



SCOPE

Thank you, Dr. Parke!

M. Bruce Shields, MD

The American Academy of Ophthalmology launched *SCOPE, The Newsletter of the Senior Ophthalmologist*, in 1997, and for two-thirds of its existence, one man has been at the helm of the quarterly newsletter and molded it into the publication we all enjoy today: Dr. David William Parke. And now, after fourteen years of dedicated service, Dr. Parke has elected to step down as Editor of *SCOPE*, leaving a legacy that will likely never be matched.

For those of us who are privileged to know Dr. Parke personally (who, I learned early in our friendship, prefers to be called Dave), we recognize this time of transition as a milestone in our profession. It is a bittersweet time, since it represents the close of an era, but also an opportunity to recognize the remarkable lifetime contributions of a man for whom so many of us have the highest respect and affection.

Dave was born on November 19, 1922 (you can do the math) in Hartford, Connecticut. He graduated AOA from Ohio

State College of Medicine in 1950, completed his residency in ophthalmology at the Wilmer Institute of Johns Hopkins University and a fellowship in ocular pathology at the AFIP. In 1956, he became a founding partner of the Eye Physicians of Central Connecticut, where he tirelessly served his community for the next 32 years. His son, Dr. David W. Parke II, commented of his father, "Growing up, I always thought that an integral part of being an ophthalmologist was postop house calls and doing surgery for squash and tomatoes."



During his years of private practice, Dave was also actively involved in both local and national medical affairs, as well as community outreach. He served six terms as Chief of the Medical Staff at Meriden/Wallingford Hospital and was on the Board of Directors for the hospital continuously for over 30 years. He was President of the New Haven County Medical Association and Chair of both the Academy's Committee on State Affairs and Government Relations. His son noted that, "As Chair of the AAO State Affairs Committee, my father traveled to 49 states and never billed the Academy for travel costs." In his home town of Meriden, he served as Chair of the Police and Fire Commission, was Director of the City Savings Bank and the Trust and Safe Deposit Company, served on the Board of Directors for the Salvation Army and was President of the Lions Club, where he earned many honors and awards, including The Knights of the Blind.

When he retired from private practice in 1988, his contributions to our profession were only beginning. Retirement gave him the opportunity to pursue his interest in low vision, and he served for many years as Low Vision Consultant for the Connecticut Board of Educa-

David W. Parke, II, MD and David W. Parke, MD on a fly fishing trip.



Pictured left to right, David W. Parke, II, MD; Joyce Parke; David W. Parke, MD; Lissa Parke Thomson, and Marna Parke Borgstrom

tion and Services for the Blind and as Director of the Low Vision Clinic of the Masonic Health Facility.

In 1996, I had the good fortune to meet Dave when I came to Yale and discovered that the department needed a low vision clinic. He not only helped us raise funds to establish the clinic through a charitable event sponsored by his Lions Club, but also volunteered to run the Lion's Low Vision Clinic at Yale, which he did for nearly the next 20 years. He not only served our patients and trained our residents in this capacity, but was a loyal member of our faculty, including faithful attendance at our 7:00 a.m. faculty meetings.

It was also in 1996 that Dave became involved with the Academy's Senior Ophthalmology Interest Group. With this background, he was a natural to take over as Editor of *SCOPE* in 2002. Those of us who have had the privilege to work with him on this publication, know how tirelessly he has been dedicated to the excellence of the newsletter, which is evident to all who have read it over the past fourteen years. Without a doubt, he will be missed.

As Editor of *SCOPE*, he served

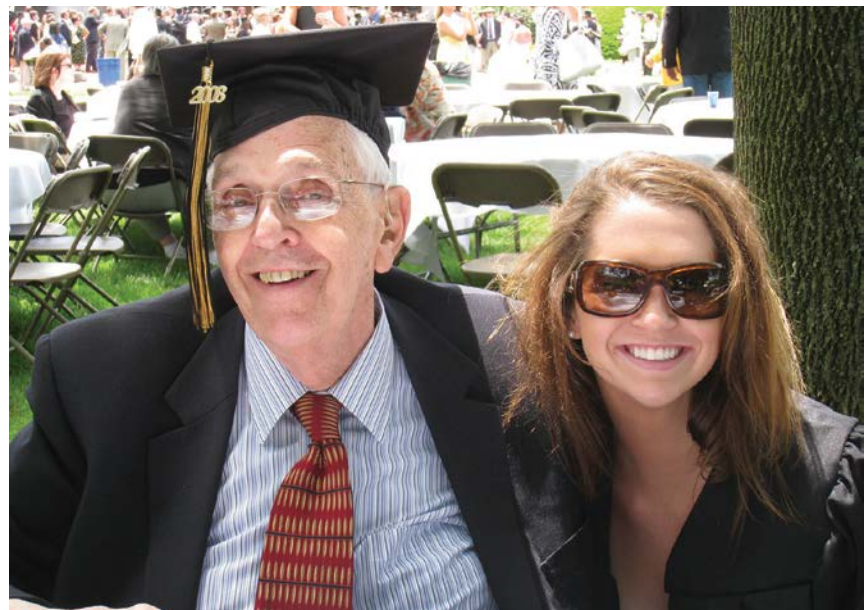
as a member of the Academy's Senior Ophthalmologist Committee, where his warmth and collegiality were enjoyed by the members of the committee as have so many others in the medical field and in his community over his long and remarkable career.

One example of Dave's thoughtfulness was at a meeting of the Senior Ophthalmologist Committee in San Francisco, when he surprised me by bringing a

box of my books, *Gifts of Sight*, which he had purchased and proceeded to give to all the committee members and that was followed by a signing party.

