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SCOPE

David William Parke, MD
Nov. 19, 1922 – Nov. 13, 2020

By M. Bruce Shields, MD

It is not the general policy of *Scope* to acknowledge the passing of our colleagues. But there is one person without whom this newsletter might not exist today. For 14 years, David W. Parke, MD devoted his time and talents to shepherding and growing the *Scope* newsletter, a publication we senior ophthalmologists continue to enjoy.

Although his work with *Scope* was a major contribution to our profession, it is only one of countless accomplishments in his remarkable life of nearly 98 years (he missed it by one week). His many accomplishments are outlined in the obituary prepared by his son, Academy CEO David W. Parke II, MD; his daughter Marna Borgstrom, CEO of Yale-New Haven Health and Yale-New Haven Hospital; and Lucian Del Priore, MD, chair of the Yale University Department of Ophthalmology and Visual Science.

As with so many of his friends and colleagues, it is a personal loss for me. He was a cherished colleague, friend and inspiration ever since my wife and I came to Yale in 1996. He and his wife, Joyce (who preceded him in death by 12 years), were among the first to welcome us into their home upon our arrival. Our department needed a low vision clinic, and Dave (as he preferred to be called) not only helped us raise funds for it through the Lions Club, but also volunteered to set up and run the clinic, which he did faithfully for nearly 20 years.

David William Parke, MD

I have saved most of the back issues of *Scope* and, when I learned of Dave's passing, I got them out and looked through the ones when he was editor. It reminded me of how much he contributed to the newsletter and how he set a standard of excellence that has been a challenge for those of us who have followed him. He personally wrote many of the articles in each issue and insured a level of quality in all the articles he approved and edited, notably those from his two excellent associate editors, Drs. W. Banks Anderson Jr. and the late William S. Tasman.

I especially enjoyed reading his thoughtful editorials. One that has stayed with me over the years was the editorial he wrote in the Summer 2013 issue titled "Roles." In it, he recalls the ups and downs of raising three children with their "emerging desire for independence" and the often-heard refrain. "I do it myself," as he put it. Of course, all three went on to be remarkably successful, and then there were grandchildren and great-grandchildren with more success.

David William Parke, MD

His editorial fast-forwards to a day when we were honored to have his son David come to Yale as a visiting professor and speak at our grand rounds. Of course, Dave was in the audience with Marna by his side. Over the years, the roles had reversed, and the children now cared for their father, somewhat to his irritation. So, as David helped his father to a waiting car, Dave

I consider how blessed all who knew him have been – to have had our lives touched by a gentleman of such good humor, compassion, humility and integrity.

was tempted to say, "I do it myself." But I'll let him tell the rest from the final words of his editorial.

"My first impulse was to pull away, but then a warm feeling came over me as I remembered the little boy whose hand I had held when we crossed the street many years ago. He opened the door for me, and as I sat down, he reached in and gave me a gentle kiss on the cheek as he said goodbye. What a role reversal! A tear ran down my cheek."

And I feel a tear welling in my eye, as I consider how blessed I have been – how blessed all who knew him have been – to have had our lives touched by a gentleman of such good humor, compassion, humility and integrity.

To those who might be interested, you may also make a donation to an Academy program in Dr. Parke's memory.

Pictured left to right – Academy 2021 President, Tamara R. Fountain, MD; David W. Parke, MD; and Susan H. Day, MD at the 2015 SO Committee Retreat.

2015 Senior Ophthalmologist (SO) Committee Retreat.

David W. Parke, II, MD, Academy CEO and David W. Parke, MD pictured at a family fly fishing trip.

From the Editor's Desk

New Blood for the New Year

By M. Bruce Shields, MD

As we enter a new year (mercifully, some might say), I am pleased to announce that *Scope* is also entering an exciting new phase with the appointment of Alfredo A. Sadun, MD, PhD, as editor of *Scope,* our newsletter for the senior ophthalmologist.

This will be a wonderful shot of new blood for our publication, since Dr. Sadun is truly a Renaissance man, with a breadth and depth of knowledge that I have seen in few people. I am looking forward to the new directions he may take our newsletter, and I wish him the very best in his new role.

