



SCOPE

Consider Board Experience as Your Next Career Move

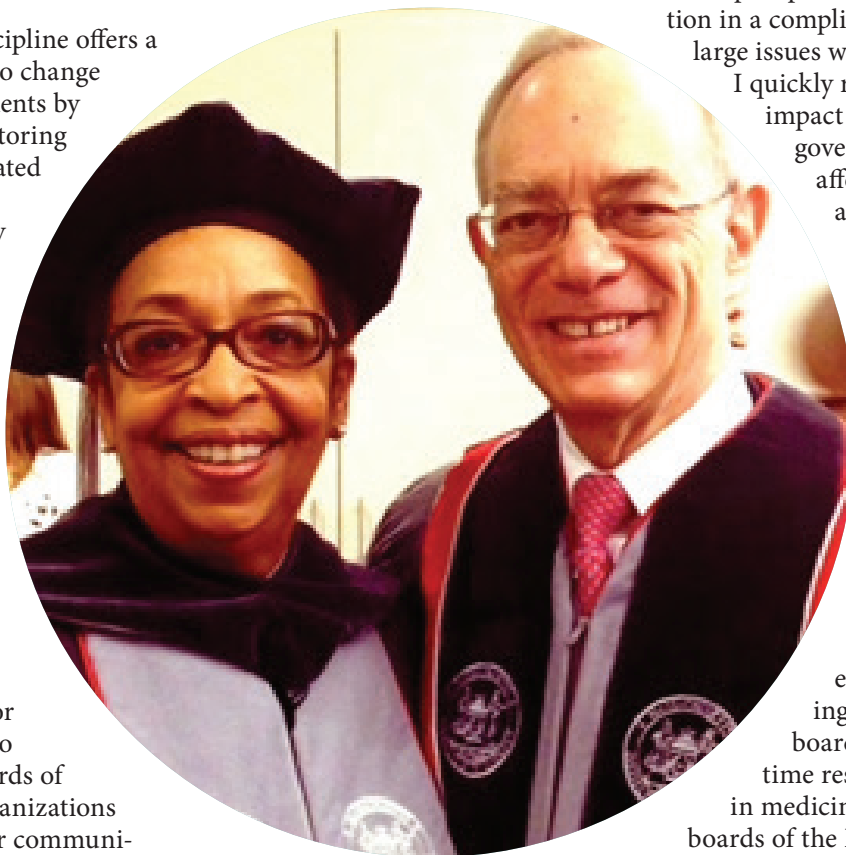
By Eve J. Higginbotham, MD, MS, ML

As ophthalmologists who care for patients over several years, our work may seem like a lifetime of service.

After all, our discipline offers a multitude of ways to change the lives of our patients by either saving or restoring vision. To be dedicated to service is truly a gift that drew many of us into the field. However, there comes a time in our lives when there is a preference that emerges to spend more time with family and friends, to fine tune or learn new skills and hobbies, or to do more traveling across the globe. For some among us who have served on boards of large and small organizations or nonprofits in our communities, we consider spending a greater amount of time serving on boards instead of taking on new activities.

For those of you who already have board service on your list, this brief article is not for you. However, if you have never served or you need convincing, then continue to read and reflect as we

consider the potential benefits of board service. Before reviewing the potential reasons for consid-



Building relationships: Participation in the MIT Commencement – Dr. Higginbotham pictured here with President Reif, 2013.

ering board service, I will share with you my experiences and why I continue to serve on boards.

For the past several years, board service has held a prominent position in my professional portfolio. In the early '90s, I served on the Academy's Board of Trustees. As my first governance opportunity, it was the first time that I was asked to consider large issues affecting a complex professional organization in a complicated industry. The large issues were fascinating, as I quickly realized that the impact of decisions at the governance level can affect the sustainability of this vital professional organization and the livelihood of thousands of professionals.

It was there that I learned the benefits of understanding the critical elements of strategic planning and the art of governance. Following this experience, board service for some time resided primarily in medicine, serving on the boards of the Baltimore City Medical Society and the Maryland Society of Eye Physicians and Surgeons, Prevent Blindness America and Alpha Omega Alpha Honor Medical Society.

One of the true highlights of my career was serving on the Defense Health Board, which advises the Secretary of the Department of

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Defense regarding matters related to health. For a decade, I had the chance to delve into key issues pertaining to military health, both in the theatre and active military. Issues such as ill effects of burn pits; the impact of the obesity epidemic on the recruitment and retention of service members; the care of the children of active military across the nation; and the care of active members who lost their limbs were among the topics we assessed. The board spent time also visiting bases around the country and learning from service members about the health issues that were most urgent.

This board experience was quite different from my tenure on the MIT Corp. and the Harvard Board of Overseers. These latter experiences provided opportunities to impact policies affecting these two major academic institutions, which of course became particularly interesting during the economic downturn in the early 2000s.

Currently I spend part of my time serving on the board of a



Defense Health Board, 2018.

large multibillion-dollar health system, boards related to the National Academies of Medicine, Engineering and Science and an independent faith-based K-8 school in North Philadelphia. I also serve on the board of a specialty hospital in the northeast. In summary,

what I have enjoyed most about my experiences are the issues that we have tackled, the impact of our work both internal and external to these organizations, and the people with whom I have had the chance to meet and form meaningful professional relationships.



Participation in the Harvard Commencement: President Drew Faust and Henry Louis Gates, 2014.

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My interest in governance went beyond my participation, as I developed an interest in learning more about the key tenets of corporate governance. Driven by this goal, I was able to complete a masters in law at the University of Pennsylvania Carey Law School in 2020. It was during this experience that I was deeply inspired by the [key principles of fiduciary responsibilities of board members](#): duty of loyalty and duty of care. When one considers these core responsibilities, it is clear that the role of boards is vital to the existence and sustainability of organizations. Although it is certainly not necessary to get a degree to serve on boards, I believe my masters degree provides a way to connect with fellow colleagues who are often lawyers and further deepens my commitment to meet fiduciary expectations.

The Triangle Community Foundation has noted [four key benefits of considering board service](#):

1. To contribute your time to an organization or cause about which you feel passionate
2. To ensure that the financial infrastructure and investments

are aligned with the core mission of the organization

3. To impact the strategic direction of the organization

4. To apply your skill set and talent to the mission of the organization

Applying one's skills and talent is worth highlighting, particularly given what we as practicing ophthalmologists bring to the table. Consider the skills that you have acquired over decades of practice covering areas such as human resources, practice development and management, legal matters, employing analytical and strategic thinking and developing innovative strategies to engage community partners. When one steps back and reviews what has been accomplished over the expanse of an entire career, it is often extraordinary. There are organizations, both nationally and locally, which can greatly benefit from your expertise and participation. Industry is also in need of our practical knowledge for its mission to deliver care for patients as well as the fiduciary obligations to its shareholders. Participation on such boards is an opportunity worth considering and that can impact thousands as you apply your practice experience.

As ophthalmologists, there is another reason for considering board involvement and that is to

advocate for eye health, particularly in those instances in which systems do not include ophthalmology as one of their specialties. Eye health remains underappreciated in population health, and yet ophthalmology remains critical to the health and wellness of populations. Eye health, however is often overlooked in discussions that often occur at the highest level of systems. A few years ago, the National Academy of Medicine convened a committee to consider the role of eye health as a population health priority. The [committee's recommendations](#) can guide the conversations that may arise during discussions in health systems. As an informed advocate, your ideas do not need to be generated from scratch.

The horizon that lies ahead forms an endless landscape which offers great opportunities for engagement and involvement. Board service offers another option to consider on your list of possibilities as you craft your next steps in your new professional chapter. There is opportunity that such professional engagement may have the chance to add to your sense of purpose while benefiting the lives of patients. You can also influence innovations yet to impact our field and inspire future ophthalmologists who will join our field.



Visiting the Vatican, 2015.



Mistakes

By Alfredo A. Sadun, MD, PhD

It comes up, occasionally, that a student or resident asks me about the sort of mistakes that physicians make.