If a person's success in life can be judged by the success of his children and grandchildren, then Dave Parke has to be in the highest echelon. Dave and his late wife, Joyce, have three children, all of whom are at the top of their profession. His son, Dr. David W. Parke II is well known to all of us as the CEO of the American Academy of Ophthalmology. His older daughter, Marna Parke Borgstrom, is President and CEO of Yale-New Haven Hospital, and his daughter, Lissa Parke Thomson, is Senior Vice President with Lockton Companies, Inc. Dave has seven grandchildren, all of whom are successful in their chosen professions, and two great-grandchildren. His oldest grandson, Dr. David W. Parke III is a vitreo-retinal surgeon in Minneapolis and has a son, David W. Parke IV, whose future success is a good bet. So, with four David W. Parkes, I guess that makes Dave "number one." And that is certainly where he ranks in the hearts of so many of us who have been privileged to call him a friend and colleague.

Dr. Parke and his granddaughter Lindsey





The Further Journey

M. Bruce Shields, MD

The majority of our *SCOPE* readers are either retired, retiring or thinking about it. And, for most of us, retirement probably represents the most important transition phase of our life. We spent the major portion of our life (up to retirement) doing what we had spent most of the previous portion of that time preparing for, and now we're done. And what's left? The golf course? A fishing hole? Just waiting for the bugle to sound the final call? There seems to be a general feeling about retirement that the important years are behind us and now we're just going to coast for a few more, and this may be especially true for physicians. But there is another school of thought which turns that view on its head; it suggests that those "important years" were only preparing us for something even more important that lies ahead.

Carl Jung, the Swiss psychiatrist and psychotherapist, popularized the phrase "the two halves of life," and that concept has been a subject of interest for many philosophers and teachers over the years. I recently read a book on this theme by a Franciscan priest, Father Richard Rohr, entitled "Falling Upward: A Spirituality for the Two Halves of Life," which provides, for me at least, a sense of perspective for those pre and

post retirement years. (I should clarify that this is not necessarily a spiritual commentary on retirement, unless you want it to be.)

The first half of life is the part with which we are all most familiar: the years we spent in formal education, marriage and family, our careers and so on. The second half of life is less well defined. In fact, I doubt that many of us even know there is a second half. I didn't. Of course, we know that the retirement years can be rewarding, with opportunities to travel, spend time with family, enjoy hobbies, read, volunteer in our community, and the like. But that is not exactly what is meant by the two halves of life. It has more to do with how the two parts of our life shape who we are in our various stages of development and what we may ultimately become.

Rohr used Homer's Greek myths as an analogy for the two halves of life. In the *Iliad*, Odysseus is fighting the Trojan War (his first half of life), and in the *Odyssey* he is returning home (his second half). On the latter journey, he is required to carry an oar as a symbol of his toil during the war years (although he later realizes that, much of the time, someone else was pulling the oar for him). Along the way, a stranger comments that the oar looks like a winnowing shovel, which you may recall is a farm tool for separating wheat from chaff (the essential from the nonessential), whereupon he is required to stick the oar in the ground and "sacrifice" that which he has come to realize he no longer needs.

Our first task in transitioning to the second half of life is to discern, as did Odysseus, what is worth bringing with us from the first half and what is not (the essential and the nonessential). We can readily identify those characteristics that we wish to retain (hopefully the parts that represent our "true self"): compassion for

our patients and all people, honesty and integrity, gratitude for life's good fortunes, love of family and friends and whatever else you wish to add. But there are other characteristics, which we may have developed in our first half of life, and which may be part of our "false self," that we might best leave behind: the need for validation, status, security, wealth, perfection, pride, illusions, prejudices, smallness. These are not all bad, and some were necessary for us to survive and succeed in the first half of life, but they are no longer essential in our second half. In their place, we may be able to substitute some of those pleasures for which we had little time when, as Rohr puts it, we were self-preoccupied with our first half of life: simply living, pure friendship, useless beauty, moments of communion with nature or anything.

I guess what all this means, to me at least, is that the second half of life or the further journey (for which, I suppose, we can roughly substitute "retirement") is the time when we can let go of some of the burdens that we, as active physicians, carried in the first half. We no longer need to worry about being perfect, in the fear that someone may suffer from our imperfection. We no longer need to be obsessed by how the world views everything we do and say (and write). It is a time when we can be comfortable in our own skin and enjoy being who we really are. It is a time to discover the things that are truly important to us—what really matters, to no longer feel that we have something to prove, to go with life's flow and simply smell the roses. Thomas Merton, a Cistercian monk, put it this way: "In the second half of life... we move from the driver's seat to being a happy passenger, although one who is still allowed to make helpful suggestions to the driver." And, ultimately, it seems that this golden time in our lives offers the opportunity to discover who we really are.

Turning a Blind Eye: Admiral Horatio Nelson's Failing Eyesight and its Impact on the Napoleonic Wars

Alfredo A. Sadun, MD, PhD, Thomas A. Lazzarini and Arthur Vallejo, MD

Admiral Horatio Nelson is remembered as one of Britain's greatest war heroes for his pivotal role in the Battle of Trafalgar, which led to his death and turned the tide of the Napoleonic Wars. The famed naval victory in essence established Britain's role as the greatest power in Western Europe in the early 19th century, ushering in the era of Pax Britannica that lasted until the beginning of World War I in 1914.

Admiral Nelson was admired for his tactical mastery and his penchant for leading from the front and boarding enemy vessels to directly engage the opponent, something remarkable for a British naval officer and which undoubtedly contributed to his extensive war injuries as well as earning him a towering statue in Trafalgar Square in London. Prior to his death, Admiral Nelson catalogued his injuries in a list that he sent to his close friend, Admiral Sir Robert Kingsmill.

