AMERICAN ACADEMY™ OF OPHTHALMOLOGY

The Newsletter of the Senior Ophthalmologist
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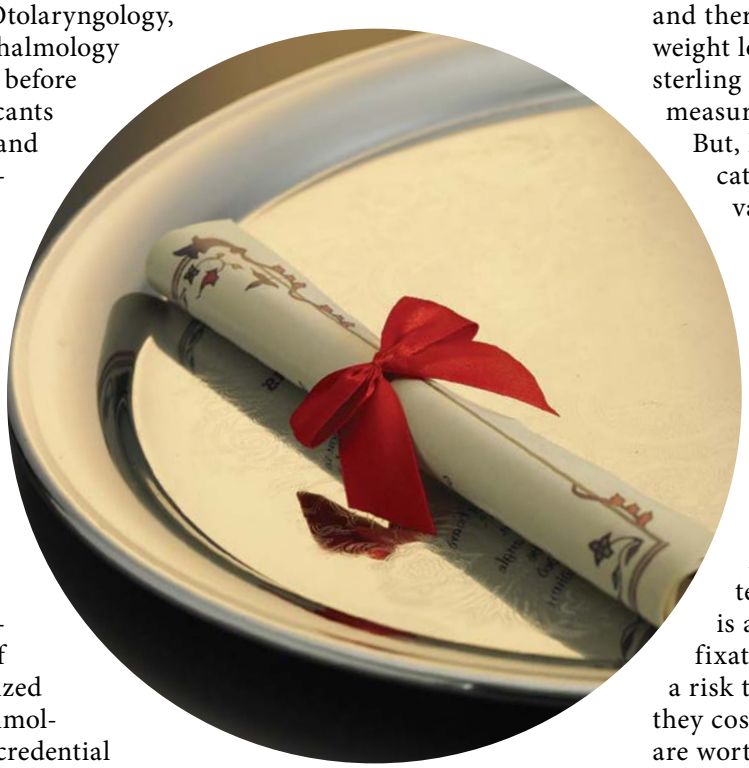
SCOPE

Certificates

W. Banks Anderson, Jr., MD

On the Airbus home from San Francisco, where we celebrated the centennial of the American Board of Ophthalmology, I began musing about the 30,000 certificates that the ABO has issued. Some certificates mark our coming into the world and our leaving it. Some are digital with public keys that secure our treasure. Those we were celebrating in San Francisco were awarded after a qualifying examination sponsored initially by the American Ophthalmological Society, the American Academy of Ophthalmology & Otolaryngology, and the AMA Ophthalmology section. A few years before the first seven applicants passed their exams and were certified, Abraham Flexner had documented that many of the medical certificates being issued were based upon little more than payment of tuition. A result was that for profit medical schools closed and also that medicine generally was bent on improving the credibility of its claims to specialized knowledge. Ophthalmology was the first to credential its specialists. Other specialty groups joined in, and there are currently twenty-four specialty certification boards vetted by the American Board of Medical Specialties (ABMS). As would be expected, there are perhaps a hundred more "board certificates" out there, some so counterfeit that all that is needed is a few hundred dollars to get one for your office wall. There are others that rival the ABO process in applicant data collection and testing procedures.

In 1916, most of the examiners and examinees also had certificates in their pockets–silver certificates. These promised redemption for their face value in silver coins. Our Treasury Department printed its last silver certificates in 1964. Amazingly one hundred years seem not to have diminished the value of the ABO paper while that dollar has lost 80% or more of its value.



The word certificate is derived from the Latin "facere," meaning some sort of work or action, while the first part implies a written truth or promise. In 1878, when our US Treasury began issuing silver certificates, such practice was not new. In 1694, banks in England issued paper notes that could be redeemed for silver coins of 92.5% purity called sterling. Sterling coins were more abrasion resistant than those of purer silver and therefore maintained their weight longer. The original pound sterling certificate was based upon measuring and testing silver.

But, like the US silver certificates, their tie to silver has vanished. A one pound sterling coin contains no silver. Indeed, even lesser coins have been debased. The US penny is zinc with a veneer of copper. If it is swallowed by a child or pet, and veneer is missing, the zinc reacts with stomach acid to produce zinc chloride. Any Mohs surgeon will tell you that zinc chloride is a good tissue killer and fixative. Our current penny is a risk to children and pets and they cost more to make than they are worth. *(Continued on page 7)*

ABO Centennial Celebration Hits Home Run

M. Bruce Shields, MD

Major League Baseball has nothing on the American Board of Ophthalmology, at least as far as those souvenir trading cards are concerned. They may have their Babe Ruth and Lou Gehrig, but we have our Banks Anderson and Bill Tasman and sixty more on priceless cards. And it is all thanks to Board Director Emeritus, Dr. Ivan R. Schwab.