My answers vary with the context. However, I am apt to mention that the most common mistakes in science usually relate to ascertainment bias. But what are the most common mistakes in medicine? I've pondered the question and thought that this forum, of senior ophthalmologists, would be an interesting place to consider the most common serious mistakes physicians make with their patients.

For the purposes of argument, I'm going to propose that we exclude the mistakes we might make in the OR. It's also not so interesting to consider the common failings we have in not making the earliest diagnosis of an insidious disease (like glaucoma) or in giving steroids to steroid responders. I want to be more philosophically broad in this article by looking for system failures. I think the biggest mistake we commonly make is to order a test that wasn't warranted.

In fact, I have written some about this. For example, I've published an article, "[Neuro-ophthalmology Safer Than MRI](#)" (Sadun AA, Chu ER, Boisvert CJ. *Ophthalmology*. 2013 Apr;120 (4):879.) But that article was rather specific and technical and not sufficiently philosophical.

I also published a [short essay for layman online in Quora](#). That article is basic and too unsophisticated for our group of senior physicians. So, I'll attempt a more sophisticated answer in this forum.

Several years ago, the Institute of Medicine for the National Academy of Sciences (a nonpartisan group of world-class physician/scientists) recommended not doing mammograms for women under the age of 50, as long as they did not have a family history or other indication of being high risk for breast cancer. You may remember that the press and politicians went crazy. I heard a congresswoman (over 50 herself) saying this was a cold attempt by the government to save itself money at the expense of citizens, and if it were her family, she'd insist on getting the mammogram. That was either insincere or idiotic. Such a test in a low-risk patient would have put her at statistically greater risk and done her a disservice.

Similar things have happened with the idea of doing PSA screening for prostate cancer. The early advocates are just beginning to understand. There are important roles for mammograms and PSA testing, but not in the low-risk patient. By the way, would you get a PSA on a woman or a mammogram on a man? Maybe our foolish congresswoman would have. Context matters. But not just in the extreme.

Simply stated, more testing is not the panacea that has been advertised. The likelihood of a positive test being meaningful requires us to estimate and then integrate the pretest probabilities in a Bayesian analysis (a statistical model named for English mathematician Thomas Bayes). I could try and show you that Bayesian analysis with a bunch of numbers, but it would be ugly. It hasn't worked out well for me at several professional presentations. So here is my best attempt at a qualitative answer to a quantitative problem (which I admit is not ideal).

When you do a test, the results may not be accurate. There is a

chance it could give you a false negative (you have cancer but the test doesn't find it), a false positive (you have no cancer but the test says you do) or a hyper-diagnosis (something is there and it's real, but it's irrelevant). Most laboratory tests provide their sensitivities and specificities so you know the false negatives and false positives, but only as it applies to a population comparable to those that have been previously tested. The classical studies used to calculate these numbers were done against a gold standard in which there were many real cases of the disease. So, if you want to assume their numbers, you need to match their population of patients. This means, you need a reasonable index of suspicion of having the disease to be compared to previous people who had the test. But if you test people without a good pretest probability of the disease, you will be misled.

Here's an example: Pregnancy tests have a specificity of 98% when done in women of childbearing age. That's pretty good. If you are a 30-year-old woman who missed her period and the test comes back positive, start buying baby clothes. But if you gave a pregnancy test to 100,000 men, it would claim that many were pregnant. This is not so funny if you used the test to decide on doing something risky, like surgery. But that's what happens when you are screening for cancers. If you did the test in enough people without enough suspicion of cancer, then you'd do a lot of surgery without merit. And all surgeries carry some risk.

Sure, a breast biopsy isn't that dangerous. Let's say it goes fine. But the pathology reports also have errors. So, there is a small probability that a benign breast lump ends up being reported as malignant. What follows then will be a big surgery and often awful chemotherapy. Now we're talking serious morbidities and even a small chance of mortality. But if you started with low enough pretest probabilities, the odds of such mortality and morbidity would actually be higher than the chances

From the Editor's Desk

that you missed some early cancers by not doing enough testing. The answers are in the math. People have done this number crunching.

The Institute of Medicine did it and recommended when mammography should be done (absent family history, starting at age 50), and it had nothing to do with saving Medicare dollars. But the politicians and the press and the talking heads never did get it. Most patients didn't get it. Most doctors today don't get it. And the testimonials only work one way (the error of ascertainment bias). Whenever someone picked up something early on a scan, they tell the patient that they've dodged a bullet with early diagnosis. Those that got unnecessary surgery never learn that they took undue risks. We never hear testimonials from the cases of hyper-diagnosis leading to unnecessary surgery leading to death and morbidity. These are chalked up as the unfortunate consequences of breast cancer.

This frustrates me since so many of my referring physicians don't get it. Commonly, I inherit patients with abnormal MRIs that I'm asked to work up. Only the MRIs should never have been done in the first place. Maybe the patient had a tension headache or had a slip and fall or they just talked their physician into ordering the scan. The patient and/or doctor said, "Better to be safe than sorry." Or "You can't be too careful." But that's the point. In medicine you CAN be too careful. If the patient just had a headache and no neurological indications for the MRI, the resulting imaging can't be compared to similar images in the textbooks showing MRI pathology, as those were obtained from patients who had symptoms. Apples and oranges. I'm often stuck explaining to the patient that what was found on the MRI was real but it was not the cause of his/her problem. It may have been there all their lives and so it probably shouldn't

be removed. That's a very hard sell. To patients. And to doctors.

There's another problem with screening tests called "lead-time bias." Supposing we compared the death rate of the U.S. vs. U.K. (the National Health Service) for prostate cancer. It turns out that they are almost identical. But if we compare the five-year survival statistics between the two, we are astonished to discover that the five-year survival is about 82% for the

*"Better to be safe than sorry."
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U.S. and only 44% for the U.K. How is that possible? The answer is that the PSA screening system widely used in the U.S. is leading to earlier diagnosis, but NOT delaying the date of death. So, the first five years in the U.S. just happens earlier in the course of the disease. But all that screening did not improve the main outcome of death averted or delayed. People with prostate cancer in the U.S. and U.K. died at the same ages despite the big differences in the use of PSA. That's lead-time bias. But in this present discussion, the focus is on the issue of making a diagnosis based on inappropriate testing or imaging.

As mentioned above, I published an article about just such a case. The patient had a brief episode of diplopia that in my hands was easily diagnosed as due to a decompensated fourth nerve palsy. Only the neurologist had seen the patient first and misdiagnosed her as having a third nerve palsy, so he ordered an MRI that revealed a small pos-

terior communicating aneurysm. The patient was scheduled to have an emergency craniotomy.

When I revised that recommendation as the MRI scan results were clearly not associated with any symptoms in the patient, this neurosurgeon told me that by not doing immediate surgery for what he thought was an aneurysm, "you just killed your patient." That was a horrific thing to hear. In other words, I decided her MRI showed an infundibulum, present since her birth and not an aneurysm, though both look identical on MRI. When I finally published the paper, it was 25 years later and she was still fine despite not having had the critical surgery. Explaining this to the patient was a very difficult conversation, although to her credit, she understood it.

On this subject, I'm resigned to the fact that some of my readers won't get it. They have absolute faith in tests like MRIs. I say that they are praying to a false icon and assume that an image can't be wrong because it shows a structural lesion. But it's the dysfunction that matters more than the structure. I often encounter medical students who are astonished that I wouldn't want to do the test. Why am I emulating the ostrich who buries his head in the sand? I grant that it's a subtle argument to make. Most modern tests are fantastic when used judiciously and in context, but dangerous when used out of context and too ubiquitously. But even in this era of fantastic imaging and other laboratory testing, I teach that symptoms trump signs, and signs trump tests. But I suspect that this is a vanishing perspective. And my attitude will soon rest in peace once artificial intelligence (AI) plays a serious role in managing patient workups.

For those interested in sharing these explanations with your patients especially regarding lead time bias, I found a video from British cardiologist Dr. Rohin Francis, "[The Epidemic of Fake Disease](#)" who does a very good job with these difficult concepts.

