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SCOPE

Leonard Christensen: A "Greatest Generation" Ophthalmologist

Gerald R. Christensen, MD

The journalist, Tom Brokaw dubbed the generation that grew up in the Great Depression and then went on to fight in World War II the "Greatest Generation." The ophthalmologist and eye pathologist Leonard Christensen is a splendid example of that generation.

He was born August 16, 1913, in Cloquet, Minnesota, the youngest of three children of working-class Norwegian immigrant parents. He graduated from the University of Oregon Medical School in 1941 and after a one-year internship at Ancker Hospital in St. Paul, MN, he served in the South Pacific as a Navy flight surgeon until the end of World War II.

He completed his ophthalmology training at the University of Oregon Medical School and received a Heed Fellowship for a one-year study of Ocular Pathology with Georgiana Dvorak-Theobald, MD, in Chicago and Algernon Reese, MD, in New York. He returned to Oregon and joined the faculty at the University of Oregon Medical School where he worked until his retirement in 1978. From 1978 until 1989 he was in private practice in Portland, OR.

Dr. Christensen began his career in clinical ophthalmology before the days of widespread subspecialization, when the specialist took on the entire repertoire of surgical eye procedures. Thus, he was one of the last of the high-volume surgical ophthalmologists who "did everything." Well, not quite everything. Since he often declared that his expertise in pediatric ophthalmology only included patients over age 65, he referred pediatric motility patients to his associate and department chairman, Kenneth Swan MD. Being based at the university, he was restricted to seeing only patients referred to his care by other physicians.

Nevertheless, Dr. Christensen had an extremely full practice that included retinal, corneal and cataract surgery as well as all aspects of glaucoma. At the same time, he was the working ocular pathologist, as well as director of the Eye Pathology Laboratory. He was one of a generation of eye pathologists who were essentially the founders of this subspecialty in the United States. It was a time when training in the discipline was difficult to come by and took initiative and sacrifice to obtain. He was an early member of the Eye Pathology Club, which evolved into The Verhoeff-Zimmerman Society.

Graduation Portrait of Leonard Christensen, MD, MS, from the University of Oregon Medical School, class of 1941. He served as a resident, and faculty member from 1951 to 1978 and helped create the pathology lab and eye bank for the Casey Eye Institute in Portland, OR.

He was a busy man who always had time to get something else done. He established the first eye bank in Oregon, served on and was chair of the American Board of Ophthalmology, and published dozens of research articles, book chapters and symposia.

He was a shy, almost reclusive man and yet *(Continued on page 2)*

Leonard Christensen

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was very approachable. He had a relaxed and easy demeanor that brought him an abundance of friends and acquaintances. To them he was just plain "Chris," to many in his family he was "Len" and for me he was "Uncle Len." He was introspective and deeply analytical in his thinking and had great confidence in the ability to solve difficult clinical problems through a combination of basic science and common sense.

This approach to solving problems is well demonstrated when one reviews his list of publications. He had several "firsts" to his credit: first histologic demonstration of cytomegalovirus in a human eye; first person in Oregon to perform a penetrating keratoplasty; first report of a drug that when given systemically reduced elevated intraocular pressure without exerting a mechanical effect on the eye. This drug, Dibenamine, was first reported in the pharmacology literature in 1947 and considered the prototype of a particular class of adrenergic blocking agents.

In 1949, Drs. Christensen and Swan completed and published a study of this drug's effect in lowering intraocular pressure when given systemically. These findings prompted other investigators and eventually led to the discovery and use of carbonic anhydrase inhibitors, which are widely used in glaucoma treatment today. Dr. Christensen submitted this work as a thesis and was awarded a Master of Science degree in pharmacology.

He was one of the first surgeons to show that eccentric corneal lesions not amenable to trephine isolation could be excised and the defect successfully repaired by freehand keratoplasty. The procedure is useful in corneal melting disorders, deep corneal ulcers and is especially helpful with acid and alkali burns that affect the limbus. With chemical burns, it is necessary to remove all damaged tissue while planning a lamellar graft repair. Many chemical burns will involve the limbus and adjacent sclera. In such cases those areas need to be removed as well. In his American Ophthalmological Society thesis, "The Nature of the Cytoid Body," he presented a significant advancement in understanding the pathological changes involved by carrying out an elegant histochemical study of the subject.

Ironically the earliest of his scientific firsts nearly became his last. It occurred on one of the Admiralty Islands in the South Pacific Ocean where he was stationed with his Navy medical unit during World War II. There was a problem of severe and sometimes fatal intestinal illness, which was narrowed to a drinking water source. But which one? The only option to find out was to test the water sources on the personnel themselves. Dr. Christensen volunteered, and the problem was eventually solved but he was hospitalized for months, severely emaciated and dehydrated.

During his hospitalization, Dr. Christensen received a visit from Robert Hill, MD, who was passing through the island. Dr. Hill, who had been a college and medical school classmate of Dr. Christensen, did not recognize him initially and was shocked to learn that his former colleague's weight had dropped to less than 100 pounds. On leave to the United States, subsequently, Dr. Hill stopped in Corvallis, OR, to visit with Dr. Christensen's brother Bert. Dr. Hill informed Bert that that he didn't think Chris would survive.

