medical Society to be their representative on the medical advisory board of Connecticut Medical Services. CMS was the relatively new health insurance enterprise owned and governed by the Connecticut State Medical Society. To my surprise, I was placed in a position to decide whether ophthalmolo-

gists' claims for compensation for surgical procedures were "usual, customary and reasonable" (UCR). My experience in that position was an introduction to what was emerging as "the health care system." The avarice of some of the more vocal members of the state society, whose claims to CMS often were felt to be beyond UCR, caused such a deep rift with the Board of Directors that CMS ultimately became Connecticut Blue Shield and I remained on the board. Parenthetically it should be noted that up until that time most physicians had had personal financial relationships with patients; few middlemen.

At one of my early meetings of CMS I recall a lengthy discussion of the Forand Bill. This was a U.S. House of Representatives bill, supposedly designed to provide medical care for the poor elderly, which failed to pass but was truly the precursor to Medicare. At that CMS meeting it was believed that the Forand Bill would permit our government's involvement in social and welfare measures championed by Congressmen who were ultraliberal and whose strongest political supporters were professional unionists and professional welfare workers. The words "socialized medicine" were frequent in the discussion as was the prediction that elective surgery of any kind would no longer be permitted.



Change occurs with time. By amending the Social Security Act, Congress enacted Medicare in 1965. It was perceived by the federal government as a way to assure access to care for the elderly who could not afford private insurance premiums and who had no savings other than Social Security. Not long after, a change in statutes provided Medicare coverage for most people over 65, regardless of financial circumstances. Organized medicine loudly denounced Medicare as contrary to the concept of free enterprise. I was hesitant about Medicare because I felt that physicians had a moral obligation to care for the elderly. Most hospitals mandated, as a requirement for staff appointment, that physicians take turns caring for the indigent, and most did so willingly.

Connecticut General Insurance Company (now Cigna) became the regional fiduciary for Medicare. I was appointed ophthalmology advisor to Medicare and felt an obligation to try to make the system work. The UCR method of payment was adopted. This precipitated a push by many physicians who originally had been opposed to the idea of Medicare to increase their service fees; it was an instant bonanza. The medical director of Medicare at Connecticut General was generous with his interpretation of UCR. He scolded me for not keeping pace with ophthalmologist's fees elsewhere when I thought some charges were truly outlandish, and unilaterally he raised the UCR for ophthalmic

procedures. In time I was being reimbursed about 400% above my pre-Medicare UCR for cataract surgery!

Hospitals also benefitted from the largess of Medicare and rates began to soar. Private health insurers of that time were forced to keep up and premiums spiraled upward. By the early 1970s individuals under age 65 and employers were alarmed by the increasing costs of health care and the increases in insurance premiums. A change in federal directives resulted in strict fee-for-service reimbursement formulae and the elimination of UCR.

The Health Maintenance Organization Act of 1973 signaled the true concept of “managed care”, with a number of types of HMOs, followed by PPOs. These brought further change to the healthcare landscape and greater physician-insurer conflict. Many HMOs were paying about 70 cents of the premium dollar for care and physicians were beginning to measure their lives in compliance with cost-driven algorithms. Time with patients became shortened and reimbursement was variably reduced. Some patients perceived that a new age of entitlement came with instantaneous and up-to-the-minute care with a guarantee of medical perfection and desired outcomes. Soon medical liability and soaring malpractice

premiums added to physicians’ concerns.

Perhaps the greatest change in the health care system occurred when the original concept of Medicare Part A for hospitals and Part B for physicians and osteopaths fell to legislative votes. Just two years after the origin of Medicare, allied health providers, including optometrists, made the first of three unsuccessful attempts to be included in Medicare reimbursement. Originally they were rebuffed in Congress on advice from HEW, NIH, OBM, and the Bureau of Health Manpower and Quality Assurance.

In 1975, Kansas Congressman Robert Whitaker, an optometrist, approached Kansas Senator Robert Dole, then chairman of the Senate Finance Committee, to sponsor legislation to amend the Social Security Act so that optometrists could be reimbursed under Medicare. With complete disregard of the negative opinions of NIH, HCFA, and the OBM, a Dole sponsored advisory committee’s “Report to Congress” declared that optometrists should be reimbursed under Medicare.