On March 12, 2016, past and present members of the ABO gathered in San Francisco at the Palace Hotel (where so many oral exams have been held) to celebrate the 100th anniversary of American medicine's oldest certifying board. At the gala banquet that evening, Dr. Schwab stepped to the podium to provide the evening's entertainment. Rather than giving a talk, however, he announced that packets were being distributed to all Board Directors. In the packets were trading cards with a picture on one side of a Director at an earlier stage of life (some much earlier) and statistics about the individual and humorous anecdotes on the back. In all, there were sixty-two cards, although no packet contained the complete set. Therefore, the remainder of the evening was spent trading cards and getting autographs,

ABO Board Director Emeritus, Ivan R. Schwab, MD, FACS

which was a great way to interact with our friends and colleagues.

It was a Herculean feat that Dr. Schwab accomplished with remarkable success. Many of us wondered how he did it, so the SCOPE editorial board approached him with the following question and answer session to learn more about the story behind the special evening.

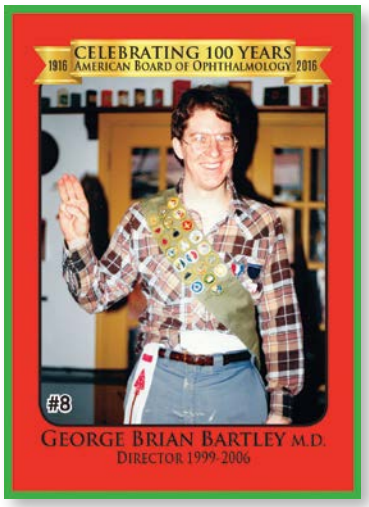
SCOPE: How did you come to think about such a concept? Had you seen it done elsewhere?

Dr. Schwab: I have never seen it done, but have thought about it since residency. The idea came from my background. During residency, I admired my mentors so much, and I remembered how I treasured my baseball cards as a child. I wondered what it would be like to open up a packet of Topps cards, and see two "William Spencer" cards and trade with my buddies to get "G. Richard O'Connor" card to help complete the set. Of course, all their statistics would be on the back and a stick of gum would be enclosed to chew while I read these stats.

SCOPE: How did you obtain the pictures and information for the cards?

Dr. Schwab: I decided that head and shoulders would not be appropriate—too formal. So, I asked some spouses, and if that didn't work, or I didn't know the spouses, I asked the Directors themselves. They responded with only a little prodding. I hinted that they would see the image again in a light-hearted way but did not want to give it away. I suspect that each Director thought I was going to project the image and "roast" him or her. I told each what photo I was going to use of myself and encouraged any "fun" photo or photo of their childhood. Almost all responded with exactly what I needed. The information for the "statistics" on the back was a little tricky. I asked each Director for his/her CV and extracted information from it. I tried to pick achievements that I thought would be considered their best. Then, I would talk to friends about the individual to get some ideas about personal interests away from the ABO. This would be information

about quirks, hobbies, abilities, or other interesting tidbits that others might not know. Nancy Hamming was most helpful with the younger Directors, as I did not know them as well. Other people including Beth Ann Comber and the various people in the ABO office had information too. It was a collection process. Throughout, I emphasized that this was to be gentle and an activity that would encourage laughter from all, including the "victim."



SCOPE: How many Directors did you contact and what percentage responded?

Dr. Schwab: It was tricky to determine who would and would not be coming but Beth Ann in the ABO office helped me with this. The list of attendees varied some during preparation time and this created problems and I made some cards of people who did not attend although I thought that they would. Of the 62 for whom I made cards all but four provided the needed images.

SCOPE: How did you go about having the cards printed?

Dr. Schwab: One can find anything on the Internet. I had my administrative assistant, Joe Valadez (an avid baseball fan and baseball card fan) help me find and correspond with a vendor who makes such cards. Once I told the vendor what I wanted he gave me a price and time frame.

SCOPE: How much time would you estimate that you spent on the entire project?

Dr. Schwab: That is very hard to answer because I started in December and would spend an hour or so here and there. Some weekends I would spend all day on it—it was fun and interesting. I cannot really say how long it took, but it was hours and hours.

SCOPE: What were some of your favorite cards?

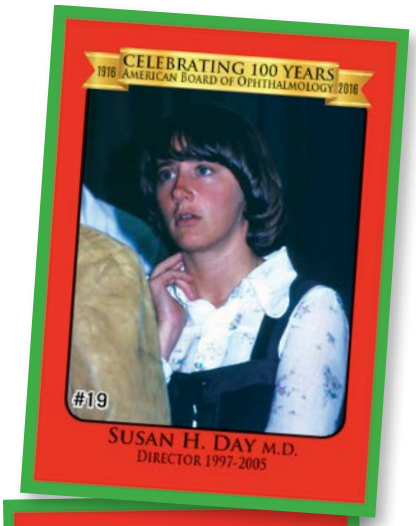
Dr. Schwab: Some are better than others so I do have favorites. I am friends with Mike Siatkowski since we served on the ABO together for some years. I know his wife, Rhea, and she supplied me with an image that really made me laugh. Mike must be about to go snow boarding and he has a helmet and an outer wind-breaker for skiing. He is holding a drink up as he is photographed. The line on the back is "When I drink, I always wear a helmet and jacket for safety's sake." And, I liked the card for George Bartley too. His wife, Lynn, helped me here by sending an image of him as an Eagle Scout. George thinks the image is "dorky" but this is in line with his abilities—top drawer in everything he does. For him, success started early. There are other cards that please me, but these are two I remember. Take a look at David Wilson's card too, when you get a chance—if you want a smile.

