



SCOPE

Retina Pioneer Paul Anton Cibis, MD: A Personal History

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Ophthalmic History Editors: Daniel Albert, MD and Donald Blanchard, MD

Paul Anton Cibis, MD, is best known for his pioneering work on the vitreous in retinal detachment surgery — specifically, the introduction of silicone oil as a hydraulic dissecting instrument to separate membranes from the retina and which remains as a vitreous substitute tamponading the detached retina.



Paul Cibis sculpting 1930.

Our father's scientific achievements are described in a number of places, but as his children and career ophthalmologists (pediatric

ophthalmology and strabismus) we have been asked to chronicle him from a more personal perspective.

Our father was born June 26, 1911, in Rybnik —part of what was then Upper Silesia. The treaty of Versailles transferred a small area including Rybnik from Germany to Poland, causing the family to flee to nearby Ratibor, still part of post-World War I Germany.

There our father grew up and went to school until leaving for university. As is common in Germany, even today, he attended several universities (Breslau, Munich and Berlin), receiving his Doctorate from Berlin in 1936.

His father, also a Paul Cibis, worked as a butcher and ran a wholesale meat business.

The surname Cibis is ethnic to Upper Silesia, and comes from the Latin word for food: Cibus. (In a similar derivation, the housing for the host on a Catholic church altar is called a ciborium).

Records going back five generations show a predominance of

butchers among our direct male antecedents, a cause of hilarity in our family of eye surgeons, mother also being an ophthalmologist. We speculate that the name is a latinization of our ancestors' occupation, perhaps as meat purveyors in the Holy Roman Empire. Until Silesia's annexation by Prussia in 1740, the region was Austrian.

Father had the traditional "gymnasium" education of the time, which emphasized Latin and ancient Greek and all the history and mythology that involves. His Latin was good enough that he enjoyed speaking it with Catholic clergy patients.

After developing an interest in sculpting, he worked after school hours in a "Bildhauer" atelier. He wanted to pursue that as a career, but his bourgeois parents refused to finance such a "hunger" profession. From the dozen or so surviving photos of his teenage work, we think they were right.

Our father admired the style of Kaethe Kollwitz, who chronicled the hardships of miners, farmers and workers of the time in prints and statuary. A close high school friend was the future art historian and Emil Nolde, specialist Werner Hoffman, and his circle of artist friends, with whom Dad reconnected during his time in Berlin. He thus had a deep interest in art that mother shared.

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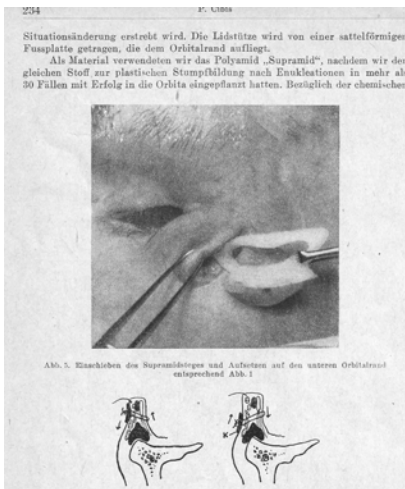
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Though our father was destined for an impact in medicine, rather than sculpture, his artistic talent is reflected in his retinal drawings, used clinically as a roadmap for planning the surgical approach.

Despite the onset of World War II, he completed his ophthalmology residency in Heidelberg in 1940, serving under Professor Ernst Engelking, and became junior faculty. In 1939, he married fellow resident Lisa Nothdurft, MD. They required dispensation from the chief, which he only gave, according to Lisa, after his wife reminded him that they, too, had had the same dilemma. Other “rules” at the time, we were told, forbade ophthalmology residents from playing tennis, chopping wood or driving cars – all of which risked their hands.

Professor Engelking’s influence helped our father get reassigned to the University of Heidelberg Hospital and Clinic on Dec. 23, 1943. After a year and a half on the eastern front as a regimental surgeon, this setting proved a better place to use his ophthalmic surgical skills on orbital and eye war casualties.

Introducing a Supramyd strut resting on the orbital rim to buttress the lower lid.



He became first to use the nylon to rebuild orbital bone, using the supramid as sheets to line orbital floor fractures and as sutures. His reputation in retina as an “almost” reckless surgeon with a “never give up” attitude probably stems from that time when he was trying to ameliorate the immeasurable war-caused misery.

He came to the plastic (nylon) supramid through an acquaintance at BASF, the manufacturer. After the war, BASF had enough of it available that they started weaving it into durable and strong carrying bags. The family used these bags on trips to the country to pick cherries or bring back provisions gifted or purchased from farmer patients/friends/acquaintances to supplement their otherwise meager food rations.

In addition, Dad’s youngest brother and a cousin had a truck with which they transported spools of this nylon, coveted by North Sea fisherman to repair their nets. In exchange they brought back barrels of Bismarck Herring.

Despite his pioneering medical use of nylon, the lack of antibiotics limited Dad’s surgical successes with large artificial bone replacements and copious non-absorbable foreign body suture supports. Supramid is still available and used today.

When our father emigrated to the United States in June 1949, he had to give up a patent he held on the supramid suture. The family followed in January 1950.

In the United States, he joined the School of Aerospace Medicine, in San Antonio, Texas. We lived in the nearby historically German settlement, New Braunfels, in which the schools had taught in German



Cibis in the slit-lamp, Meyer-Schwickerath standing; explaining Oscillation slit lamp photography invented by Dad and used in illustrating his book.

up to World War I. Dad’s mother, who emigrated with us, was able to go almost anywhere in town and find an older person who still spoke some semblance of German.

During the five years at the school, Dad’s research included problems of visual distortion at high-speed flight and retinal damage from high dose X-ray, ionizing and gamma radiation. Most important for Dad’s future, he also worked on retinal damage from atomic bomb blasts. He and his colleagues placed rabbits with the lids held open at varying distances from the Nevada atomic bomb blasts and then histologically looked at the retinal damage. In a 1955 publication, they speculated on clinical photocoagulation.

