

The Foundation of the American Academy of Ophthalmology
Museum of Vision & Ophthalmic Heritage

Conversation Between H. Dunbar Hoskins, Jr. MD and Alice McPherson, MD
In Partnership with StoryCorps, San Francisco CA, October 24, 2009

Drs. H. Dunbar Hoskins, Jr. and Alice McPherson recorded this conversation on October 24, 2009 during the Annual Meeting of the American Academy of Ophthalmology, in San Francisco CA.

Dr. Hoskins is a glaucoma specialist from San Francisco and Dr. McPherson is a retina specialist living in Houston.

You are invited now to listen to excerpts and read the complete transcript below.



[Here](#) Dr. McPherson discusses what it was like being the first woman retinal specialist in the United States.

In this [excerpt](#), Dr. Hoskins is asked by Dr. McPherson to predict the future of ophthalmology.



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DR. H. DUNBAR HOSKINS, JR.: Hi, my name is Dunbar Hoskins. I'm 70 years old. Today is October 24, 2009. We're in San Francisco and I'm here with Alice McPherson who is a colleague and a friend in ophthalmology.

DR. ALICE McPHERSON: I'm Alice McPherson, age 83. I'm meeting today, October 24, 2009 at the San Francisco hotel, with good friend and colleague, Dunbar Hoskins, whom I have known for many decades.

DR. HOSKINS: Many decades. Alice I remember the first time ... not we met, but the first time we spent any time together was in Calle, in Columbia. Do you remember that meeting?

DR. McPHERSON: Oh, I. ..

DR. HOSKINS: That's was back about 1974 or thereabouts.

DR. McPHERSON: Yes, I certainly do. You were the expert on glaucoma and giving quite a wonderful lecture, which was very well-attended. You were the expert there, as usual, and I was there as a retina specialist. It was a great meeting organized by Dr. Rodriguez, from Bogota.

DR. HOSKINS: Right, Alvero Rodriguez was a good retina man, himself. And you had been in retina now for a few years, a few years.

DR. McPHERSON: A few years.

DR. HOSKINS: How did you get into ... where did you grow up?

DR. McPHERSON: I grew up in Wisconsin, Milwaukee and Madison.

DR. HOSKINS: Wisconsin. In a big city.

DR. McPHERSON: Well, yes, but I was born in Regina, Saskatchewan, then lived in Canada, and then my family moved to Portage la Prairie, which is not a big city. My early childhood was spent in a very small town, near Winnipeg, just to get you oriented. Then, from the north, we migrated south to Milwaukee and Madison.

DR. HOSKINS: And how did you happen to end up in Madison?

DR. McPHERSON: Well, actually, I knew at a very young age, I'd say about 13, that I was going to try to be a doctor, because that's the age where we were doing work studies, and I did one in social work. I soon learned that being a social worker was great in concept, but you really couldn't accomplish anything for people in the sense that I wanted to. So, at 13 or 14, I knew I wanted to become a doctor.

DR. HOSKINS: Anybody in the family were doctors?

DR. McPHERSON: No. In fact, I think another thing that influenced me was that so many of my relatives in Canada died as a result of having surgery. In those early days, surgeries were very risky. As a child, I kept wondering why they were dying, when they had otherwise been in such good health.

DR. HOSKINS: Yeah?

DR. McPHERSON: So one thing led to another and that's when I was really focused on going to medical school.

DR. HOSKINS: So you picked a target and you went after it.

DR. McPHERSON: That's exactly right.

DR. HOSKINS: And where did you go to medical school?

DR. McPHERSON: University of Wisconsin, Madison.

DR. HOSKINS: And then on to residency?

DR. McPHERSON: Yes, I did some residency in Hartford, Connecticut and Chicago and then back to the University of Wisconsin. I was an instructor there for a year or two. I became interested in retina and then I went to Mass Eye and Ear.

DR. HOSKINS: To Schepens.

DR. McPHERSON: Yes. Those are the schools that I attended.

DR. HOSKINS: And who do you think had the most influence on during residency?

DR. McPHERSON: There's no question that I chose ophthalmology during medical school because of two professors that made the ophthalmology course so interesting. It dealt with the young and the old, they described the surgery, and it was relatively bloodless compared to other specialties. They made the field sound very exciting, so I decided to go into ophthalmology.

The same two professors, Drs. Davis and Duehr, ran the residency program at the university. I always thought they were high-caliber, well-trained ophthalmologist. Davis had trained in London and Vienna, as well as good schools in the United States. It was everything I wanted and it was perfect.

DR. HOSKINS: Is he any relations to Matt Davis?

DR. McPHERSON: Matt Davis?

DR. HOSKINS: Yes.

DR. McPHERSON: Oh, yes, that's his father.

DR. HOSKINS: That's his father.

DR. McPHERSON: Yes.

DR. HOSKINS: So that's a dynasty they've got up there.

DR. McPHERSON: Yes. Matt Davis played a significant role in my life too, because he went to Boston for three months to be with Schepens. And why did he do that? Because his father was a top-notch ophthalmologist and was well aware of what was going on in the country. At that time, it was quite a radical situation, if you heard about a doctor who was wrapping and shrinking an eyeball and indenting it 360 degrees. That was big news. So he sent his son, Matt Davis, out there for three months and when he came back to the University of Wisconsin he looked in eyes. I had been doing retina work with the top two professors, but I

realized that, compared to Matt Davis, I could hardly see anything using my direct ophthalmoscope. In those days, people looked at retina and they'd say, 'Well, it's on. It looks good.' When, in reality, it wasn't. We looked at just a small central area, and it had temporarily reattached, but over the long-term it was not good. Matt Davis came back with this new idea, so I immediately started training on the indirect ophthalmoscope and doing the procedures that he had learned for three months in Boston.

When *I* went to Boston, I had a great advantage. Dr. Schepens had never before had a fellow that had training and knowledge of how to use the indirect ophthalmoscope or knew how to do a lot of the surgical procedures. That was quite a blessing. It helped me so much in dealing with the fellowship at the time.