Dr. Christensen was also an iconoclast and frequently skeptical of the ophthalmic dogma of his day. He demonstrated that narrow angle glaucoma and flat anterior chambers required a component of positive posterior vitreous pressure and was not caused simply by an enlarged lens and/or wound leak, the prevailing wisdom at the time.

During his early career, it was not uncommon for some practitioners, including a few ophthalmologists, to prescribe long acting topical anesthetic ointments for corneal abrasions and other surface problems. Topical anesthetics are not appropriate for chronic use for several reasons including corneal drying, loss of the blink stimulus and its action to stop mitosis of the corneal epithelium. He reported these severe complications and even advocated abolishing their production.

A rare but devastating complication from cataract surgery is epithelial ingrowth, usually through a corneal-scleral surgical wound. One study showed about 1% incidence when no limbus-based conjunctival flap was used. By using a limbal-based conjunctival flap this complication didn't appear in a series of 3,000 cataract cases studied. He also described numerous surgical innovations, many of which are still in use today.

Even at the end of his professional career, he was looking forward to and excited by new developments and innovations in ophthalmology. His enthusiasm was infectious to those around him. I was privileged to live in his home during my medical school years, a time during which he was widowed with three small children. Our numerous talks developed my own interest in ophthalmology. Most ophthalmology topics usually centered around procedures and recently published scientific data.

When his daughter Laurie was in medical school and it was 20 years later, his focus was on care and empathy, especially for patients who were going blind. He felt that care was more important than diagnosis and treatment in these cases, but diagnosis and treatment were still important and necessary. Also, he reminded her to *(Continued on page 3)*

Leonard Christensen

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retain a caring attitude with patients experiencing complications.

He never talked much about the war, but he told Laurie that his near fatal illness made him realize how frightening these situations can be and why kindness, care and empathy are so important. He was the perfect role model of the dignified, compassionate physician with excellent clinical skills and a strong science background. His keen intellect and dry wit revealed a particularly insightful view of the world. This alone was an invaluable experience, which has served me well. He had an avid interest in current events, especially political and economic issues.

He always looked for investment opportunities, preferring those which he felt would be stable and conservative. His investment habit began in 1938 during medical school. The stable and conservative self-restrictions followed this first endeavor. He and fellow classmate Robert Rinehart decided to open a for-profit bookstore at the medical school (image on next page) as the students believed that the downtown stores were too expensive. It started in a large closet in the Basic Science building and was only open for limited hours.

It wasn't long before the administration responded to complaints from the downtown booksellers. When the partners were ordered to close the store, they began to operate only in the evenings and required a secret code knocking sequence to gain admittance. However, it wasn't long before the "secret knock" turned out to be the dean. Chris was there alone but out of panic and fear he picked up a large box of pencils and asked the Dean where they would get the money to pay for all this merchandise. Eventually it was decided they could stay temporarily. When I was a student ('57-61), the student bookstore was still going strong and was privately owned by a couple of my classmates who were required to sell their interest upon graduation. The store is still in business; I am not sure of the ownership.

You might ask what Dr. Christensen did in his spare time and what were his hobbies? Most Saturday afternoons he played golf. He had a low handicap, and one year he was the champion at his country club. He was also a football fan both as a spectator watching TV football on Sunday, and occasionally playing touch football in the back yard with his *(Continued on page 4)*

Multnomah County Hospital house staff, 1946-1947. Dr. Christensen is fifth from the left in the top row.

1946-47

Rear: Burns, Brooks, Perkins, Rice, Christensen, Jacobsen, Hank, Fluke, Auman
Middle: Holman, Bennett, Lindgren, Ogilvie, Gould, DeLateur, Larsell, Herman, Warrington, Fuson, Teutsch, Myers, Cardon, Luehrs, Krippaehne, Trainer, Watkins, Foltz, Breese, Seely, LeCocq
Front: Robinson, Emmens, Lebold, Short, McCallum, Lloyd, Browning, Kirchhof, Armentrout, Branford, Hessel, Lagozzino, Bitar, Dietz, Keizur

Absent: Moreland, McGowan, Cales, DeMars, Richardson, Cochran, Morris, Terry, Carlson, Lawson Peterson, Tuhy, Lowell, Coddington, Burt.

Leonard Christensen

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boys, the neighborhood kids, and me. Since he and I were the only adults, we were always on opposite sides. My position was usually a roving one but his was quarterback and he passed almost all the time. I will say he had an advanced skill set for backyard touch football, which usually beat my team.