When Zeiss introduced the Meyer-Schwickerath Xenon photocoagulator, our father became an early champion and had one of the first machines in the United States. Their early results with treating diabetic retinopathy later prompted his Retina Institute colleagues Edward Okun, MD; Glen Johnston, MD; and Isaac Boniak, MD; not to join the 1971 National Institutes of Health random treatment Diabetic Retinopathy Study. They believed the study design would require them to unethically withhold a useful therapy from half of their patients (Continued on page 3)

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— judgment validated by the study's successful, early conclusion.

Dad developed a very close friendship with Gerd Meyer-Schwickerath, MD, who visited St. Louis frequently. A gadgeteer, Dr. Meyer-Schwickerath assembled his first, sun powered photocoagulator on the roof of the Bonn eye clinic. He patented an unsinkable toilet tank float. He would arrive in St. Louis with an empty second suitcase, returning it full of finds from the hardware store not available at home. We remember him and Dad standing in an empty bathtub, gleefully exchanging the showerhead with a fancier model.

As part of his contract with the School of Aerospace Medicine, they promised our father citizenship for the family after he completed the mandatory three years residence. At that time, the government had annual quotas by country. When we reached the three-year mark, the German quota had been filled.

The Mexican was not. The U.S. Air Force, in an official vehicle escorted by an active duty officer, transported us across the Rio Grande to Laredo, Mexico, gave us new paperwork

and photos, then brought us back across the river as Mexicans.

Dad wanted to be able to practice clinically, but the Texas State Board of Medical Examiners declined his application, not recognizing the 400-year-old University of Heidelberg as an institute of higher learning.

At that time, the Washington University Department of Ophthalmology had a longstanding association with the School of Aerospace Medicine. Richard Scobee, MD, partly wrote his classic strabismus textbook while serving there; his close friend Phil Shahan, MD, whose father had chaired the Washington University department, served there simultaneously with Dad.

Shahan introduced Dad to the newly appointed department chair, Bernard Becker, MD. Knowing our father had experience with the monocular indirect (Bonnoskop), Dr. Becker assigned Dad the job of developing a retina service. For that purpose, the family spent the summer of 1955 in Boston while Dad trained with Charles Schepens, MD, before moving to St. Louis.

In those days, retina patients spent a week to 10 days in the

hospital for pre-surgical workups, then post-surgical bed rest with sandbags and pinhole spectacles to avoid eye movement. Dad's patients on average took up an entire floor with lengthy daily rounds.

His dedication to his patients was exemplary. Once, a physician patient, when told that his choroidal melanoma was not responding to photocoagulation and he would need an enucleation, said "I need to get drunk." Being Sunday, Dad drove the half hour home and then back again to bring the requested medication.

That dedication to his patients, regardless of their status or background, was returned by many patients. Over the years, they planted numerous trees in Israel in his name and endowed perpetual masses elsewhere. He always said where the Almighty was concerned, you couldn't get enough help.

At Christmas, we always received cases of liquor and deliveries of other delicacy items, even years after his death. I still have a classic black doctor's bag, a gift from a mafioso. He gave the story of having accidentally dropped a blasting cap in his garage to account for the copper intraocular foreign body.

He and our father developed an empathetic doctor-patient relationship, to the point that the man steered many mafiosi friends to the practice. Mother, who functioned as Dad's patient coordinator, met them all. When a gang war broke out years after Dad's death, she knew most of the victims.

Our first dachshund pet in St. Louis came as a gift from Rommel Hildreth, inventor of the battery-powered surgical cautery pen. Traditionally in Bavaria, people call their male dachshunds Seppi, a diminutive of Joseph, so ours all have had that name.

The first Seppi liked to stay out late at night, wandering astray. He therefore proved a pain (Continued on page 4)

Grand Rounds. Front row right Cibis, Becker to his right then Sanders, Kayes. Pollack standing, Constant behind Becker the only woman in the room. Miller to her right.



From the
Editor's
Desk



Gratitude: A 'Poet' of Medicine's Insight on Age

M. Bruce Shields, MD

As a senior ophthalmologist entering my “golden years” (actually well into them), I find that my predominant feeling these days is increasingly one of profound gratitude. I hope you are able to enjoy the same feelings as you look back on your life so far.

The feeling rose in my consciousness recently when I pulled a small book off a shelf in my library. It had been given to me a couple of years ago by a dear friend and my first glaucoma fellow, David Berry, MD, on the occasion of his 70th birthday (which certainly made me feel old). But it reminded me that one of the greatest benefits of our professional

life, for which we have much to be grateful, is friendship.

The book is entitled *Gratitude* by the well-known neurologist and author, Oliver Sacks, MD. Sadly, it proved his last book, written as he was dying of liver metastasis from an ocular melanoma. What I want to share with you today, however, is not about dying, but living, which Sacks describes so beautifully in his book.

He was born in 1933 in England to physician parents and grew up in an Orthodox Jewish family. The discovery of his sexual orientation as a young man led him to leave his tight family unit after graduation from medical school and come to the “New World,” where he completed his neurology residency at UCLA. Life was not easy for him in his early days, as he searched for “meaning” in his existence and nearly succumbed to an amphetamine addiction in the 1960s. But a move to New York and the discovery of his ability to relate stories of his unusual patients gave him the fulfillment he sought. His well-known book, *Awakenings*, put him on the map (*The New York Times* once referred to him as “the poet laureate of medicine”) and he would eventually publish 13 books, including one of my favorites: *The Island of the Colorblind*.

After a 2005 diagnosis of ocular melanoma, he lost sight in that eye following treatment, but continued to live a robust and fulfilling life for

nearly a decade. In 2014, however, within days of completing his memoir *On the Move*, he learned that his cancer had metastasized to his liver and that his days were numbered. But this only caused him to recognize, all the more, the beauty of every new day and to make the most of each one — a lesson for each of us.