DR. HOSKINS: And this was ... when was this? How long had Schepens been in Boston at that point?

DR. McPHERSON: Dr. Schepens came to Boston in 1947 and Boston was very fortunate to have him. You probably know this story about his background. He had the choice of many cities, but he chose Boston and came as a research fellow at the Howe Laboratory. Dr. Dunfey really understood what he was trying to do. At that time, he was accused of not being as accurate as he claimed to be about what he saw in the periphery because nobody believed him. And so...

DR. HOSKINS: Because nobody else could see it.

DR. McPHERSON: No, but Dr. Dunfey was very open-minded and had realized and seen some of the results, so he helped him [Dr. Schepens] tremendously. Dr. Schepens left the Howe Laboratory a little early to go to Boston. Dr. Dunfey acquired special rooms in which Dr. Schepens was to work. It was the size of a small closet, but the space was very good and he could use his indirect ophthalmoscope to study the retinas. It soon became evident that he could reattach retinas at a much higher percentage than anyone else.

DR. HOSKINS: And what kind of teacher was he?

DR. McPHERSON: Dr. Schepens or...

DR. HOSKINS: Dr. Schepens.

DR. McPHERSON: When you're with a man like Dr. Schepens, he just oozes a mission and purpose and dedication and knowledge, and so you couldn't help but respect everything he did. He respected others, too. He respected the students and was understanding.

DR. HOSKINS: So everything he did generated respect because he was dedicated?

DR. McPHERSON: Yes, very much so. We were all there learning the use of the new indirect ophthalmoscope and his surgical techniques. Looking at the retina with the indirect ophthalmoscope is like punching a hole in the ceiling and looking at the sky with new binoculars. Prior to that we were all trained with the direct ophthalmoscope and then we naturally made the transition. Being in retina at the University of Wisconsin, I really appreciated the new scope as a gift to doctors to enable them to have better visualization.

DR. HOSKINS: So you went back to Wisconsin to stay at the university.

DR. McPHERSON: Yes, that's right. I was single and they were kind enough to suggest I could stay there as an instructor. However, this was a long time ago in the 40's and 50's when women were not being accepted as referral surgeons in the Eastern United States. I think we had the respect of our working companions, but it was just not possible for a young woman. So I knew I had to go somewhere else to do surgeries and to do what I wanted to do in ophthalmology.

I think I had pretty good training. At that time, I was lucky enough to spend a short time with Claes H. Dohlman, MD and some time on the glaucoma service. I was very eager to get out and do something, had licenses in every state, and was prepared to choose anywhere I wanted to go. At the time, there were, at most, eight specialists in the United States that were really trained in retina, so we just divided up the country. After touring around the country, I came to Texas, because people were very nice and it's turned out just as I had anticipated. They were open-minded and they eventually did get to the point where they were referring patients to me. The older men and the older ophthalmologists were referring cases to a young squirt out of Boston. I was a fairly young woman at that time.

DR. HOSKINS: So you ended up in Houston?

DR. McPHERSON: Yes, sir.

DR. HOSKINS: And that was probably what, about 1955 ...

DR. McPHERSON: No, 1960. I had gone to Scott & White for about nine months, because I went between Dallas and Houston looking at both schools. I introduced the residents at both places to the indirect, even what lens to use. At that time, my personal impression was that Houston would be my future medical home. I've never regretted that choice; it's been a very enjoyable experience.

DR. HOSKINS: You touched on being a woman in ophthalmology, or being a woman surgeon, actually, at that time. And you were, in many ways, a pioneer because of that. There weren't very many of you, were there?

DR. McPHERSON: I was the first, no question about it. I was the first female, full-time retina specialist in the world for a long time. I was very proud of that distinction. In the 60s, the Club Jules Gonin, which was a very exclusive society for retina in Europe, accepted me as a member. At the time it had a small membership; only about 100 members. When I received that membership as a female from America, I thought I'd died and gone to heaven. I had done everything.

DR. HOSKINS: Now, how did you deal with all of that?

DR. McPHERSON: Oh, I ...

DR. HOSKINS: I mean, you go down to Texas. Texas is a ... I mean, you say they're warm and welcoming, but they have little macho attitudes down there, maybe.

DR. McPHERSON: I would say it was minimal, compared to certain other places in the country. If you can do something and you can show them you can do it, things fall into place. I was in Houston and had good friends there, but they didn't refer any cases to me. As I said, it was a problem. The thing that got me started were patients that drifted up from San Antonio. They were told they would be blind and I happened to reattach some of the retinas in those cases and then they went back to San Antonio with improved vision. The physicians were such a strong group of honest, ethical men, that they recognized the success rate was higher just by referring their patients to me in Houston. Within about a year to a year-and-a-half, I was getting all of the detachment referrals from San Antonio. It then took me another year to a year-and-a-half, to obtain referrals from Dallas and then finally referrals from the Houston area. The referring doctors were from nearby cities around Houston, and from other states, of course. Houston was very

generous about referring patients, and they have been ever since with regards to referring patients to specialists; glaucoma, muscle, etc.

I didn't expect any special consideration. If you're a woman and you have as much ability as anyone else, the men in science are very fair thinkers. If you produce, they understand. This idea of whining and feeling that, 'I'm not getting an equal chance because I'm a woman', I never felt that way in my whole life. If you can't produce and you're not good, whether you're male or female, it's not going to make a particle of difference. You'd be treated the same way. It was just a fact that surgery referrals were something people just didn't do very easily, especially experts in the field who were much older.

DR. HOSKINS: Yeah, I remember when I joined Bob Shaffer, you know, I was a young whippersnapper and he ... I'd go and see the patient and they clearly needed something done, and I'd say, 'Well, I think you need such and-such.' And they would say, 'Well, what does Dr. Shaffer think about that?' And so we all go through that, you know, we all go through that.

DR. McPHERSON: Sure. I think that's right.

DR. HOSKINS: You have at least a 50-year perspective on ophthalmology in this country. What do you think ... when you think about that, who are the people that you remember that stood out in your mind as having supported you, helped you move forward, the mentors you remember. .. besides Dr. Schepens.