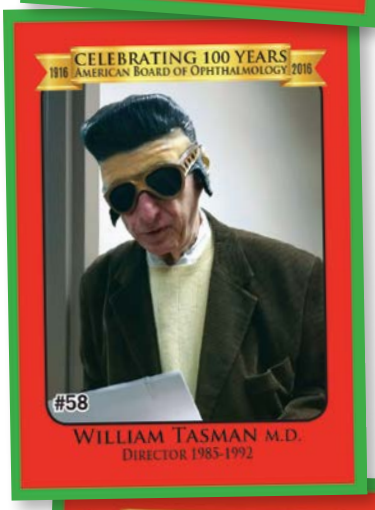
SCOPE: Would you ever do anything like this again?

Dr. Schwab: I have waited 36 years for this idea to find a home—I doubt I will have an opportunity to do such an event where this idea would work. Hence, I doubt that I will ever do this again—it takes a special event for it. Besides, there are other ways to please a crowd.

SCOPE: What did you learn from this project?

Dr. Schwab: I was most impressed at the diverse abilities and activities hidden in the ABO directors. What an accomplished group! Within the men and women that have been and are ABO Directors, there are many highly successful individuals with so many achievements and have devoted so much time to our specialty. It made me humble and proud to be a part of an amazing community.





From the Editor's Desk

The Senior Ophthalmologist Committee

Susan H. Day, MD
Guest Editor

Virtually every person who becomes a freshly minted member of the SO Committee begs the question: "isn't there a better name than calling us seniors? It makes me feel so old!" I must confess that it was a ribbon for the annual meeting that I didn't honestly relish! So (SO)—what's in a name?

A dictionary includes nice spins on the word: a person of authority; etymology shared with sire, signor, monsignor to name a few. But looking further, the root words "senex" and "senis" also point blank translate into "old;" even "senile" traces to the same roots.

What senior does not mean is one universal connotation that is age-specific. Seniors are steps away from graduating from high school and college. Senior residents get all the interesting surgery. Senior vice presidents make important decisions without the headaches of a CEO. Senior consultants are revered for their mentorship and expertise. All of us senior ophthalmologists have probably relished senior something –elses in our lives.

What is strikingly true, as our committee re-deliberates our name, is the diversity of ribbon-warranting senior ophthalmologists. Some are in the prime of their career; others well down the path to a new career. Seniors create; travel; give; they see cycles of their own grandchildren, and share the beauty of decades of relationships with their patients, and live with the wisdom that, if one day brings great sadness, there will be a new dawn and a new opportunity for beginning.

Perhaps it is that seniors, just by virtue of being fortunate survivors in life, finally begin to become comfortable with who they are, and begin to appreciate what wisdom really means. In different eras, lifespans were shorter. Look at the incredible power that modern medicine has played in the simple ability to live longer! We have benefitted so profoundly, perhaps not even realizing that the Mozarts, Washingtons, and Michelangelos's of the past would probably have traded all of their talents and accomplishments to join our ranks.

Perhaps they would even have been senior ophthalmologists...

Delectable Eating Can Tweak Your Desires

Robert L. Slavens MD

How did you get interested in ophthalmology? the lady asked. "Well, it started when I was still in junior high school," was my response.

My mother and I would make regular treks to California and because my town in Colorado did not have an eye doctor of any type, she took me to see Dr. Mayo Poppen, an ophthalmologist in Van Nuys. My desire to play football necessitated the need for contact lenses, which I could not afford. So Dr. Poppen agreed to pay for them if I would be his gardener for a summer. His kindness was tweak one.

Tweak two came when he took the time to explain why his patient had to wear very thick glasses; telling me how much he liked his job and not reprimanding me for nearly killing his dichrondra while I was his gardener.

Tweak three came during my ophthalmology internship, part of which was spent at the Syracuse Memorial Hospital. The operating room was on the fifth floor as were all of the inpatients recovering from cataract surgery. There I had my first experience of making rounds with the Chief of Ophthalmology, Dr. James McGraw. The entourage of residents who assisted him changed dressings, listened to his dialogue with the patient and his final summary of the progress of the patient in the hall.

The residents and I would adjourn to the coffee shop in the hospital lobby, operated by a wonderful group of volunteer women, one of whom was an excellent pastry baker. The discussion, led by the chief resident, focused on the morning's patients as well as other problems encountered by those present in the last twenty four hours—a superb teaching experience forever lost in the technological revolution.

