

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

**Conversation Between Robert Taub, MD and Susan J. Taub, MD**  
Chicago IL, October 16, 2010

---

Drs. Robert and Susan Taub recorded this conversation on October 16, 2010 during the Annual Meeting of the American Academy of Ophthalmology, in Chicago, IL.

Together this father and daughter discuss their family history and how the field of ophthalmology has evolved from one generation to the next, building on the museum's [Legacy Project](#) which celebrates families with multiple generations of ophthalmologists.

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



The Taubs represent two out of three generations of ophthalmologists in their family. In this [excerpt](#), they discuss their family history

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

**Conversation Between Robert Taub, MD and Susan J. Taub, MD**  
Chicago IL, October 16, 2010

---

SUSAN JANE TAUB: My name is Susan Jane Taub, MD, and I'm an ophthalmologist from Chicago, Illinois. And I'm here with my father.

ROBERT TAUB: Bob Taub, Robert Taub, also from Chicago.

SUSAN: So, you know, Dad, our family has a very rich and long history of eye care. We have history in ophthalmology, optometry, opticianry on both sides of the families for what you have just informed me is four generations. So why don't we talk a little bit about our family history and who was doing what when?

ROBERT: Okay. Well, my grandfather on my father's side, Louis Taub, was an optician in Germany and he immigrated here to the states in the early 1880s. And when he came over here he did not do opticianry.

My father was a physician, graduated from the University of Illinois. He entered the armed forces then, which was kind of interesting. He was a major in the cavalry. He had never even seen a horse. He was raised on the west side [of] Chicago. But they put him on a horse down at Fort Oglethorpe in Georgia. He served for a year, and then they sent him to a special training program at Cornell. They had a new device, x-rays, for locating bullets. And he took that course for a year. By the time the year was up, the war was ended, World War I that is. Married my mother during a Christmas vacation. That would be in, I think, the Christmas of 1918.

And then I became a physician, and studied ophthalmology. I became interested in it. I liked the physics of it. And, you know, went to school, did all my training at Northwestern, and then I took a fellowship in ophthalmology at the Mayo Clinic and I worked for a masters degree in ophthalmology from the University of Minnesota. You could do that then, simultaneously. Mayo Clinic did not have a medical school yet at that time. Well, you should take over now.

SUSAN: Well, then we've forgotten Mom's side of the family.

ROBERT: Right.

SUSAN: My maternal grandfather was an optometrist and my maternal grandmother was his optician. And I'm not certain how they were related, but Uncle Lou was also an optometrist.

ROBERT: Yeah, that was your grandmother's brother.

SUSAN: Brother, okay. And then my brother, your son, is also an optician.

ROBERT: Right.

SUSAN: So we now have an integrated family of four generations in the three Os.

And I did my undergraduate work at the University of Michigan with all intentions of being an architect. I was a child who was interested in light rays and color wheels, and glitter, glue and glop. And found out that architecture was a little too subjective for me and wandered a bit and never, ever even intended to be a doctor, did I?

ROBERT: No, no that was quite a surprise to us.

SUSAN: No, never talked about it. When I left the school of architecture and was not enchanted with that I took a course in human genetics and was fascinated. And as you know, I then went and tried to get my MD-PhD so I could do genetic research. And as God would have it, I was not accepted to any PhD programs or combined programs, and I was accepted to two MD programs and picked the one that I felt had better genetic programming. And I kind of became tired of working in the lab, in the dark with little tiny mammals. You remember in the dark, all those pipettes, you know, little tiny mammals doing research?

And eventually medical school where I went, at Indiana University, had only one elective and it was toward the end of your third year. And by now I had

gone through a lot of clinical rotations saying, 'Well, I don't want to be this and I don't want to be that.' I'm sure you remember me saying, 'How can anybody do these types of careers.' So finally they gave us electives and I had a choice between ophthalmology, urology and oto... ENT. So I said, 'You know, I'm going to go see what my dad does'. And I walked into the clinic and, lo and behold, there we were, light rays, color wheels, physics, eye-hand coordination. Not exactly glitter, glue and glop, but surgery. And so I called, and you know I remember I said, 'You know what Dad? I think I want to do this'. Do you remember what you said to me?

ROBERT: No, I don't really.

SUSAN: You said, 'Susie, people who want to be ophthalmologists know they want to be ophthalmologists from the time they were born. You'll never get in'. And I did. And so now, I followed in my father's footsteps and we've made yet another generation of ophthalmology.

So is there anyone, in particular, that you would say, in your training, in your education part of your career that was particularly outstanding as a teacher for you?

ROBERT: Well, yeah, I think Dr. Rucker, Wilber Rucker at the Mayo Clinic was. He was a neuro-ophthalmologist. I had always been interested in multiple sclerosis. I had an Aunt Sally, who I used to see frequently, in a wheelchair and she had multiple sclerosis and that kind of intrigued me. And Dr. Rucker had written quite a bit on multiple sclerosis and eye findings. And I worked with him on several research projects about multiple sclerosis and ophthalmology, and we... I think we were the first ones to show the relationship with retrobulbar neuritis to multiple sclerosis and the frequency with which that lead... when you had an episode of retrobulbar neuritis that lead to multiple sclerosis. I think that was the first paper I ever published. It was the lead article in the *Medical Academy of Ophthalmology* publication. And I think Dr. Rucker was the most influential in my career in ophthalmology. What about your training program? You had much more interesting professors.