What We're Doing Today – Eye on Photographer: Jeff S. Maltzman, MD

By Alfredo A. Sadun, MD, PhD

Jeff S. Maltzman, MD, completed his residency at the Baylor College of Medicine/Cullen Eye Institute, and then followed with a glaucoma fellowship at the Tufts-New England Eye Center in Boston.

Dr. Maltzman then joined a small, private group practice in Tucson, Ariz., which has grown from four to eight providers. He has been involved in organized ophthalmology focusing on physician advocacy, serving on the Academy's OPH-THPAC® and State Governmental Affairs committees, most recently completing a term as chair of OPH-THPAC in 2021.

Dr. Maltzman has also been an Arizona Ophthalmological Society board member and past president. He currently holds clinical faculty appointments at the University of Arizona School of Medicine, the A.T. Still University School of Osteopathic Medicine and Midwestern University College of Osteopathic Medicine.

Last year in Chicago, Dr. Maltzman presented during the Senior Ophthalmologists Special Program on artistic photography with landscapes. He just blew everyone away. I was so impressed that I had to prevail on him for an interview as part of What We're Doing

Today, our series that looks at our colleagues' avocations.

Alfredo A. Sadun, MD: Jeff, how and when did you become interested in photography?

drawing throughout my childhood. I also loved nature and wildlife and was fortunate to live near a wooded area which offered plenty of space to explore and discover, the forest scenes and animals that I encountered often serving as subjects for my drawings. I had limited exposure to photography in my youth, though I do recall being intrigued by images of the American West made by well-known artists like Ansel Adams and Josef Muench, works that first stirred my interest in photography as an artform.

I didn't pick up a camera, however, until my ophthalmology residency. But at the time I wasn't creative enough to identify suitable subjects around Houston. Furthermore, with a busy resident's schedule, the cycle of shooting, developing the film, reviewing the images and getting back out to shoot again wasn't very conducive to learning. By 2009, I had been living in Tucson for about seven years and was simply astounded by the endless beauty and tremendously varied landscapes of the area. Digital photography was beginning to rival film, so I decided that it was time to give it another try. I bought my first digital camera, a Canon 40D, and have been hooked ever since.

Dr. Sadun: How did you learn and evolve?

Dr. Maltzman: While standing with my shiny new camera at one of my kids' school events, I was approached by another parent who started questioning me about the camera and photography. Admitting immediately that I had little idea what I was doing, he relayed



Early morning light on the Teton range. This is one of the most photographed barns in America. I wanted to give the barn and the distant mountains equal presence in the image, so I photographed with a long focal length (telephoto) lens from a moderate distance, compressing the distance between the subjects in the image. Grand Teton National Park, Wyo.

Jeff S. Maltzman, MD: I've had artistic proclivities from a young age, enjoying sketching and

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that he was an experienced amateur photographer and offered an introductory class for novices like me. I accepted, took his short course and was now further hooked. With fervor, I sought out information about both the technical and artistic aspects of my new hobby. I read countless books, studied online resources, and evaluated the work of other photographers. I occasionally contacted artists whose work I admired, some of whom graciously provided advice and critiques.

In the autumn 2010, I attended my first photo workshop shooting fall colors in Sedona, Ariz. The professional photographer who led the event was very complimentary of the images I was making, providing me a tremendous boost of confidence and enthusiasm. I've been fortunate to have developed friendships with numerous talented amateur and professional photographers over the years, all of whom influence my work and my growth as an artist.

Dr. Sadun: Do you collect photographs/albums as well?



Warm morning light reflects in a relatively still section of Aravaipa Creek as red sandstone cliffs tower above. Aravaipa Canyon Wilderness, Ariz. This is one of my favorite places to backpack and photograph.



The turquoise waters of Havasupai Creek flow over a small cascade below Mooney Falls, Havasu Canyon, Ariz. The smooth, silky appearance of the water is created by using a longer shutter speed, a half-second in this case.

Dr. Maltzman: I have a slowly growing collection of books of photographers' work, including Ansel Adams, Josef and David Muench, Eliot Porter, Gregory Heisler, Charlie Waite, Thomas Mangelsen and numerous others. I enjoy these both for the simple beauty of the images and the inspiration they provide as well as for their value as educational devices. I have collected a handful of prints over the years, mostly from photographers that I know personally.

Dr. Sadun: How are you inspired to do a landscape?

Dr. Maltzman: I think that, for any visual artist, the inspiration to create comes from both external and internal sources. *National Geo-*

graphic photographer Jim Richardson purportedly said, "If you want to be a better photographer, stand in front of more interesting stuff." But I've found the reality to be more nuanced. I photograph for different reasons. I've been fortunate and honored to have my work published in *Arizona Highways* magazine for the last seven years. The magazine's 100-year-old mission is to promote tourism in Arizona.

When photographing for the magazine or with the intention of submitting images for publication, I approach the process with a specific goal and mindset. I know the style of images that the editors like, so I search for the types of scenes that are likely to be pleasing to them. Time of day often mat-

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ters, as the direction and quality of light varies as the sun moves across the sky. These photographs, while necessarily aesthetically pleasing, are somewhat documentary in nature. On the other hand, I often shoot purely for my own enjoyment, creating images that reflect how I feel, and how I interpret the landscape. In this scenario, I've discovered that internal influences weigh heavily. My mood strongly influences how I perceive a location and impacts the images that I create. I've stood in astoundingly majestic places and been unable to produce a photograph that has meaning to me or adequately expresses the beauty of the location.

Dr. Sadun: Do you experiment with different approaches?

Dr. Maltzman: I've experimented with different types of photography and various techniques over the years. As I've noted elsewhere,



Cholla (*Cylindropuntia* sp.) blossoms. This is a macro image, made with a lens capable of focusing very closely. A series of about 30 images were taken, each with a limited depth of field, from front to back of the flower, much like slices of a CT scan. Software was then used to combine the individual images to create this photo, isolating the flowers from the background. Tucson, Ariz.



A pair of bison emerging from the steamy mist at Grand Prismatic Spring in Yellowstone National Park, Wyo. I love the mysterious feel of this image.

my style is moving toward what can be described as more “intimate landscapes.” However, I still like to infuse a bit of variety into what I do; it keeps life interesting! I occasionally enjoy night photography, including shooting the Milky Way or star trails over interesting locations. During the beginning of the pandemic in early 2020 while my practice was closed and travel was limited, I spent a bit of time photographing close-up “portraits” of cactus flowers using a technique known as focus stacking, in which numerous images are made by focusing on different parts of the subject and then combining all the shots together using sophisticated software. The result is a flower sharply focused throughout and isolated from an out-of-focus background. I've also played a bit with another technique known simply as “intentional camera movement” which combines slower shutter speeds with movement of the camera while the exposure is being made, resulting in beautifully abstract images.

Dr. Sadun: Do you, like many painters, go through phases of style?

Dr. Maltzman: When I first started, I tended to copy the styles of other photographers whose work I admired. However, as Oscar Wilde famously said, “Imitation is the sincerest form of flattery that mediocrity can pay to greatness.” At some point, an artist must use the inspiration drawn from others' work to develop a style of their own. As I've grown as a photographer, I've come to favor photographing in locations that are less frequented by others.

National parks and monuments are wonderful and iconic scenes are considered so for good reason. But amazing beauty can be found almost anywhere, and I prefer to camp, hike and photograph solo away from others and immersed in nature. My photography time is also my personal relaxing time, to refresh and reset. My style of photography continues to evolve, and I am moving toward being less reactive and more contemplative, focusing on more intimate landscapes. This term was coined by Eliot Porter and describes smaller scenes within the greater landscape. Such images often lack the “wow” factor of grand,

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expansive scenes with brilliant skies, but are meant to tell a simpler story or serve as metaphor.