Additional luster to this experience at that circular table in the coffee shop were the warm, shaved-almonds-on-frosted-bear-claws, home made in the wee hours by their famous pastry lady. My summary to the interviewing lady was that all of these tweaks came together to influence my choice of becoming an ophthalmologist.

"And which was the most important in your making that decision?" she asked. "That's easy, the bear claws."

Help Wanted: Experienced Senior Ophthalmologists

C. P. Wilkinson, MD

Eyecare America (ECA), the Academy's public service program that is dedicated to medically underserved seniors and those who are at increased risk for eye disease, is seeking the assistance of older ophthalmologists to increase its pool of volunteer physicians.

Academy surveys demonstrate that an increasing number of ophthalmologists continue to practice after age 65 but tend to see fewer patients and operate less frequently. These realities demonstrate potential opportunities for senior ophthalmologists (SO) to give back to society by becoming ECA volunteers without having to leave their offices. In spite of Medicaid, Medicare, Obamacare, and the V.A., there are a multitude of patients in our country who cannot obtain the proper eye care that they need, and that is why we SOs are desperately needed.

A brief history: ECA originally recruited physician volunteers to launch the National Eye Care Project (NECP) under the leadership of Tom Hutchinson, MD in 1985. The premise of the project was to provide seniors on Medicare, those who had not had an eye exam in 3 or more years, with examinations and up to one year of care for any condition diagnosed in the initial exam. The care provided would be at no out-of-pocket cost to the patient; volunteers waived Medicare co-payments and un-met deductibles that were made possible through an advisory opinion waiver from the Office of the Inspector General. The project has been recognized by every US president since Reagan, and it became fully web-based in 2010. Patients are screened for eligibility through an online referral questionnaire. Since 1985, ECA has helped more than 1.8 million people.

Due to the natural attrition of retiring ophthalmologists, in spite of those who remain active volunteers, EyeCare America needs your help. Maintaining a viable program, one in which the number of patients seen averages only 2-5 patients per year, will require a growing pool of volunteers. I believe that we SOs can be of tremendous importance in this effort. Please join me as a volunteer to see ECA patients by visiting our volunteer page to fill out our online enrollment form.

Here's how the program works: Volunteers may choose between all or any of the programs listed below.

Seniors' Program: For patients who have not seen an ophthalmologist in 3 or more years, you provide a comprehensive exam to eligible seniors (citizens or legal residents) and up to one year of care for any condition diagnosed at the initial visit. This care is furnished at no out-of-pocket expense for the patient; Medicare is billed and the co-payments and unmet deductibles are waived.

Glaucoma Program (1-visit only): You provide a glaucoma eye exam to patients not eligible for the above program but with increased glaucoma risk based upon age, race, or family history.

Retina-referral: You provide follow-up care to an ECA senior patient who needs specialty care not provided by the original volunteer.

Patients are referred on a rotating basis within a geographic area near the patient's zip code. You will receive a letter with the patient's name explaining the service to provide and a short outcome form to be returned to ECA.

I encourage you to volunteer today. Staff can be reached by email, eyecareamerica@aao.org or toll-free 877-887-6327 (M-F, 8am-Noon PST).

Oh, The Things We Have Seen!

M. Bruce Shields, M.D.

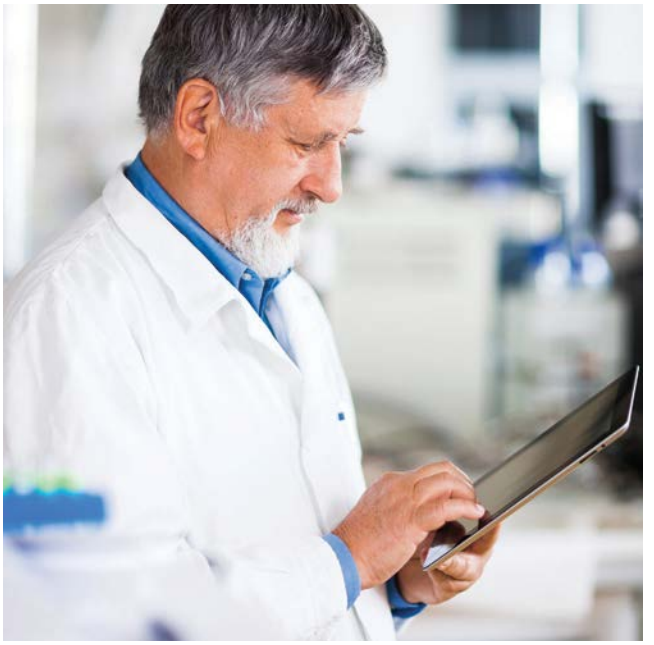
This spring, I attended the 50th reunion of my medical school class, which gave me pause to reflect on the remarkable advances in medicine that you and I have been privileged to witness in our careers.