SUSAN: I had two very strong mentors in my career in training. Dr. Merrill Grayson was the chief of Cornea and External Disease at Indiana University.

And he had an almost impish demeanor in his zest and love of what he did and his desire to teach and to involve the students and the patients with their care, extremely compassionate and multi-talented. And I think that he was very influential in my clinical approach to patients and my philosophy of medicine, which is to educate patients.

And then there was also someone who was very influential who would be Dr. Eugene Helverson, who was the head of pediatric strabismus and adult strabismus, as well. And he and I published a lead article, the first article that I ever published, that came out in the *American Journal of Ophthalmology* the summer before I began training on congenital esotropia, which had been a tangent of this genetic research project that I had been working on at Indiana and did not know that they were even connected. And so between those two people, I've spent the most of my career doing those two things from what I think were the two most academically influential people in my career. And I think that we crossed paths in pediatrics and cornea and general care and philosophy, as well.

So I have a question. What was the funniest experience in your practice or your life, career?

ROBERT: In ophthalmology?

SUSAN: Yeah, in ophthalmology, I'm sorry.

ROBERT: Well, I think the funniest one, when I was up at the Mayo Clinic. I just came up there right after World War II ended, shortly thereafter, and the Eye Department was housed in the Quonset hut. And after it was there about a year-and-a-half we finally moved to this amazing, huge, towering building, which still exists, it's still the main building for the Mayo Clinic, 24 or 25 stories high, and everything was all automated. It was amazing. You know, you could step on a peddle and the chair would go up, step on a peddle and the chair would go down. You want the lights on you push a button, you want the lights off you push another button. One day, we had just moved in, maybe been there about three weeks, and I came in after lunch when I was usually a little sleepy anyway and this sweet, little lady, she was probably about 90, was in the chair. And I said, 'Oh, well, let's take a quick look'. So I turned out the lights like I always did and I pressed the

button, and the chair starts going up and it passes my face and it's still going up, and it's going up higher and higher and I don't know... I thought for sure it was going to go through the roof. I never had run it out to the end. And it locks with the motor still on and she's way up in the air. I turned on the light and her head is just about touching the ceiling. And I looked at that and I said, 'Well, don't move, I'll be right back.' I had to find an engineer to get her down. Thank goodness it ended all right. But I remember that. What about your career?

SUSAN: You know, I can't remember any one incident that would be quite as fascinating as that. But I have to tell you that there was a series of events when I was in training at, what was then called Wishard, which was the county hospital in Indianapolis at the Indiana University School of Medicine. And in those days we didn't have HIPAA and privacy, and to afford private examination rooms, it was almost unheard of. And so there was a very large gymnasium that had eight examination lanes lined up side by side by side, and eight residents would be working continuously next to each other. And you could overhear every conversation from every certain person in the clinic, and so if you heard that someone had an unusual disease you could get up and walk over and look at the patient and you could come back. And the anecdotal stories are things like, 'Gee, Mr. Jones, did you know you have your shoes on the wrong feet?' And then they would take 20 minutes for Mr. Jones to bend over and put his shoes on the proper feet. Or to say, 'Gee Mr. Jones, did you know you have bad blood?' or any kind of anecdotal things. And while in this room and there was a very large speaker system that was blaring typical disco music from the 80s. So I can't say that there was any one incident that tops your equipment malfunction but training in those days was quite different, and I was able to be exposed to more in a more condensed period of time than the students today are.

I also have to say that I had a very interesting experience in my career. I would like to say one of most interesting experiences I had was when I inadvertently met my husband. As you know, Dick was my patient. I did a cornea transplant on both of his eyes when I took out his cataracts. And he disappeared for a few years for another opinion for his... one of his transplants had failed, and said, 'You're my doctor and I want a second opinion. I've been told I need this procedure and I want to know, is it the right procedure. And if it is do you do it, and if you do it would you do it?'

And I told him it was the proper procedure, but that I didn't do it and that I couldn't do it and then he asked me out.

And so how did you meet Mom?

ROBERT: On the beach. We were teenagers. We met each other down there, and then we both ended up at Northwestern, and one thing led to another...

SUSAN: Oh, not exactly, one thing led to another. You and Mom were fixed up. You can tell that story. How did you meet Mom when you were in college?

ROBERT: Oh. Well, she was invited to a homecoming event by one of my good friends and she kind of blew him off, and so they decided to fix her up with the nastiest person they knew, which was me. That's how I went out with her again.

SUSAN: It didn't quite work that way.

ROBERT: No, no, no.

Why don't you touch on your teaching in ophthalmology? You have done a lot of teaching all the way.