It has been a privilege for me to serve as editor of *Scope,* especially because of all the generous and talented colleagues with whom I was fortunate to work. During my tenure, we introduced several new features, none of which would have been possible without the help of these individuals. Our "Ophthalmic History" series, which is one of the highlights of the newsletter for many of us, has been ably edited by Daniel. M. Albert, MD, MS, who was initially assisted by Donald L. Blanchard, MD, and more recently by Ms. Jane Shull. Dr. Albert also introduced the intriguing feature, "Notable Dates in Ophthalmic History". I wish to sincerely thank Dr. Albert and his colleagues and am pleased to report that he has agreed to continue his contributions to *Scope.*

Another regular feature that has been well received is our book review series, which has been edited by Thomas S. Harbin, MD, MBA. Dr. Harbin and I are grateful to our many colleagues who have shared with us their favorite non-ophthalmic books, and I thank Dr. Harbin for this contribution and am delighted that this feature will also continue to appear in our newsletter.

Alfredo A. Sadun, MD, PhD - 2021 Editor of *Scope.*

It has been a special pleasure for me to write the "What We Are Doing Today" series, which has revealed how many talented colleagues we have, not only as outstanding ophthalmologists, but also their avocation. *Scope* has included artists, photographers, world travelers, musicians, a writer of crossword puzzles, cabinet maker, collector of ophthalmic artifacts, documenter of bird life, dog breeder and student of Sanskrit. More recently, we have explored the nonscientific writing talents of our colleagues in the "What We Are Writing" series, and I am grateful to all these individuals who shared aspects of their special talents with us.

I also want to sincerely thank all those who have written articles for *Scope*, most of whom have been members of the Senior Ophthalmologist Committee of our Academy. A very special thanks to W. Banks Anderson Jr., MD, and the late William S. Tasman, MD, who were associate editors of *Scope* long before I became editor and who continued for many years to grace us with their wisdom and wit.

And a most sincere thanks to Neeshah Azam and her colleagues at the Academy, including Gail Schmidt, Psyche Pascual, Lourdes Nadon and Jim Frew, without whom I can guarantee you this newsletter would never happen. It has been a joy to work with them, and I know that Dr. Sadun will continue to profit from their talents.

Finally, I wish to thank you our readers for your generous acceptance of *Scope.* Many of you have provided comments and other content, and I encourage you to continue doing so, since this is our newsletter, to be shared and enjoyed by all senior ophthalmologists. It has been my privilege to be a part of it, and I wish each of you the very best.

Susan H. Day, MD: A Life of Medicine, Music and Repotting

By M. Bruce Shields, MD

"Everyone needs repotting times." Those words were once spoken by Dr. Jerry Bateman to a young ophthalmologist, who would take them to heart and follow her life trajectory, from a love of music to ophthalmic practice and teaching, medical ethics, assurance of quality international health care and eventually back to her music.

Such is the unfolding world of Susan H. Day, MD, who continues to bring joy and wisdom to each life she touches.

Dr. Day was born in Shreveport, La., and grew up in a house filled with music. Her mother played the piano and was the accompanist for a glee club in which her parents met. Her father also played the piano, as well as the carillon in the Rockefeller Chapel at the University of Chicago, and later became professor of music education at Louisiana State University. With such a family background, a life in music seemed to be her destination. At a young age, Dr. Day began to study piano, play the flute and sing in her church choir. But it turned out that her early experience in music may have been what led her to consider a career in medicine, when a female pediatrician in the choir took the young Day under her wing.

Still uncertain about her future, Dr. Day entered LSU with a major in zoology and a minor in music. But a fascination with embryology and comparative anatomy, as well as a part-time job as a surgical technician, soon convinced her where her true destination lay: her first "repotting," as it were. So, after graduating magna cum laude, she matriculated at the LSU School of Medicine, where she earned her MD. Her experiences during those years also convinced her that she wanted to be an ophthalmologist. But this led to a rude awakening, when she learned how difficult it was for women to be considered for positions in surgical fields in the southeast United States during the 1970s. It turned out to be a blessing in disguise, however, since it led to one of the most important repottings of her life.

Susan H. Day, MD

San Francisco in the 1970s was barely on the map for a young lady from Louisiana, but during a fortuitous trip there with the LSU band, to play at the East-West Shriner's game, she was captivated by the beauty of the region that would eventually become her new home. She returned a few years later for an internship at Letterman Army Medical Center and then her ophthalmology residency at Pacific Medical Center (now California Pacific Medical Center). She recalls the serendipity of entering "the elite worlds of Drs. Bob Shaffer, Bruce Spivey, Bill Spencer, Art Jampolsky, Alan Scott and Bob Stamper." These luminaries of our profession helped shape her career in such a way that her name would one day be added to that list.