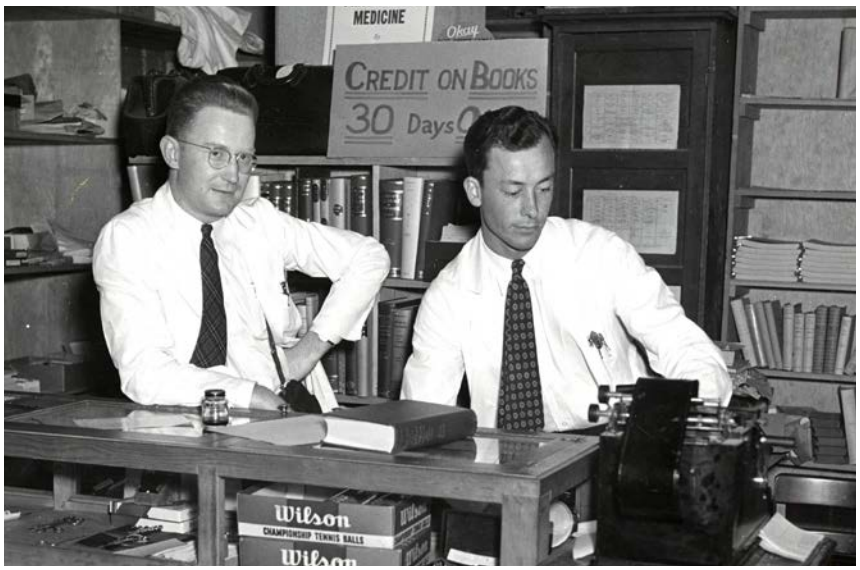
Other interests he enjoyed were reading, moose hunting once a year with his brother Harold, and raising Norwegian Elkhounds. As a result, we all got to enjoy moose meat several times during the following winter as well as having bones for the dogs.

He expanded his non-medical interests in 1961, when he married Kathleen "Kaye" Mahoney, who among other things had a wonderful positive influence as a stepmother for the children. This was important for all the kids but especially daughter Laurie, whose birth mother, Virginia, had died after a long and debilitating illness when Laurie was only 4. In addition to her stepmother duties, Kaye was part of the volunteer administrative staff whenever the American Board of Ophthalmology oral exams were held.

Dr. Christensen encouraged his children to follow their own dreams and they did. His son Mark is a novelist; his other son Scott is a musician and composer; and his daughter, Laurie, chose to be a pediatric ophthalmologist. Had they elected to practice together, the office could have included motility patients under the age of 65.

Leonard Christensen, MD, died peacefully in his home Nov. 2, 1999, from cancer and complications of Parkinson Disease.

Ophthalmic History Editors: Daniel M. Albert, MD, MS and Donald L. Blanchard, MD



Leonard Christensen, MD, (left) and Robert Rinehart, MD, as medical students, working behind the counter in the student bookstore, spring 1941. Note: Wilson tennis ball also for sale.

Correction: In the online version of the 2018 issue of Scope, the article "Retina Pioneer, Paul Anton Cibis, MD: A Personal History" was originally published with incorrect author information. The information was corrected on June 25, 2018. Gerhard W. Cibis, MD and Andrea Cibis-Tongue, MD are the sole authors of the article. Daniel M. Albert, MD, MS and Donald Blanchard, MD are co-editors of the history section of Scope, but are not authors of the article.

Historical Excerpts and Quotations Corner

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

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

"The art of medicine consists in amusing the patient while nature cures the disease."

— Attributed to Voltaire (1694-1778)

"Why has not Man a microscopic eye?

For this plain reason, Man is not a Fly.

Say, what the use, were finer Opticks given

T' inspect a Mite, not comprehend the Heav'n?"

— Alexander Pope
(Patient of Chevalier John Taylor)
"An Essay on Man," Epistle I

"The intention is
to stare into space
to ease tired eyes
but seeing more
disturbs the tranquil spirit."

— A zen-like quotation from an 11th-century Buddhist monk. Submitted by Jurn Sun Leung PhD.

From the Editor's Desk

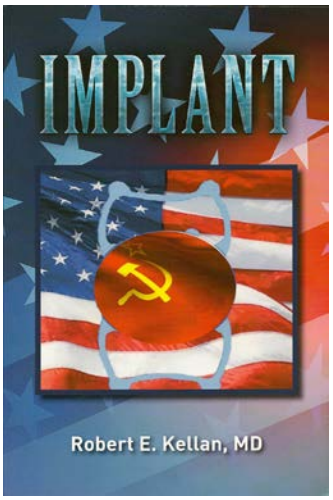
What We Are Doing Today

M. Bruce Shields, MD

A downside of retirement is losing track of many of our colleagues with whom we established friendships throughout our careers. One of the things I looked forward to when going to medical meetings was being with those friends and hearing what new and exciting activities they were enjoying. In retirement, we keep up with some friends, but eventually lose track of others, and that is a sad loss. I often wonder what they are doing today in the new chapter of their lives.

We know that many of our friends have found interesting and rewarding avocations in their retirement, and it occurred to us at *Scope* that we might share some of those activities with our readers in a new, ongoing column titled "What We Are Doing Today."

The nidus for this idea came when I received a correspondence from one of our colleagues, Robert E. Kellan, MD. His history is like so many distinguished members of our profession. He graduated magna cum laude from Boston College, obtained his medical degree at Tufts Medical School and completed his residency at New York Eye and Ear Infirmary. After more than 40 years as a fellow of the American Academy of Ophthalmology, during which time he enjoyed a busy practice and designed several surgical instruments and intraocular lenses, including the Tetraflex IOL, Dr. Kellan moved on to the next chapter of his life by becoming a writer, with several plays and novellas to his credit.



One of his recent novellas, titled *Implant*, shows what a creative mind he has by combining the science of cataract surgery with international espionage. An "internationally acclaimed eye surgeon" is called upon by the State Department to create and assist in the implantation of an "information-gathering" IOL in the eye of a Russian ambassador, which brings the ophthalmologist into unexpected and frightening contact with the CIA and Russia's Federal Security Service. It is a clever plot and a good read. More recently, he has published another novel, titled *C.A.G.E.*, and both books are available on Amazon.