The year I graduated (1965) was the same year that Medicare and Medicaid were implemented, having been signed into law the previous year by President Johnson. It was a highly controversial issue at the time, much as we have seen in recent years with the Affordable Care Act, and had been ever since it was introduced twenty years earlier by President Truman. Time, however, would prove its merit, not only by insuring health care for elderly and indigent segments of our society, but also by enhancing medical education through allowing medical schools to increase the number of full-time faculty.

Another advance in health care delivery, which also began fifty years ago, was the introduction of the Physician's Assistant (now Physician's Associate) program. This began at Duke University Medical School in 1966 under the leadership of Dr. Eugene Stead, Jr., the former Chairman of the Department of Medicine at Duke. Today, the PA program is a significant component of our American health care system across the country, and will undoubtedly become increasingly important as continuing changes in the system place an ever greater burden on the physician workforce.

In addition to major advances in health care delivery, we have also witnessed remarkable technological advances in our ability to diagnose and treat diseases. At the dawn of the 1960s, Theodore Maiman reported on the first successful laser, a concept that scientists had been postulating for decades, beginning with Albert

Einstein. Maiman's report led to an explosion of technological advances in the field, and the first medical treatment with a laser was performed just one year later (1961) by Dr. Charles Campbell at the Eye Institute of Columbia-Presbyterian Hospital, where he destroyed a retinal tumor with a ruby laser. Most of us can probably remember our first laser. For me, it was the arrival of an argon laser at Duke in the early 1970s when I was a resident. It was certainly a quantum leap from our xenon arc photocoagulator, although I don't think any of us then could have guessed how lasers would revolutionize our treatment of ocular conditions, not only in the subspecialty of retina, but also in glaucoma, cornea, oculoplastics, and many other areas of ophthalmology, not to mention in other fields of medicine and how it has permeated so many other aspects of our society.



If there is any technology that has had an even greater impact than lasers during our careers, it would have to be computers. As a medical student in the mid 1960s, I worked for a professor who had one of those early computers with thousands of punched cards in a machine that filled up most of a good size room. That was the standard of the day, and if you had told me then that I would one day hold a computer in my hand with thousands of times more power than that old clunker, I wouldn't have even understood enough to question the likelihood of such a claim (and I still find it hard to comprehend). Of course, many physicians today consider computers to be both a blessing and a curse. They allow us to analyze, store and share volumes of data that would not have been possible in the pre-digital age. They have also been the foundation for new generations of diagnostic devices, including visual field and image analyzers, and are increas-

ingly being used to drive therapeutic instruments (with laser energy), especially in the fields of cornea and cataract surgery. On the other hand, computers have also led to the national mandate for electronic health records, which has become the bane of existence for many physicians, especially those of us who are older and more digitally challenged. But these are just the inevitable growing pains of new technology, and EHRs will undoubtedly one day become as routine a part of our patient care as the bulky medical charts of a previous era.

Of all the advances in medicine over the past fifty years, the one that has most revolutionized our understanding of the human body in health and disease is the field of genetics. And, again, 1966 proved to be a propitious year. Although it had been more than a decade since Watson and Crick described the double-helix model of DNA in 1953, it was in 1966 that scientists finally cracked the genetic code, showing how the 4-letter alphabet of nucleic acids determines the order of amino acids in proteins. By the early 1970s, the introduction of DNA sequencing and the subsequent methods for gene linkage and mapping began to open up our understanding of the genetic basis of many diseases, with the potential for revolutionary advances in the diagnosis and treatment of countless conditions. If the 20th century can be seen as the century of antimicrobials, when we finally got a handle on infectious diseases, historians may one day look back on the 21st century as the age of molecular medicine, when we accomplished the same for genetic disorders.

This, obviously, is by no means a comprehensive review of all the advances that have occurred in medicine over the past fifty years, but it may serve to remind us of what an unprecedented time you and I were privileged to live through in our profession. With a healthy dose of humility and gratitude, I think we can take pride in having been a small part of what history may look back on as the "golden age" of medicine (at least it was for us).

Certficates

(Continued from page 1)

Perhaps the biggest threat to debasing our ABO certificate is its aging. The recent explosion in medical knowledge means that any single attestation to a level of competence may decades later be obsolete. Medical competence requires continuing mastery of new knowledge and skills. Time-limited certificates requiring maintenance to remain valid are a response. Another threat to the certificate is political because self-regulation by professions is under attack as being anti-competitive. The ABO is now a self-perpetuating board because of FTC concerns that our three sponsoring organizations could distort the certifying process through their power to suggest new members for the board. Should it ever become possible to routinely measure the benefit added to patient outcomes attributable to a given physician's encounters, the board certification process would become redundant. By 2116 this might be possible and board certificates like silver certificates relegated to collectors' catalogs. But at present, that American Board of Ophthalmology certificate remains the gold standard of our credentialing and our specialty started it all one hundred years ago.

As I Remember It

Vignettes of the days of training and early practice

SCOPE solicits interesting and entertaining vignettes of readers' days of training and early practice.

Please limit your submission to about 500 words.

Send submissions by email attachment to scope@aao.org

Cadaver Bones and Eels?