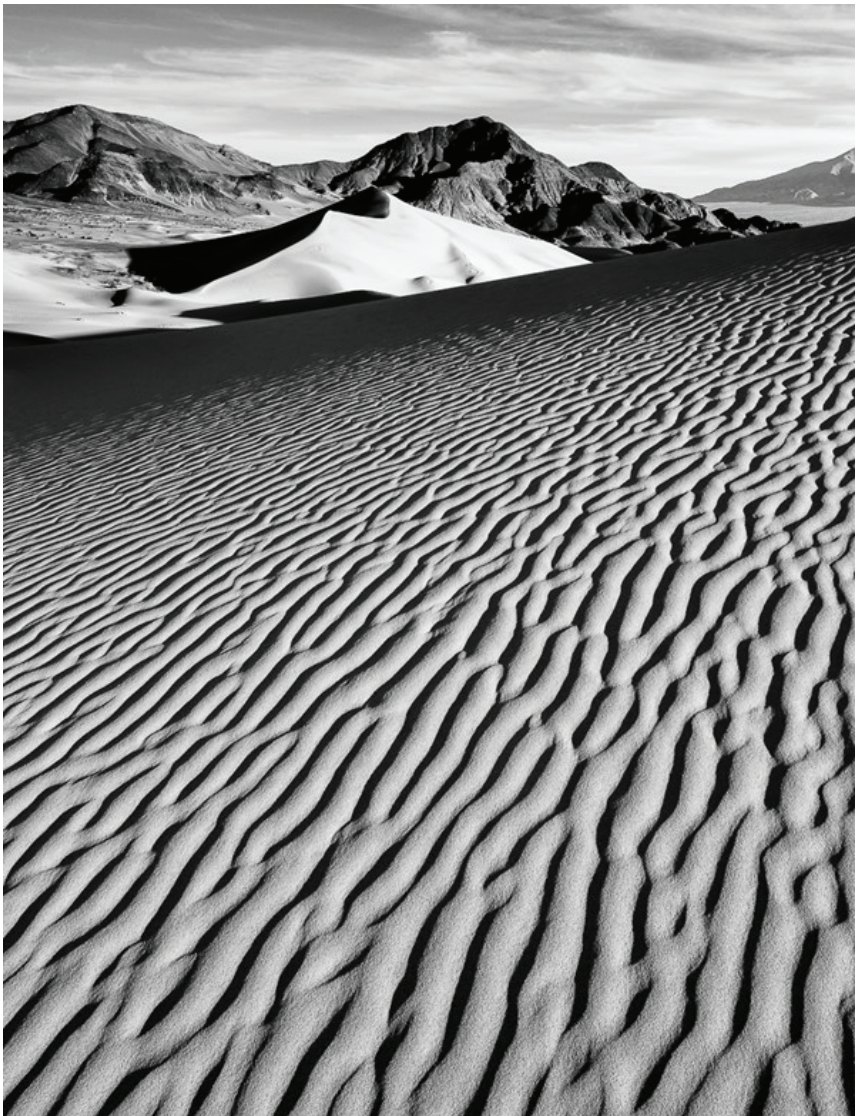
Dr. Sadun: What is your favorite camera/lens?

Dr. Maltzman: As an ophthalmologist, I have an innate love of useful technology, and modern digital cameras are amazingly intricate, computer-controlled tools. While the creativity and skill of the photographer are far more important than the specific camera used, these modern devices offer tremendous features that simplify and smooth the process of making images. If money were no object, I would love to have a high-end, medium format digital system such as the Phase One XT, which offers unparalleled image quality and flexibility.

On the other hand, I've been quite impressed by the quality of images produced by my iPhone 13. There's a saying in photography, "The best camera is the one you have with you." And we all have our phones with us all the time, making them a spectacular tool to document our experiences. I have produced some lovely images on my phone. However, for most of my work I currently use the Canon R5 system along with several RF [a new Canon mount] and adapted EF [older Canon] lenses. I primarily shoot with a 24- to 70-millimeter lens, though as I've shifted to shooting more intimate scenes, I find myself using a 100- to 500-mm lens quite often. This longer lens allows me to isolate small details even at great distances.

Dr. Sadun: What are some of the things you have learned about your subjects (terrain, nature, light) that came from photographing them?

Dr. Maltzman: At its essence, photography is all about illumination. It is, quite literally, the art of drawing with light. A thorough



Sand patterns and dunes, Ibex Dunes, Death Valley National Park, Calif. In order to achieve absolute sharpness from foreground to background, a tilt-shift lens was used. This lens employs the Scheimpflug principle, tilting the lens away from the sensor plane in order to change the focal plane.

understanding of visible light — its quality, color temperature, directionality, interaction with the atmosphere — is vital to becoming a competent photographer. Light changes throughout the day, across the seasons, and around the globe. My photographic pursuits have dramatically improved my appreciation of the light cycle, the movements of the sun and the moon and how it impacts the landscape. This has not only positively influenced my photography, but also my simple appreciation of the beauty and elegance of our natural world. On a broader level, my photographic journey has, without a doubt, forti-

fied my already strong connection with nature and wild spaces and has literally changed the way that I see and experience everything.

Dr. Sadun: What connection have you found between ophthalmology and photography?

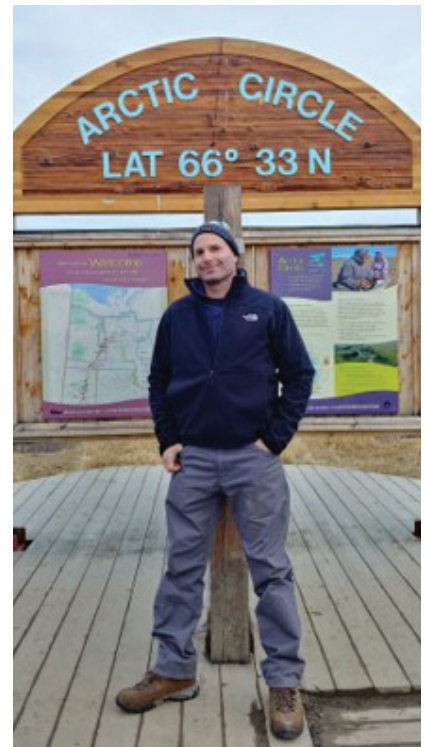
Dr. Maltzman: Photography has always struck me as a perfect artistic outlet for the ophthalmologist. Our knowledge of optics is a tremendous benefit, allowing a more detailed and nuanced understanding of light and how it interacts with lenses and surfaces. Likewise, a familiarity with

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photographic principles has given me an even greater appreciation for the eye's incredible elegance of form and function. Photography is an art that has always depended upon technology, and I think it's fair to say that many of us pursued ophthalmology as a profession partly due to the varied and evolving technologies. The making of a good photograph requires attention to detail and the ability to make numerous decisions simultaneously, skills that most ophthalmologists possess. Photography allows us to engage both our technical and creative brain in a way that few other pursuits offer.

I firmly believe that each of us can benefit greatly by having an avocation, some pursuit outside of medicine that fulfills, energizes,

and restores us. Though we ophthalmologists have the privilege to work in a spectacular profession that provides great intellectual stimulation and the reward of truly improving our patients' lives, we all need a means to manage the stresses that a career in medicine brings. Humans have an innate desire to create and to share experiences, and art can serve as a valuable conduit for such expression. I'm aware of many of our colleagues' artistic pursuits, including photography, painting, sculpting, mixed-media creation, music composition and/or performance, map making, etc. I encourage anyone in need of diversion to pick up a camera, a paintbrush, a musical instrument and create something. And reach out to your colleagues with experience in that endeavor, as I know that they would love to offer support and guidance.



Dr. Maltzman



Star trails over the Chapel of the Holy Cross, Sedona, Ariz. This is essentially a 60-minute exposure. However, the image was made by taking 120 30-second exposures and using software to "stitch" them together into the final image.

The Way We Were: Meet Neil R. Miller, MD

By Alfredo A. Sadun, MD, PhD

In this issue, *Scope* interviews Neil R. Miller, MD, who is the Frank B. Walsh Professor of Neuro-Ophthalmology at the Wilmer Eye Institute, part of Johns Hopkins Medicine. Dr. Miller has published over 500 articles, 93 chapters, and 13 books, including the fourth edition of *Walsh & Hoyt's, Clinical Neuro-Ophthalmology*. It has long been regarded as the bible of neuro-ophthalmology, and the five volumes of the fourth and later editions have influenced the field beyond measure.