After her residency, Dr. Day completed two fellowships in pediatric ophthalmology and strabismus at The Hospital for Sick Children in London, with David Taylor, and at the University of Iowa, with Dr. Bill Scott. She then returned to her new home in San Francisco, where, with the exception of a brief time at King Khaled Eye Specialty Hospital in Riyadh, Saudi Arabia, she would remain throughout her ophthalmic career. In 1981, she joined the faculty at CPMC as service chief for pediatric ophthalmology and strabismus. She became program director for the residency in 1997 and was appointed chair of the department three years later.

During her years in ophthalmology, Dr. Day rose to international prominence as a clinician and surgeon, an educator, administrator

Susan H. Day, MD

and a leader of our profession. She served as president of the American Academy of Ophthalmology, the American Ophthalmological Society, American University Professors in Ophthalmology and the American Association for Pediatric Ophthalmology and Strabismus, and was the chair or member of numerous other organizations and committees. It was my pleasure to serve with her on the American Board of Ophthalmology's Board of Directors and the Academy's Senior Ophthalmologist Committee, which she chaired for many years. During these and other encounters with her, I came to love her bright spirit and warm sense of humor, both of which bring joy wherever she goes.

Dr. Day has been in constant demand nationally and internationally as a visiting professor and guest lecturer, which includes 17 named lectures. She has published extensively in her chosen field of pediatric ophthalmology and strabismus and has been the recipient of numerous honors and awards, including the AOS Lucien Howe Medal, the Academy and AAPOS Lifetime Achievement Awards and the Academy's EnergEYES Award.

In 2014, Dr. Day sensed that it was time for another repotting. With a passion for medical ethics, education, standard-setting and quality assurance in health care both nationally and internationally, she could not resist when the president and CEO of the Accreditation Council of Graduate Medical Education, Dr. Thomas Nasca, offered her a leadership position to help other countries create their accreditation programs. She soon learned that graduate medical education internationally is "the wild, wild west," with widely disparate standards, and that there was a great need for her services. Over the next six years, she would travel 250,000 to 300,000 miles annually to countries around the world: from Vietnam to Saudi Arabia, Guatemala to Finland, Singapore to Haiti and many, many more. Possibly the biggest sacrifice was leaving her beloved San Francisco to be near the ACGME headquarters in Chicago. But she maintained her home in the Golden State, always with the thought of one day returning.

Susan H. Day, MD playing the flute. Photo taken by Dr. Ralph Eagle, archivist. Image courtesy of the American Ophthalmological Society.

And now, as Dr. Day contemplates yet another repotting, her thoughts return to her love of music, but this time to combine it with her passion for medicine. Throughout her career in ophthalmology and medical education, music remained an important part of her life. During medical school, she played in a woodwind quintet and later joined a group of ophthalmology musicians who provided noontime concerts for many years during the Academy's annual meetings. Her most memorable musical experience came in 1982, when she performed Mozart's D major concerto in Davies Hall with the San Francisco Symphony.

Dr. Day has decided to step down from her position at ACGME, which will become effective at the end of July, 2021. She has been accepted to the Schulich School of Music of McGill University, where she plans to immerse herself for the next few years in studying the science of music with the goal of combining medicine with music.

"I would like to take on a project where both disciplines are essential to make a contribution," she said. "Specifically, I'd like to explore how musical aptitude develops in people with congenital blindness." She will continue to play the flute and learn piano to a greater depth, but as for singing, she says, "That will most likely be limited to leading choruses of Happy Birthday."

And so, the remarkable life of Dr. Susan Day continues to unfold with multiple repottings. And, although it is hard to say precisely where this new chapter will lead, two things are clear. She will continue to bring joy to the lives of others through her dedication to medicine and music. And she will eventually return to her beloved home by the Bay.

Twenty-Five Years Behind Bars: Treating Patients Inside Massachusetts Prisons

By Jean E. Ramsey, MD, MPH

I'm not going to tell you stories about the terrible things that may happen inside the prisons … although you do hear and see a lot over a 25-year period. I'm not going to tell you how difficult the inmates are … because most are not. I am not going to tell you how scary it is inside a prison … because I don't feel scared when I am there.