One of the joys he experienced in those days, while he underwent immunotherapy, was a visit to the lemur colony at Duke University (for “a little fun”). That reminded me again of my many reasons for gratitude. It was a visit to that same facility in the 1970s, and a mutual interest in an unusual form of buphthalmos among some of the lemurs, that led to my lifelong friendship with Bob Ritch, MD.

So, as we enter these special years of our lives, we cannot only look back with profound gratitude for so much that we have been given and for the opportunity to give back, but we can also look forward to our next (and maybe most exciting) chapter.

Dr. Sacks expressed this most eloquently in his final book: “I do not think of old age as an ever grimmer time that one must endure and make the best of, but as a time of leisure and freedom, freed to explore whatever I wish, and to bind the thoughts and feelings of a lifetime together.”

May it be so for all of us.

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for both us, who had to go out and find him, and for the neighbors with his barking and roaming. Once the suburb Creve Coeur where we lived locked him in the pound, refusing to give him up. Tom Eagleton, later a U.S. senator and brief McGovern running mate, served as attorney general. His father, a local politician, was also Dad's patient, so Dad called

him to see if his son could help.

We got the dog back. Constituency service.

Benjamin Milder, MD, included in his 1997 book on the history of the Washington University ophthalmology department a long and admiring description on Dad's activities and impact in the department, including the days following his death. John Scott said of

him, “His understanding of the nature of vitreous pathology and how it related to complex retinal detachment laid the foundation for modern vitreoretinal surgery.”

Though his textbook *Vitreoretinal Pathology and Surgery in Retinal Detachment* as not published until the year of his death, Thompson and Blanchard rank it among the 100 most influential books in ophthalmology in the 20th century.

The Great Split: Our Oral History, Pt. 1

Susan H. Day, MD

Each of us has had a fair share of experience with the Academy: attending meetings, using educational products, serving on committees, contributing to advocacy efforts. But not all of us know its history.

We all are familiar with the three incredible leaders (“executive vice presidents”) we have had: Bruce Spivey, MD; H. Dunbar Hoskins, MD; and David W. Parke II, MD. But we have only had one deputy EVP David Noonan. He served in this capacity (first for the combined American Academy of Ophthalmology and Otolaryngology) for 37 years. Such experience highly qualifies him to tell a very unique story of our organization’s history.

During AAO 2017, Noonan entertained those attending the Senior Ophthalmologist Committee’s special symposium with his tales, offering stories of challenges and successes with his unique brand of humor. This presentation deserves a wider audience. Thus, we’ll offer it in serial fashion to *Scope* over three successive installments.

The following is adapted from Noonan’s October 2017 remarks, interspersed with a few of my comments to provide more context.

The Early Years; Growth of the Independent Organization; Evolution of Governance and Outreach.

David Noonan: How many of you were members of the Academy when I joined the AAOO in 1972? You have to admit that it is very presumptuous of me, a non-physician, a non-ophthalmologist, to be giving a talk on the history of the organization you led for years. I hope that I can add a little color to some of the events you all led or witnessed. It

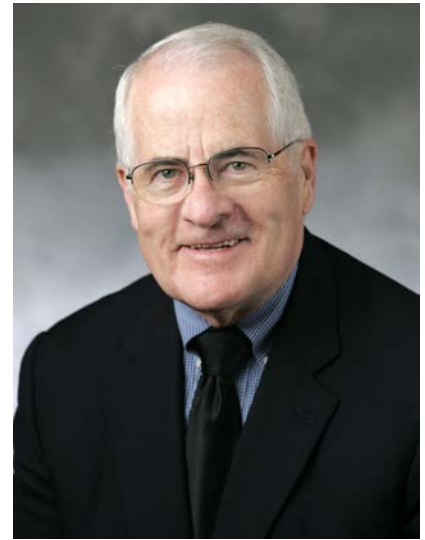
will not be a tell-all story, so some of you can relax.

Susan Day: A bit of serendipity had resulted in David’s working in an Iowa City hospital in which he met Michael Kos, MD, and Bruce Spivey, MD, (one was destined to run the AAOO, the other to serve as the first Academy EVP). Noonan detoured to Utah for further education but was quickly tabbed upon return to Iowa by Dr. Kos, who by then had moved to Rochester, Minn., to lead the AAOO. Soon thereafter, David packed his bags for the move to Rochester. The AAOO staff at that time consisted of Dr. Kos, Noonan and 23 “ladies,” as they were addressed. (contrast this to the size of the Academy staff now – nearly 200).

DN: The AAOO was led by a “council” up to 22 members divided by O and O specialties. The president rotated each year between the two specialties. The organization had total assets of \$1.6 million. And the membership was just north of 8,000. Today we (the Academy) have a budget in excess of \$60 million and a membership over 30,000.

When Dr. Kos inherited the secretary-treasurer job, he created quite a stir by presenting a written agenda backed up with materials for review in advance of the meeting. I was told that under Dr. Benedict’s leadership, the council meeting had one sheet of paper on the table – his!

The council membership consisted largely of representation from academia as benefitted an organization dedicated to education. I quickly learned that any correspondence involving political or socioeconomic issues was to be routed to the offices of the American Association of Ophthalmology or the Council of Otolaryngology. The Academy was all about education.



David J. Noonan

One of the biggest challenges Dr. Kos faced was the growth spurt of membership attending the meeting. For 26 years the Academy had met in the Palmer House in Chicago. Mike convinced the board and the leadership of both Las Vegas and Dallas to expand their convention centers and add 20 meeting rooms for the Academy’s instruction courses.

Two factors changed the focus and the structure of the AAOO under Mike Kos: the availability of appropriate meeting space, and the acknowledgement that EENT training had evolved into such distant pathways that there was no natural adhesion of the specialties.

While there had been a suggestion in the 1950s that the Academy should split, that was defeated. By 1973, however, a motion for separation was validated by mail ballot of the membership that resulted in a 60/40 vote to separate.