SUSAN: Well, as have you. I followed my father's footsteps. And the adage at Indiana was always 'see one, do one, teach one.' So I joined you in practice, and, as you recall, shortly after I joined you in practice I felt that itch to teach. And after my momentous occasion of passing my boards when I had a little time, but wasn't busy enough in the clinic working with you, I was the Director of Pediatric Ophthalmology and Strabismus at the University of Chicago for about five years. And it got to be a very busy service, and I enjoyed it greatly. I've always enjoyed teaching. But the threshold came when I had to make a choice of teaching full-time or teaching part-time because the service had grown so large, and I opted not to take a full-time position, and then continued practicing with you, as you know. And then of course the itch, I got it again, and so I joined the faculty at Rush. And while I was at Rush, I was teaching residents and student of

lots of different disciplines in ophthalmology. By the way, simultaneous to being the Chief of Ophthalmology at the University of Chicago, I'm sure you will recall that I did a fellowship in ethics.

ROBERT: Yes, right.

SUSAN: And so people have sought me now because I'm one of the few Ophthalmic Medical Ethicists who actually did a fellowship in Ethics. So that then launched me also into being on the faculty at Northwestern and at Children's. And I've continued to write and research and do things primarily in the field of ethics. In fact, I trademarked a word that I use when I write and all my works in ethics are called 'ethiquette,' because in ophthalmology there is a lot of ethics and etiquette that blend into the work ethiquette. And so as you know, I've had to have your help and Mom's help, with Mom being the family grammarian and you being my medical sounding board in writing some of these very treacherous, long articles about HIPAA, and the physician-patient relationship which is now called 'the patient-physician relationship,' thanks to my article called 'The Turnabout.' And I've enjoyed it a lot and I continue to teach.

And you teach, too. And you have for how many years?

ROBERT: Well, I went on the faculty in the Department of Ophthalmology when I returned from the Mayo Clinic, and I've been teaching there ever since 1955. I think that's 55 years of teaching.

SUSAN: Since before I was born.

ROBERT: Yes, that's right, definitely before you were born. But my father taught and he kind of got me interested in the whole teaching thing. He was the head of the Department of Internal Medicine at the old Chicago Medical School for many years, maybe 20 years. And I remember attending some of his lectures, and he certainly... I got the idea that we should certainly teach and try to help the evolving next generation of doctors. Of course, I've been around so long now, I've got several generations of doctors behind me. But I've always enjoyed teaching. I still do it and I still enjoy it.



SUSAN: And I think there's another dimension that we've shared all along, and I think it must go back to family or two families' philosophies, is charity work. We both have done a fair amount of volunteering in multiple dimensions. We've both been part of Eye Care America since its inception.

ROBERT: Yes.

SUSAN: I have volunteered to do glaucoma screening with the AMA and done a few volunteer things through the Academy. But I think the most important thing that we've done is, for example, both of us have spent many years seeing prisoners as patients.

ROBERT: Yes, that's always a challenge.

SUSAN: And that started... well, yeah. But that started with Mom's dad, is that correct?

ROBERT: Yes, that's right.

SUSAN: So that would be Grandpa Ben Kaplan who was an optometrist.

ROBERT: Right, and he was the optometrist at the Indiana State Prison. In those days you went into the prison to do the examinations. But he happened to be there on the day when Dillinger escaped, and that was his last journey into the Indiana State Prison. He just left, left all his equipment there, and donated it to the State of Indiana. That was a little too harrowing for him.

SUSAN: Then what happened to those patients?

ROBERT: Well, now... they bring them out to us now. You know, they brought... that was quite an entourage because with each prisoner there had to be two guards so there was quite a group who would come in when we saw the prisoners. And then we had a special wing where they were housed in the hospital and we operated on them there. And they were an interesting bunch, that's for sure. I think they were grateful for whatever we could do to help them.

SUSAN: In your training did you ever treat prisoners?

ROBERT: No... well, not really. The Mayo Clinic, at that time, did all the eye care for all the state mental institutions, so we as residents would make the circuit every couple of months through all the mental institutions. And of course there were those who were criminally insane also, but they were institutionalized. And then if they needed surgery they were transported down to Rochester for their surgery, and the residents, we did the surgery. We would have to go out in the field and kind of examine them one by one.

SUSAN: Well, that evolution changed by the time I entered school. The prisoners came to us in training one day a month... or, no, no, no, one day a week. Every Friday was prisoner day at the county hospital in Indianapolis. And I will never forget, I was forewarned by the nurses in the clinic that Friday was pants day because I always wore skirts and thought that a doctor should wear skirts. And I just thought they meant it was Casual Friday. And so the first Friday I on in the clinic, I came in in a nice short little skirt and the nurse just shook her head and said, 'No, Dr. Taub, no, no'. And it was unbeknownst to me that men who are shackled at the waist can tickle your knees underneath the microscope. And I soon ran out and bought a few pair of slacks for Fridays at the county hospital.

But then it evolved, as well, as you and I shared two practices, one in Chicago and on back where I was born and raised, in Michigan City, where the prisoners came to us, and saw them there and continued that type of work, until, if I'm not mistaken, there were a fair number of attempts for them to escape, and it became difficult for them to continue that. And the prisoners coming to us changed and I honestly don't know at this point what they're doing.

ROBERT: I really don't know, but that is true, we had some problems there.