Wounds received by Lord Nelson:

- His eye in Corsica
- His belly off Cape St. Vincent
- His arm at Teneriffe
- His head in Egypt
- Tolerable for one War

While being transported to his final exile on the island of Saint Helena by his British captors it was Napoleon Bonaparte himself who remarked that it was Admiral Horatio Nelson, above all, who had frustrated his dream of global domination. Napoleon's statement was compelling in light of Nelson's spectacular victories at The Battle of the Nile in 1798 and at the Battle of Trafalgar in 1805, whose devastating effect added to years of British naval blockades of French ports by Nelson during the French Revolutionary Wars.

Admiral Horatio Lord Nelson was a bold risk taker since his youth, but it is arguable that his tolerance for risk-taking increased to the point of recklessness during the last seven years of his life. A previously unrecognized possibility is that as a result of his penetrating ocular trauma suffered at Calvi, in Corsica, during the Spring of 1794, Admiral Nelson may have subsequently developed Sympathetic Ophthalmia, which ultimately may have had a profound effect on his late life vision and overall health. The impending loss of his eyesight may be in part responsible for his notoriously reckless behavior towards the end of his military career as he also sought ship bounties to afford his divorce and to fund the lavish lifestyle of his mistress, Lady Hamilton.

Decades before, Sympathetic Ophthalmia was first characterized by Edinburgh's William Mackenzie in 1840, in the June of 1794, Nelson was initiating an amphibious assault on Calvi by strategically mounting guns on hilltops surrounding the town and bombarding enemy positions. On 12 July, in the midst of ongoing fire, Nelson was positioned at a forward battery when an enemy shell struck nearby, spraying sand and stone splinters into his right eye. Nelson returned quickly to action and claimed victory in August; however, Nelson's eye had been irreparably damaged by the injury. In a letter to his uncle, Captain Suckling, he wrote, "I can distinguish light from dark but no object." To his wife, Fanny, he divulged that he, "most fortunately escaped only having my right eye nearly deprived of its sight" and that his right "pupil is nearly the size of the blue part [iris]."

Today, ophthalmologists are



Admiral Horatio Nelson c. 1800. Portrait attributed to William Beechey (1753-1839). Oil on canvas.

aware that Sympathetic Ophthalmia, also known as sympathetic uveitis, is a rare, bilateral granulomatous panuveitis that occurs following ocular trauma or less commonly ocular surgery. The disease was first coined "Sympathetic Ophthalmia" by Mackenzie and was initially proposed to be an autoimmune inflammatory disease by Elschnig in 1910, who posited that the inflammation occurred in response to systemic exposure to uveal antigens following breakdown of the blood-ocular barrier. After an inciting ocular trauma, there is a variable latency period, after which sight-threatening inflammation occurs in both the exciting (injured) and sympathetic (contralateral) eye.

Sympathetic Ophthalmia is hypothesized to be the result of a T-cell mediated autoimmune inflammatory response to choroidal melanocytes after disruption of the blood-ocular barrier. The established preventative measure is enucleation of the injured eye within 2 weeks of the traumatic event, a treatment that was first introduced by Prichard in 1851 and became established best practice by 1863. With proper management,

modern rates of Sympathetic Ophthalmia are quite low with an incidence of 0.3-1.9% following open globe injuries. There is, however, no known estimate for the rate of Sympathetic Ophthalmia following penetrating ocular injuries without subsequent and timely enucleation.

The likelihood, however, of developing the devastating autoimmune complication is undoubtedly much higher following ocular trauma with retained foreign bodies and without early enucleation, as was the case for Admiral Nelson. If untreated, Sympathetic Ophthalmia generally has a long course remarkable for intermittent periods of acute inflammation with quiescent intervals ranging from months to years in between flares.¹

There is considerable inconsistency of opinion regarding the state of Nelson's eyesight in either eye in his later years. A frequently quoted article from *The Times* in October 1804 claimed that despite the general understanding that Nelson had lost an eye, according to the "very best authority [...] he could see best with (what people called) his worst

eye." Hence there was at least confusion as to whether Nelson's worse eye was that originally injured. These are Nelson's own comments from the same year: "my eyesight fails me dreadfully; I firmly believe that in a very few years I shall be stone blind." According to an official filing by the Court of Examiners in 1797, his eye injury was "fully equal to the loss of a limb."

The theory that Admiral Nelson suffered from Sympathetic Ophthalmia is further strengthened by an ophthalmic exam documented by naval physician Dr. Thomas Trotter in 1801, who attended to Nelson when he developed a "violent ophthalmia in his only eye with a membranous substance seemingly spreading fast over the pupil." After three days of hourly bathing and ocular rest, the inflammation dissipated. The "membrane" noted by Dr. Trotter is unlikely to reflect his known bilateral pterygia as it was localized to his left (uninjured) eye and was observed to subsequently recede, a pattern consistent with an acute flare of anterior uveitis involving immune cells in the anterior chamber and fibrin deposition over the lens capsule.

Furthermore, Nelson complained of photophobia, requesting green eye shields for both eyes, which he hung from the brim of his hat. Another example, from a letter written by Admiral Nelson to Emma Hamilton in 1801, states that, "Nelson's left (uninjured) eye became inflamed as it did in periods of stress, and he begged Emma (Hamilton) to sew him some green shades to shield it from the light." Finally, we find an excerpt from the same book dating to 1801, "Suffering from stress and searing eye pain which he could only dull with opium."