Divorce is never easy. There were strong feelings for and against within both specialties. These tested the character of the leadership. They had to surmount legal hurdles and separate assets. They could have employed legal maneuvers to capture the entire assets. Dr. Kos absolutely refused to go down the path. Though the mem- (Continued on page 10)

The Ophthalmologist's Non-Exit Strategy

Samuel Masket, MD

The boxing adage that “father time is undefeated” can easily be applied to ophthalmologists. At some point in our careers we will need to decide if we are desirous and/or capable of continuing to practice our specialty in full or in part.

For some, health conditions and personal economics may be the deciding factors to stop or continue,



Figure 1 - Proportion of Academy SOs active in 2006 and 2015 (courtesy of Harry Zink, MD, and the American Academy of Ophthalmology).

whereas for most, the decision and timing will be elective. No template matches the needs or plans for all, as most situations are very personal and to some degree emotional.

The typical physician prepares more years, works more hours and is more invested in his/her career than are most other professionals. Many of us tend to consider our professional life as our lives. We might have fewer hobbies and “outside interests” than people in other professional groups.

Given good physical and financial health, physicians often prefer to taper our workload in stages, affording more free time and less responsibility while not “cutting the cord” abruptly.

Understandably, we face many facets to the process as we prepare for and learn to accept our “seniority,”

both personally and professionally, just as we hopefully learned to accept the dreaded “Senior Ophthalmologist” ribbon when registering for the Academy annual meeting.

Consider the following dialog. Upon visiting a colleague (let’s call him Ted) who was well into his 70s, I noted a new physician’s name on his door.

Masket: “Ted, are you planning a partnership?”

Ted: “Nah!!”

Masket: “Then what is your exit strategy?”

Ted, without batting an eyelash: “Death!!”

One might consider his response an extreme form of non-exit strategy, but in fact, his plan will lead to an abrupt exit.

While I did not find his strategy an appealing one, there are several non-exit or gradual exit pathways ophthalmologists can consider. These include reducing work time or services, discontinuing or transferring their current practice, working for industry, working for health plans, working

in a university or VA setting, doing volunteer or mission work, etc. Much of what follows I’ve garnered from the presentations of colleagues during Academy annual meetings.

Ophthalmologists Working Longer

Academy surveys of senior ophthalmologists (those 60 and above) indicate that, as a group, we tend to stay active longer than our predecessors. Presently 50 percent of SOs aged 76 are professionally active in some form; 10 years ago, the 50 percent active mark was true for those of us age 71. In fact, nearly 25 percent of the overall physician work force nationwide is of Medicare age.

As you can see in Figure 1, the number of Academy members ages of 60 to 84 who consider themselves to be active rather than inactive has doubled from 2006 to 2015.

Age and continuing education

One concern of staying “too long” is erosion of manual and cognitive skills. Certainly, we are susceptible to age-related diseases and degenerations. American Medical Association research also suggests that physicians over age 60 are less likely to acquire new knowledge and skills over time, although they may retain their existing knowledge base. Indeed, *(Continued on page 7)*

Age	Fail	Fail %	Pass	Pass %
30s	1	0.27%	369	99.73%
40s	72	1.54%	4589	98.46%
50s	90	3.21%	2714	96.79%
60s	25	10.04%	224	89.96%
70s	11	37.93%	18	62.07%

Figure 2 - Failure and pass rates over varied age groups show lower success rates for older ophthalmologists on DOCK exam (courtesy of John B. Clarkson, MD, and Meghan McGowan, American Board of Ophthalmology).

The Ophthalmologist's Non-Exit Strategy *(Continued from page 6)*

American Board of Ophthalmology data show that older ophthalmologists have a declining pass rate when taking the Demonstration of Ophthalmic Cognitive Knowledge exam for maintenance of certification (Figure 2).

The ABO encourages all ophthalmologists to participate in the MOC process to keep their knowledge base current. In some circles (i.e. hospital credentialing), people have called for mandatory evaluation of physician competence beyond certain ages, in similar fashion to airline pilots. However, others also consider such policies discriminatory. Some European centers mandate surgeon retirement at specific ages.

Does age affect surgery?

A related and common concern is that surgical complications may rise along with surgeon age. Indeed, fear of complications and difficulty adapting to ever-emerging techniques and technologies induces some ophthalmologists to “slow down” by stopping surgery but continu-

ing in a medical role in the same practice setting. Following a major coronary infarction, a colleague discontinued surgery, likely prolonging his life and his occupation.

However, OMIC malpractice data on claims versus surgeon age (Figure 3) shows that the number of claims correlates well with the percentage of insured surgeons. Put another way, only 10.5 percent of OMIC claims involved surgeons between 60 and 85, while that group accounted for 21 percent of those insured.

Nor does OMIC drop insured ophthalmologists for underwriting purposes as they get older. Figure 4 shows that only 13 percent of dropped physicians were over 60, although over-60 ophthalmologists represent 21 percent of those insured. In sum, it appears that ageing surgeons do not experience greater malpractice claims. Perhaps this reflects better judgment regarding case selection, etc.

Changing roles

All that said, one must accept that stopping surgery may reduce your self-esteem. As one colleague said, in another sports analogy, quitting surgery can be like “going to the bench after being the starting point guard.” Nevertheless, the reduced stress and responsibility can and hopefully will positively balance the change.

Each of us must determine when it is appropriate to make that move, always keeping

OMIC Insureds Cancelled for Underwriting Reasons 2000 - 2011

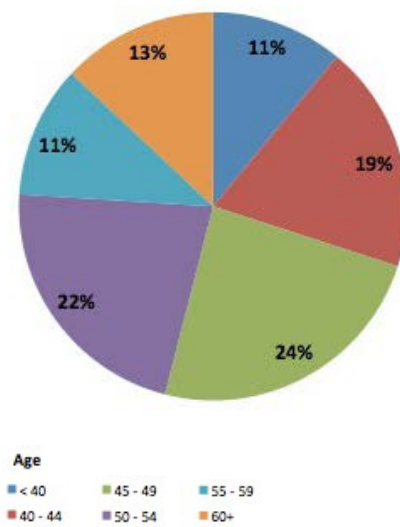


Figure 4 - Age distribution of OMIC insureds cancelled for underwriting purposes (courtesy of Harry Zink, MD, OMIC and the AAO).

patient safety first in our minds. It is prudent to ask a colleague to observe surgery first hand or review surgical videos and objectively comment on one's skills.