But talking about charity work, I do have to touch on that for a moment. When I was young, 9 or 10 or 11, I don't know, I used to sometimes make house calls with my father. I remember he used to make eight or ten house calls and then the big celebration for the night was if we collected \$2 for one house call out of the eight. The rest were just charity. I thought that was how medicine was practiced, really, because most of the poor people didn't

have any money during the Depression. And services were rendered, but we seldom got paid anything.

SUSAN: Well, and the practice in Indiana wasn't too far from that target in a completely different direction. And I remember, as a child, when I believed this was a barter system, you would come home with a bushel of corn, jars of homemade jams and jellies...

ROBERT: Right.

SUSAN: ...hand-knitted sweaters...

ROBERT: Paintings.

SUSAN: ...paintings—any form of gratitude that they could afford. People who canned goods would bring them in. And I continued the same tradition carried forward, and, you know, a few dollars here and a few dollars there were ignored because they gave what they could. It goes back to, kind of, a barter system.

ROBERT: Well, we're kind of back in that era now, I can tell you that.

SUSAN: Have you been receiving canned goods?

ROBERT: Well, more, but they pay what they can and that's that. I've been there before, so I know about it.

SUSAN: So of all the things that you've done with your career, and I guess this shouldn't be necessarily limited to ophthalmology but it probably will be, what would you say would have been the most rewarding thing you did?

ROBERT: Well...

SUSAN: Any one thing, or maybe just...

ROBERT: I think it's just really everything. I think the biggest reward is a smile or a thank you from a patient. You know, that means a lot. I think, you know, if you want to help people you should go into medicine. That's

what I told my grandson. You know, all these bad things he hears about medicine, he's smart enough and dedicated enough as a student, but I told him, 'You know, if you want to help people all the rest doesn't really matter.'

SUSAN: And I remember your words of wisdom very similar to that, I don't know if you remember saying this to me, but at one point... actually at more than one point in my career, I kept saying I wanted to go back to school and do more fellowships because I was bored, and I wanted to do this and I wanted to do that, and I wanted this and I wanted to do that, and it was always a bone of contention. And finally one day you sat me down and you said, 'You know, Susie, you've got the picture wrong here. This isn't about you. This is about the patient...'

ROBERT: Right.

SUSAN: ...and your goal should be to make every patient leave here with either a glimmer of hope, or a smile on their face, or clear understanding of why they don't have a smile on their face or a glimmer of hope.' And I have always carried that in my mind as the point of helping others.

ROBERT: That glimmer of hope is a big issue. You know, I've been training residents now for 55 years, and that's the one thing I always tell them, you know, always leave a glimmer of hope. Don't destroy the hope, because, number one, you don't know what the outcome is going to be anyway. But you should always leave a patient with some level of hope. 'The situation is bad and, you know, things may not work out, but I think it's going to be okay.' I think you should always tell a patient that. I think you've got to... to crush them with the final diagnosis or a sentence, you know, that things are really bad and you're going to go blind or you are blind, even blind patients have to be told, 'You know, we're working on research. We've got implants coming. Don't give up. Something may be here tomorrow or next year.' So I think that's a big issue in medicine. Too many of the young doctors forget all about that.

SUSAN: And that's where my 'ethiquette' teaching at the bedside manner comes in. 'Ethiquette,' meaning etiquette. I mean, true ethics talks about a lot of really meaty issues like death and dying, right to life, right to choice,

right to whatever want to pick. And in ophthalmology, to me, it boils down to bedside manner and having an appropriate relationship with your patient, and trying to establish good dialogue and make sure that the patients understand their medical concerns to the best of their ability. And continue to give them that little... that little glimmer of hope. And if there is no glimmer of hope, which happens, to at least help them understand why or what could be done or where to look, as you said, or where other research is.

So who was the most important person in your life or who were the most important people in your life? Now, we're talking life, not necessarily just ophthalmology.

ROBERT: Well, my wife for sure. She was always a great help. And maybe I was gone long hours, worked seven days a week, and she was... you know, she never complained about it. And had to put up with a lot—phone calls night and day. And so she had to sacrifice a lot and... so I think she was the most important person in my life anyway, definitely. How about yours?

SUSAN: Well, that's obvious, it's you and Mom. And you are in a tie in two completely different levels. You, both professional and personally, and Mom both personally and professionally, but in a different way. You, of course, are my role model. I worked with you. We've discussed professional things, medical things, and so forth. But being a woman in medicine had a different slant to it.

ROBERT: Oh, yes, very much so, especially when you came in.

SUSAN: Absolutely. I was the only one in... I was the first woman in the program in something like 25 years.

ROBERT: Right. It's always embarrassed me, I changed in the surgeons lounge, you had to go into the nurses' lounge as I recall.

SUSAN: This is true. It was just named the 'nurses' lounge.' I worked very hard to petition and get that changed to 'men and women' instead of 'nurses and doctors.' And sometimes it worked and sometimes it didn't.

But there were... I can remember females who would be very belligerent and change in the surgeons' lounge.

ROBERT: Yes, we did have one or two, that's true.

SUSAN: I don't remember any of the male nurses coming into the females' nursing lounge. They changed in the doctors' lounge.

So of course I think that's very obviously for me, that throughout my entire life both you and Mom, of course, have always encouraged me. You've always encouraged me to be the best in what I do. To pick what I want to do but do it well, and given me encouragement and support and options and the wherewithal and some economics that were thrown in there, as well, to get me to where I am. And I'm very fortunate.