William Tasman, MD

Here we are in 2016, and another presidential election year is upon us. Certainly this one has had a tendency to be tempestuous, although in this article I have no intention of advocating for any candidate or party. I recently returned from the 100th Anniversary of the American Board of Ophthalmology. In 1978, when time-limited certification was first proposed to the Academy membership in Kansas City, there was a very acrimonious discussion, and I couldn't help but be reminded of this when I saw the melee at the Trump rally in Chicago.

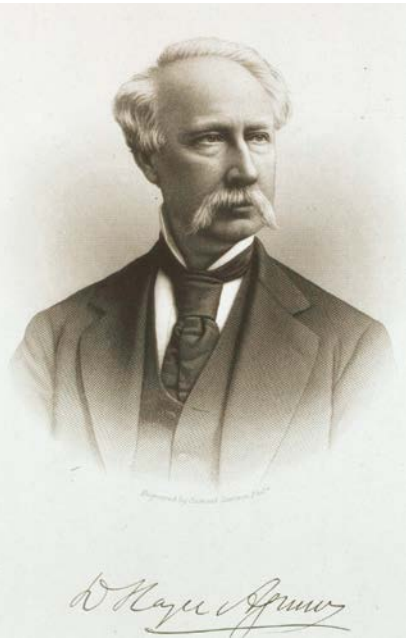
Having said all that, I am going to start by talking about a totally unrelated incident that involved Dr. D. Hayes Agnew. An extremely well respected General and Ophthalmic Surgeon of the 19th Century, Dr. Agnew was a doctor during the Civil War and treated several victims of the Battle of Gettysburg. He also was called as a consultant for President James Garfield, who had been shot while waiting in the Washington, DC train station to attend his 25th reunion at Williams College where he had also served as President.

Dr. Agnew was an only child and, when he graduated from the University of Pennsylvania, he was determined to become a surgeon. In 1841 he married Margaret Creighton and began the practice of medicine. However, that was derailed when his brother-in-law approached him about going into the iron business. Agnew thought it over and decided to give up medicine to join his brother-in-law. Apparently the two of them were not able to get all of the wrinkles out of the iron business and the venture failed.

Agnew returned to Cochranville, Pennsylvania, and re-entered the practice of medicine. Still determined to become a surgeon, he had cadavers transported from Philadelphia to Cochranville so he could study anatomy. Much to the dismay of the local townspeople, he performed his dissections at home, creating some concern, about what to do with the bones.

Over the course of time, a nearby farmer approached Agnew and asked if he would like to dump his cadaver bones in the farmer's fishpond. Don't ask me why. Maybe he was just a good citizen who wanted to keep the neighborhood clean and respectable. In any case, Agnew agreed to this. Subsequently, one of the local fish dealers became well known for the numbers of eels he sold, all of which were plump and juicy. The same farmer who had used Agnew's cadaver bones in his fish pond had asked how the dealer had so many wonderful eels, and he was told they had come from his own freshwater pond, alleviating any concern about encountering Moray eels.

Thinking of Moray eels, reminded me of a horrendous scene in a 1957 movie starring Sophia Loren called "Boy on a Dolphin." Sophia plays a sponge diver. One of her coworkers is seen submerged in front of a reef when suddenly a large Moray eel comes out of a crevice and grabs him by the head.



D. Hayes Agnew, 1818–1892

My own experience with Moray eels is extremely limited. It happened in Florida ocean waters when I got into a canal where our runabout was moored to the dock which was built over a reef. Whenever I did something like that I usually had my snorkel, mask, and underwater camera close at hand on the dock, since the reef fish are often beautiful. Suddenly from the surface I saw an unusual green form, so I reached for my snorkel and mask, and grabbed my camera. It turned out that my visitor was a Moray eel. However, he or she seemed quite docile and was happy to pose for pictures.

But, most of the time these days my eel exposure is confined to occasional Sushi, and only if the eel is freshwater and has been broiled. Because of this, I have finally gotten over the Moray eel scene in "Boy on a Dolphin," but not Sophia Loren.

As I Remember It

An Enigmatic Patient

Ali Aminlari MD, FACS

While I was examining a patient in the clinic, I was watching another patient in another exam room across the hall, waiting to be seen.

I noticed that he was curiously playing with the eye instruments in the room, removing the direct ophthalmoscope, carefully looking at it and then replacing it in the socket, removing the retinoscope, evaluating it carefully and putting it back. He then was playing with the Slit Lamp, turning it on and off. As I was watching him, I was worried that he might break one of those instruments.

After finishing with the first patient, I then moved to the room that he was waiting for me. He was a new patient and was referred for cataract evaluation.

After introducing myself and asking him several questions, I gave him a long lecture about how delicate and expensive all those instruments were. As I saw him interested, I explained the function of each of those instruments to him.

During my lecture he was quiet and did not ask any questions.

After I finished examining him and surely I found he had significant cataract in his both eyes therefore I explained the cataract and the procedure of cataract extraction to him as well.