Some physicians adjust their work routine by sharing the practice with a new colleague, each working a month, a week or what have you, while the other takes the equivalent time off. This approach lets the doctor get a sense of life absent work and find new opportunities and interests, both inside and outside the profession. At the same time, it protects the practice from economic disruption, as it will be staffed full time.

Gradual reduction of work time and practice responsibilities seems to offer the best opportunity for many physicians in transition. However, one must also look at the business-related impact on the practice. The practice must remain structurally and financially viable while transferring ownership, workload and responsibility from the senior principal to others.

Claims Activity by Age Group

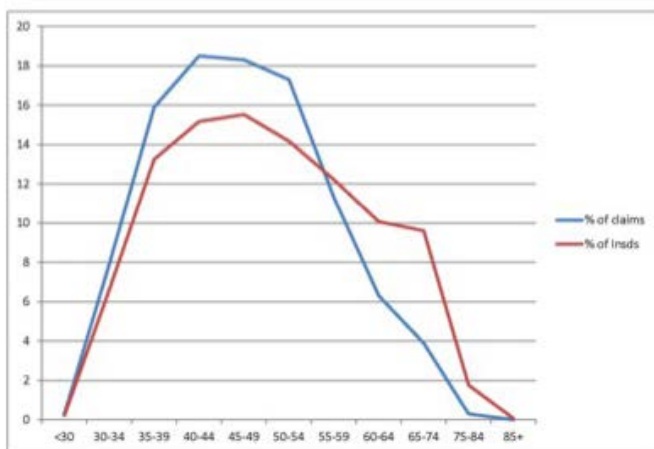


Figure 3 - Curves show similar patterns for claims made against ophthalmologists and age distribution of insureds (courtesy of Harry Zink, MD, OMIC and the AAO).

It depends on the situation, but generally:

To the "non-exiting" doctor:	To the practice:
1. Recognize how your choice will affect your partners	1. If possible keep the "non-exiting" doctor in the practice
2. Give plenty of notice	2. Make sure shareholders agreements address "non-exit" well before it happens
3. Help the practice prepare	3. Buy his shares
4. Be flexible	4. Pay a percentage of collections similar to what the other partners get
	5. Be flexible

How change affects your business

Among the issues to consider is office space; can existing or new doctors fill the office lanes? The same holds true for office staff: will need for their skills remain the same or will some accept fewer work hours? New physicians may also need mentoring and assistance in filling their schedules.

Regardless of the practice situation, one guiding principle is flexibility (Table 1). Without doubt, the projected change will affect compensation for all physicians in a practice. You will need to adjust accordingly, unless you can shift the workload from the "slowing down doctor" to others. Tables 2 and 3 show the possible financial consequence should the principal partner reduce workload without reducing overhead or having other practitioners increase their workload.

In my own case, I brought a colleague into the practice 10 years ago. As she rapidly proved her mettle, I sensed that she could and would succeed me over time, allowing a very gradual strategy — not at all like my friend Ted's plan. After two years, we formed a partnership that allowed us to share revenues in part by production.

Five years ago, at age 70, I resigned from all insurance carriers and reduced my workload to three half days per week. That decision enabled me to continue to practice, perform surgery and generate adequate revenue while shifting the bulk of patient care to my partner and the other doctors in the practice.

Now, at age 75, I have voluntarily discontinued surgery, reduced my workload further and transferred practice ownership,

Table 1 – Suggested approach for a gradual non-exit strategy with regard to practice-related business concerns (courtesy of Derek Preece, MBA, and BSM Consulting).

Example				
	You	Partner A	Partner B	Totals
Collections	\$1,000,000	\$1,200,000	\$800,000	\$3,000,000
Overhead %	60%	60%	60%	60%
Overhead Paid	\$600,000	\$720,000	\$480,000	\$1,800,000
Income	\$400,000	\$480,000	\$320,000	\$1,200,000

Table 2 – Income and expense flow chart using example where "YOU" is the physician about to reduce workload. (Courtesy Derek Preece, MBA and BSM Consulting)

	You	Partner A	Partner B	Totals
Collections	\$500,000	\$1,200,000	\$800,000	\$2,500,000
Overhead %	72%	72%	72%	72%
Overhead Paid	\$360,000	\$864,000	\$576,000	\$1,800,000
Income	\$140,000	\$336,000	\$224,000	\$700,000
Previous Income	\$400,000	\$480,000	\$320,000	\$1,200,000
Change	(\$260,000)	(\$144,000)	(\$96,000)	(\$500,000)

Table 3 – The financial impact on a practice when physician YOU reduce workload and income by 50 percent without shifting workload to other practice members (courtesy of Derek Preece, MBA, and BSM Consulting).

while mentoring a young physician and introducing him to my patients. The most recent change has allowed me to devote time to training, to our Foundation and to the research arm of the practice.

Thanks to Amir Arbisser, MD; John G. Clarkson, MD; Meghan McGowan of the American Board of Ophthalmology; William Fishkind, MD; Derek Preece, MBA, of BSM Consulting; Paul Orloff, MD; and Harry Zink, MD; for their contributions to this article.

Mark Your Calendars for the 2018 Orbital Gala at the Chicago Cultural Center

Christie L. Morse, MD
Chair, Foundation Advisory Board

Without our Foundation donors, the Academy could not lead change in ophthalmology management, clinical care and education. We thank you for your years of support and would like to bolster our reach in the community with your help. We welcome you to join us for the 15th annual Orbital Gala, Oct. 28 at the Chicago Cultural Center. This year's dazzling, '60s-themed gala will be one to remember, with a reception dinner, silent auction and live music under Louis Comfort Tiffany's stunning glass dome.