The theory that Admiral Nelson may have in fact suffered from Sympathetic Ophthalmia can help explain some of the legends involving this war hero. One such myth takes place during the Battle

of Copenhagen, in which Nelson famously claimed not to see his commander-in-chief's flags signaling retreat. Legend has it that Nelson held a telescope up to his right (first injured) eye and stated: "I have only one eye, — I have a right to be blind sometimes," before leading a victorious offensive.

This incident gave birth to the English phrase: "Turn a blind eye," which means to willfully ignore undesirable information; however, in the context of war-time stress and excitement may represent evidence of decreased vision caused by uveitis related to a Sympathetic Ophthalmia flare. In the time before his death, Nelson sought every opportunity to take an enemy ship, frequently assuming significant risk. This was during the same period in which he went through a costly divorce and assumed financial responsibility for Lady Hamilton's extravagant taste.

Perhaps, as the years passed and repetitive bouts of ocular inflammation took a toll on his vision, Admiral Nelson saw the end of his career fast approaching and his opportunities for creating an estate closing. Clearly, he seized every opportunity to claim the prize and acclaim that accompanied taking enemy ships and not just beating, but demolishing the enemy fleet.

This last battle showed Nelson at his most courageous and though ending in a great victory, Nelson was killed by a musket ball from close range that severed his spine. His legacy included fame though not fortune. His objective at Trafalgar, and in previous naval battles, was the total destruction of a numerically superior fleet. This tactic demoralized the enemy, rendered Britain master of the seas, and turned Napoleon to the East where he lost his Grand Armée on the Steppes of Russia. Ultimately, Nelson set the stage for Napoleon's defeat and, perhaps, Sympathetic Ophthalmia set the stage for Nelson's actions.

HMS Victory was Admiral Horatio Nelson's flagship at the Battle of Trafalgar in 1805 during the Napoleonic Wars. She is currently in a dry dock at Portsmouth, England.



Will the Real Myles Standish Please Stand Up?

William S. Tasman, MD

This year, 2016, is the 100th anniversary of the First American Board of Ophthalmology examination in 1916. The parents of the American Board of Ophthalmology (ABO) were the American Medical Association (AMA), the American Academy of Ophthalmology (AAO) and the American Ophthalmological Society (AOS). In 1914, representatives from each of these organizations met in Boston to develop plans for the Board. It was a special time because the ABO was the first certifying Board. The ABO would be followed a few years later by ENT and then obstetrics.

There were many illustrious founding Board members whose names are still well known today. They include Edward Jackson, a Chief at Wills Eye and famous for the Cross cylinder. Jackson later moved to Denver because of his wife's health. Others included Walter Lancaster of Boston and another Bostonian, Myles Standish, a direct descendent of Captain Myles Standish who made the original trip on the Mayflower to Plymouth. Standish was accompanied on the voyage by his wife, Rose, who unfortunately died that first winter, as did many of the colonists. Standish met a young girl named Priscilla Huggins, and fell in love with her.

Their courtship, which is told in Longfellow's poem, "The Courtship of Miles Standish." Standish sent a young man,

John Alden to visit Priscilla and to propose marriage to her on Standish's behalf. Alden, who also was in love with Priscilla, arrived carrying flowers only to learn from her that she had been thinking about John. When he made the proposal Priscilla's response was, "Prithee, John, why do you not speak for yourself?" John, who was shy, could not speak, but instead thrust the flowers into her hands. Priscilla married John, but the date is not known. However, by 1627 they had two children. Standish married a girl named Barbara, who had arrived from England and both the Alden and the Standish family helped to settle Duxbury, Massachusetts. In addition, the second Standish offspring, Alexander, married Sarah Alden, the fourth child of John

and Priscilla. Myles and Barbara had 10 children and the Aldens 7. Remember, the winters were cold.

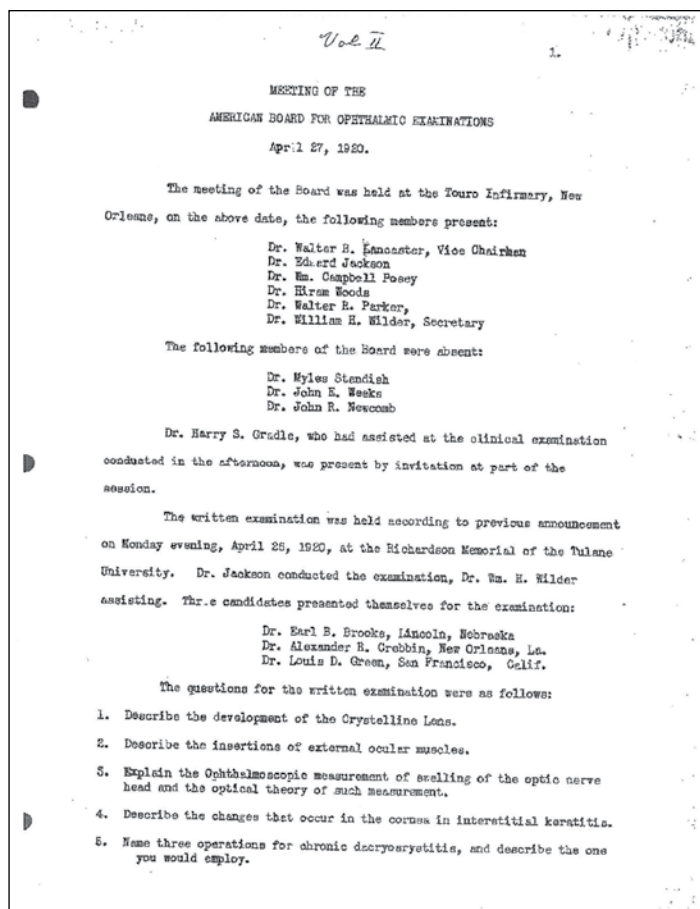
Standish had a good start on his lineage which is of Biblical proportions, squared. Thus about 300 years later Myles Standish, a direct descendant of the Captain becomes a founding member of the ABO. He was a graduate of Harvard and taught at the Massachusetts Charitable Eye & Ear Infirmary for more than 20 years. But just as with his famous ancestor, sometimes it is Myles with a "Y" and sometimes Miles with an "I." As a matter of fact, Longfellow spells it Miles. But in the ABO minutes in 1920 the younger Myles is spelled with a "Y."