The story I have to tell is about a grateful population of patients, and a team of correctional officers and medical staff that make it possible to care for inmates in a prison ophthalmology clinic. I hope what follows will answer some of the questions I have been asked through the years about working within the prison system.

First of all, I am the on-site prison ophthalmologist in Massachusetts. I don't go to the jails, just prisons. Most people in jail are awaiting trial or have been convicted of minor crimes. I go to prisons where people have been tried and convicted of more serious crimes. Consequently, many of the inmates have lengthy prison sentences and I have managed their eye care for many years.

I remember well the first time I entered the prison. I had to wait to be allowed entry into the institution, as I was unknown to security staff. I was not able to proceed into the facility until the clearance authorization was verified and the paperwork completed. Once cleared, I was herded through security with a large group of staff and correctional officers who were about to start their shifts. I learned that day that you don't refer to the correctional officers as guards. Good to learn that early.

I was then subject to a visitor search: the officer went through a detailed inspection of my exam bag and personal belongings. I was patted down and instructed to walk through the metal detector. I then had to wait for someone to escort me through the grounds to the health service unit. They gave me a visitor ID tag, which I attached to my jacket. I was instructed to never lose that tag or else "something" would happen. "Something" was later described to me as a shutdown of the entire prison site as all visitor tags needed to be accounted for. Maybe the officers just wanted to get the point across to a newbie, but it worked. The importance of securing that tag left a lasting impression on me.

Jean E. Ramsey, MD, MPH

As I entered the prison site I was struck by the number of locked doors and gates I had to walk through in order to reach my destination. I would count them. There were between six and eleven locked doors/gates between the entry point and my final destination. The exact number varied depending on where I was going. Traveling to the disciplinary unit, for instance, inevitably added at least six additional doors/gates to that final number. I found myself thinking that a prison is probably not a good place for someone who suffers from claustrophobia.

The grounds were well-kept but barren. There was a large area with multiple identical block buildings for inmate housing. I did not walk past that area. But I did walk past the culinary area for staff and inmates with the unmistakable smell of breakfast being cooked. The inmates were in single file as they prepared to enter the "chow hall." The line of inmates obstructed the walkway, but as I approached the inmates would clear a path for me to walk through. Officers were positioned throughout the area, and regularly patted down the inmates.

Upon entering the health service unit, I was dismayed by the gray-

ness of it all: the gray floors, walls, clothing, the disheveled men in the inpatient ward, some in bed, some in wheelchairs, some walking around, and the emaciated patients — patients dying of AIDS. I remember thinking, "Where are the colorful get-well cards?" It seemed like a terrible and lonely way to die. But these AIDS patients were the reason I was there. The Department of Corrections' health care team had sought me out to examine the eyes of these very sick HIV patients.

That was 25 years ago. Things have changed since then. My responsibilities quickly expanded from AIDS patients to comprehensive ophthalmology services, and from one prison site to nearly all prison sites throughout the state of Massachusetts. I no longer have to routinely wait for entry into the facility. I now possess a Department of Corrections ID, and I go through security like other staff and correctional officers, with no special modifications. The exception is if I happen to be the "search of the day."

In that case, I would be subject to a more detailed security clearance process, similar to what I experienced in the early days. I have learned the rules, and there are a lot of them: rules specifying what types of bags can be carried into the facility, what size coffee cup is allowed entry, what is considered "contraband" such as paper clips, binder clips and pens. Cell phones are typically not allowed in the institution. Rules vary somewhat by prison site, and they often change, so you learn to be flexible and patient. I no longer need to be escorted through the facility. I know the facility, the staff, correctional officers, and they know me. They call me "doc." I don't need a visitor pass, so I don't have to worry about losing the pass. (It is funny how some things stick in your mind.)

Nearly all of my scheduled patients will typically show up for their appointments with me. There

are 15 to 30 patients scheduled. The inmates are held in the health unit "cage" until I call for them. The correctional officer assigned to the clinic does a "pat down" on each inmate prior to entering the exam room. The hours for clinic are limited as the inmates need to return to their units in time for "count," which occurs at a regular time each day.