Dr. Miller has taken great interest in the subspecialty and its practitioners, as evidenced from being a past president of the North American Neuro-Ophthalmology Society (NANOS) and three-time president of the International Neuro-Ophthalmology Society. He has given 44 named lectures around the world, including the Jackson Memorial Lecture at the Academy's 2001 annual meeting and the Academy's 2005 William F. Hoyt Lecture. His numerous awards include the Distinguished Service Award from NANOS and the Academy's Lifetime Achievement Award. Most recently, he has added basic wet bench research to his lengthy opus in clinical research. He even had a cameo in the 2009 Hindi-language action movie, "Kurbaan."

Alfredo A. Sadun, MD, PhD: Can you start us off with comments about your early life?

Neil R. Miller, MD: I was born in 1945 in Wichita Falls, Texas, where my father was stationed with the Army, but raised mostly in Omaha, Neb., where my father settled in private practice after completing a surgical internship and

Dr. Miller: It saved my life. The summer between high school and college, I developed a very severe headache and fever. My father gave me some type of analgesic, but the headache didn't improve. He suspected there was something serious and took me to the hospital where I was found to have bacterial meningitis. I was treated with hourly intramuscular injections of antibiotics. Fortunately, I made a complete recovery. It is likely that had my father not recognized the seriousness of my condition, I would not have survived!

Dr. Sadun: This was in the early 1950s, when antibiotics were nascent. So, you were also lucky to have not been born a decade or two earlier. When did you decide to become a physician?

Dr. Miller: As my father was a physician and loved being one, I probably always assumed that I would follow in his footsteps. I'm not sure there was a particular moment when I said to myself "I have decided to become a doctor."

Dr. Sadun: Where did you attend college? What was your major?

Dr. Miller: I went to Harvard college where I majored in biochemistry. During my first year, I met another freshman, Harry Quigley, MD. We subsequently became friends and were roommates during college. We then went to the same medical school where we again roomed together, were in the same resident class at Wilmer Eye Institute, joined

Dr. Miller (left) celebrating graduation from Harvard college with Lou Nadler, student director of the Harvard Band (Miller was the student conductor).

residency in Chicago and a fellowship in surgical oncology in Boston.

Dr. Sadun: So, you weren't born and bred as an East Coast elite? And how was it being in the Midwest and being the son of a physician?



Neil R. Miller, MD

the Wilmer faculty after our fellowships and have been friends ever since. Of course, Harry has gone on to be recognized as one of the national and international experts in glaucoma.

Dr. Sadun: I'm laughing as I know Harry, and I would consider you two as an odd couple. That aside, you are rather modest in only highlighting his prominence in glaucoma. I refer the readers to my introductory paragraph to reiterate that you are, right now, the world's most preeminent neuro-ophthalmologist. But back to the chronology. You both went to medical school at Johns Hopkins. What got you into ophthalmology?

Dr. Miller: In those days, A. Edward Maumenee, MD, then the chairman of ophthalmology at the Wilmer Eye Institute, would actively recruit entering first-year medical students who often were from ivy league colleges. This would be known to the current residents who had gone to the same colleges. He would meet with these prospective first year medical students and pitch our field. Maumenee would, tell them how great ophthalmology was, and provide them with funds



Dr. Miller (left) playing some jazz with Dan Milea at the 2022 meeting of the European Neuro-Ophthalmology Society in Birmingham, UK.



Dr. Miller pictured with his wife Carol on a barge trip in France in 2018.

for summer research. I was one of several students in my class (Harry Quigley, again, was another) who was recruited by Dr. Maumenee, and so I spent a summer doing research in the ocular pathology laboratory at Wilmer under the auspices of William Richard Green, MD. By the time that summer was over, I was hooked, though at the time I assumed I was going to have a career as an ocular pathologist, not as a neuro-ophthalmologist!

Dr. Sadun: Just to remind the readership, before the match program the process of applying for a residency in ophthalmology was a bit wild and very subject to randomness, confusion, capriciousness and serendipity. How was it for you?

Dr. Miller: The application process was straightforward. Each eye department had its own application form. You filled out the hard copy application form and sent it in. You would then be notified if you were invited for an interview with various faculty. Once you visited the program and the

interview was finished, you were informed if: 1) you were accepted; 2) you were on a waitlist; and 3) you were not accepted. Being from Omaha, I was interested in a residency position at the University of Iowa; however, the residency had already been filled for several years ahead. Later, Frederick R. Blodi, MD, chairman of the University of Iowa Department of Ophthalmology, asked me why I didn't do my residency in his department. I explained that I didn't even get an interview because the residency positions had all been filled for my year, and several others that I would have had to wait through.

The process was problematic in several ways. One was the hassle and cost of filling out multiple applications. But more importantly, the dilemma was that some programs offered you a position but required you to accept or decline the offer within a day or two, even though you might have to wait many months to hear from other programs. In this way, some programs were able to attract excellent applicants who might have gone

Neil R. Miller, MD

to other programs but who didn't want to take a chance of not getting a residency position at all.

Dr. Sadun: Yes, that could be very stressful. Before you started at Wilmer, you had to do an internship. How was that?

Dr. Miller: I have often said that my internship in medicine, which was also at Johns Hopkins, was one of the best years of my life! I had a chance to learn "real" medicine, knowing that I had only one year to do so. We were on call two nights out of every three, and even when we were not on call, we were on the wards until almost midnight! In addition, I was able to spend two months covering the neurology ward, so I got to learn a lot of neurology during the year. As if this were not enough to make it a great year, this was the year that I met Carol Rogues, a dietitian at the hospital, who would become my wife the following year. We're celebrating 50 years of marriage in 2023!

Dr. Sadun: Just to remind the audience: Johns Hopkins was



Dr. Miller with David Knox (left) and Tom Hedges Jr (right) at a meeting of the Frank Walsh Society in Baltimore in 1993.

regarded then and, perhaps still now, as the ultimate trial for training in medicine. It was a grind. In fact, it was at Johns Hopkins that Sir William Osler created the term "internship" to reflect the idea that you lived and worked "in" the hospital all the time. When you graduated to "resident," you still resided there but could leave for short stints. A residency at Wilmer was said to be not only

educational, but hard and colorful. What was it like for you?

Dr. Miller: As residents, we were largely autonomous. When we were in clinic, we were pretty much by ourselves. If we didn't know something, we asked a more senior resident. If the senior resident didn't know, he (all men at this time) would ask the chief resident (a former resident who had been away for a fellowship and had then come back for a year to lead the residents). If the chief resident didn't know, he would escort us to Dr. Maumenee or one of the other five or six faculty, introduce us and say something like, "Dr. Maumenee, Dr. Miller would like to discuss a case with you." It was very, very formal. When we were in the OR, our assistant was likely to be a senior resident or the chief resident, only rarely a faculty member.

Finally, as all patients undergoing surgery (whether cataract removal, retinal reattachment, glaucoma filtering procedure) were admitted the evening before surgery and kept as inpatients for five to seven days, we went on ward rounds every morning at 7 a.m. and every evening at 7 p.m. We also had weekly grand rounds with live patients and intermittent lectures. One of the most important people



Dr. Miller (right) with Tony Arnold (left) and Andy Lee (center) at the World Congress on Controversies in Ophthalmology in 2013.

Neil R. Miller, MD

in my life during my first year of residency was the chief resident, Ron Smith, MD. Ron knew how to not only motivate but to support us. He knew that I was interested in neuro-ophthalmology, so he allowed me to be the “resident expert” in neuro-ophthalmology!

Dr. Sadun: I love hearing that about Ron Smith. He was one of my closest friends, a very kind chairman and always amazing as a supporter. Tell us more about your residency.