At the bottom of the 1920 minutes are 5 questions from that year's exam. Questions 1 and 5 indicate that the Board Members didn't have spell check. On question 1 about the crystalline lens,

crystalline is spelled with an "e" instead of an "a." Question 5 talking about the lacrimal system, the writer of the question (I think) has a terrible time with dacryo (-whatever). (Figure) I found one more Myles Standish (Myles spelled with a "Y") and several Standishes, had first names beginning with an "M."

Coincidentally, I found a Bill and Alice Standish, and even though Alice Lea's ancestors go back to the Mayflower, she assured me that these were not relations. So, to sum it up, I prefer Myles spelled with a "Y" rather than an "I." but don't ask me why.

Both questions 1 and 5 have misspellings



America's First African American Eye Specialist: David K. McDonogh, MD

Richard S. Koplin, MD

In 1838 David K. McDonogh, a 19 year old slave, arrived at Lafayette College in Easton, PA with a fellow slave, Washington McDonogh, sent by their owner, John McDonogh, an iconoclast New Orleans plantation owner, mercantilist, the owner of more than 500 slaves; arguably one of the wealthiest men in the south.

John McDonogh had initiated a secret plan to free his slaves. Known as the McDonogh Experiment, his scheme required that a slave work an extra day a week for 10-15 years. But the experiment came with a non-negotiable caveat. Under the auspices of the American Colonization Society, his freed slaves were obligated to emigrate to Liberia.

But John McDonogh was not content to free all his slaves to an unchartered destiny in the nascent Republic of Liberia. Instead he planned to educate several of his brightest slaves to serve as stewards of the black democracy, still in its infancy.

David and Washington (both electing to take their master's surname), were the benefactors of John McDonogh's extended experiment. Pennsylvania Senator Walter Lowrie (Secretary of the Senate and in 1821 a strong voice opposing slavery in the soon to be minted state of Missouri) was engaged by John McDonogh to act as David's and Washington's legal guardian while they were in attendance at Lafayette College.

David faced obstacles from the moment he arrived on campus. (Washington left for Liberia before completing his studies). Although he was legally free as long as he remained in the north, he was tainted by the stigma of his color and his status as a recent slave and was forced to take classes and meals separately from the other students. David bridled under the strict con-

straints imposed by the college president and was not loath to complain openly about his treatment. But he knew if his slave master wished, he had the power to bring him back to New Orleans in chains; and in one powerful letter John McDonogh wrote Walter Lowrie expressing just that threat.

By his junior year, David began to lobby for an opportunity to study medicine as part of his curriculum. His persistence paid off and eventually John McDonogh gave grudging approval for David to apprentice himself to a local Easton physician.

As graduation loomed David proclaimed that he would not honor his contract with John to emigrate until he completed a medical education. Frustrated and fully aware of David's implacable spirit, John realized he had lost the battle of wills and washed his hands of David, leaving him rudderless and without funds after graduation. Adding to his anxiety Walter Lowrie informed David that no credible medical institution was willing to admit him, even with his academic record and his apprenticeship to a local physician. David's anger and despair are apparent in this passage written to John McDonogh and Walter Lowrie: "the refusal on the part of the medical faculties, and the worse than slavish treatment which I have suffered here, and from those, too, who are looked upon by their kind as saints on Earth, have given me the strongest reasons to distrust the fidelity of the white man. Therefore sir—with due deference to your honor, I have resolved to cover my sable brow with a cloud of despair and never more to look up to the white man, whatever may be his profession or condition in society,

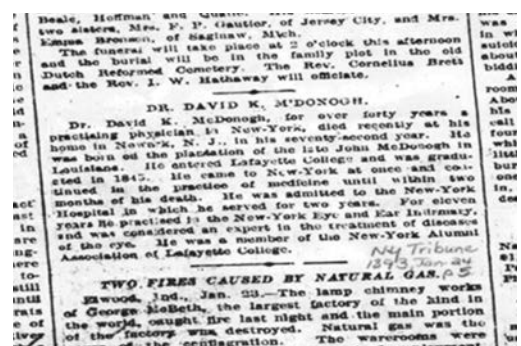


The first McDonough (sic McDonogh) Memorial Hospital (1898). A second hospital was planned in 1908, but was never built

as a true friend. These concluding remarks are general and consequently liable to honorable exceptions."

Perhaps the "honorable exceptions" that David alluded to materialized in the guise of two sympathetic individuals. Senator Lowrie apparently intervened on David's behalf and made contact with an eminent New York physician and the co-founder of the New York Eye and Ear Infirmary, John Kearney Rodgers. Rodgers championed David's cause and remarkably mentored him through his medical studies at the College of Physicians & Surgeons (later (Continued on page 9)

David's obituary in the New York Tribune 1893; Noting that he was an eye specialist at the NYEE for 11 years.