ROBERT: Well, thank you.

SUSAN: I'm very fortunate.

I'm trying to think of anything else that we could discuss and I'm running dry here. How about you, Dad?

ROBERT: Well, the Academy of Ophthalmology has been a big part of our lives, certainly. It was quite a thrill when I finally passed the Boards and could join the Academy of Ophthalmology. It's a symbolic... I think it's the oldest professional organization among all the specialties. It's taken a lead role and set a course of ethical behavior for all of medicine, because, really, they were the first group. I think it started out as Eye, Ear, Nose and Throat with Laryngologist included, and I don't think that broke away until, maybe, 40 years ago, 35 years ago. But without the Academy of Ophthalmology, without a beacon of how things should be, I just wonder where all of organized medicine would be today. You know, they set a pattern of behavior that was proper, ethical, morally correct, how we should behave as doctors, and what we should do. So it's a great organization and I'm proud to be a member of it really.

SUSAN: Not only a member but a fellow.

ROBERT: A fellow, yes.

SUSAN: And now a life fellow.

ROBERT: Now a life fellow, that's right.

SUSAN: A new category.

Yeah, I'm proud of the Academy as well, and they are indeed, as a fact, the oldest board established. But I'm also proud of, not just the ethical, behavioral and political things they have done, I'm also proud of the academic and the teaching avenues that they have for us to continue our continuing medical education and stay current and stay abreast of a field that's evolving very quickly.

ROBERT: Yes, it is.

SUSAN: Science is moving fast with computers and chips, and, you know, it's tough enough to keep up with our profession, nonetheless with what general medicine is doing and other professions. And the Academy has several paths for continuing education, core education, as well, in the residency from day one forward. And of course I'm also very proud to not only be a member but also a fellow. And I have to say, one of the most difficult things I think I did in my life was to pass those boards. How many years did I study in the office, sitting there reading those books over and over and doing ophthalmology flash cards, and asking you questions, and asking the opticians questions, and asking my brother the optician questions and... oh, my goodness.

ROBERT: Yeah. Well, and also remember the 13 core books that the Academy has come out with, and that they update every year or three years, depending. That has become the mainstay for all the training programs, not only here in the United States, but around the world. That's what everyone studies. You know, and I think almost all the residency programs have a pattern for making their residents go book by book by book, and they even give quizzes so that they know that if their residents know what's in those core books they're going to pass the board's exams. It used to be Duke Elder was the expert of the Duane *Textbook of Ophthalmology*, but let's face

it, now it's the 13 books which are published by the Academy of Ophthalmology that keep us all abreast. And not only ophthalmologists but also ophthalmic assistants, they have books now, and teaching. So they've really led the way, also, in education.

SUSAN: Well, Dad, you know, throughout the years you've referenced Dr. Rucker, as you talked about him earlier on, and it's my understanding that Dr. Rucker was a pioneer in many ways in his field, and that not many people had the luxury of meeting him. And I did when I went to interview at the Mayo Clinic for their medical school, and he was kind enough to meet me at the hotel and walk me over to my interview there for medical school, and he was a charming gentleman. And that was my only actual, physical contact with him, but you spent much more time with him and worked with him. I'm wondering if you have any more insights or things about the history of Dr. Rucker that people might appreciate.

ROBERT: Well, yeah... in those days we did a complete funduscopy exam on almost all the patients coming through the Mayo Clinic, a dilated exam. And I remember I shared a section with Dr. Rucker—he was on one side, the left side, and I was on the right side. And I remember that your mother, shy, she taught school up there in Rochester but during the summer she didn't have anything to do so we put her to work in the Eye Department. I think she was the first drop girl on the planet. She used to put in drops in the patients. And then she was always amused because if she seated them over on the left, they would see the Chairman of the Department who has been doing this for a long, long time and if she told them to go right they saw me, and I had probably been there about six months and could barely do it. But, anyway, Dr. Rucker was close at hand if I had any questions, that's for sure.

But I did spend a lot of time with Dr. Rucker because I had to have a thesis to get a master of science in ophthalmology, and, I think I mentioned before, I went into the... did a study on the relationship of retrobulbar neuritis and multiple sclerosis. So I remember writing the thesis and writing the thesis and writing the thesis, and no matter how I presented it, Dr. Rucker was so precise and so persnickety, the wording... each word had to be exactly right. And I remember your mother used to type the revisions and we must have had 10 revisions. I didn't think I was ever getting past his eagle eye. But he not only was a wonderful, wonderful person and ophthalmologist but, as I



learned, he was a strict Romanitarian [?]. Coming from Chicago I realized how much I had missed in English education.

Also, I remember Dr. Rucker, he was an avid golfer, and I was not a very good golfer but some Sundays I would go out with him golfing, and I was always amused. Sometimes he said, 'Bob, do you want to bet a nickel on the hole?' So I said, 'Okay.' You know, and I have to tell you that I usually lost, but also Dr. Rucker always collected the nickel on the spot when he won. That really always amused me. He was really serious. When he said, 'do you want to bet a nickel on the hole' he meant it.