Dr. Miller: Every month, one of the first-year residents was designated as the “slide rookie,” in charge of making sure that the slides of one of our many guest lecturers was properly set in the slide projector, that the slide projector was working, etc. This was in the days of dual carousels as slide holders. Once when I was slide rookie we had a visiting lecturer, and I was checking the slides on the slide projector. One of them seemed to be stuck in the carousel. I took the top off the carousel to manipulate the slide, then lifted the entire carousel off and flipped it over, having forgotten that the top was still off, whereupon most of the slides fell out! I was so embarrassed that I didn’t tell the lecturer. Instead, I just put the slides back in the carousel as best as I could but knowing I hadn’t maintained the proper order. The lecturer started the lecture but as each slide came up, he said, “That’s not the right slide!” I finally had to admit my error, and we then waited for 20 minutes or so while he put all the slides back in the correct order!

Dr. Sadun: Ah, yes, those infernal carousel projectors. We all made that same mistake once. It was a version of the childhood game, 52 card pick-up. But for most of us, the spillage was to our own slides. Tell us about your fellowship.

Dr. Miller: Because I was planning to be an eye pathologist, I



Dr. Miller (center) discussing an interesting case with Jack Selhorst (left) and William Hoyt (right) during his fellowship in 1975.

decided to spend some time at the University of California San Francisco with William Spencer, MD, then one of the leading eye pathologists in the country. When I told my medical school advisor at Johns Hopkins, David Knox, MD, of my plan, he suggested that I spend some time learning more neurology as it related to vision. This could be with Bill Hoyt, who was also at UCSF. It was Dr. Hoyt who with Dr. Walsh had just published, *Clinical Neuro-Ophthalmology* as the third edition of the textbook that Dr. Walsh had previously written alone. My time with Dr. Hoyt convinced me that what I really wanted was to be a neuro-ophthalmologist. Accordingly, when I finished the Wilmer residency, I asked Bill Hoyt if he would take me back as a dedicated neuro-ophthalmology fellow, and he agreed. It was a marvelous experience. My co-fellows were Drs. Jack Selhorst and Tom Shults, now both retired. We had a great time together and have remained good friends.

Dr. Sadun: And then what was your first job?

Dr. Miller: After I finished my fellowship, I returned to Wilmer as chief resident, at which time Dr. Maumenee asked me if I would stay on to run the neuro-ophthalmology division. I discussed this

with the chairmen of the neurology and neurosurgery departments, and both said that they would give me their full support. I therefore accepted a faculty position and have been at Wilmer ever since!

Dr. Sadun: Not many people have spent their entire careers at one institution, especially having made themselves so renowned. Any regrets in your career in ophthalmology?

Dr. Miller: I sometimes regret not having accepted a chairmanship position. But at the time I was being so considered, my daughter was at an age where a move to another city would have been detrimental to her social and school life. In addition, chairs by then were spending more and more time doing administrative work and less and less time teaching and seeing patients, and I didn’t want to give those academic elements up.

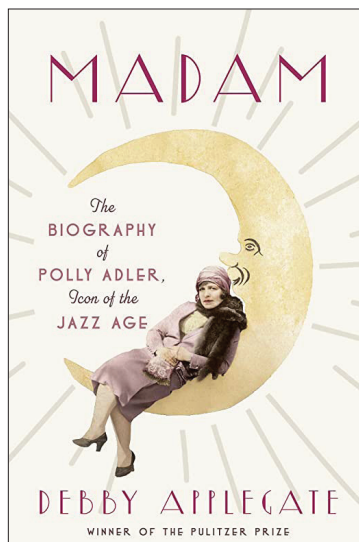
Dr. Sadun: And the world was much better for that. You were made for academics, not for administration. Let’s end with a positive. What in your career gave you the greatest satisfaction?

Dr. Miller: Making a difference both individually caring for my patients and on a larger scale through teaching, writing and research.

What We're Reading This Winter, 2023

Book Review Editor, Robert L. Stamper, MD

Senior ophthalmologists share the best of what they're reading this winter. Share what you're reading and send your review to our book review editor, Robert L. Stamper, MD, at scope@aao.org.



Madam: The Biography of Polly Adler, Icon of the Jazz Age

By Debby Applegate

Reviewed by
Samuel Masket, MD

Pearl (later known as Polly) Adler was born about 1900 in Belarus, near Pinsk. Belarus was a portion of an area known as the “Pale,” encompassing parts of Poland, Ukraine, Russia and some neighboring countries that allowed Jewish inhabitation.

They lived primarily in small communities, or “shtetls. Life in these towns was meager with men largely studying the Torah and other religious matters while women ran the household, raised children and often managed the family business. As a result, women were better prepared for the external world than were men.

When Adler was 13 years old, conditions for Jewish families had soured significantly owing to

“pogroms,” organized massacres and similar actions against Jews that led to mass emigration. Since it was costly and risky to leave the Pale, generally one child was sent to the U.S. or elsewhere to stay with previous emigres and pave the way for other family members. Pearl was selected from her sibling brothers to make the voyage because young men, if caught, were conscripted to the military, sent to the battlefield, and typically never heard from again.

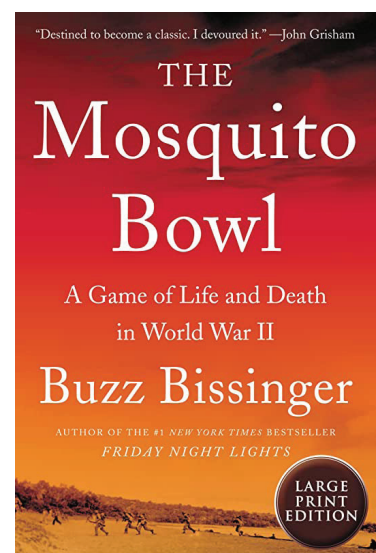
Adler’s toughness and tenacity portended her future and allowed her to make the long journey to Springfield, Mass. where she lived for a short while with an extended family before leaving for Brooklyn and another negative family experience. However, she discovered the adventures of Coney Island, learned to have fun, socialized and worked in a menial job.

Soon afterward she “discovered” Manhattan and all its wonders and opportunities and through a circuitous path came to understand that women could make sizeable money in offering sex for sale. However, owing to her small stature and self-described plain features, she eschewed prostitution for herself but was able to procure attractive, albeit financially needy women and through her guile developed a trade as a madam.

What followed was a remarkable and notable career, although fraught with the hazards of working in an illegal profession. By its nature she encountered many underworld figures including Dutch Schultz and Legs Diamond; some of these men would partner with her, protect her and at other times, torment her and her girls and ransack her brothel. Obviously, the police could not provide protection from hoodlums, but were heavily on the take for money and sexual favors in order

to look away from Adler’s business. Nevertheless, from time to time she was arrested and had to close shop and start anew. At one time she went legit and opened a retail store, only to watch it fail. She returned to the business that she knew and flourished.

She had the panache to develop high end salons that offered more than sex for hire and attracted a clientele that included the upper echelons of New York society, including prominent politicians, entertainers, athletes, journalists, intellectuals, etc. She was aided greatly by Prohibition. Through her connections the best illegal alcohol flowed through her establishments. They became the place to be for many of the glitterati of the roaring ’20s. The list of those who frequented Adler’s will truly astonish the reader.



The Mosquito Bowl: A Game of Life and Death in World War II

By Buzz Bissinger

Reviewed by
J. Kemper Campbell, MD

Sports pages across the U.S. inevitably make the comparison between gridiron exploits and war. Sportswriters, coaches, and fans use clichéd words and phrases like “the battle in the trenches,” “blitzes” and “bombs” to link the two entities. The comparison, of course, is patently absurd.

What We're Reading

Buzz Bissinger is author of the classic football book *Friday Night Lights*. In his latest book, *The Mosquito Bowl* describes a forgotten game played on Christmas Eve 1944 between two regi-

Bissinger uses the game, which he describes only superficially, to prepare readers for the participation of the athletes in the bloody invasion of Okinawa, Japan. The fierce battle for that island was one of the primary factors considered by President Truman in his decision to drop the atomic bombs causing Japan to surrender.

ments of the 6th Marine Division assigned to the South Pacific. It is not a book about sports.