Vision Rehabilitation and Why SO's Care

Lylas G. Mogk, MD

In the 1950's ophthalmologists Gerald Fonda, MD and Eleanor Faye, MD conceptualized a middle ground of vision impairment emphasizing usable residual vision rather than blindness and coined the term low vision. Forty years later four major factors had converged to prompt the rise and expansion of vision rehabilitation services for adults: change in demographics, pathology, lifestyle and perceptions of aging; recognition of the mismatch between seniors' needs and existing services; increased rehabilitation capability; and changes in funding.

Demographics, Lifestyle and Perceptions of Aging

Decrease in blindness among children and young adults due to medical advances, protective eyewear and changes in the weapons of war developed simultaneous to the escalating senior population with low vision. In 1957 60% of the low vision clients at a visual aid program in NY were ages 20-60, and 3.6% of clients had macular degeneration. Today, those numbers are reversed. Our concept of aging has also changed, with 65 year olds no longer automatically giving up employment and activities to sit in their rocking chairs. Visual demands for performing daily activities are greater in our complex society, basic services are often distant from home and inaccessible by public transportation and adult children live far away. Survival of seniors therefore requires greater independence than in previous generations so seniors with vision loss are in desperate need of maintaining their function.

Mismatch of Seniors' Needs to State Services

While all states have mandated educational services for children, vocational services for adults and

"Older Blind" services, the needs of seniors are mismatched to these in six regards. First, adult state services usually require legal blindness (20/200 or 20 degree field) but sighted adults with gradual vision loss, the situation of most seniors, need intervention to preserve activities and quality of life well before that point. Second, state services, designed for small numbers of young individuals, are overwhelmed by the population of seniors in need. Third, the emphasis and funding for state services is employment. Fourth, rehabilitation training is often conducted without a preceding low vision evaluation, so individual pattern of loss and usable residual vision are overlooked although they require different rehabilitation strategies. Fifth, comorbidities common to seniors - balance, memory, shortness of breath or muscle weakness, for example - impact rehabilitation strategies but are beyond the scope of practice of non-medical rehabilitation professionals. Finally, sighted individuals understand blind to mean no vision and do not realize that an agency for the blind means for the legally blind, nor do they wish to be identified as such.

Increased Rehabilitation Capability

Improvement in four areas has increased our capability of providing effective vision rehabilitation services. These include visual aid technologies, evaluation tools, training materials and strategies and professional preparation: closed circuit TVs, computers, electronic devices and GPS systems; standardized continuous print charts to accurately measure low acuities, contrast charts, and peripheral and central perimetry to map patterns of vision loss; training strategies and materials for consumers; and training for rehabilitation professionals. Certification in Low

Vision Therapy was added to the degree programs in Orientation and Mobility and Rehabilitation Teaching, recently renamed Vision Rehab Therapy. The Occupational Therapy Department at the University of Alabama at Birmingham is now offering a graduate certificate in vision rehabilitation for OTs and the Occupational Therapy Department of Western MI University has just announced a similar certification program. Occupational therapists are uniquely qualified for this specialty, as they are adept at problem solving functional deficits from all causes, including vision loss from strokes, and with the addition of expertise the intricacies of vision loss and rehabilitation strategies, they are exceedingly effective and efficient.

Changes in Funding

In May of 2002 CMS granted national coverage for vision rehabilitation when ordered by a physician and performed by an occupational therapist. The Academy, members of the Vision Rehabilitation Committee and others had successfully advocated for regional policies that were in place in 28 states by that time. The national policy, however, opened the way for academic ophthalmology programs and others to offer comprehensive vision rehabilitation across the country, on the same basis as therapy for patients with functional difficulties from any other physical impairment. Ophthalmologist/optometrist/occupational therapist teams are providing comprehensive vision rehabilitation services in many academic ophthalmology programs, as well as increasingly in private non-profit agencies and even some in private practices. It is certainly the wave of the future.

AAO PPP in Vision Rehabilitation: The Standard of Care

The Academy's PPP in Vision Rehabilitation describes the three parts of comprehensive rehabilita-

tion for adults, which studies find improve function and quality of life. First is the low vision evaluation including assessment of the pattern of loss, contrast sensitivity, spot and continuous print reading, writing, activities of daily living, refraction if indicated, degree and types of magnification needed, safety, psychosocial status and community participation. Referral with recommendations to specialized occupational therapists follows. They will train patients to use their residual vision efficiently, apply recommended strategies and devices to desired tasks in the clinic and ideally in the patient's home and community, adapt living environments, address safety issues including medication management and basic mobility, facilitate community participation including transportation and consider the patient's psychosocial condition. The final step is referral to support groups, counseling, and/or other appropriate community services. It has become the standard of care for ophthalmologists to direct patients whose best vision is 20/50 or less to further services, which can be easily accomplished by handing patients the free Academy Smart-Sight™ patient handout, available on the Academy website, in English, French and Spanish. Without this information, those with even early vision loss are at high risk for depression and injuries.

Why Do Senior Ophthalmologists Care?

Because senior ophthalmologists and their siblings and spouses

develop macular degeneration at the same rate as other seniors and need access to high quality vision rehabilitation services. Only one ophthalmologist has gone public at the Academy about his own vision loss from AMD and immediately began advocating for awareness of vision rehabilitation, as he discovered its existence quite by accident. There are certainly more, who need to know that rehabilitation facilitates living fully with vision loss.

For senior ophthalmologists who would like to continue making a difference, part time, being the lynchpin of a vision rehab service is terrific. One day a week of performing low vision evaluations can keep an occupational therapist busy and billing for multiple visits, making the service financially viable. The current chair of the Academy's Vision Rehabilitation Committee, is an interventional cardiologist whose myopic degeneration prompted him to retrain as a Certified Low Vision Therapist and launch a private non-profit vision rehabilitation service in his home town. A retired ophthalmologist is gaining much satisfaction from changing lives with vision rehabilitation a couple days a month in an east coast nonprofit. Those of us in vision rehabilitation like to say that we don't save eyes but we save lives, and patients' comments confirm this. If you are interested in exploring this fulfilling option, you are most welcome to visit any of the current programs near you or contact the AAO Vision Rehabilitation Committee via Joe Fontenot, MD, jfontenot@bellsouth.net.