But, anyway, he was a great person, and wonderful ophthalmologist, and we certainly all owe a lot to him. He probably was one of the first that did medical and neuro-ophthalmology as far as I know. Maybe there was a predecessor in the Mayo Clinic, Dr. Wagner maybe preceded him, and that probably is true. He also was a neuro-ophthalmologist, Wagner was, going back in time.

So those are some other things I remember about Dr. Rucker. I never called him Wilbur either. I always called him Dr. Rucker, forever.

SUSAN: Did he ever tell you you could call him Wilbur?

ROBERT: No.

SUSAN: No.

ROBERT: And it always kind of struck me as being the wrong thing to do. When some of the junior members of the staff who were already attending Dr. Rucker, when they would call him Wilbur. To me, it just didn't sound right. I don't know why, I just could never do that.

SUSAN: Indiana University had a... and I don't know if it was a generational thing or if it was just a tradition, but they had a little bit more of the individualized approach. This was back in the day, in medical record-keeping, when you didn't have to sign your entire name at the end of your clinical notes, you simply put your initials. And so Merrill Grayson was known as MG, and Eugene Helvison was known as EMH, and Forest Heltz

was known as, you know as FDE, and I was SJT, and, you know, everyone was known by their initials. And we actually were encouraged and called each other by our initials. And we would say, 'Hey MG, can you look at this for me?' And it was not meant with any element of disrespect it was just sort of understood that this was code as are many of the acronyms we use in our charting today, and it was just sort of an adopted thing. And, of course, we all had nick-names for each other as well. For example, my mentor to whom I was assigned in my first year in residency was Lou Cantor, who's just been made the chairman of Indiana's Department of Ophthalmology. And I used to say 'Come on Lou, let's go to skurgery,' and he would say 'Okay Skusan.' And so we all had little nick-names and innuendos and we had fun with it. We had a very good congeniality in our group, and everybody was pretty good and took punches very well, including the attendings.

ROBERT: How many did you have in each class? I don't remember.

SUSAN: Yeah, we had the biggest class at the time, if I'm not mistaken, other than perhaps some of the schools on the East Coast. We had seven per year. So we had 21 residents, which was a large group. I was the only woman in the program the first year I joined... or was accepted. The next year they accepted another woman, and the next year I think they accepted another woman. So when Dr. Helvison interviewed me he made a faux pas and he knew he had. He told me, he said, 'You know, I'm going to ask you something that's not correct but I'm really very interested in this.' And I said 'Yes?' And he said, 'You know, the last time we took in a woman in ophthalmology she went half way through the program, got pregnant and left. You're not going to do that are you? I mean, after all, I want my daughter to go to Michigan like we did.' And I said, 'Well...' and this was the honest truth, I said, 'Well, you know, I kind of have to find a boyfriend first,' and left it at that.

But that opened the way in for me to get into ophthalmology in a time when women in medicine were few and far between. At the Indiana University School of Medicine there were 350 students who entered every year and about 25 or 20 who left, and of them less than a fourth were women. And those statistics were skewed then, and I don't know what Indiana's statistics are now. And then I was one out of 21 when I was in my training. And then I was one out of two out of 21, and then three out of 21. So I was always,

you know, in minority in terms of being a woman in training. I mean, it was an interesting time because being at the tail end of the Baby Boomers lots of women had sort of tried to pave the path for women in professions.

And I have to say that I personally do not know of any overt, anti... any chauvinistic remarks or anything that was made to me as a woman. In fact, I found that my faculty and colleagues and co-workers and residents fostered a way to make me more comfortable as we were talking about before, with changing in the nurses' lounge and the nurses would say, 'Sorry, but you know, this is the way it is' and things like that. And I do remember, though, I was most flabbergasted to have grown up in Indiana, in the north part of Indiana and then gone to Michigan where equality was nothing but equality, and then to pop down into southern Indiana where they had a bit of a drawl, 'ya'll,' and these nice boys from nice homes would pull the chair out for me in medical school. And I thought, 'Well, isn't this nice. This has never happened to me before.' And they would hold up my coat, and they would open the door and I thought, 'Boy, I'm being treated like a woman.' Now, there were people in my class who were offended by that. I personally thought it was kind of sweet, you know? I mean, nobody had ever deferred to me as a female. But then I realized as I went farther in and when we started in our clinicals, I started thinking, 'You know, if someone's going to defer to me because I'm a woman and someone's heart stops beating, are they going to push me out of the way and say, 'Oh no, you're a woman, you can't jump in?'' So I got active and proved that there are ways to make paths and make simple little sweet ways instead of making a big noise. And I got active in my medical school, was the class president all four years, as you recall.

ROBERT: Yeah.

SUSAN: And I remember that I would do things like... the university hospital had a double set of doors that you had to open. So the men would open the first set of doors and I would go through singularly, and then I would grab the second set of doors and smile and curtsy and signal to them to follow through. And they were a little taken aback at the beginning, and then as we all became used to this type of behavior, they got the picture. And so little by little, by gently nudging people and encouraging them to realize that just because I wore a skirt or I was a female I shouldn't be

treated any differently. And I really never encountered any friction from anyone.