This is just one example of what our colleagues are doing today, and we hope to share more such stories in the coming issues of *Scope*. To be successful, however, we need the help of our readers. If you have an interesting hobby or second career, or know of a colleague who does, we hope you will share that with us by contacting our assistant editor, Neeshah Azam, at scope@aao.org.

We very much hope to hear from you and begin learning more about what we are doing today.

Growth of the Independent Organization, Pt. 2

Susan H. Day, MD

In our last issue, we published "The Great Split: Our Oral History, Pt. 1" from Mr. David Noonan's Academy history, he recalled his first days with the combined American Academy of Ophthalmology and Otolaryngology, the singlehanded focus on education, the governance and meetings, and the "divorce" organizationally between ophthalmology and otolaryngology. We now pick up on his description of the American Academy of Ophthalmology's infancy under the leadership of Bruce E. Spivey, MD.

Moving the American Academy of Ophthalmology to San Francisco was approved by the new Board of Directors, ostensibly based on a 30-page document demonstrating the comparison of sites among Washington, DC; Chicago; and San Francisco, Dr. Spivey's home. They wanted Spivey! The Spivey years have been described as the era of growth. Growth springing out of a much broader role the organization could fulfill by maximizing members' interests beyond clinical education.

No sooner had the ink dried on the divorce papers than the membership recognized decisions were being made in Washington affecting research and *(Continued on page 6)*

Growth of the Independent Organization

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residency training. It was deemed advisable to have an Academy "listing post office" in Washington DC, to be sure you had a voice. As this voice grew in volume and success, members who belonged to both organizations (AAO and American Association of Ophthalmology) recognized the employment of similar tactics and began to wonder if one voice would better serve the profession.

If divorce was hard, marriage can be difficult too, particularly when it calls for joint family reunions. Issues and egos were assuaged. New membership categories allowed for a much broader membership involvement, the new Academy Board represented a broader pallet of interests beyond education.

The merged ophthalmic Academy included a Council that you might recognize today. The Board saw the Council as an advisor to issues needing organizational involvement by the Academy.

Here are some examples of growth and expansion of scope for the Academy:

When 600 members of the Academy were told that their malpractice insurance was no longer going to be underwritten, OMIC (Ophthalmic Mutual Insurance Company) was formed. OMIC not only underwrote those immediately affected, but within five years could demonstrate that the level of malpractice incidents could be reduced from that comparable to neurosurgery, to that akin to family practice. This fact alone caused other insurers to reduce their premiums as well.

The "new" Academy, upon merger, required an amended tax status. This, in turn, permitted the creation of the Foundation, which could advance the philanthropic and public service aspects of the organization. As a result, EyeCare America remains the only national medical society service outreach program, recognized by presidential citations from multiple administrations. The Foundation also gave rise to our Ophthalmic Heritage Program, which we hope will finally evolve to a freestanding Museum of Vision.

Bruce E. Spivey, MD,
Academy EVP, 1979 – 1993

When I was a high school student, my father's opinion was that in any organization, you will find about 2 percent who do not behave well either out of avarice or ignorance. In recognition of this, the Academy established its Code of Ethics. With its clear, concise, aspirational principles, coupled with examples of appropriate behavior, the Academy's Code rarely has had to employ its enforcement provisions to the final disposition. In my opinion, this program ranks as high as any achievement, developed by the Academy in protecting the public opinion of your profession.

A challenge to the organizational structure occurred in 1990-91. Dissatisfaction grew within some members of the Academy with its decision process, organizational representation, and strategic direction. It grew out of the belief that a House of Delegates structure would lead to a more representational governance. This structure had been adopted by the American Medical Association and many state medical societies. This dissension led to the largest and most comprehensive examination of the Academy in its history.

The final report preparation included 220 individuals involved in its creation, review and critique with the report 79 pages in length. The study concluded that a House of Delegates structure would not serve the Academy well. It recommended that a Board of Trustees involving highly representational positions with staggered terms and responsibilities was a better pathway. The Council would continue as an advisory body to the Board and represent both state and subspecialty interests. This report was submitted to the entire membership at the Annual Meeting and was adopted by a vote of 2011 to 6.

Private Equity Buyouts of Ophthalmology Practices – Update 2018

Thomas S. Harbin, MD, MBA, and Gary Markowitz, MD

Do you really want that $50 million?

A year ago, *Scope* published an article on Private Equity (PE) Buyouts of Ophthalmology Practices in which the first sentence was a question: "Do you want $50 million?" Now the question is slightly different. Be sure you can answer it.

Seniors viewed this article in unprecedented numbers and, given that level of interest, we now present an update. One of this article's authors, Gary Markowitz, MD, participated in one of the early buyouts and has experienced this phenomenon. The past year has seen a number of new companies enter the arena and many more practices have sold. At the end of this article we list the companies that are engaged in some sort of PE acquisitions.

Private Equity Models

Private equity buyouts comprise a number of different features with a continuum from extremely centralized to decentralized.

Centralized:
With this model, the acquiring company takes over all administrative and management functions including billing, collections, optical, etc. Here the doctors lose all control over decisions heretofore theirs. All acquired practices employ the same EHR system. The goals of the new owners are efficiency, control and cost savings. The focus is on acquiring more and more practices with centralized management and maximized short to medium-term profits, thus making a future sale of the rolled-up entities more attractive.