Bissinger again demonstrates the consummate skill in character portrayal found in his acclaimed earlier works as he acquaints

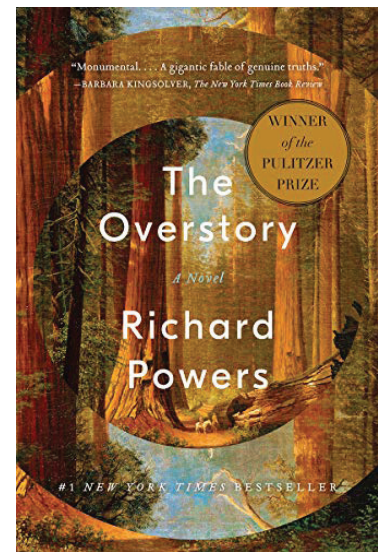
readers with the generation of young men drawn into the maelstrom of war by the attack on Pearl Harbor. Although none of the men featured are still alive, by the book's end readers will feel they had known them during the prime of their lives.

The difference between this book and another of the reviewer's favorites concerning young athletes, Daniel James Brown's, *The Boys in the Boat*, is that Brown's "boys" were competing for gold medals and Bissinger's were trying to stay alive. Most of the 65 men who played in the book's titular game were collegiate or professional football stars. Tragically, some did not survive the war.

Bissinger uses the game, which he describes only superficially, to prepare readers for the participation of the athletes in the bloody invasion of Okinawa, Japan. The fierce battle for that island was one of the primary factors considered by President Truman in his decision to drop the atomic bombs causing Japan to surrender.

Five years of meticulous research provided the author with the historic background to the protagonists' lives before, during and after their military service. He does not shrink from acknowledging the prejudices common to both military and civilian society in that era. Rivalry between military branches, faulty tactics and inexperienced leadership are not spared from criticism.

By the book's end, Bissinger has managed to connect readers to the young men whose lives were irrevocably altered by the politics of their time. The youths who did most of the fighting and dying on Okinawa were plagued by boredom, an implacable and fanatic foe and the constant underlying fear of the random and sudden death which characterizes war. These forgotten men deserve this book, which is destined to become an instant classic.



The Overstory: A Novel

By Richard Powers

Reviewed by

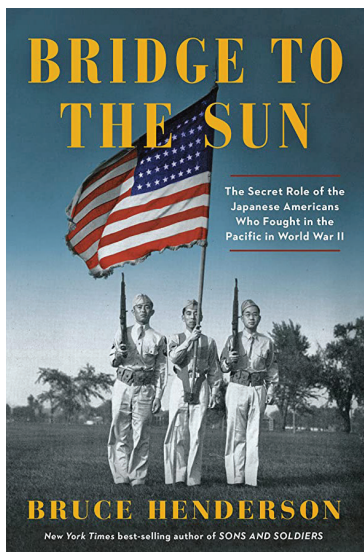
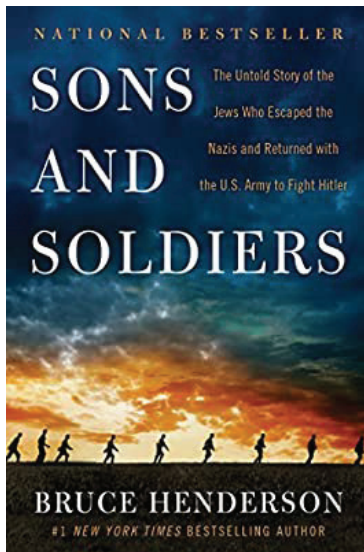
Laurie Gray Barber, MD

Richard Powers begins, "Let me sing to you now, about how people turn into other things," and then sweeps us into this epic book describing five trees that permanently change the lives of nine diverse characters. Settle in for a rewarding, although sometimes tedious, splurge into the lives, communication, and survival of trees. The word "overstory" relates to the canopy of the forest, and Powers starts at the top and digs into the science of roots, branches, leaves and man's reliance on (but careless tending of) our earth.

In 2019, Richard Power won the Pulitzer Prize in fiction with, *The Overstory*. The Pulitzer board described the book as "an ingeniously structured narrative that branches and canopies like the trees at the core of the story whose wonder and connectivity echo those of the humans living amongst them." This 612-page novel opened my eyes to human's tenuous relationship to nature, climate change and other people, as well as our warped perception of time.

Perhaps a book such as this prods us to mindfulness and better stewardship of our only home. Let this be your "hard" book this season.

What We're Reading



Sons and Soldiers: The Untold Story of the Jews Who Escaped the Nazis and Returned with the U.S. Army to Fight Hitler
By Bruce Henderson

Bridge to the Sun: The Secret Role of the Japanese Americans Who Fought in the Pacific in World War II
By Bruce Henderson

Reviewed by
Robert L. Stamper, MD

In his first book on the overall subject of unsung heroes of World War II, *Sons and Soldiers*, Bruce Henderson tells the fascinating story of Jewish boys who grew up in prewar Germany, got sent by prescient, albeit distraught

parents to be raised in the U.S. as Naziism grew and who ultimately played a critical role in the Allied victory in Europe.

These boys were bilingual but thoroughly American. As a group, they tried to enlist in the early days of the war but were spurned by the U.S. armed forces and the War Department as potential enemy aliens despite their refugee origins. However, as the early days of the war saw many Nazi victories, the potential value of these men as interrogators of prisoners and even as frontline spies began to dawn on the powers that were. The author zooms out to tell us what was happening on the larger fronts and then zooms in on the individual acts of heroism that helped turned the tide of the war in Europe. This very readable book adds a refreshing and little-known aspect to the chronicles of World War II in Europe.

In a sort of sequel, *Bridge to the Sun*, Henderson turns his attention to the Nisei, second-generation Japanese men born in the U.S. and full American citizens. After Pearl Harbor, as much as they wanted to prove they were true and loyal Americans, they were found unfit for the armed forces since it was thought they would naturally want to help the Japanese. Some were already in the U.S. Army or Navy but were pushed into noncombatant roles. At the same time, the Japanese -born and second-generation civilians were being rounded up. They were given little time to sell their farms, businesses and homes, and were sent to "relocation camps" in inhospitable places away from the West Coast (as far away as Arkansas).

Japanese is a very complex language with several different dialects and intricate written symbols. In fact, the Japanese were so convinced that no enemy could decipher their language that they did not bother to code their military radio signals or operational commands.

Enter the Nisei, especially those who had been schooled in Japan for a few years prior to the war. Despite being angry at having their families imprisoned in camps surrounded by barbed wire and armed guards, they volunteered for hazardous duty. Like their German Jewish counterparts in Europe, they were invaluable at crawling up to enemy lines and bringing

The author zooms out to tell us what was happening on the larger fronts and then zooms in on the individual acts of heroism that helped turned the tide of the war in Europe.

important information back. Very useful information also came from the diaries of dead soldiers and the intercepted battle plans.

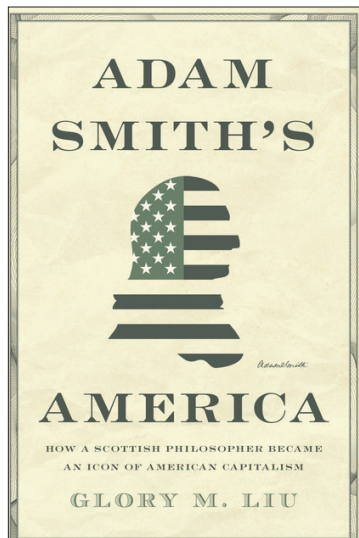
Initially, however, they were less effective at interrogating prisoners because the Japanese soldiers were imbued with the idea that surrender was shameful and preferred suicide to capture. Eventually, there were enough surrenders (sometimes of Nisei who had not left Japan in time and were conscripted into the Japanese army) that useful information was obtained.

Henderson writes well and, although filled with details, the prose flows easily. I learned a lot about the costly battles for control of the many islands in the South Pacific whose names echo from my childhood, history classes and the movies. The terrible devastation produced by the atomic bomb-

What We're Reading

ing of Hiroshima and Nagasaki probably saved millions of both Japanese and American lives. However, the author explores the decision with the nuances it deserves, and we are left to draw our own conclusions about atomic warfare in that situation.