DR. McPHERSON: The specific names escape me, but there were many individuals, including the Chairmen of the Departments in San Antonio and Dallas. There were also ophthalmologists from all over the southwest; Oklahoma, Mississippi, Arizona, New Mexico, and so forth. . I hate to list one or two as outstanding, because they were all so good.

It was an exciting time. Schepens established a retinal fellowship. It was the first time that somebody had to be trained one year, which was considered forever for a fellowship. As a specialty, ophthalmologists had to get used to referring patients to another specialist. They were doing detachment work, diathermy, and a few of them had started buckles.

I think the turning point, when more and more ophthalmologists gave up doing the general field of surgery for retinal detachment, was with the advent of the lasers and the cryoplexy. When these started to immerge, just like they used in the first

xenon arc, Gerd Meyer-Schwickerath ultimately changed that whole field. Then the first lasers came in at red, the ruby laser, and then it went over to the different colors, the blue and then the green, and so forth, and then the dyes. This is where the well-educated ophthalmologists, doing very excellent work in all the branches, cataracts, glaucomas and the like, started to think that maybe a specialist could more successfully do the primary case. You see in detachment work, we like to get them as primaries, because we have better success rates. Before, it was very common for the general ophthalmologist to do the first case to see if it would work or not.

DR. HOSKINS: You had to dissect out all that thermal scar, didn't you?

DR. McPHERSON: Yes. We had to pick it up and carry it on. There was a fundamental change in philosophy. Because they were such high-caliber ophthalmologist, they wanted the best for their patients, so each one of them, gradually, began to change. The indirect ophthalmoscope wasn't quite as popular at the time. I think the ophthalmologist themselves, wanted to get away from performing those reattachment surgeries, because the success rate was so low. In Texas, it was a common statement: 'Well, if they've one good eye, forget about the other one.'

DR. HOSKINS: Well, I think all that pioneering worked ... turned the whole field around.

DR. McPHERSON: Oh, yes.

DR. HOSKINS: So innovation was key to these developments, people creating new ideas, bringing new technology and allowing the doctors to be more effective. What other big changes have you seen in ophthalmology over the years?

DR. McPHERSON: The big change I've seen in ophthalmology?

DR. HOSKINS: Yeah, in the profession, what do you think are the big changes?

DR. McPHERSON: I'm not thinking of the instruments or chemicals. I think the big change is in the attitude of the ophthalmologists in practice and the development of all the subspecialties. Retina was the first. After that, there were many fellowships in other specialties. Originally, the young doctors' big choice was to be a good general practicing ophthalmologist. Now, when they come to the end of their residency the choice is in what specialty they are going to take a

fellowship. They want that extra training and I think that's a major change in philosophy.

The big change in the field of retina itself, is fantastic. I understand that during the sub-specialty day of retina, at this years' Academy meeting, they had over 3,000 doctors interested in additional training in retinal detachment. Better care is a direct result of this change in practice and philosophy.

Perhaps even preceding that was the education of the ophthalmologists and sharing of new developments, such as the indirect ophthalmoscope, which changed the whole field. People could look to the periphery, and make better diagnosis in children, infants, trauma cases, the near-sighted ... it goes on infinitum because it's an entire field. Case in point, you can go to underdeveloped countries today and perhaps the only good instrument they have in their department is an indirect ophthalmoscope.

DR. HOSKINS: You've had a lot of interest in that. I know you've done a lot of support for the Pan American and been to Latin America many times supporting less developed areas.

DR. McPHERSON: Yes.

DR. HOSKINS: You've created a foundation to help do that. Talk a little bit about that—how you've done that, why you've done that.

DR. McPHERSON: It was so fulfilling to be able to get the education and do the work I wanted to do. I've enjoyed it immensely. It was such a privilege. I may be prejudiced, but I think for young doctors today who want to specialize, there is nothing better than ophthalmology.

I believe providing opportunities for fellowship training to young doctors from all over the world is of paramount importance. They can then bring back new talent and skills to their country, which is the way you prevent blindness. We're out there trying to prevent blindness, and what better way than to train the youth of today. When you die, you take your knowledge with you. It's the people you leave behind, the people that you have trained, that will hopefully train others and that will, in turn, decrease the incidence of blindness.

I've been very interested in North and South America, and we've been interested in providing fellowships and scholarships, and in working with exchange students.

We've worked on that through the Retina Research Foundation of Houston. I'm very happy I've accomplished one other thing this past year, and that is to establish two, one-year Helmerich International Fellowship Awards that will be administered by the International Council of Ophthalmology Foundation and funded by Retina Research Foundation. This is the first time that this has been done. Prior to this, all the fellowships on an international level offered only three months of training. Now, with the International Council of Ophthalmology Foundation (ICO Foundation), they are able to have two international fellows per year. They will have special training and, as one of the prerequisites, they have to return to their native country. Brad Straatsma and Jean-Jacques De Laey, from Belgium, head the Application Committee for the ICO Foundation this year. For the first time, two fellows have been appointed.

DR. HOSKINS: Where will they train?

DR. McPHERSON: One will be trained in India.

DR. HOSKINS: But it's more difficult now to let people train in the United States, isn't it?

DR. McPHERSON: Oh, yes the regulations and rules about surgery and so forth are very strict. There are good training clinics in many other countries in the world. Training sites are supervised and approved by the Selection Committee. I observe and participate in that Committee in a very limited way. The other members of the Committee have such experience and provide exemplary guidance on an international level. The application data is so well standardized and good that it is going to turn out to be a wonderful international scholarship for the poorer countries.

DR. HOSKINS: That's wonderful. And it's very frustrating that our regulations in the U.S. prevent us from bringing people from other countries and training them properly. It's a great frustration. We've run into the same thing with our Glaucoma Foundation, where we can bring them in, but they can't operate, you know, they're not even really supposed to touch patients, but... it is very frustrating. Because I agree with you. I think this is the way to distribute care, is to distribute well-trained people, you know? And I applaud you for doing this. It's really nice.