These practices are usually acquired for cash, note and stock. The stock is in the management company, which is essentially a mutual fund of practices which is generally sold in three to seven years.

Several companies employ this model, and many practices have been acquired under this scenario.

Decentralized:
This model has fewer centralized services or administrative functions and a smaller corporate structure. Practices have more ability to continue in much the same way as before they were acquired. At the same time, the practice is incentivized to grow by endogenous growth and local acquisitions. The doctors receive money and stock in the buying entity as in the centralized model and frequently have more control in day-to-day decisions and actions as compared with the centralized model.

There is an extreme variant of the decentralized model done by one company under which the perspective is much longer term than in the centralized model and the objective of the practices is to grow both internally and externally, thereby increasing practice profitability. As practices are added in different areas and incentivized to grow individual practice profits, the entity as a whole grows. In this model doctors, invest only in their own practice and the philosophy is buy and hold and there are no plans of a future sale.

The majority of models are decentralized with different blends of centralized management. A common feature of all models is reduced future income for the doctor in return for a lump sum of cash, taxed at capital gains rates, based on current practice profits— earnings before interest, taxes, depreciation and amortization (EBITDA). In addition, the doctors receive stock in the new entity, which theoretically will grow in value.

Is the bloom coming off the rose?

Paul Koch, MD, wrote an editorial for *Ophthalmology Management* (March 2018, p. 16) titled "You may want to think twice about private equity." The subtitle was "Every positive has a negative, and PE is no exception." His practice was one of the first to sell to a private equity company. As time went by, he noted the lack of long-term planning because of the short-term profit mentality. He noted that "requests for equipment and facilities that would enhance the practice over the long term stalled." His practice is now with a different company with a different model.

Another quote from his editorial: "Once this model achieves national penetra-

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Private Equity Buyouts of Ophthalmology Practices

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tion, it's hard for me to see why any medical group would go the PE route and be subjected to short-term practice management instead of long-term stability; senior partner cash-out versus all doctors having skin in the game."

Clearly, there is a lot to consider before embarking on such a journey, if one wants to go there at all.

What to do?

Plan, plan, plan. Due diligence to the max. The article last year listed reasons why a private equity buyout might be right for a given practice. The doctors in a practice need to engage in considerable long-term planning before deciding to go with a buyout. Be sure you know the model the company employs and whether you can live with the constraints, whatever they may be, as well as the reduced future income. Be sure the details are fair to all doctors in the practice, young and old. In fact, you should have a plan to attract new doctors to the practice. Have an idea of how the change in ownership will affect the culture of your practice and the care of patients.

Get advice from attorneys and other advisors. Matt Owens, a corporate partner at Arnold & Porter in Washington, DC, says, "While PE firms and other potential partners will be doing their due diligence on the physician practice, the physician practice likewise needs to do its due diligence on its potential partner. It's not always about the money; you want to make sure you and your new partner share the same vision with respect to the future of your practice and how it will grow and be managed." Be savvy with your choice of attorneys and be sure there is specific experience in the area of practice buyouts. Investment bankers and practice brokers can be very expensive so get the fees set ahead of your engagement.

Doctors should talk to as many other doctors as possible. Reach out to unhappy people as well as happy ones. You want to discover problems. Some ophthalmologists have been squeezed out of their practice with nowhere to go. They may have received a nice sum of money, but does that compensate for losing their practice?

Be aware that some doctors enmeshed in a new entity may not be able to be totally frank and open for legal reasons such as a non-disparagement clause or the desire to maintain the financial health of their new company. Such doctors could be heavily invested in the company you are considering with a consequent conflict of interest. Your due diligence should be extensive.

After long-term strategic planning, getting advice from knowledgeable attorneys and other advisors, you may decide private equity is the way for your practice to thrive. Or, you may not. Selling now is not imperative. Some practices need time to grow on their own before considering this option. Whether you sell or hold, we wish you the best.

Private Equity Companies — Summer 2018

Authors' note: We contacted several sources before assembling this list, and it is as complete as we could make it. Companies wishing to be listed should contact *Scope* at scope@aao.org

- Acuity Eye Specialists – Comvest Partners
- American Vision Partners (AVP)
- Ampersand Capital
- Amsurg (publicly traded)
- Ares Management Private Equity Group
- Belhealth
- Blue Range Capital, LLC
- Boyne Capital
- Centre Partners
- Century Vision Global
- Covenant Surgical Partners (publicly traded)
- Eye Care Partners – FFL Partners
- Eyecare Service Partners (ESP)– Harvest Partners, LLC
- EVP Eyecare-Cortec Group
- Eye Health Partners (EHA) – LLR Partners
- Eye South Partners-Shore Capital
- Gauge Capital – Comprehensive EyeCare Partners
- GP Partners
- Grand Rapids Ophthalmology – Sterling Partners
- Lineage Capital
- McLarty Capital Partners
- Northwood Healthcare Partners
- Omni Eye Services – New Mainstream Capital
- Pleasant Bay Capital
- Revelstoke Capital Partners
- Revere Capital
- Sheridan Capital Partners
- Southeast Eye Services – Flexpoint Ford
- Spectrum Vision Partners – Blue Sea Capital-(OCLI)
- Unifeye Vision Partners (UVP) – Waud Capital
- Vision Group Holding

News From the Chair of the Academy Foundation Advisory Board

Christie L. Morse, MD
Chair, Foundation Advisory Board

In Memory of Tom Hutchinson, MD

As many of you know, our dear friend and colleague, B. Thomas Hutchinson, MD, died April 10 at the age of 84.