Help extend the Academy's impact worldwide by contributing to our educational, quality-of-care and service programs. Learn more:

Foundation Advisory Board Welcomes 3 New Members

Three new members have joined the Foundation's Advisory Board. These individuals will help guide the Foundation in strategically building and using its resources to achieve the Academy's mission. I'm pleased to introduce: George B. Bartley, MD, current editor-in-chief for the Academy's flagship *Ophthalmology*[®] journal; F. Michael Ball, CEO of Alcon; and Thomas Frinzi, worldwide president of surgi-



George B. Bartley, MD

cal, Johnson & Johnson Vision.

Dr. Bartley is a respected ophthalmologist who also has extensive editorial experience, having authored approxi-

mately 250 professional publications. He continues to position *Ophthalmology* as a key source for groundbreaking clinical research.

Ball began his career in health care in 1981. Soon he led strategy and execution of global commercial activities for a wide range of eye care pharmaceuticals, over-the-counter products and surgical devices. His insights as past CEO of Hospira, a world leader in injectable pharmaceuticals and infusion devices, makes him a valuable contributor.



Thomas Frinzi

With a wide portfolio covering cataract and refractive surgery, Frinzi produces immeasurable insights on the state of ophthalmology. He won the 2015 Ophthalmology Innovation

Award at the Ophthalmology Innovation Summit and continues to apply his leadership

and expertise to advancing surgical systems for eye care.

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Join an elite group of funders by becoming a Partners for Sight donor. As a member, you can choose to support any Academy program of your choice. Whatever your passion — education, public service, ophthalmic history or helping colleagues in developing countries — we have an Academy program that needs your support.

“When I donate to the Foundation, I'm honoring all of the ophthalmologists who worked to develop such a wonderful profession. Even with many organizations requesting time and money, the Foundation is always a priority. When I give, I show that I value the Academy's leadership in the field and its members for helping patients to face some of their toughest challenges.”

— Paul P. Lee, MD, JD,
Ann Arbor, Mich.

Partners for Sight donors provide access to medical textbooks in developing nations, help seniors obtain free or low-cost exams through Eyecare America and preserve the history of ophthalmology for future generations.

1896 Legacy Society — A Great Way to Give Back

The 1896 Legacy Society, named for the year the Academy was founded, is a special group of donors who have included the Foundation (Continued on page 10)

Historical Excerpts and Quotations Corner

Ophthalmic History Editors: Donald Blanchard, MD, and Daniel Albert, MD

Our history editors compile quotes and wisdom from medicine's long history. Send your favorite timeless pearls on ophthalmology to scope@aao.org.

1 “One should treat as many patients as possible with a new drug, while it still has the power to heal.”

— *Most famously attributed to William Osler, 1901.*

2 Aphorism

“Heed the teaching: Recline the cataract before all vision is lost

The cataract should be white
Then you will receive money, praise,
honor and reward...”

— *Caspar Stromayr,
cataract and hernia surgeon
Practica Copiosa, 1559*

Pre-operative caution was advised in an era when posterior segment status was unknown and ocular phthisis, sepsis and even death all too commonly resulted after couching a cataract.

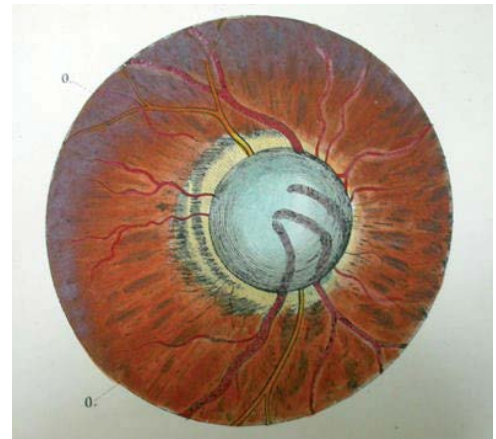
3 Amaurosis arthritica (glaucomatosa) in a 68-year-old woman who had the process for one half a year.

“The diseased optic nerve is light yellow, green color and swollen (bulged forward, elevated, domed, convex). The blood vessels show through this swelling with a dark reddish hue. In the retina, the vessels are very distended and more apparent. This is especially true of the veins, which are a very dark blue, cherry red color. In the limited area around the optic nerve they have an intense bright yellow

color. See o. These flecks are the residual of extravasated blood.”

— *Eduard Jaeger, Ueber Staar und Staaroperationen, 1854.*

This is the first published illustration of a glaucomatous optic nerve head with a description. The misconception of a swollen, bulged forward, elevated, domed or convex optic nerve head was soon corrected to a depression by Adolf Weber, using a variety of lenses and observing parallax.



Academy Foundation Update

(Continued from page 9)

in their estate plans through cash gifts, bequests or other planned gifts. It would be an honor to have you join the ranks of this prestigious group.

William L. Rich III, MD, FACS says, “I joined the Academy’s 1896 Legacy Society because I believe in giving back. I’m leaving more than 25 percent of my estate to help support Academy programs that are important to me and



William L. Rich III, MD,
FACS

the future of the profession. I urge other members to consider making a bequest.”

I encourage you to consider establishing a legacy gift and joining the ranks of this great group. It’s a convenient, meaningful way to support the Academy programs you care about and may also provide tax benefits. What’s more, members receive year-round acknowledgment and personalized support from the Foundation.

Cheers to all fellow ophthalmologists and eye-care professionals! I always welcome questions or feedback from you. Feel free to reach me anytime at cmorse@aao.org.

The Great Split: Our Oral History

(Continued from page 5)

bership voted 60/40 in favor of division (not ophthalmology), Dr. Straatsma led a move to divide the educational trust fund equally.

The divorce process took the better part of a year and a half. As a child of the divorce, I was given the choice of which parent I should live with. I chose ophthalmology, due to the ascendancy of its science and the character of its leadership and the chance to escape Rochester’s 20-below-zero winters for San Francisco.

Besides, if you’ve ever been propositioned by Spivey and Straatsma, with a closer like Ed Norton, you know I really didn’t have an option.

What You're Reading: Mascot Theft, Spies and Memory

Book Review Editor, Thomas S. Harbin, MD, MBA

Senior ophthalmologists share the best of what they're reading this spring. Share what you're reading and send your review to scope@aaopt.org.