Optometrists, joined by chiropractors and podiatrists, succeeded in having legislation passed allowing their reimbursement by Medicare. When the COPs law (as it was called) was incorporated into the Omnibus Reconciliation Act of 1980, it was specified that Chiropractors, Optometrists and Podiatrists were to be considered physicians for purposes of reimbursement for similar or same services as provided by Doctors of Medicine or Osteopathy, and as allowed by state law. Among the great changes that resulted were a spate of scope of practice bills in state legislatures. Those that were passed permitted medical care and judgment to be a capability of nonmedical providers by legislative fiat

and greatly increased the cost of health care for the elderly, and ultimately for all patients. Quality of care was affected.

Since 1980 a number of other allied health providers and facilities have gained reimbursement privileges under Medicare. Also many people with behavioral, congenital or otherwise disabling problems, who are well below 65 years of age, have been added to Medicare roles. Funding has not kept pace with spending, and the slices of the reimbursement pie have been increased in number and reduced in size. In many respects the changes we have seen, though often beneficial for the elderly, have been accompanied by escalating costs, reduced payments, and medical care has become a small part of “health care.”

“Reform” has become the chant of many who wish to see a change in “the health care system,” but there is, at this writing, much disagreement and frustration in Washington. Commentaries by physicians on the need for health-care change generally are more harmonious than they were 50 years ago. We have to be engaged in the debate as to how we maintain quality care for all, and how it may be financed responsibly and with compassion. As Gunter Grass, the German Nobel Prize winner said, “You cannot delegate your conscience... Citizens cannot leave politics just to politicians.” Likewise we cannot leave medicine just to nonphysicians, insurers and bureaucrats. Americans now get the best medical care in the world. Each of us, in our own way, must be inspired to work on responsible health-care reform both directly and in concert with our leaders in the American Academy of Ophthalmology who are in the thick of the fray. Let us keep that which is good and help change only that which needs change.

DWP



DICKENS, OSLER, AND MOTHER TERESA

Robert U. Massey, M.D.

One might ask what Dickens, Osler and Mother Teresa have in common except that they were exceptionally good people. Charles Dickens was 37 years old when William Osler was born, and had begun to write *David Copperfield*. Osler was 61 when Mother Teresa was born. Thus, for a time, Osler could be said to have been a contemporary of each of the other two, although the overlapping years of their lives were miles and oceans apart.



Charles Dickens

The Osler Library included a copy of a facsimile edition of the 1859 edition of *A Tale of Two Cities*, but the two men can hardly have met since Dickens died in 1870 when Osler was just 21 years old and still lived in Canada. I'm sure Osler had a special interest in Mr. Cruncher, the resurrectionist, one of the unforgettable among many in that novel.

In *Bleak House*, one of Dickens' minor characters, or caricatures, is Mrs. Jellyby whose morality is of the "telescopic philanthropy" kind, whose far off gaze "could see nothing nearer than Africa." She worked night and day for the mission at Borrioboola-Gha,

neglecting her numerous children, her poor husband slipping into bankruptcy, her house a mess, cold and smelling of hot tallow, and her cook an alcoholic. "You find me, my dears, as usual, very busy, but that you will excuse. The African project at present employs my whole time... We hope that by this time next year to have a hundred to a hundred and fifty healthy families cultivating coffee and educating the natives of Borrioboola-Gha, on the left bank of the Niger."

All of us have seen these telescopic philanthropists all over the place, but mostly, unlike Mrs. Jellyby, they are frequently among the well-off who can easily afford to farm out their children to expensive boarding schools and their husbands out to nightly board meetings. Nearer home, many of us must confess to our own varieties of telescopic philanthropy, devoting energies to great causes while neglecting families, close friends, and the neighbors next door whose names we often do not know.

Osler denied being a philosopher. "I have never succeeded in mastering philosophy—'cheerfulness was always breaking in.'" But then, misquoting Thomas Carlyle, and, just maybe with Mrs. Jellyby in mind, he said his phi-



William Osler

losophy was "...not to see what lies dimly at a distance, but to do what lies clearly at hand." He returned to this sentiment over and over, and in 1913 delivered an address to Yale medical students, *"A Way of Life,"* in which he advised them to live "... a Life of Day-Tight Compartments."