B. Thomas Hutchinson, MD

A long-time resident of Boston, Tom earned his undergraduate degree at West Virginia University and his medical degree from Harvard Medical School. He pursued ophthalmic training at the Massachusetts Eye & Ear Infirmary, where he completed residency and a fellowship. A force in the academic realm, he inspired and mentored generations of residents and medical students at institutions including Harvard Medical School, where he was a revered associate clinical professor.

Tom served as the Academy's president in 1993. But perhaps we'll remember him best for his role in establishing EyeCare America®, a public service program of the Academy that provides eye care through a pool of nearly 6,000 volunteers.

More than 30 years ago, Tom had the foresight to harness the support of Academy member ophthalmologists to provide access to medical eye care for underserved older Americans. Tom helped build EyeCare America into the largest medical public service program in American medicine, recognized by every U.S. president since Ronald Reagan. To date, EyeCare America has helped nearly 2 million people get sight-saving care.

"Tom Hutchinson impacted every facet of our profession. He was a superb and caring physician who always put his patients' interests above all else," said David W. Parke II, MD, Academy CEO. "But he also played a pivotal role in establishing and serving our sentinel public service program, EyeCare America, our ethics initiatives, the Academy Foundation, quality of care programs and advocacy initiatives. He was elected by his peers to serve as Academy president. He was a true servant leader. But above all else, he was a warm, genuine, and devoted friend and colleague whom we will dearly miss."

Aside from his prolific contributions to the field of ophthalmology, Tom was an avid antique clock collector, with deep knowledge of early American history gained as he sought to understand the life stories of the clockmakers whose creations he admired. Fishing was also a passion for Tom, and he looked forward to the running of the blues off Nantucket Island each season.

Tom's wife, B. June Hutchinson, and his son, Daniel Thomas Hutchinson, remember him fondly. "Daniel and I are still trying to get through each day without our sweet and gentle Tom, a gentleman in the truest sense of the word, a man of honor and goodwill," June said. "We are so proud of his amazing accomplishments, and more importantly his ability to connect with almost anyone and communicate that he was on their side. Dan and I hope that there is a place of warmth and love to shelter our Tom's beautiful soul."

If you'd like to make a memorial tribute gift, visit aao.org/foundation/donate and select "The Hutchinson Fund." The Academy has established this fund in Tom's memory to support EyeCare America and other public service programs of the American Academy of Ophthalmology.

Join us in Chicago at our 15th annual Orbital Gala

Join the American Academy of Ophthalmology Foundation for a groovy evening at our '60s-themed Orbital Gala on Sunday, Oct. 28. This 15th annual fundraiser will be ***the*** social event of AAO 2018. Dine, dance, and enjoy live entertainment under the Chicago Cultural Center's stunning Tiffany stained-glass dome. Get great silent auction deals on fine wine, vacations, ophthalmic equipment and more. Proceeds will support the Academy's educational, quality of care and service programs.

To learn more, visit aao.org/gala. To donate an item to the silent auction, contact Claire Lewis at clewis@aao.org.

What You're Reading This Summer

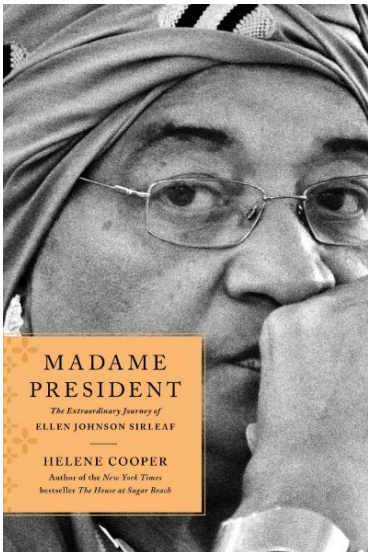
Book Review Editor, Thomas S. Harbin, MD, MBA

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

From Susan H. Day, MD

Madame President: The Extraordinary Journey of Ellen Johnson Sirleaf by Helene Cooper.

Admittedly, it was the title of this book that caught my eye. This biography chronicles the "journey" of Madame President Ellen Sirleaf: her devotion to her country (Liberia); her political rise (first woman president in Africa); her well-deserved honors (Nobel Prize).

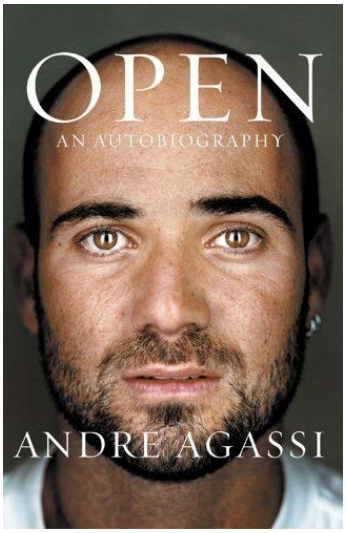


It is the "extraordinary" component, however, that creates such a captivating read. When is it time to draw a line in the sand, and when is it time to retreat and plan? What happens to a survivor who has witnessed the murder or torture of loved ones? How does one convince an international audience to not only forgive a multimillion-dollar debt but also to provide seed money for a country's re-birth? What is tougher to endure — a civil war or an Ebola crisis? Where does strength come from? What might a woman do to express her femininity as well as authority in a predominantly male environment?