Hear David W. Parke, II, MD and other prominent colleagues discuss the role of vision rehab in ophthalmology and its benefit to ophthalmologists and their practices in this six-minute video: (<http://www.aao.org/smart-sight-low-vision>) Funded by a Reader's Digest Partners in Sight grant to the AAO Vision Rehabilitation Committee.



David K. McDonogh, MD

(Continued from page 7)

Columbia University Medical School) where he taught, in spite of the objections of the president of the medical college who refused to enroll David as a bona fide matriculant and at graduation refused to award him a diploma.

None the less, Rodgers provided him a staff position at the New York Eye and Ear Infirmary. Remarkably, David's peers embraced him as a bona fide colleague and by all accounts he was considered a respected physician. Throughout his career David held out that he was a graduate of P+S, a claim never challenged by P+S. When John Kearney Rodgers died in 1850 David took Kearney as his middle name, in honor of his mentor.

David began a practice on Sullivan Street in the Village and, in league with Frederick Douglass, became active in the abolitionist movement as well as a champion of workers' rights.²

David married Elizabeth Van Wagoner and of their three children only one survived into adulthood. Our research has identified one surviving member of David's family who is presently being introduced to her remarkable great, great, great grandfather.

David died in 1893 at the age of 72. As a testament to his legacy — appreciated by both black and white members of society — the McDonough (sic) Memorial Hospital opened on West 41st Street in 1898. (Figure 1). David attended the Infirmary for more than eleven years, making him the first African-American eye specialist (Figure 2). Additionally, as far as we know David is the only American slave to have gained a professional medical education.

References:

1. David McDonogh letter to John McDonogh and Walter Lowrie 1844
2. The Frederick Douglass Paper 1851

AAO 2016 Highlights for Senior Ophthalmologists

Neeshah Azam

We hope to see you at AAO 2016 – Oct. 15-18 in Chicago! The Academy's Senior Ophthalmologist Committee highly recommends the following meeting highlights:

Featured Session

Senior Ophthalmologist Special Program and Reception (SPE23)

Oct. 17 from 2:30 p.m. to 4 p.m.; reception until 5 p.m.

Location: McCormick Place, Room S101AB

The 2016 SO Program will feature two speakers who will talk about Abraham Lincoln – *Lincoln, Chicago, and Convention Politics* by Douglas Carlson, JD and Thomas Campbell, JD, author of *Fighting Slavery in Chicago, Abolitionists, and the Law of Slavery, and Lincoln*. Following these presentations, the Academy's YO Committee will present the 2016 EnergyEYES Award to an ophthalmologist who energizes and inspires the next generation. Enjoy a complimentary reception, mingle with members of the Senior Ophthalmologist Committee.

SO Lounge – Grand Concourse Lobby

Saturday, Oct. 15 to Tuesday, Oct. 18
Open daily from 8 a.m. to 5:00 p.m. and on

Tuesday 8 a.m. to 3 p.m.

Receive assistance, access computers, view the SO committee's photo archive or just relax and enjoy light refreshments with your colleagues. "SO" Ribbon required for admission.

SO Lounge Event: Practice Management Roundtable Discussions

Saturday, Oct. 15, 3-4 p.m.

Stop by the SO Lounge and meet with practice management experts from OMIC and AAOE who will discuss a variety of practice transitioning tips. Moderators include: Tamara R. Fountain, MD; Anne

Menke, RN, PhD; Robert J. Landau, JD; James Hiles; Justin Nabity, CFP and Robert A. Wade, JD

New! Learning Lounge Session

An Exit Strategy: Practice Transitions Monday, Oct. 17, 12:15-1:15 p.m. taking place in the Learning Lounge in Hall A

This interactive session will cover options for smoothly exiting out of practice, technical tools for SOs, job sharing, and life transitions. Presenters: Samuel Masket, MD; John G. Clarkson, MD; Lisa B. Arbisser, MD; Amir I. Arbisser, MD; and William J. Fishkind, MD

SO Symposia

Patient Engagement (SYM 25)

Sponsored by the SO Committee
Monday, Oct. 17, 8:30 to 10 a.m.

As patient satisfaction/outcomes grow in importance, understand how this concept becomes incorporated into policies and services such as Share Decision-Making Resource Centers and how geriatric patient populations will be participating in the patient engagement movement.



AAO 2016
In conjunction with APAO
INNOVATE

Global Ophthalmology: Opportunity for SOs (SYM29)

Jointly sponsored by the Committee on Aging and the SO Committee

Tuesday, Oct. 18 from 10:15-11:15 a.m.

Explore meaningful opportunities to contribute and serve overseas by providing clinical care in underserved areas, teaching surgical techniques, vision rehabilitation, and resident education.

Special Sessions

Brain Health and Longevity for SOs in the Digital Age (SPE05)

Saturday, Oct. 15 from 9 to 11 a.m. Attendees will gain pearls on improving brain health in the digital age and how, when used in moderation, technology improves visual acuity, mental processing time, and memory and when used to excess, may lead to behavioral dysfunction and health problems.

Use Blogging and Social Networking to Supercharge Your Website and Internet Marketing (SPE09)

Saturday, Oct. 15 from 1 to 4 p.m. Get hands-on, step-by-step instruction on how to construct your blog; publish articles and use the power of search engines to attract people to your practice, website or business.