From Michael W. Brennan, MD

The Golden Fleece by Tom Carhart and Wesley Clark

It's quite challenging for a first-time author to review a published adventure one personally enjoyed in planning, execution and joyous punishment ... more than 50 years ago. In *The Golden Fleece*, a forever friend and West Point classmate of mine has artfully and humorously described the 1965 kidnapping of the U.S. Naval Academy mascot, Billy the Goat, by a band of West Point cadets and an unusual, most critical accomplice, my then fiancée, Helen.

Author Carhart was the instigator and the ultimate motivator. He artfully intertwines four years of regimented cadet life with the sequence of absolutely unregulated events leading us to the ultimate capture of "Billy" from the guarded Marine compound near Annapolis and transport to temporary containment north of West Point.

Tom also engages the reader with the unique timeline of the Vietnam conflict and relates many personal experiences of our classmates. As entering cadets

in 1962, we only knew it was out of sight on the other side of the globe. By the time we were about to graduate, it was on our mind and we knew we would all soon be there. Tom provides personal insights into the lives of many classmates in the challenges of adjusting from a cloistered preparation for professionalism to the chaos of the battlefield.

He integrates the unique drama of six crazy cadets capriciously seizing Navy's prize animal inspiration. Unfortunately, despite inspiring our cadet colleagues and certainly the football team, Billy returned to Navy after a brief vacation in New York. The Nov. 1965 game ended in a 7-7 tie and Billy bleated at us the entire afternoon.

The Golden Fleece alludes the adventures of Jason and the Argonauts

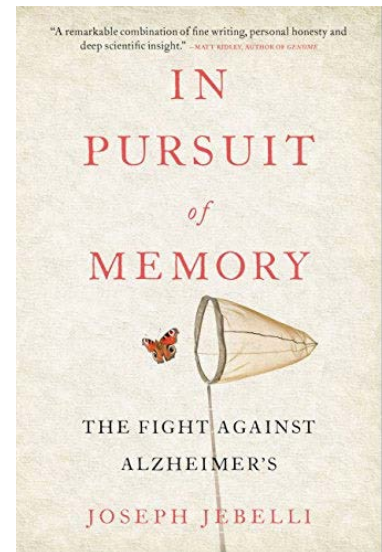
in Greek mythology. Those of us in the adventure will remember the collegiality, unusual professionalism of temporary "purlainment" and the eternal friendship of West Point classmates and their spouses. Thanks, Helen.

From J. Kemper Campbell, MD

Memory: The Fight Against Alzheimer's by Joseph Jebelli

Favorite books should always delight the reader, but equally valuable are the books which educate the reader. *In Pursuit of Memory* belongs in the latter category.

Author Joseph Jebelli is a British

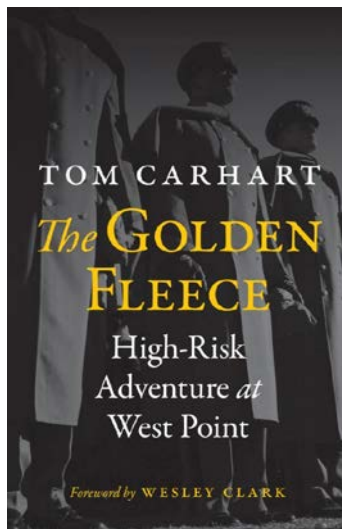


neuroscientist of Iranian descent whose grandfather's mental decline motivated him to enter the murky field of Alzheimer's research. His passion to discover the cause and find a treatment for this devastating disease fuels his writing. His book will serve as an excellent primer for anyone dealing with the dreadful condition.

Alois Alzheimer, a German psychiatrist, first described his eponymous disease in 1906. Originally thought to involve only middle-aged females, it is presently defined as a type of dementia with progressive deterioration of the brain that has characteristic anatomical findings, multiple stages and symptoms that include memory loss. In its final stages, the brain can no longer support vital life functions, making Alzheimer's the fourth leading cause of death in America.

Politicians Ronald Reagan and Margaret Thatcher, entertainers Jimmy Stewart and Glen Campbell, and sports icons Dean Smith and Pat Summitt Head number among the famous examples of the disease's relentless course. Experts estimate that one in three people living in today's society will either develop or care for a loved one with the disease. Heredity, environmental factors like diet and the nor-

(Continued on page 12)



What You're Reading

(Continued from page 11)

mal ageing of brain cells may all play a role in Alzheimer's ever-increasing incidence.

Jebelli's emotional involvement with its victims and his skill as a writer make his descriptive vignettes of patients and their families difficult reading. Nevertheless, the book has a decidedly upbeat ultimate message.

As a lifelong researcher in the field, Jebelli has literally traveled the globe to search out and summarize the latest and most promising information available. He carefully explores genetic, biochemical and epidemiologic theories on possible breakthroughs. He seems sure that, with enough worldwide attention and funding, we can conquer Alzheimer's within a few decades.

Meanwhile, those who wish to understand the scope of the task involved should read this book.

J. Kemper Campbell, MD, is a retired Lincoln ophthalmologist whose grandmother and great grandfather had Alzheimer's disease.

From Thomas S. Harbin, MD, MBA

The Billion Dollar Spy: A True Story of Cold War Espionage by David E. Hoffman

In the Vietnam War, the Russian fighter jets flown by North Vietnamese pilots were superior to those of the United States; as a result, we lost one jet for every

two we destroyed. Fast forward 20 years to the war in Kuwait. This time, our planes were superior to the Russian planes piloted by Saddam Hussein's Iraqi pilots. We downed close to 90 in that and two other skirmishes and lost none. How did this happen?

The above facts were detailed in the epilogue to *The Billion Dollar Spy*. We gained our technological advantages by better pilot training and research but also in no small measure thanks to the espionage material Adolf Tolkachev gave the CIA.