"Shut close in hour-tight compartments, with the mind directed intensely upon the subject in hand, you will acquire the capacity to do more and more, you will get into training; and once the mental habit is established, you are safe for life."

Mother Teresa has been criticized for not advocating family planning or other far-reaching social schemes for eliminating poverty and reducing the burden of unwanted or unsupportable



children. She worked instead only to relieve human suffering that lay immediately at her feet, one by one, day to day. It seemed that she had never heard of the social gospel; like many of us she probably was never able to find it in the Gospels, where we are bidden to ask only for our daily bread, and where, as Osler reminded us, the workers in the vineyard were hired by the day, “and we are expressly bidden to take no thought for the morrow.”

Malcolm Muggerid called Mother Teresa and her Sisters in Calcutta “love in action,” and love is always one to one, day by day. She summed up her Way: “The greatest scourge is to forget the next person, to be so suffocated with things that we have no time for the lonely person, even in our own family, who needs us.”

A physician friend used to tell his residents that doctors were “numerator” people, one patient at a time, each one the most important one in the denominator of 1,000! The one-on-one notion may be easier for us.

Of the three, Dickens, Osler, and Mother Teresa, only she lived almost entirely according to the message that she taught and embodied. Such discipline, in spite of Osler’s assurance that once established we “are safe for life,” is no easy task. Quoting the 17th century divine, George Herbert, Osler urged the Yale students to “Undress your soul at night,” and reminded them that “The load of tomorrow, added to that of yesterday, carried today, makes the strongest falter.” He might have added another Herbert aphorism, “Be useful where thou livest.”

Adapted from an essay by Dr. Massey which was published in Connecticut Medicine Vol 61, No. 10. Dr. Massey was the Dean of the School of Medicine at the University of Connecticut.

TRENDS AND TIDBITS

What Causes Arthritis?

A sweaty, drunken man sat down on a seat in the subway next to a priest. The man’s tie was stained, his face was plastered with lipstick, and a half-empty bottle of gin stuck out of his pocket. He opened his newspaper and started reading. After a few minutes he asked the priest, “Say, Father, what causes arthritis?”

The priest replied, “My son, it’s caused by loose living, being with cheap wicked people, too much alcohol, sleeping with prostitutes, and lack of a bath.”


The drunk muttered, “Well I’ll be damned,” and returned to his newspaper.

After thinking about what he had said, the priest nudged the man and apologized. “I’m very sorry; I didn’t mean to come on so strong. How long have you had arthritis?”

“I don’t have it, Father,” answered the drunk. “I was just reading here that the Pope does.”

Choices

The country preacher thought it was time for his teenage son to choose a profession. One day while the boy was at school, the preacher went to the boy’s room and placed four objects on his desk. These were a Bible, a silver dollar, a bottle of whisky, and a *Playboy* magazine. When it was time for the boy to come home, the preacher hid behind the door. He believed that if he chose the Bible, the boy would become a preacher. If he picked up the dollar first, he would become a businessman. But if he picked up the bottle first, he would probably end up a drunken bum. Worst of all, if he picked up *Playboy* he would most likely become a skirt-chas-



COGAN OPHTHALMOLOGIC HISTORY SOCIETY

The 23rd annual meeting of the Cogan Society will be held on April 16-18, 2010 at the Embassy Suites Hotel, Chicago-Lakefront, Chicago, IL. The Society provides a forum for scholarly presentation and discussion of research on the history of ophthalmology and its associated fields. More information regarding reservations and the program is available on the Cogan Society website: www.cogansociety.org.

ing womanizer.

Soon the front door opened and the whistling boy headed for his room. He tossed his books on the bed, and as he turned to leave the room noticed the objects on his desk. Filled with curiosity he went to inspect them. Finally, he picked up the Bible and placed it under his arm. Next the silver dollar went into his pocket. He then uncorked the bottle and took a big swig of whisky and then admired the magazine’s centerfold.

“Lord, have mercy,” the preacher whispered to himself. “He’s gonna run for Congress!”