Would I ever love to share a cup of coffee with this president!

From Samuel Masket, MD

Open by Andre Agassi



"Open," Andre Agassi's autobiography, will surprise readers on several levels. We learn from the outset that Agassi hated tennis; he always did. Yet, having played it with such passion and success over so many years, readers will find the concept dichotomous to their own beliefs.

The book is largely about human relationships with tennis as a backdrop; at the center is the relationship with his father, a poor, albeit highly motivated displaced person at the end of World War II. His father was also an intense and accomplished athlete. Often, to the unintended detriment of their children, parents foolishly attempt to correct or relive the flaws of their own life or childhood by exerting rigid control over the lives of their children. Typically, that plan is a recipe for failure at best, disaster at worst.

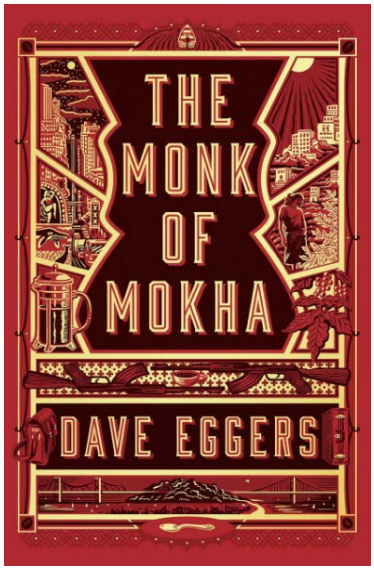
We come to understand and appreciate the rebellious nature of young Andre, his failed relationships with (celebrated) women, his dedication to his siblings, and his ultimate success as a husband, human, father, philanthropist, and, yes, tennis player along the way.

This book captured my interest and became that rare page-turner that one loves to read and hates to finish. Highly recommended.

From J. Kemper Campbell, MD

The Monk of Mokha by Dave Eggers and Alfred A. Knopf.

The year is half-way over, and this reviewer may have already read his favorite nonfiction book of 2018. "The Monk of Mokha" by Dave Eggers is that book. It is a story about coffee, entrepreneurship, Yemen, the lives of immigrants, and pursuit of the illusive American Dream.



Eggers has published successful works of both fiction and nonfiction and his spare, Hemingway-esque style suits this true tale of danger and determination, which requires no literary embellishment.

Mokhtar Alkhanshali is a young Yemeni

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What You're Reading

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American raised in the hard-scrabble Tenderloin district of San Francisco. After an aimless succession of menial jobs, he chances upon the unlikely scheme of re-establishing Yemen's five century-old tradition of coffee exportation. Lacking business acumen and expertise in either growing, or even drinking, coffee, his chance of successfully achieving this dream was dismal at best. And to complicate his task further, a brutal war with Saudi Arabia and stringent American travel restrictions to Yemen occurred simultaneously.

The author describes Mokhtar's dogged pursuit of his goal to its ultimate conclusion despite the deadly surrounding circumstances. Meanwhile he introduces the reader to a previously unknown region of the world and to the esoteric craft of producing gourmet coffee.

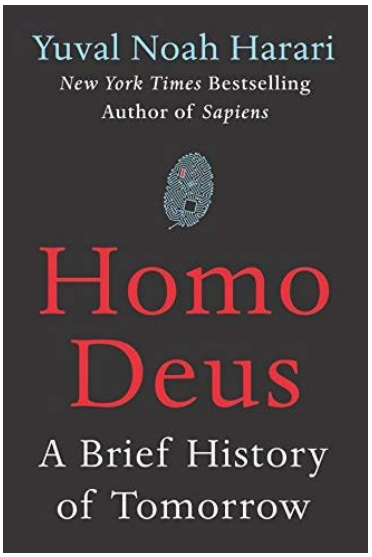
This handsomely bound book provides a worthy companion to a comfortable armchair and a freshly brewed cup of coffee. Unfortunately, no photographs are provided of the exotic locales or the colorful characters involved in this adventure which seems torn from the pages of "Arabian Nights."

From Alfredo A. Sadun, MD, PhD

Homo Deus: A Brief History of Tomorrow by Yuval Noah Harari.

I thought that Harari's first book, *Sapiens*, was one of the most thought-provoking and remarkable books I had ever read. So, I had very high expectations with this second and related compendium. Perhaps my expectations were set too high as I was less "wowed," but still, this is an outstanding work.

The *NY Times* bestseller, *Sapiens*, described man in evolutionary terms as a peculiar primate. It ended as Homo Deus begins, that



the story of homo sapiens is coming to a tipping point. We are about to turn into something new. The conclusion of the first book became the premise of the second. A capacity to tell myths that are full of values and rich with meaning allows men to organize, not on the scale of dozens, as in a hunting party, but of thousands and millions. Cultures, civilizations as well as religions and armies, inspire and even compel the individual to suborn himself to the greater good. This has given us greater control over other animals, our enemies, and the world, but less control over our own future.