DR. McPHERSON: Thank you.

DR. HOSKINS: What would you like to talk about?

DR. McPHERSON: Oh, I'm running out of hot air. All my life my main interest has been retina and surgery, so I am talking about my primary area of interest.

DR. HOSKINS: If you had a magic wand and you could change something about our profession, whatever you might think, what would it be?

DR. McPHERSON: Oh, that's a big question. What would I change? I would increase the communication between clinical investigators and the basic sciences. This is the goal that Schepens had and I try to carry on. I liken the two groups to two species that have to communicate. The big breakthrough, from the 40's to the present, is that they have begun communicating. It has evolved and is progressing. They're currently discussing translation research, which was unheard of decades ago.

If the clinical investigator and the, so-called, bench investigator, are somehow able to communicate the needs, we'll reach answers to problems in ophthalmology; What are we doing? How can we do it better? As I say, our goal is to decrease blindness. It would be a huge breakthrough, if basic scientists and clinicians could develop good relationships, better communication, and understanding of the needs of each type of specialty..

DR. HOSKINS: How do you think industry fits in to all of that?

DR. McPHERSON: Well, I grew up in a time where physicians remained independent and did not rely on industry because they thought it might bias their opinion. In recent years, industry has shown a greater interest and is much more influential now because they're investing so much money in their own research. They have fantastic funds available for the type of research in which they're interested. There, again, to take advantage of that, you need cooperation, strict guidelines, rules, and honesty. I think the main thing is honesty in results and not being influenced by trying to increase sales or income. That is the little danger about industry. They have to be able to produce a product and make a profit in the market. I think the relationships are good and they are improving, but, it's one of those precarious, ethical gray areas that we must enter carefully.

DR. HOSKINS: We have to protect our integrity. If we can't do that, then we shouldn't be involved in it at all.

DR. McPHERSON: Yes.

DR. HOSKINS: It's a real challenge, I think, because the industry has one goal. I think we all share a goal of finding something that really helps the patient turn out better, because ultimately then the industry won't be successful and the doctors won't be successful. But there have been some egregious abuses in the relationships, and maintaining our integrity as we deal with these is going to be critical for the future. I totally agree with that.

DR. McPHERSON: Yes. That is the danger, especially when young clinical investigators project the lecture slide disclosing their financial interests and advisors. Sometimes there are so many you really do start questioning the paper, even before you've heard a word.

DR. HOSKINS: Exactly.

DR. McPHERSON: That's bad news.

DR. HOSKINS: Is there something we and organizations should do ... and this is a debate that goes on vigorously within organizations. The Academy actually commissioned a group to look at it and suggest changes. How do you help the audience know what the biases of the presenter might be, expose the relationships when we ask that they disclose those? You can't exclude these people, can you, because they're the ones that know what's going on.

DR. McPHERSON: Oh, no, exactly. They have to be allowed to present their findings and research. I have observed recently that younger doctors are being trained to think critically and analyze. They're not just blindly accepting the information or the word of someone who gets up and thinks they're an authority on the subject. They have a healthy degree of skepticism and are critically scrutinizing the results. In my time, we listened and trusted and believed a little more. Now, they're so much smarter and analytical.

DR. HOSKINS: Well, what have you enjoyed most about ophthalmology?

DR. McPHERSON: What do I enjoy the most?

DR. HOSKINS: Yeah, other than ... let's take the when the patient does well. I think that's our great satisfaction and pleasure that we all get. But there are probably other things, as well, in ophthalmology.

DR. McPHERSON: It's also the challenge an individual gets from handling a difficult case. I find myself doing less activity as I grow older, but I enjoy the challenge. Even now, I'm seeing cases in which I am able to look at the problems, think of the solution, make a judgment call, and successfully handle the treatment or cure. You want to be of help solving the complex questions sometimes. The simple questions are somewhat boring after so many years. It's the complex problems you can enjoy.

DR. HOSKINS: And there are lots of them out there, aren't there?

DR. McPHERSON: Yes. Yes.

DR. HOSKINS: We're not short of problems.

DR. McPHERSON: They're not decreasing. They're there.

DR. HOSKINS: The more we know, the more we have to find out.

DR. McPHERSON: Yes.

DR. HOSKINS: So what are you going to do the next 25 years in ophthalmology?

DR. McPHERSON: At this time, my interest is in foundations. Currently, I'm on five foundation boards relating to ophthalmology and, believe me, I enjoy every one of them. The missions and the purpose of them are just what I like to hear about. I hope to continue my participation in these activities as long as possible.

DR. HOSKINS: Well, you've done a lot, Alice. You've pioneered, you've broke the glass ceiling, shattered it completely. You rose up in the ranks.

DR. McPHERSON: Yes.

DR. HOSKINS: It wasn't an easy time. You make us all proud.

DR. McPHERSON: Well, thank you very much. It's always such a pleasure talking to you. Remember, from Calle on?

DR. HOSKINS: From Calle on.

DR. McPHERSON: That's right. We've enjoyed it all.

DR. HOSKINS: Thank you very much.

DR. ALICE McPHERSON: I'm Alice McPherson, and I'm 83 years of age. This is October 24, 2009. We are speaking together at the San Francisco Marriott. And it's a great pleasure to talk to Dr. Dunbar Hoskins, who has been a friend for many, many decades.

DR. H. DUNBAR HOSKINS, JR.: Thank you, Alice. I'm Dunbar Hoskins. I'm 70 years old. Today is October 24, 2009. We're in San Francisco, and I'm being interviewed by Alice McPherson, who's a great friend and colleague in ophthalmology.

DR. McPHERSON: Well, I'll just do... to know a little more detail about your background, since I have asked you many questions, but not about... something like this, about... first of all, how did you get interested just in the field of ophthalmology?

DR. HOSKINS: Well, my father was doing eye, ear, nose and throat. And he finally decided after getting up in the middle of the night with tonsil bleeders back in the 40s and 50s that he would just dedicate to ophthalmology.