AS I REMEMBER IT

Landlords and House Mothers

During the first year of medical school, my best friend and his wife, both of whom had more moxie than a case of the beverage, talked my wife and me into joining forces to buy a duplex house just a block away from the Ohio State University campus. The asking price was a whopping \$12,000 for the old twelve room brick house, and among the four of us we had eighty three dollars for a down payment. Not surprisingly, we had been turned down by three banks, but were able to convince the kindly, elderly loan officer at the fourth bank that our wives' incomes and our knowledge of how to prevent having children while we were in school (after all, we were studying to be doctors) entitled us to a mortgage. Also my friend, his wife and I were WWII veterans, which also provided some priority in securing a mortgage. I can still picture the smile on the old man's face as he shook his head at having allowed himself to be talked into such a risky scheme.

Each couple fixed up their three downstairs rooms into personal living quarters, and then bought used furniture at attic sales and old army bunks to furnish the upstairs rooms so that we could rent them to university students. We hadn't counted on the rule that we could not advertise rooms for rent in university publications without prior approval of the housing department. Not only did we have to pass an inspection, but our wives had to be certified as house mothers. A really sticky point was that there was only one bathroom for each duplex, so we had to develop a schedule when my wife and I could use the bathroom and when the students could use it. In the end, the university gave

us clearance to advertise. And thus we had a source of money to help make our monthly mortgage payment.

All of our student renters were freshman, eighteen or nineteen years old, and all were living on very tight budgets. It soon became apparent that their diets consisted mostly of White Castle hamburgers and bowls full of dry cereal. My wife and I also were on a tight budget with medical school expenses, trolley fares for my wife and our own grocery bills, (My wife made \$1300 a year an elementary school teacher). We came up with the idea that if our student renters added the money they paid on weekends for food, we could feed them home cooked breakfast and dinner on Saturdays and Sundays. We had ready takers!



We had the same student renters for four years, got along famously, and kept in touch for many years after they graduated. When I think of my wife cleaning student rooms and washing their sheets weekly, cooking tasty meals on a shoe-string budget, and acting as mother confessor to young men with study and girlfriend woes, I feel that my part of the medical school experience was a breeze. To top it off, when my friend and I left for our residencies, we sold the house at a profit. My medical school buddy and his wife remained our closest friends.

TRENDS AND TIDBITS

Old

Very quietly, on the eve of our 50th anniversary I informed my husband that I was having an affair. He turned to me and asked, "Are you having it catered?" And that, my friends, is the definition of "Old."

Puns

She was only a whisky maker, but he loved her still.

A hole has been found in the nudist camp wall. The police are still looking into it.

Time flies like an arrow. Fruit flies like a banana.

So Sorry

Three good ol' boys, Cooter, Ronnie and Donnie, were working on a cell phone tower. Cooter slipped and fell and was killed instantly. As the ambulance took away the body, Ronnie says, "Well, damn. Someone should go tell his wife."

Donnie says, "OK, I'm pretty good at that sensitive stuff. I'll do it."

Two hours later he met up with Ronnie and was carrying a case of Budweiser. "Where did you get that there beer, Donnie?"

"Cooter's wife give it to me."

"You told the lady her husband was dead and she give you beer?"

"Well, not presactly," says Donnie. "When she answered the door I says to her, 'You must be Cooter's widow.'"

She says, "You must be wrong. I ain't no widow."

"Then I says to her, 'I'll bet you a case of Budweiser you are.'"

Rednecks are good at sensitive stuff.

NEWS

from the
Academy Foundation

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

THE ACADEMY FOUNDATION CELEBRATES 30 YEARS OF SUPPORTING OPHTHALMIC EDUCATION AND PUBLIC SERVICE

By B. Thomas Hutchinson, MD

In 1980, the Academy developed a partner in extending its service to members and fulfilling its educational mission—The Foundation of the American Academy of Ophthalmology. Since then, the Foundation has served as the fundraising arm of the Academy, a grant making entity that provides support for member education and a steward of valuable public service programs that extend the reach of the Academy and ophthalmology. With the start of 2010, the Academy Foundation is proud to announce its 30th anniversary as well as the 30th anniversary of its very first program, the Museum of Vision. This year also marks the 25th anniversary of the Academy Foundation's award-winning public service program, EyeCare America. For many of us, it seems there has always been a Foundation associated with the Academy, but in fact, the Foundation is young compared to the Academy's 114 years. Yet in that relatively short amount of time, it has achieved a great deal.