Only our stories have changed. Where we once had myths, religions and gods, we now have humanism, science and technology. As a consequence, we have almost overcome famine and disease. For the first time in our history, more people will die from overeating than starvation.

Having increased our access to the world's energy and other resources, we are now tapping into the greatest resource of all — data. Technological advances have not only allowed the accumulation and processing of massive amounts of data, but now, human values, and even human beings, can be left out of the loop.

Hariri suggests that we have come to the end of the human story. Either because we humans will go extinct or simply because we humans will no longer be integral to the vast network of information flows. Only information will have value. The new religion is dataism. And the new gods may be a very few super-elite who live in Silicon Valley, or they might not be people at all. Maybe that is what the TV show, *Westworld*, is about.

From M. Bruce Shields, MD

Grant by Ron Chernow.

If you think you know the historical facts of Ulysses S. Grant, you should read this book. The media (basically newspapers) of his day and many of his subsequent biographies have depicted him as a drunkard, a butcher with little concern for human life and the president of a dysfunctional and corrupt administration. Ron Chernow, in *Grant*, presents a more nuanced picture of the general who won the Civil War and served as the 18th president of the United States.

Grant attended West Point and graduated in the middle of his class (not at the bottom as some have rumored), then served with distinction in the Mexican War. But, by the late 1850s, his life was in shambles, as he was forced to resign from

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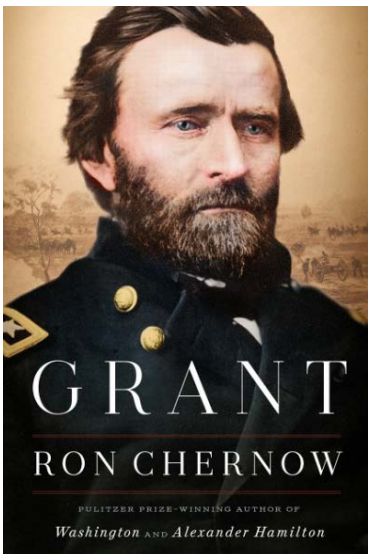


What You're Reading

(Continued from page 11)

the Army due to alcoholism and having failed at one business enterprise after another. He would have been less than a footnote in American history had it not been for the outbreak of the Civil War.

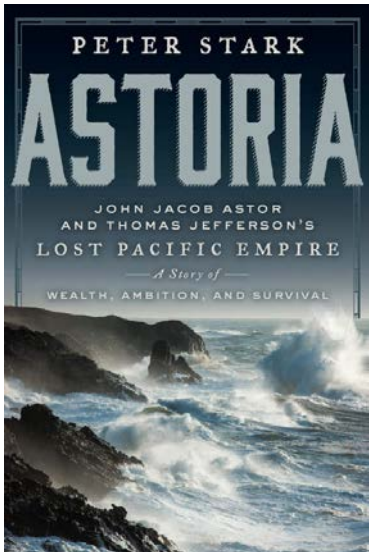
After struggling to regain his commission, his rise through the ranks in the Union Army was meteoric, with successful campaigns in the West, while Union generals in the East were losing successive battles to Robert E. Lee and the Confederacy. This caught the attention of President Lincoln, who promoted him to lieutenant general, the highest rank in the military, and charged him with defeating Lee and winning the war, which he did.

Although the loss of life was staggering under Grant's command, Chernow depicts a man with great compassion for human life, but with a soldier's dedication to do his duty. As to his drinking, he apparently inherited a family trait of alcohol intolerance, but he is said to have avoided drinking when his sobriety was required, even though the press continued to emphasize his problem during the war and throughout his presidency.

Chernow pictures Grant as a quiet, modest man, who refused to write his memoirs until forced to by his dire financial state (another business failure due to his trust in the honesty of others). His biggest vice, at least the one that finally brought him down, was smoking cigars, which led to throat cancer and a painful death. With one final show of courage, he worked through his pain, completing his memoirs within weeks of his death.

From Thomas S. Harbin, MD, MBA

Astoria: John Jacob Astor and Thomas Jefferson's Lost Pacific Empire: A Story of Wealth, Ambition, and Survival by Peter Stark.



Why isn't British Columbia part of the United States? A few answers reside in this book.

In 1810, John Jacob Astor, already wealthy from fur trading, dreamed of a Northwest trading station that would extend his empire and exploit the vast natural resources reported by Lewis and Clark when they returned in 1806. Meriweather Lewis had strongly recommended to President Thomas Jefferson that such a seaport on the Pacific rim should be established. Jefferson gave Astor his blessing and approval.

Astor sent a ship, the Tonquin, and an overland crew. The Tonquin made it to the Columbia River, crossed the bar and thus Astoria was founded. Unfortunately, the Tonquin then sailed to Vancouver Island, treated the Clayoquat Indians poorly, was attacked and blown up by its own crew.

The overland crew finally made it to Astoria, but continued poor treatment of the Native Americans, vast distance from the East Coast, and the War of 1812 allowed the British to take possession of Astoria. Ownership of this area remained in limbo until 1846 and the 49th Parallel Agreement.

If Astor's plan had succeeded, the United States might now own British Columbia. A fascinating history of the Pacific Northwest.

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