Chicago Awaits! Can't-Miss Events at AAO 2016

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

AAO 2016 is right around the corner and I'm excited to be heading off to Chicago! I hope to see many of you there. To help schedule your plans for the meeting, here are some great lectures and events you won't want to miss. These are well worth your time and were made possible, in part, by Foundation funding and generous donor support.

Saturday, October 15

Foundation Donor Reception
4:00 – 5:00 p.m. in the Academy Resource Center (Booth 508)
New this year! Academy leaders are looking forward to thanking our donors. Stop by, have a glass of wine and learn about the impact of your gifts.

Sunday, October 16

Michael F. Marmor, MD Lecture in Ophthalmology and the Arts
12:45 – 1:45 p.m. in room S406A

The Alchemy of Color in 19th Century Art

Presented by Francesca Casadio, PhD, Senior Conservation Scientist with The Art Institute of Chicago

Monday, October 17

Dr. Allan D. and Claire S. Jensen Lecture in Professionalism and Ethics
10:15 – 11:15 a.m. in room S406A

Ophthalmology Took a Stand!

Presented by Alfred Sommer, MD, MHS, professor of ophthalmology at the Wilmer Eye Institute, and Dean Emeritus and professor of epidemiology and interna-

tional health at the Johns Hopkins Bloomberg School of Public Health

Museum of Vision History Symposium

12:15 – 1:45 p.m. in Grand Ballroom S100C

Giants in Asia-Pacific Ophthalmology

Hear stories of historical giants in ophthalmology from the Asia-Pacific region. Seminal figures include ancient practitioners, early modern legends, great discoveries and innovations.

C. Stephen and Frances Foster Lecture in Uveitis and Immunology

12:45 – 1:45 p.m. in room S406A
Immunosuppression for the Uveitides: Current Status and Future Directions

The inaugural lecture will be presented by Douglas A. Jabs, MD, MBA, professor of ophthalmology at Mount Sinai's Icahn School of Medicine.

When you visit the exhibit hall, remember to stop by the Museum of Vision (Booth 704, next to the Academy Resource Center) to check out the latest exhibit, "History of Ophthalmology in the Asia-Pacific." Explore this unique ophthalmic heritage largely unknown in the West, including Sushruta Samhita, the world's first description of cataract surgery written in 600 BCE India, and the first medical school in China established by the T'ang Dynasty in 624 CE.

A huge thank-you to those who bought tickets for the 13th annual Orbital Gala, "A Walk on the Wild Side," on Sunday, October 16 at

the Field Museum. We're excited to honor our beloved friend and colleague, Richard P. Mills, MD.

Can't attend the gala? You can still participate in the silent auction. The auction opens to all U.S. members on October 6, and bidding is easy and fun on our mobile app. You can register to bid at aao.org/foundation and get great deals on ophthalmic equipment, an African safari, prime NFL tickets, fine wine, hotel stays and much more. And the best part is that all proceeds benefit the Foundation!

For those of you attending AAO 2016, travel safe to Chicago! And as we approach the holiday season, I hope you'll consider the Foundation in your year-end giving plans. Learn more about the work we do and how it benefits ophthalmologists and patients at aao.org/foundation.



Spectacle case, China, c1780. This beautiful spectacle case depicts a scene from the 15th-century book, *Three Kingdoms*, by Luo Guan-zhong. Learn more at the museum's new exhibit at AAO 2016.



Syncope and Air Travel

Alan J. Clark, MD

When the flight attendants announce, “Is there a physician on this plane?” and there is a 40 year lapse in emergency care experience, what do you do but offer yourself into the unknown. Retirement does not mean the end of service as a physician.

The young man upright in his seat is barely coherent with pale fingernails. The flight attendants have already given him a mask with oxygen. The first thing is his pulse is very slow about 40 beats per minute. He is not diaphoretic. There is a suggestion that he convulsed briefly. There is denial of complaints of chest pain but perhaps some stomach discomfort. I suggested the steward lie the man down in the aisle. A cardiac nurse took his blood pressure with difficulty at 105 systolic.

There was no history of medications, allergies, heart disease or family history of early heart disease and no history of seizures by the wife of this 51 white male.

The time was midnight on a five-hour flight from Seattle to Orlando and the man had been sleeping with a rather firm collar. The male steward noted that he had seen this situation many times on night flights.

Fortunately, the man recovered color and consciousness and pulse

of 70 almost immediately.

Review of the literature on vasovagal carotid syncope suggests that tight shirt collars and even massage of the neck by professional masseuses can cause syncope but no mention of firm sleep collars used on airplane flights.

I remember as a medical student there was a caution to not take bilateral carotid pulses simultaneously to avoid causing bradycardia and syncope. In this case the sleep collar was tight and firmly stuffed and not air filled so that bilateral simultaneous carotid artery compression had occurred. The collar reminds me of a horse collar used for carriage draft horses.

The bradycardia induced by neck and carotid artery compression can cause a chain of reactions to include unconsciousness followed by seizures, stroke and heart attack and nausea and vomiting all from lack of oxygen, with the help of comorbid disease. So it is not something to treat lightly. I would note that those of us old enough to sport a pacemaker might be immune.

Until proven otherwise I am the first to report this cause of syncope in milk runs. I suppose milk run refers to getting to your destination in the early morning hours in time to milk the cows. Thus I will call this Clark’s Horse Collar Syncope Syndrome. Lawyers take note.

SCOPE

The Senior Ophthalmologist Newsletter

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Associate Editors

W. Banks Anderson Jr., MD
Durham, NC

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Design

Lourdes Nadon