So I went to medical school at the Medical College of Virginia in Richmond, Virginia, and I got a job in the lab. My father always made sure I had a job when I was growing up. I had a paper route at the age of 10, you know, and everywhere I was I had a job doing something. And so I got a job in the lab with a researcher by the name of Walter Gerraets and Dupont Guerry MD who chaired the department at that time. They were beginning laser experiments with Bill Hamm. Dupont brought one of the early xenon photo coagulators over from Meyer-Schwickerath and I found it all fascinating. So it was a natural trend to go into ophthalmology because I had been involved in some of the research at the basic level, as well as clinical activities. So I did a residency at the Medical College of Virginia.

I was in the Berry plan and joined the Navy in Newport, Rhode Island after Residency in 1968. I wanted to do a sub-specialty in something. Since I was planning to practice in Richmond, Virginia, I looked around to see what sub-specialties are not represented there. Well, Tom Stratford was there in retina, and they had somebody in every specialty except glaucoma. So that's how I chose glaucoma. I talked to Dupont Guerry and he suggested I go see an ophthalmologist in San Francisco by the name of Bob Shaffer and see if I could get a fellowship with him. I met Bob at the Academy meeting in 1968 and he accepted me in the fellowship in San Francisco and I came out here and I've been here ever since.

DR. McPHERSON: Oh, he's such a mentor. Now how long was a fellowship at that time?

DR. HOSKINS: It was one year. And it was a delightful year. Bob treated you like you had just joined his family. He and Virginia would invite you to their house frequently. We both lived out of town, about... maybe a 30-minute commute out of town in those days. And so I would ride in with him in the morning and ride home with him at night. And it was a great experience, because I learned so much more than just the clinical aspects of glaucoma.

DR. McPHERSON: Were you married at the time?

DR. HOSKINS: Yes I was. After Fellowship, I had a choice. I could have stayed in Richmond and been a glaucoma specialist there, but when offered the opportunity to join Bob Shaffer it seemed like the right thing to do. It was a bigger pond, and San Francisco is a beautiful place. I had a good time.

DR. McPHERSON: Well, I remember those years, they would advise young doctors that don't try to set up a practice out in San Francisco because it is so crowded like that. But you never regretted wanting to move and you've lived here ever since and then your practice and everything?

DR. HOSKINS: Yes, I've been here now since 1970.

DR. McPHERSON: Oh, my goodness. Well, ... of course, you've enjoyed the field of glaucoma and then you changed your activity and added the Executive Vice President of the Academy. How many years were you in practice before that, and what made you do this transition?

DR. HOSKINS: Well, I was always involved with the Academy. Bob was involved with the Academy. He was the vice president of the Academy at one time and he would put together courses and symposia on glaucoma at the Academy. In fact, he chaired the first symposium about trabeculectomy in this country back in 1970. So his activity in the Academy, I think, is what got me involved.

He was also very involved in Pan American Association, and in 1974, I remember we went to a meeting in Puerto Rico. Bob asked me if I was interested in doing any work with the Academy. And I'm sure Bob Shaffer arranged all this. But Bob Reinecke came up to me to ask me if I would be interested in doing a videotape on

glaucoma treatment for the Academy. So Bob Shaffer and I worked together on that and we created a videotape. And I ended up as part of the COVE Committee, which was the Continuing Ophthalmic Video Education Committee. But during this time we were very busy in practice, private practice, teaching at the university, and...

DR. McPHERSON: It was like halftime at the university or...?

DR. HOSKINS: Well, never really employed at the university. I was a clinical professor, so we were attending as, you know, townies coming to the academic center.

DR. McPHERSON: But would you go and practice as a solo or with... were you with a clinic or a group or partners?

DR. HOSKINS: Bob had four people in the practice at the time. It was Bob Shaffer, Jack Hetherington, Bill Van Herick and Bill Ridgway. Van Herick and Ridgway did general ophthalmology, and Jack Hetherington and Bob Shaffer did glaucoma. And so I joined that practice and worked with Bob and Jack Hetherington, and still do work with Jack now some 40 years later,

DR. McPHERSON: All these years that you've been active with the Academy, did you continue at all with your private practice or with any seeing patients?

DR. HOSKINS: I did. I became the Executive Vice President of the Academy in 1993. But I kept seeing patients a half-a-day a week whenever I was in town for all that time. And it seemed important to me that if we're going to kind of lead a profession to be still involved in the activities of that profession, and seeing patients, because that's what it's all about. Also, nobody thanks you the way patients do, either, so it's a great reward.

DR. McPHERSON: Everybody... for me it's always been a question that I never asked, but that is so how did that happen where you're in practice and then you're switch over to be Executive Vice President of the Academy? I know that the search committees are out and you were asked, probably, to be interviewed, etc., but somehow did... tell us a little bit about that. I would be very fascinated to hear.

DR. HOSKINS: Well, my road in the Academy started when I went to my first Academy meeting in 1968 at the Palmer House in Chicago. I was so impressed

with the luminaries, giving papers in front of the Academy and thought, 'Now, that's really a great thing to do.' I think it's giving back. It's participating. It's discovering new ideas. It has a creative aspect to it. So I really loved the Academy after my very first meeting. And then Bob encouraged me to get involved in that and the Pan American Association of Ophthalmology. So I joined some committees in the Academy. I was the Secretary for North America for 10 years in the Pan American Association of Ophthalmology, and traveled a lot through Latin America, as you did.

But working through these committees, I ultimately became the Secretary for the annual meeting [at AAO]. So it was my job with the professional staff to organize the scientific program and instruction courses for the annual meeting every year, and that was a delightful job. I enjoyed that. I enjoyed that a lot.

And then I was on the Board of the Academy for about seven or eight years. And when the time came that Bruce Spivey wanted to step down, there was a search and they asked if I wanted to do the job. And it's effectively a full-time job. But I think for you and me full-time means 70-, 80 hours a week. It's not 40 hours a week.

DR. McPHERSON: No, it isn't. Yes, I know how you work.

DR. HOSKINS: But I did want to maintain that connection to the private practice. So I took over the Academy in 1993 and I did that until March of this year, 2009.