While I was doing the paper work to schedule him for surgery, I said "by the way you seem very interested in these instruments; you must be an engineer, a mechanic or a scientist."

He looked at me and said, "None of the above, I am a retired ophthalmologist!!!" I paused for a while and did not know what to say. I was blushed and sweating. I apologized to him and scheduled him for his surgery.

On Oral Exams

Paul R. Honan, M.D.

In 1959 the three day oral exams of the American Board of Ophthalmology took place in St. Louis, MO. I traveled from Indianapolis, IN by train. It was an exam to be remembered.

My examiner for the surgical part of the exam was from New York City. He asked me to describe my technique for intracapsular cataract surgery. My description included the use of three 6-0 black silk sutures to close the corneal incision. At that statement the examiner excitedly called to other examiners present, "Hear this guy from the cornfields of Indiana who is using sutures in cataract surgery."

Conrad Berens, MD, 1889–1963

Dr. Conrad Berens was my examiner in ocular motility. Fortunately the instruments I had brought for the exam included several that Dr. Berens had designed. He was pleased and only asked me to explain the use of each of these instruments.

Another examiner stopped me at the door as I entered an examining room. A patient was sitting at the far side of the room. He asked me to look at the patient from that point and present a possible ocular diagnosis. I noticed the tall, slender physique and long fingers, so I responded, "From here it could be Marfan's syndrome. I would look for a lens subluxation." Thus his inquiries ended.

I trust that the orals today are more technical and more revealing of an applicant's knowledge and competence.

The Biggest Challenge

Stuart L. Fine, MD

In 1972, I began a medical retina fellowship at Wilmer with Arnall Patz.

Arnall Patz, MD, 1920–2010

Fellows were invited to participate in all of the departmental teaching activities, including the Monday morning conference. Each Monday at 8 am, there would be six to 10 patients in exam chairs in The Wilmer Clinic, each having been asked by his or her ophthalmologist to come to Monday morning conference to be examined by "experts" who would, after examining all the patients, go to a conference room where each patient's problem would be discussed. The conference was moderated by Ed Maumenee, the Wilmer chief who was known as "The Prof."

A. Edward Maumenee, MD, "The Prof," 1913–1998

(Continued on page 12)

Innovate With Your Colleagues in Chicago!

Neeshah Azam

AAO 2016
In conjunction with APAO
INNOVATE

This fall, the Academy community returns to Chicago and we encourage you to take advantage of AAO 2016 – Where All of Ophthalmology Meets™. Join us for the 120th Annual Meeting of the American Academy of Ophthalmology on October 15-18 in conjunction with the Asia Pacific Academy of Ophthalmology (APAO). Get inspired and innovate in the largest ophthalmic arena in the world. Learn from innovators on the front lines of medicine as they deliver the latest research, techniques and technologies.

Enhance your meeting experience by attending the following SO Events in Chicago:

Back by popular demand–2016 Breakfast with the Expert courses for our SO members. Transitions in Practice–Slowing Down and its Implications and Stopping Surgery–When, Why and What it means to Your Practice.

Andrew P. Doan, MD, PhD will be back this year with, "Brain health and Longevity for SOs in the Digital Age" as well as, "Use Blogging and Social Networking to Super-Charge Your Website and Internet Marketing" with guest presenter Randall Wong, MD.

The SO Special Program and Reception on Monday, October 17 from 2:30pm to 5pm will offer a great lineup of speakers. Look for more details in our next edition!

SO Lounge

The SO Lounge will be centrally located this year in the Grand Concourse at McCormick Place. This member perk allows attendees to take a break in a quiet relaxing environment. Enjoy light refreshments, computer/printer access, view photo archives, and meet new or longtime colleagues. Remember, the SO Lounge is complimentary for all Academy members 60 years and over.

All meeting dates and times will be distributed this June, 2016 and member registration for AAO 2016 will open on June 25.

Make the most of Chicago's many theaters, restaurants, tours, parks, and cultural institutions. The dynamic city is constantly evolving just like the profession of ophthalmology and the medical world as you know it.

$2 Million Gift Establishes Glaucoma Education Center

Christie L. Morse, MD, *Chair, Foundation Advisory Board*

Spring is in full swing and I'm excited to share a huge win for the American Academy of Ophthalmology, its Foundation and all of us in ophthalmology! The David E.I. Pyott Foundation has pledged $2 million for glaucoma education—the largest-ever gift from an individual donor. The endowment will establish the David E.I. Pyott Glaucoma Education Center on the ONE® Network.

David E. I. Pyott

Formerly the CEO of Allergan, David has been a member of the Foundation Advisory Board since 2002. "This is my way of giving back," he said. "I am delighted to continue a long and rewarding heritage of helping the physicians all over the world speed improvements in patient outcomes."

Expected to be launched by the end of 2017, the Pyott Center will provide free, easily accessible training to ophthalmologists globally. It will offer interactive cases, simulations and other learning activities, plus a network for physicians to discuss challenging cases with each other.