In fact, I remember very vividly, the nurses took us aside when we finally entered the hospital and did clinical rounds and said, 'Now even though you're little doctors, you have to abide by the same type of dress code as the nurses do, which means, no open toe shoes, no bare legs, pull your hair up when you work, or cut it short or wear a hat,' as they used to. And those were the rules that we agreed and accepted. And a lot of women wore slacks and that was acceptable, as well. But in the summertime when it was hot in Indianapolis, no open toe shoes meant no sandals and pantyhose, and it was hot and uncomfortable but that's what we were taught we should do. And to this day, I still feel that that's the dress code that no longer exists, but there are hygiene reasons that were developed that was the reason these nurses were educated to have this type of attire, and we were encouraged to follow them. I don't know that anybody was ever sanctioned for not following them.

But I found it was an interesting... I found it interesting, in that by fostering friendships with the women who had already broken ground or who were already in the medical arena, I learned a lot and I found that nurses had a wealth of knowledge and they could teach you a lot about a lot of things that even your mentors may not know or complement your knowledge because they were doing something different. And it fostered, eventually, the whole idea of teamwork in medicine, which is what you do when you are in the operating room or in your office or with a group... with whatever mission it may be. And so I found being a female not actually a detriment, but actually an accent... you know, it was actually a very positive experience for me, especially from my background. And they still deferred to me and they still pulled out my chair and they still respected me but they didn't... in a medical dimension way, where I didn't feel that they would not allow me to do the same kind of case or make derogatory remarks because I may not be as strong or something like that. And I found it to be a very charming challenge to wander through without any sense of friction at all.

I don't remember. I'm sure you do because in the in between of the time I that I went through and the time that the women before me do, I suspect

there was more friction and I suspect there were women who had other perspectives.

ROBERT: Yeah, I think the team approach is important. I learned early on the team approach. And the least member of the team can sometimes tell you something and educate you on something very insightful that you may have overlooked completely, never even thought of. So it's a good way to practice.

So, anyway, going back a little bit, when I opened up my office, you know, I just hung up my diploma, opened the door. I had one girl working in the office who answered the phone and made appointments, or I'd make them myself, but compared to how medicine is today, it's entirely different. Between the insurers, the HMOs, the PPOs, it's become so complicated now for everything, not only for making appointments and getting it all straight with the patient on the phone, to filing of claims, it's become a major thing. I now have nine or ten people working for me and you need all those folks just to navigate through the problems that we have every single day and every hour in the office. There isn't a moment that goes by where we don't have some issues over HMOs, or trying to get a prescription drug for a patient and she's, you know, 'Well, it's not on her list.' So, you know, what do you do now? Naturally, they bother you and interrupt you, and you have to go to the phone and try to find some equivalent drug. And there's the argument about generics that, especially everybody that goes to Walgreens, they want to get them all generics. So it's become so complicated and so many issues now, where before there weren't any issues. It was so simple. You saw a patient, rendered care, they paid or they didn't pay, but at least we didn't go through three or four changes of the claim and of the... what we're going to do and trying to get an authorization. And today it's just unbelievable how much red tape it takes to get an MRI of a head or orbits. That's really mindboggling when that comes on your desk, you know, that there's a minimum of 30- to 45 minutes arguing and talking to a whole series of people who know absolutely nothing about ophthalmology. And it's often very frustrating to get the tests that you need. You have to persevere endlessly, endlessly.

I don't know if this new "Obama care" is going to make it any better. I don't know, maybe, perhaps it will. Personally, I just see it a 30 more

million people that we're going to have to take care of, which is fine, you know, but I sense that there is going to be a lot more red tape, a lot more arguing, a lot more discussions, a lot more HMO meetings, and it's depressing to look forward to it in that sense. I'm glad more people are getting care. I don't want anyone to go without care. I'm not sure anybody in America ever did go without care. We've always had county hospitals and charity hospitals, but maybe there are some people who are going to be served, and that would be worth it I guess, yeah.

SUSAN: I remember when I joined you and you had been one of the very first to computerize medicine.

ROBERT: Yeah.

SUSAN: And had spent a great amount of money on computerizing and trying to work with the billing systems. And this was a time when each individual insurance company had their own form that the patient brought in and had to be completed, and it needed to be completed on a typewriter, and the staff had to look at each form and hunt-and-peck, not by typing hunt-and-peck, but, I mean, hunt-and-peck and look for the proper box and phew [?] and X to mark because each form was different, and there were one-hundred insurance companies and there were one-hundred forms.

And then I remember patients coming to me and saying, 'Dr. Taub, I like you so much, but you're not in my insurance and this is my new insurance.' And this was the beginning of what we now know as managed care. And so I thought, 'Well, as a patient advocate, I'm going find out what this insurance is and put in an application and find out what it's all about.' And all of a sudden, I was being told how much I could charge and how much I couldn't charge, whether I could charge, whether I couldn't charge, what was eligible. And all of the sudden I fell into a group of patients which required more administrative power and more administrative energy and people-power than the clinical arena, at which case it became sort of lopsided when we then went ahead and jumped into new computers to try and keep up with this. And of course then you look back into the whole HIPAA regulation which, of course, people think of only as privacy, but it did beget the Unified Insurance form in a computerized format so that computers could be used for these things and be a bit more efficient.