DR. McPHERSON: Of course, you had such a... Well, you say it was a full-time job and still you tried to keep on a little bit with contacts with patients. But, you know, you started out , and this Academy has grown, for example, what would be the membership when you started and those years, and then what it is now? It's been just growing. And as that grows, so do your problems grow, I'm sure. If you could just describe a little of that for me.

DR. HOSKINS: Well, I think in 1993, we had about a little less than 90% of the ophthalmologists were members of the Academy, which was very good for a specialty society, but there were a lot of things going on. Ophthalmology had come under criticism by Congress because of the cost of cataract surgery. You remember back in those days, cataract surgery was being reimbursed at a high level. And lots of ophthalmologists were talking about how they could do their 15-, 20 cataract surgeries in a morning, and Congress didn't understand why they were paying so much money to people to do so many procedures.

Also intraocular lenses and refractive surgery had come along, and the Academy had really not opened the doors so much to have the debates on these new technologies held within the Academy. It seemed important that we needed to make sure that when there is debate about new technology and new techniques and new procedures and new ideas that that debate occurred within the Academy. So we created forums for refractive surgery to be debated in the Academy, and tried to insist on an integrity within that debate, so that there was honesty in a presentation, as much as you can determine that. And we do that by creating balanced discussions.

So we grew from about 89% to nearly 95% now. Plus, the international expansion has increased it, so the Academy now has about 27,000 members worldwide.

DR. McPHERSON: That's fantastic. And then all this, you did help the Pan American a lot. Maybe a few words on that. I told you I know you were the Secretary for the North America, but...

DR. HOSKINS: The Pan American is a great organization. It's just fun people with good hearts, who really want to improve things. Ben Boyd was the Executive Director of the Pan American and I was the Secretary for North America. And at that time most of the dues and most of the money was coming out of North America. There was less money available in Latin America. So most of the funding for the organization came through meetings in North America and membership from North America. I think that's shifted now.

DR. McPHERSON: Yeah.

DR. HOSKINS: I think the Pan American is really a very strong, healthy organization that's grown up. And people like you supported the Pan American and helped it grow, as so many people did in those days.

DR. McPHERSON: Yes, it's been very rewarding to see its wonderful development. Now, with all those years that have gone on and your term office and doing all this for Academy, the government seemed to be playing more and more a significant role, and the problems certainly had increased and reimbursement factors. You say the government didn't question when they were doing 10 cataract visits, you know, in the early morning or something. But could you... I know there's a lot of political action. Could you say a few words about that and your activity in that field?

DR. HOSKINS: Well, the Washington office was established under Bruce Spivey, and Bob Reinecke. And OPHTHPAC was established at that time, but OPHTHPAC grew and became the largest medical pact, other than the American Medical Association in Washington. So we did have access and we could have influence on how things evolved.

We knew there was strength in numbers so in the mid 90s when there was a big battle between primary care and specialty medicine, three of us got together—Mike Maves MD, who now is the Executive Vice President of the American Medical Association [but at the time was the Executive Vice President of the American Academy of Otolaryngology], and a fellow by the name of Bill Tipton MD, who was running the Orthopedic Association—created something called the Surgical Specialty Care Coalition. We recognized that surgical specialties were being left behind in this battle over appropriate reimbursement. So we were able to create this coalition and raised a few million dollars to fight the battle for specialty medicine in Washington, and it was very successful. We didn't get steamrolled the way we thought we might be with reimbursements in... because it was a great shift to push more money into primary care.

Those battles continue in Washington today, and Congress has done what it's does very well, you know, divide and conquer. They've got one group of people in medicine fighting another group of people in medicine. And I think that's a shame because when we do that it guarantees that one group is going to lose, and maybe both groups will lose because Congress says, 'Well, they're divided. We can do anything we want, we can make any decision we want, because there's no cohesive group in Washington dealing with these issues.' And this is becoming obvious in the battle over healthcare reform. The AMA has less influence than it used to. And it's a shame because medicine needs a strong voice in Washington.

DR. McPHERSON: Yes. It seems to me, too, as the years have gone, the young doctors are not really interested in the AMA as they were originally. It looks like they ask the question: 'What did they do for me?' and...

DR. HOSKINS: You mentioned earlier that you noticed that there was increasing specializing in ophthalmology and that's absolutely true. When I started as the EVP, about 65% of the members said they were general ophthalmologists. That's down to probably 45% now. And the residents... not all the residents, but on the last survey, 90% of the residents wanted to do some sort of sub-specialty training. So we are seeing increasing gravitation towards specialty areas, and that's

probably natural. You know, medicine has gotten more complex. It's hard to know everything about everything, and patients want specialty care.

DR. McPHERSON: And I think, you know the results and care if somebody is fortunate enough to have all the specialties. But I noticed that so many medical schools, like the University of Wisconsin, is trying to concentrate more on primary care and training young doctors, that that's a goal now, primary care, which is I'm sure because of the recent health situation.

DR. HOSKINS: Well, Congress really believed that primary care that will solve the healthcare problem. I have my own opinions on that and I'm not sure that it's correct. Patients want the best care they can get and they want to see the specialists. And, yes, specialty care costs more, but it's all about doing the right thing at the right time the first time. And like you were talking about having to re-operate on failed retinal detachment procedures, that's a lot more difficult and a lot more time-consuming and troublesome, and it's much better to do it right the first time. So this battle will go on between primary care and specialty care, no question. But I don't know that that's heading in the right direction, trying to increase the primary care.

DR. McPHERSON: Well, this is why the country is a little bit divided on this subject so much. I just hope they keep the interest up and keep the interest in what's happening to their healthcare.

DR. HOSKINS: Exactly right.

DR. McPHERSON: Because what's going to happen in the next 10 years will certainly determine so much, and with the increased population and aging group. And certainly I agree with you that I think we all mentally in the United States want the best care. We want the latest equipment. We want the latest tests. And I hope that some of this can be accomplished. What is your sort of way of representation in Washington or is there a council that meets there once a year, or what is that?