"This endowment will serve as a legacy gift for decades to come," said Academy CEO David W. Parke, II, MD. "It will help current and future physicians around the globe, as well as providing resources for their patients."

Mr Pyott's gift brings us closer to our $10 million goal for the ONE Network Campaign. The AAO Foundation has raised more than $8 million to date, but there's still more work to do!

The Pyott Center joins the Munnerlyn Laser Surgery Education Center and the Knights Templar Eye Foundation Pediatric Ophthalmology Education Center as centerpieces of the ONE Network. If you're interested in discussing a naming opportunity to celebrate your own legacy in ophthalmology, please reach out to Tina McGovern at tmcgovern@aao.org or 415.561.8508. In addition to content on the ONE Network, there are a variety of other opportunities we would be happy to review with you.

The legacy we leave behind for future generations is very personal and important to each of us as ophthalmologists. And unquestionably, the Academy has been there for all of us at many points in our careers. When defining your legacy (with the help of your financial advisor), I encourage you to include the Academy or the Foundation in your will/trust, or as a designated beneficiary. It's a convenient way to give back, and may also provide those all-important tax benefits.

John F. Bigger Jr., MD, from North Augusta, S.C. shares why he became a member of the Legacy Society by including the Foundation in his estate plans: "I have been involved with the Academy since I was a resident in the 1960s, and with the Museum of Vision since it was founded in the early 1980s. Throughout my career, the Academy has been there as both an educator and a partner. It is my pleasure to support the Academy Foundation and the Museum through a bequest in appreciation for all they have meant to me."

Richard P. Mills, MD, MPH

Finally, although it may seem a bit early, the 2016 annual Academy meeting will be here before we know it. Save the date of Sunday, October 16, for the 13th annual Orbital Gala at the fabulous Field Museum in Chicago! This year, we're honoring the incomparable Richard P. Mills, MD, MPH, who has created quite a legacy of his own!

We've all enjoyed Dick's wit and insight throughout his 14 successful years as chief medical editor of *EyeNet*®. A noted glaucoma specialist, he is also an Academy past president and former chair of EyeCare America®. Additionally, Dick has dedicated his time and talents to the American Board of Medical Specialties, the American Board of Ophthalmology, the American Ophthalmological Society, and the Accreditation Council for Graduate Medical Education. What he has done for ophthalmology is beyond measure, and we're thrilled to be honoring him this year.

If you're a huge Dick Mills fan, like I am, or just want to have fun and help the Foundation, this is a great opportunity to show your support. Orbital Gala tickets go on sale May 16, but you can make a tribute gift now at aao.org/foundation/tribute-gifts. Those making gifts will be able to place a congratulatory message to Dick in his tribute book.

I always welcome questions or feedback from you. Please feel free to drop me a line any time at cmorse@aao.org.

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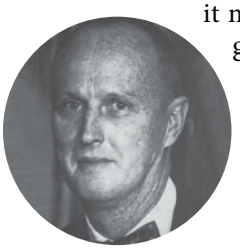
As I Remember It

(Continued from page 9)

After each patient was presented to the audience by either a resident or the community practitioner who had brought the patient to Wilmer, the Prof would lead a discussion about the case. In those days, there were typically 60 to 70 doctors at each Monday morning conference and at least a dozen were private practitioners from the community.



Howard Naquin, MD, 1918–1972

While waiting in line in the clinic to examine patients, residents and faculty and fellows would engage in discussion about the patients as well as about other topics. It was during one of the first Monday morning conferences that I attended that I engaged in discussion with the part-time faculty, Dr. Stewart Mackay Wolff, who was in private practice and who helped teach strabismus to the residents.

Stewart had been a Hopkins medical student and a Wilmer chief resident and was wonderful about telling me about many of the Wilmer faculty members, most of whom I had not yet met. He regretted that I would not be able to meet Dr. Howard Naquin who had passed away quite recently. Stewart mentioned that Naquin, in addition to being a talented eye surgeon and his good friend, had a wicked sense of humor. "Give me an example," I suggested, at which point he related the following story.

One evening, at an elegant dinner party, a society matron, upon learning that Naquin was an eye surgeon at Wilmer, gushed that it must be wonderfully gratifying to perform eye surgery and restore sight. Continuing her admiration for Naquin and his specialty, she asked, "What is the biggest challenge you face while performing eye surgery at The Wilmer Institute?" Without missing a beat, Naquin exclaimed, "It's the flies!" "The flies?' the woman asked incredulously. "Yes," replied Naquin. "There is fly paper hanging from the ceiling on both sides of the operating table and there are always two nurses with fly swatters whose job is to keep the flies in the room from contaminating the operative field." At that point, Naquin excused himself and wandered off, leaving his admirer in a state of shock!

SCOPE
The Senior Ophthalmologist Newsletter

Ideas and opinions expressed in *SCOPE* are those of the authors and editor and do not necessarily reflect any position of the American Academy of Ophthalmology.

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