The very first program under the Foundation was its museum which was established at the request of AAO President Frederick C. Blodi, MD in 1979. When the Foundation was established, the museum's collection initially included literature, instruments, photographs, spectacles and the Academy's archive. Now known as the Museum of Vision, today it houses 38,000 items related to ophthalmic history and has

expanded its holdings to include art, furniture stamps, coins, medals, memorabilia and pharmaceuticals.

The National Eye Care Project (NECP) public service program was the next major initiative to be added to the Foundation. President Ronald Reagan opened the NECP pilot project at a White House ceremony in April 1983 and in 1985, the NECP was officially added to the Foundation. As a reflection of its growth and popularity, in 2002, the NECP changed its name to EyeCare America. Since the program's inception, it has helped more than 1 million people receive the sight-saving resources they needed including free educational eye health information and access to eye exams and care of which over 90% is provided at no cost to the patient.

It was in 1991 that the Foundation embarked on its first major fundraising capital campaign to create an endowment that would provide R&D funding in perpetuity for new educational initiatives by the Academy for its members. Named The Bruce E. Spivey, MD Educational Trust Fund in 1992 to honor the leadership of Dr. Spivey, this initial campaign proved immensely successful. The income from the endowment has been used to underwrite much of the R&D expense associated with creating the Academy's Ophthalmic News and Education (ONE) network. Since its launch in 2007 as a free member benefit, ONE has been

used by more than 16,000 members worldwide.

In addition, since ONE's launch, the Foundation has also secured enough funding to support the expansion of offerings and to update its content over the next five years. Foundation support also made the network available to over 6,000 of our colleagues in developing countries, many of whom do not have access to other educational opportunities.

All of these successes would not have been possible if not for the generosity of the members, individuals, foundations and corporations who have supported our efforts through the years.

It has been three decades, and in that time so much has changed and yet we remain steadfast to our original educational mission. We want to take this time to thank you, one and all, for being a part of our history and playing a key role in our 30 years of growth, our 30 years of success. We look forward to sharing additional highlights about the work of the Museum and EyeCare America in upcoming editions of "SCOPE." Most importantly however, we look forward to remaining a valuable partner to the Academy in the years ahead.

Please visit www.faaoo.org to learn more about our programs and to make a gift toward the Academy and Foundation's missions or contact Joanne Neuman at 415.447.0356.



The 2009 Joint Meeting in San Francisco was a great meeting in a great city. Here are some highlights from the Academy Seniors events:

The Club Lounge

Back by popular demand, the Academy Seniors Club Lounge was busy as ever in San Francisco with close to four hundred visitors over the four day meeting period. The Lounge provided Academy Seniors with refreshments, comfortable seating, Internet access and Academy photo archives. The Lounge was a great success and thanks to everyone who visited. Please stay tuned for details on next year's Club Lounge in Chicago.

The Academy Seniors Special Program and Reception

Two fantastic presentations were in store for those who attended the Academy Seniors Special Program.

First, Dr. Peggy Hellweg, a Seismologist from UC Berkeley provided an overview of the world's largest earthquakes to date: 1906

Great San Francisco earthquake, 1989 Loma Prieta San Francisco earthquake and the 2004 Sumatra earthquake and Tsunami. In depth, Dr. Hellweg described earthquake phenomena and effects. She explained the study of seismic waves and plate tectonics taking place in California and in other regions around the world that experience significant seismic activity. Dr. Hellweg's presentation was informative and well received by all.

The second speaker was Dr. Andrew G. Lee, a neuro ophthalmologist who presented a talk on the aging brain in, *It's Not the Age, It's the Mileage*. Dr. Lee provided an overview of Dementia and its main contributors such as family history, obesity, stress and smoking. Dr. Lee also shared information on the projected increase in obesity in America and the concern that it is becoming an overwhelming public health problem for people of all age groups. Dr. Lee concluded his presentation with a picture of *Star Trek's*, Spock and reiterated to the audience, "*Live long and prosper.*"



SCOPE Newsletter of the Academy Seniors

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