DR. HOSKINS: One of the other challenges facing the Academy during the last decade, is the sub-specialty movement. There are more Ophthalmic sub-specialty organizations and they are growing in strength and influence. But ophthalmology is 2.7% of medicine. We're a very small fragment of medicine. So if we fragment further, our political power will really decline. So one of the roles and goals of the Academy, as I see it, is to hold everybody together. And we do that through

education that is broad, but also focused on the sub-specialists. The Annual Meeting Subspecialty days have been very popular.

We do bring the subspecialty leaders together in Washington every year. We call it the Ophthalmic Leadership Group and they are representatives from all the major sub-specialty organizations who come to D.C. and decide what the issues are and what should be addressed and they help set the agenda for each year going forward. And then we meet regularly with those people to tell them about what's happening and how it's evolving. But it's all about trying to keep everybody together and prevent fragmentation.

DR. McPHERSON: Yeah. Well united we stand.

DR. HOSKINS: United we stand.

DR. McPHERSON: We go right back to that.

DR. HOSKINS: Exactly.

DR. McPHERSON: And now is the time we need it. And I think that... working all these years and you have been so... done such excellent work with the Academy. But what do you think of your outstanding accomplishments before... you know, since you now turned over the reins of the directorship to Dr. Parke? When you look back on your years, what stands out? What significance do you think you contributed?

DR. HOSKINS: Well, I think as you think through all of this there are several things that come along. One, I think, you look around this Annual Meeting, and you see the enthusiasm and the huge volume of people. I think Retina Sub Day had 3,300 people in it. And all these people have come to learn something, to learn on how to treat their patients better. And what they are looking for, more than anything else, I think, from us in the Academy is the same thing our patients look for in us, ... trust. They want to be able to trust what they hear. So protecting and preserving the Academy's integrity, I think is one of the significant achievements.

The second is that the medical bureaucracies, in my opinion, are beginning to get a little out of control. We have the American Board of Medical Specialties. They created recertification at 10 years. Now they're talking about doing it every five years. And the states are talking about recertification for licensure. I recognize that the American Board of Ophthalmology would have to do these things because

they work under the American Board of Medical Specialties. But we thought that within the Academy if we were going to do that that it should be truly relevant to the practitioner, that we shouldn't test them on obscure things like the Krebb Cycle, which they never use, but we ought to test them on what's clinically relevant for their practice. So we created the Practicing Ophthalmologist Curriculum. We brought specialty groups together in all the major specialties of ophthalmology and developed nearly 8,500 areas of important information that should be known, and then distilled those to 3,500 areas that would fit all the sub-specialists. And that's what the American Board of Ophthalmology uses to develop their tests. So it's clinically relevant, it's meaningful patient care, and is designed to ensure that they are safe ophthalmologists, not the people who know the most a particular drug formulation or that sort of thing, and provide a high-quality clinical care. And I think developing that process was very important. It basically created the curriculum for the clinical ophthalmologists in all the specialty areas.

DR. McPHERSON: Yeah, as the bureaucracy grows. They can form all those committees. They never seem to take one away.

DR. HOSKINS: They don't. That's the job of a bureaucracy is to grow.

DR. McPHERSON: They multiply.

DR. HOSKINS: They do, indeed.

DR. McPHERSON: Oh, yes.

DR. HOSKINS: The other thing I think we try to do in the organization is make people welcome. There's a story I tell about Stan Truhlsen. Stan is a delightful person as we all know. He was President of the Academy a number of years ago. But I remember early on in one of my Academy meetings. It was the first time I had been on a committee, and I walked into the room, and Stan was there for some reason. He welcomed me like a long lost son with his, and that open arm look. And I think we've tried to do that as well, to make people feel like the Academy is a home for them, a professional home.

DR. McPHERSON: Well, that's right. You certainly have done that for the American... What about the international membership and your activity outside of the United States? Has that changed at all or is that just...? Could you tell us a little about that?

DR. HOSKINS: Well, it's expanded a lot. We've created a division now for Global Alliances, as we call it. We recognized that the Academy can't do it all, it shouldn't do it all. And so what we try to do is create partnerships with other national societies, both in the developed and the developing world. And one of the things we do is have agreements with various national societies about *Academy Express*, which is a little e-mail blurb that goes out once a week with highlights of the clinical areas. We've also got the ophthalmic news and education network called the ONE Network, and it's designed to be , and probably is the most... the best populated educational site for a specialty in all the world. People can access this through their membership in the Academy free. And we've also negotiated contracts with other national societies, so their members can access it. What we hope is to provide all the news and all the education that people need that can be delivered through the Web, and make it available worldwide.

DR. McPHERSON: Yes, with communication as it is, it's such a great way for information to be spread so quickly and so efficiently. And it's a great contribution.

DR. HOSKINS: But the real contributors are the doctors, you know. I often tell people that we facilitate within the Academy. We make the opportunity available, and if people want to take advantage of it and do a good job, then they have the opportunity to participate.

DR. McPHERSON: Yeah, especially with the good treatments and the latest developments. And I think all the doctors usually are hungry for new information and what's going on. So we all like to read that.

Someone asked about the Prime Sight. What... and I didn't... I'm afraid to tell you, I didn't know. I mean, I'm...

DR. HOSKINS: You probably didn't know..... It just as well you didn't know about Prime sight.

DR. McPHERSON: That shows you how ignorant I'm. I didn't know to ask the question or not.

DR. HOSKINS: This started about six or seven years ago. This was when vision care plans were evolving, and the Council wanted the Academy to create a vision

care plan, so that members of the Academy would join this plan and we would market it to the population and provide eye care services and that sort of thing.

And so we started the process and hired some people and raised some money. But it fairly soon became obvious is that what we would have to do is set prices that the members could charge, and that having the Academy determine the pricing structure for its members made no sense, that we would soon be in conflict with the members. We should have figured that out at the beginning, but...

DR. McPHERSON: It was a learning experience.

DR. HOSKINS: It was a powerful learning experience. Fortunately, we were able to kill it before it caused any real problems or it cost us too much money, so it worked out all right.