But I have to agree with you, the regulations for cost containment, is my understanding is what most of these regulations have been for, has taken it to the point where I, even with a completely electronic medical records system and electronic prescribing, find that it still takes people as much time either out of the office or while you're in the office simultaneously to see the patients as it does to try and achieve getting payment for the services. So sometimes I look at those little canned goods and think they look pretty yummy.

So I think that along with this whole transition of practice management and practice evolution and everything, I think it's been very interesting to watch how the public's perceptions of people have changed. There was a time, I recall as a child, reading a list of 50 professions, and they were ranked by other professionals as to who was on the top. And, of course, usually number 1 was a clergy, number 2 was a physician, number 3 was a dentist, number 4, I don't know, and it would go down and at the very bottom I don't even remember. And now physicians, instead of being in the top five are down in the bottom five. And I don't know how or why the public persona of a physician sunk, but I think a lot of it had to do with this modification or these modifications in the way that we've been forced to practice medicine because we have to take so much time away from our patients to accomplish our administrative duties. And you can only delegate so many things in either the clinical or the administrative arena that it takes time. And the patients don't understand what your time is worth and they don't understand that when the bill goes out for \$500 and we get paid 50, they don't notice that we're getting paid 50. They only notice that the bill went out for... this is just an arbitrary amount... but for the \$500, and think that doctors, you know, have done very well and are extremely lucrative and so forth. And yet they don't know how much we put into it in our regular daily life, not to mention taking calls weekends, and, you know, the part that we do, what we call the for gratis, and the teaching that's gratis and things like that.

So I think there's been a change in the perception of doctors and I think that, then, has also began to change in the type of people who are interested in medicine. And I think I would like to ask you what your thoughts are of what you've seen over the last 55 years in terms of the students and what

they think medicine holds for them. And why they're going into medicine now versus before, and what they expect.

ROBERT: Well, I think there has been a decided change in the students. I would say one thing, they're all sure a lot smarter than we were. They are a very, very bright group and very teachable in that sense. But the thing that I try to teach them, and I just in the last 15-, 20 years I would say, anyway, is the practice of medicine, that medicine is really not a firm science. It's not like physics problem or a math problem. And the most important thing is relating to the patient, taking an interest in the patient, talking with them about their family, or something or anything but the immediate medical problem, so that you can relate to them as a human being. Sadly enough, I think the young doctors, while they're extremely smart and know a lot of things they just often don't know how to relate to patients. They just aren't simpatico, sympathy, I don't know, but I see it all the time. And each year it seems to get a little worse and I just wonder where medicine is going to go. And I think some of the bad imagery that we get is because I have failed or we have all failed as teachers to make the young doctors more empathetic, more human. I think that's probably been my fault, or our fault, because we certainly failed. And I think the image of medicine is going to continue to deteriorate more unless something turns it all around. Every once in a while there is... no, there is... I think we've talked about this before... there is maybe 1% of physicians who go into it for the wrong reason. But with that 1% aside we still have to do more to teach, I guess what we would call years ago, bedside manner, or know how to talk to a person and his family and how to relate with them more. I don't know what the answer is, but hopefully we'll find some.

SUSAN: Well, I've changed too. And, again, Indiana spent a fair amount of time teaching bedside manner. As a matter of fact, I neglected to mention someone who is rather key in my medical training at Indiana, and that would have been Paul Honan. Dr. Honan actually had the idea of the word 'ethiquette.' And he and I wrote a couple of papers and did some teaching, and he always talked about bedside manner. And he was the one who turned his papers over to me at some point and said, 'Susan, have fun with the project but make it work.'



And I have to say that I agree with you, there is an element of failure. There seems to be something that I've always wondered about ethics. I mean, you can surely teach ethics. The question is can people learn ethics and bedside manner? And are these things that you can instill in them at the point in their lives when they're already at the educational level that we encounter them, or is this something they learn when they're younger and it has more to do with familial relationships or cultural relationships or something that is different? I mean, obviously... well, maybe not so obviously, but you would like to believe that people going into medicine are going into medicine because they do want to help people. And part of helping people is understanding the entire picture of the patients, and that includes family members or having an understanding of their complete needs or a little bit more than just, as you said, the immediate need and the emotional attachment that people have about whatever healthcare concern it is. I mean, we happen to be in a field where people, our patients, seem to be extremely sensitive about sight, and we, of course, agree. And I'm sure that every physician, in their field, feels the same way about their issues.

And in so doing, I've taught ethics now for 20 years, and despite it, I agree with you. I still see that the students seem a bit more callused and I think that they are a bit more narrow-minded and focused. And I almost wonder if it's because of the information overload. As you said, they're so smart, they've had to learn so much more. There's been so much more education and time spent dedicated to learning so much more information that I almost wonder if they just don't have the time to step back, while they're in training at least, and have that little bit of empathy or sympathy. But I certainly hope that by exposure from mentors like you and me that when they turn around and enter practice that perhaps they'll hear our echoes, or at least I hear your echoes and so I hope they hear my echoes. And I would assume, or I don't know for sure, that you hear your father's echoes. And I know I hear my Mother's echoes.