A Russian engineer in Moscow, Tolkachev worked in one of the research institutes that dealt with radar and other technologies. Disheartened by Russia since Stalin, he contacted the CIA's Mos-

cow station and began a multi-year program to supply the latest details on Russian military's radar and other advanced technology.

The U.S. military and other agencies lapped up his material and estimated that he saved the U.S. several billion dollars in research and development. They dubbed him the Billion Dollar Spy and treasured his information. Tolkachev worked with the CIA from the mid-1970s to the mid-1980s. After his betrayal from within the CIA, he was arrested

by the KGB and executed.

The book provides details of the Moscow scene in those days and the tradecraft necessary to run a spy under the nose of the KGB. Fascinating.

From Samuel Masket, MD

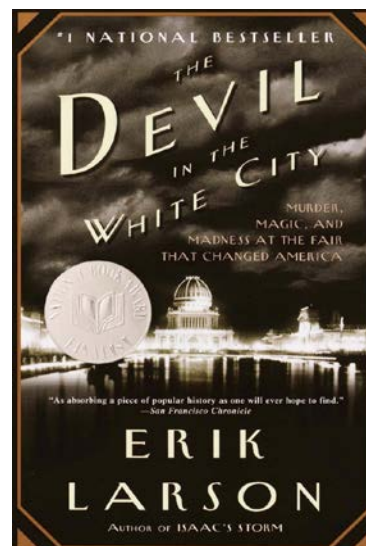
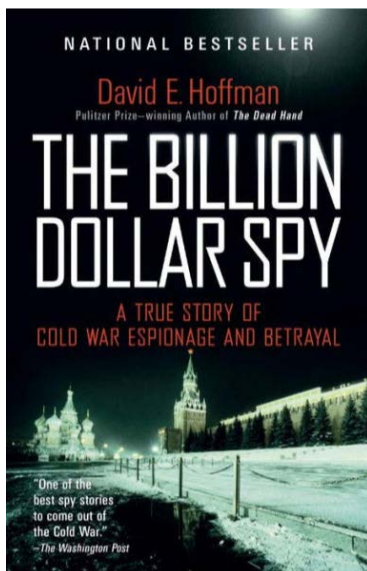
Devil in the White City, by Erik Larson

This remarkable tale chronicles the conception, construction and culmination of the 1893 World's Fair in Chicago. Larson's extensive research provides background details of the fair. On the heels of the Paris exposition during which Eiffel's Tower was unveiled, the Chicago Fair's success was of particular importance to U.S. pride.

Larson's account chronicles the trials and tribulations of construction snafus, budgetary constraints and political machinations. From these trying times, however, came many firsts: the Ferris wheel, Cracker Jack and Juicy Fruit chewing gum, to name just a few.

The fair, its architects and its landscaper would be adequate subject material for reading entertainment, but Larson also provides a parallel plot. Chicago was a dangerous city, especially for young women who could easily turn up missing. Beyond that however, he unveils the first American serial killer, a handsome and charming swindler who used his guile to lure unsuspecting young women in order to take their wealth and, ultimately, their lives.

For Erik Larson fans, this is another masterpiece of education and entertainment.



The Board Exam that Eclipsed My Front-Page Adventure

Ira Eliasoph, MD

It seemed surreal: walking into a strange hospital in an unfamiliar city to be interrogated by strangers about one's competence. I had conquered some challenges by then — I didn't expect my ophthalmology board exam to hit me that way.

At age 16, I got on a train and travelled far to a college I had never seen. Later, the head psychiatrist at my medical school told my class that we were all smart enough, but had signed up for the long haul of training that did not certify us as *normal* — au contraire!

One day in training I had a triumphant moment, when the chief of medicine, after listening to the gathered doctors state their diagnoses on a complex case, agreed that I (a mere medical student), and he, did not know!

Subsequently, I had sailed off as a ship's doctor on U.S. Navy transport ships to take care of women and children, Turks, Greeks and Ethiopians. I had gone in an open boat, in heavy midwinter seas in the North Atlantic, on a rescue mission that made the front page one Sunday long ago.

I then went from being saluted and addressed, "Yes, sir!" to life as a lowly ophthalmology resident whom others called, "Hey, you!"

I was lucky enough to have a full graduate ophthalmology year taught by some of the top people of the time (Alfred Kestenbaum, MD; Arthur Gerard DeVoe, MD; Goodwin Breinin, MD; Ramon Castroviejo, MD; Arthur Linksz, MD; Conrad Berens, MD, et al). As a resident, I also enjoyed excellent personal mentors who helped me get broad clinical experience and much surgery practice. Yet, here I stood, to face some widely known professors of ophthalmology, the top specialty of the world of medicine, to prove I

was worthy of acceptance into that elite group. Yes, I was apprehensive.

Two episodes stand out from that fateful day. Paul Chandler, MD, remains a giant figure in our field. He sat next to me on a bench, after I had examined a patient with a total retinal detachment and large hole in his retina. He talked quietly with me for a while and found out much about me, and at the same time taught me several things. From my high school days, I hated guys who said, "I enjoyed that exam," but thanks, in part, to Dr. Chandler, this time I enjoyed that exam!

My other experience that day occurred with Edmund B. Spaeth, MD, who was intimidating. He started off this confrontation supposedly *about ophthalmic surgery* by quizzing me about radiotherapy. It took little time to discern that I knew little about this, other than Castroviejo's strontium 90 applicator for the limbus for pterygia.

Then he says, in a sarcastic tone of voice, "Doctor, you are doing your first Kronlein operation for a suspected deep orbital tumor." (Unbeknownst to him, I had actually done two and also had scrubbed with neurosurgeons on at least 20 craniotomies).

He went on, "The instrument nurse hands you a long skinny alligator biopsy forceps when you have managed to get a fingertip deep into the orbit. You now feel two firm rounded structures — one is likely the tumor you seek and the other is the optic nerve. What do you do?"

I was able to answer without hesitation, "I would close up and call my neurosurgical friend to do a frontal cranial approach to the orbital roof." Doctor Spaeth put out his hand to shake mine and said, "Very good. You are the first of fifty to give me a proper response."

SCOPE

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