DR. McPHERSON: Ideas have been tried. Another thing I'm always interested in, too, is the price of the... eye drops and everything, and medication for people. Is there a role that commercial drug companies play for the Academy work or any way?

DR. HOSKINS: Well, we can't get into pricing issues for products for commercial companies. But we do provide opportunity for people to try to get orphan drug usages and that sort of thing. The thing that is under debate right now is how much involvement should industry have in financing continuing medical education. Right now, there are huge sums spent by industry, not just in ophthalmology, but in all of medicine on continuing medical education, some of which is done through societies, but an awful lot is done by hiring a commercial medical education company, and spitting out information that they want to produce without any real oversight by the professions.

Congress has gotten into this. There have been some egregious abuses of this. And, again, within the organization, we have very strict rules that people who pay for the education, if they help finance it, can't be involved in the delivery of it or the development of it. So if we have funding to help an educational product, it's a pure funding grant that is independent of the material that's presented. The material that's presented has to be vetted by a committee of physicians, members of the Academy, and one of our standing committees. And we've set this up as rules. Now, we've gotten a lot less money because of that. You know, we've rejected grants. I remember one time I turned down a million dollars.

DR. McPHERSON: Oh, that doesn't happen every day.

DR. HOSKINS: No, but it didn't seem right to me because it was a million dollars, but they wanted to develop the programs, and I don't think that's what the Academy is there for. So I think the organizations can manage this, and I think it requires discipline and integrity and making sure you don't get into financial difficulties.

DR. McPHERSON: It takes a lot of stewardship, I think, and thank heavens the Academy is doing that.

DR. HOSKINS: Yeah, I think we've done well.

DR. McPHERSON: Just as a final word, could you say... tell us what you foresee the future of the ophthalmologist and the role of the Academy? I mean, with all of this... I understand politically about the... but go ahead and give us a personal opinion.

DR. HOSKINS: Okay.

DR. McPHERSON: Throw it out.

DR. HOSKINS: I believe in great American philosophers, and I think one of the best of those was Yogi Berra. And Yogi Berra told us the one thing you cannot predict is the future, and so I'll use that as a disclaimer right up front that my crystal ball isn't any better than anybody else's, but a couple of things are obvious. One, the demographics are changing. The population is aging. The growth in population over 65 is going to be enormous, and the amount of ophthalmic work that's going to be required in the next 20- to 30 years will double. Now, the ophthalmologists aren't going to double in number because we're not training many more. But right now, when we survey the members we find that about half of them would like to see up to 30% more patients. So we may have a slight excess supply right now, but not in certain areas. San Francisco is really crowded. My daughter-in-law, who is trying to find a job in San Francisco right now has discovered that there are not very many available. But there are other places less crowded, in rural areas, where ophthalmic care is lacking some. But, given that, I think that ophthalmologists will be very busy in the coming decades. That's number one.

Number two, I think it's certain that reimbursement paradigms will shift from fee-for-service to some other mechanism. And this is being talked about daily in Congress that fee-for-service develops the wrong incentives, and this is for all of medicine. So we're going to see a shift, and I think reimbursement per unit of service will decline.

So if you're increasing volumes and you've got less reimbursement per unit of service, then you're going to have to figure out how to manage the volume of care that's going to be necessary for the future, and I think it's going to require support. I think we're going to have to have ancillary people supporting our practices. And, obviously, one group that comes to mind are the optometrists. Amazingly, they can come into a practice, and working with them with leadership by the ophthalmologists can be very effective in helping deal with the throughput that's going to be necessary for the future, and still insuring that we have the high quality care that is given by the highly-educated and trained ophthalmologists. So that's a mechanism.

The other mechanism will be technicians, people who can just help with the volumes that are going to need to be seen.

Now, these transitions will be relatively slow, but I think we'll actually see the impact in the next 10 years.

DR. McPHERSON: Yeah, but it's wonderful to sort of end this conversation with a upbeat note, because what you're saying is so true. We all feel we can do a lot of work, but we don't... and help from the optometrists and the technicians is so... you know, it's going to be so important when the volume increases. So I think it's very fine.

DR. HOSKINS: I think we're going to be fine. Where else can you help patients through difficult times and improve their quality of life the way we can by restoring vision or preventing its loss? And nobody thanks you the way patients do.

DR. McPHERSON: That's why I think doctors are a rather dedicated, or maybe obsessed with their practices.

Now, what about your family? You haven't neglected them with all of this work and the patients and directorship of the Academy?

DR. HOSKINS: Well, we finally got an ophthalmologist into the family, but my son had to marry one to do it, so there will be another Dr. Hoskins in ophthalmology.

DR. McPHERSON: Well, he must have very good judgment. So I hope that your family carries on. But you're living in such a beautiful area, and you're so fortunate to come out here. Virginia would have been nice, too.

DR. HOSKINS: Virginia is a nice place, it is.

DR. McPHERSON: They would have enjoyed both. But I imagine it seems strange going back to a practice now. It's like the circle goes around.

DR. HOSKINS: You know, I feel so good about David Parke, who is the new EVP of the Academy. He's had 20 years of involvement with the Academy, maybe more. He understands it. He's got all the skills and the talent, and I believe it's just going to grow and grow and grow. And it's got great new leaders, and continues to have dedicated ophthalmologists supporting it. So I think the future is bright.

DR. McPHERSON: Well, the Academy has been so fortunate, with Dr. Spivey and Dr. Dunbar Hoskins and now David Parke, we are really under wonderful leadership, and thank heavens for that. I think it's one of the reasons why ophthalmology, I think, is also so popular with the doctors. And everybody is happy with the Academy, and it's done such splendid job, and especially when we come to meetings now and the attendance is so high. And so it's really been a great organization. And you've been part of building it, and you should be proud because we're proud of you, I'll tell you that.

DR. HOSKINS: Well, thank you, Alice. We appreciate all the support we can get. It's great. Thanks very much.

DR. McPHERSON: I enjoyed the conversation very much, Dunbar. Thank you.