Perhaps even more interesting and astounding is what we learn about the individual Nisei soldiers. Henderson treats us to the story of their lives before, during and after the war. He explores their various emotional conflicts at having to fight an army that might contain cousins, uncles and even siblings. We learn not only the military strategies of the war in the Pacific from the birds' eye view but about how those strategies played out in the trenches and the critical contributions to the final victory by the heroism of these dedicated American warriors.



Adam Smith's America: How a Scottish Philosopher Became an Icon of American Capitalism

By Glory M. Liu

Reviewed by Alfredo A. Sadun, MD, PhD

There are several reasons for reading this book. The obvious one is that it tells the story that we Americans are so fond of, that

Adam Smith an early economist and social philosopher who pointed out our economic and cultural north stars. We say this to justify capitalism and more particularly, the American view on free markets. But it turns out, that self-serving narrative is inaccurate.

Smith's, *The Wealth of Nations*, came out just as the American Revolution was launched. A few years later it became a reference point by America's founding fathers. It details the economic theory that described the true nature of national wealth and a treatise that described the best form of government not only for the economy. Its pages promoted moral virtue (a phrase our founders used all the time — in the Federalist Papers, and it appears more often than the words democracy or even freedom).

Smith's popularity was not surprising. Our founders embraced the European Enlightenment and, the Scottish Enlightenment was a particularly secular version that. Scottish Enlightenment became popular in America (especially at Princeton where founding father James Madison and others were assuming this philosophy in our constitution) and might be considered our nonreligious moral foundation.

Even today, Smith remains influential for his economic theories, especially in the U.S. and U.K. However, Glory Liu teaches us that much of what we think we know and hold dear about Smith is not true. His narrative has slowly evolved in the last two centuries. And it is startling that his common image as the icon of American-style capitalism and free markets is simply not justified.

As Glory Liu describes, over a period of two centuries and as part of the American narrative, Smith was given credit for a new philosophy of political economy that was firmly associated with free trade. Eventually, the University of Chicago, Department of

Economics promoted this idea to the point of suggesting Smith as the genius who understood that enlightened self-interest was the key to the miracle of free markets. In other words, they claimed that Smith's invisible hand was propelled by greed. But that was just too convenient and as Liu explores the primary sources, she shows how we can recover Smith's original intentions and restore his reputation as a moral philosopher. Smith was much more nuanced. He understood human psychology and that self-interest was not driven simply by hyperrationality.

Smith argued there were certain circumstances in which government intervention might be necessary to improve the lives of the less wealthy. For example, Smith believed that government intervention was necessary to help ensure that the benefits of economic growth were more evenly distributed. He argued that the government should provide basic education and infrastructure and basic necessities like food and shelter, so that all members of society had the opportunity to participate in and benefit from the prosperous economy. And as a moral philosopher, he felt that government could nudge modern capitalism, achieving both wealth and general prosperity.

Oh yes, I did say that there was another reason for reading this book: Glory Liu is the daughter of Donald Liu, MD, whom many in our readership will know well. Dr. Liu is a renowned ocular plastics academic who spent portions of his career at the Doheny Eye Institute when it was part of the University of Southern California, later at the King Khalid Eye Hospital in Saudi Arabia and since 2001, at the University of Missouri. I knew Don well as a thoughtful and insightful intellectual, and it's not surprising to find these same traits in his daughter, Glory M. Liu, who is a fellow at Harvard University.

News from the Foundation

By Gregory L. Skuta, MD, Chair, Foundation Advisory Board

The Academy Foundation reached historically high fundraising totals during a challenging economic year. It is thanks to you, our donors, who gave back so generously that the foundation was able to support all of the major Academy programs and launch new ones. As your gifts make a positive impact on the lives of our patients, we raise a glass to you in 2023 with hope and confidence in the future!

At this time under the leadership of the Foundation Advisory Board, we are focused on raising funds to support two major initiatives, the Parke Center Campaign and the Minority Ophthalmology Mentoring Program.

THE PARKE CENTER

The Parke Center honors David W. Parke II, MD, Academy CEO from 2009 to 2022. The [Parke Center Campaign](#) will create a much-needed conference facility that will enhance the Academy's ability to build and strengthen relationships with ophthalmic leaders and key partners. We are delighted to announce that we are working with Tim Padovese, Ophthalmic Mutual Insurance Co. (OMIC) president and CEO, to design the new conference center. We look forward to updating you in the spring with more details. For more information, updates, and how to provide support, contact Tina McGovern, foundation executive director, at tmcgovern@aao.org or +1 415.581.8508.

MINORITY OPHTHALMOLOGY MENTORING PREPARES RESIDENCY APPLICANTS

Completing its fifth year and now supporting 225 students, the [Minority Ophthalmology Mentoring program](#) prepares students who are underrepresented in medicine to become competitive ophthalmology residency applicants. Over 390 ophthalmologists participate in the program as mentors, committee members, presenters for the Student Engagement Program and Zoom sessions, speakers promoting the program to medical students and champions who serve as liaisons at academic institutions. The February 1 match announcement revealed that all 16 students in the Minority Ophthalmology Mentoring program who applied for residencies this year were matched – for the first time.



Students from the Class of 2022 at Student Engagement Weekend in Chicago.

News From the Foundation

New for 2023, the program will focus solely on M1 students to enter the program and align with their journey through medical school. This will allow a cohort of students to progress through the program as they move through medical school and have the unique support that each year requires. The program will announce the Class of 2023 in March. Learn more at aao.org/mentoring.

ANNOUNCING A NEW WAY TO GIVE BACK

This past year, the foundation created a new [Recurring Gift Program](#). What's a recurring gift? Recurring giving is when a donor elects to make a regular, ongoing donation to our organization instead of a one-time gift. This program allows both new and seasoned donors to give any amount on a monthly or quarterly basis. It is a "latte a day" concept, painless and generous at the same time. You will be acknowledged by name in our annual report in the fall. Thank you in advance for your support!

ESTABLISH YOUR LEGACY WITH A PLANNED GIFT

The [1896 Legacy Society](#), named for the year the Academy was founded, is a special group of donors who have included the foundation in their estate plans through cash gifts, bequests or other planned gifts. These 1896 Legacy Society members are integral to the Academy's mission and are regularly informed of our achievements, challenges and future plans. Members are recognized through invitations to our annual donor reception and other events, and by acknowledgment in the foundation's annual report, on our website and on the donor wall at the annual meeting. We would be honored to count you among its members.

Naming the American Academy of Ophthalmology Foundation in your will with the flexibility

to change can be done in as little as [one sentence](#). This type of donation to the Academy Foundation in your will or living trust helps ensure that we continue our mission for years to come.

FOUNDATION'S FUNDRAISER CELEBRATES ITS 20TH ANNIVERSARY

Join Chair Christie L. Morse, MD, and the 2023 committee to celebrate during the annual meeting in San Francisco on Sunday, Nov. 5. This will include a toast to the Academy's 2023 Artemis Award recipient by the Senior Ophthalmologist Committee who selects the awardee. The Academy's Leadership Development Program (LDP) will be the beneficiary of this year's fundraising. More details to come. Save the date for this unique, fun party to raise funds while you raise a glass.



Examples of touch exhibits built by 3DPhotoworks.

MUSEUM OF THE EYE TACTILE EXHIBITS

The Truhlsen-Marmor Museum of the Eye® has announced plans for new tactile exhibits. The 3D tactile exhibits are designed for all visitors but especially accessible to those who are blind or have low vision. They will consist of full-color images printed, framed and hung on gallery walls. The images are rendered in plastic with raised edges and different textures. The new exhibits will provide an enhanced experience for all museum guests. Donations to the Museum of the Eye will ensure that each gallery has a dynamic, hands-on learning exhibit to amplify the wonder of our profession.

SCOPE

The Senior Ophthalmologist Newsletter

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

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