I recall only one episode during my 25 years of caring for prison inmates when I experienced a fleeting concern for my safety.

No movement is allowed throughout the institution during count time until "count clears," indicating that all prisoners are accounted for.

Some people are surprised to learn that I spend most of my exam time alone with the inmates and that generally they are not in restraints. After all, when inmates are seen in the outside hospital clinics, they are likely to be in restraints and accompanied by multiple officers. Inside the prison, the correctional officers are immediately available should they be needed. Restraints are primarily placed on inmates from the disciplinary units, who are also escorted by multiple correctional officers. I have felt safe with my patients in prison.

I recall only one episode during my 25 years of caring for prison inmates when I experienced a fleeting concern for my safety. A patient with a history of mental illness and a phthisical (dying) eye insisted that I restore the vision in his phthisical eye. While I focused on trying to reassure him about the good vision in his seeing eye, he became increasingly agitated and angry and demanded that I immediately fix the vision in the dying eye.

Unable to relieve his anxiety, I backed out of the exam room. As a routine precautionary measure, I stand between the patient and the door during my visits with patients. Some of the prisons have red emergency buttons on the wall. On one occasion, I mistakenly pressed the red button outside the bathroom, thinking it was a light switch for the bathroom. Eight to ten correctional officers appeared almost instantaneously from seemingly nowhere. That was a big surprise

and slightly embarrassing, as I had obviously created a false alarm. The officers had good spirits about it, reassuring me that things like this happened and they were there to protect us. As I think about it, I imagine they were probably relieved that it was not a true emergency.

Although many of the inmates appear disheveled, it is not infrequent for an inmate to present to the on-site ophthalmology clinic freshly showered with clean clothes in anticipation of their visit with me. They are very respectful and express appreciation for my care. I have followed many of these patients for 10 to 20 plus years. The most common disease I see in prison is glaucoma. These patients are ready for my questions because I ask them every visit, "Are you having any trouble getting your drops?" and "Are you ever without drops?" Then I move to the more standard questions: "What drops are you using? How many times a day do you put them in? How often do you forget to put them in?" We have regular discussions about the importance of using eye drops.

In any institutional setting, there is a lot that can go awry in the process of ordering, receiving and dispensing medications that is beyond the control of the patient. But prison adds an additional list of unpredictable obstacles: unit and cell searches, lockdowns, transfers, disciplinary unit admissions and more. Eye drops may get lost or be temporarily unavailable to the patient after a move, or during disciplinary segregation.

All this can make it difficult for patients to strictly adhere to the medication plan. I typically schedule many patients to see me sooner than might otherwise be necessary for the sole purpose of checking on the status of their medications and their adherence to the medication plan. Taking care of prison patients necessitates interacting with numerous systems

and processes that can be challenging and frustrating at times.

People often ask me if I know what crimes an inmate has committed. I do not know because I choose not to know. Early in my prison work an event occurred while working in the prison dedicated to inmates who have been determined to be sexually dangerous.

I mistakenly pressed the red button outside the bathroom, thinking it was a light switch for the bathroom. Eight to ten correctional officers appeared almost instantaneously from seemingly nowhere.

Once while waiting for a patient to arrive, I scanned a page of his paper chart that was opened to information about his criminal background. It outlined details of the inmate's molestation of a young child. It was then that I made the decision to avoid any knowledge of a patient's criminal background. I was concerned that my knowledge of an inmate's crime could unwittingly affect my care of the patient. It is my firm ethical and professional belief that my job is to give these inmates, and all patients, the best possible care that I can.

I do believe that the inmates are grateful for the care they receive. Although many start with a distrust of the system, I do my best to reassure them and hopefully a trusting relationship evolves. Recently, the inmates heard a false rumor that I might be leaving the position that allows me to visit prisons. Word of this apparently spread and one after another of the inmates expressed their gratitude, their concern and their fear. "What are we going to do without you?" was a common concern expressed, some with tears in their eyes.

Over 25 years, I have learned a lot about the prison system, the inmates and the people that keep it running. The on-site ophthalmology clinic has allowed more inmates to get the eye care that they need. I hope my work may inspire others in ophthalmology to care for this special population of patients, a population that needs to be seen, even if they are often kept out of sight.

J. Donald M. Gass, MD: Physician, Scholar, Teacher & Mentor

By Anita Agarwal, MD

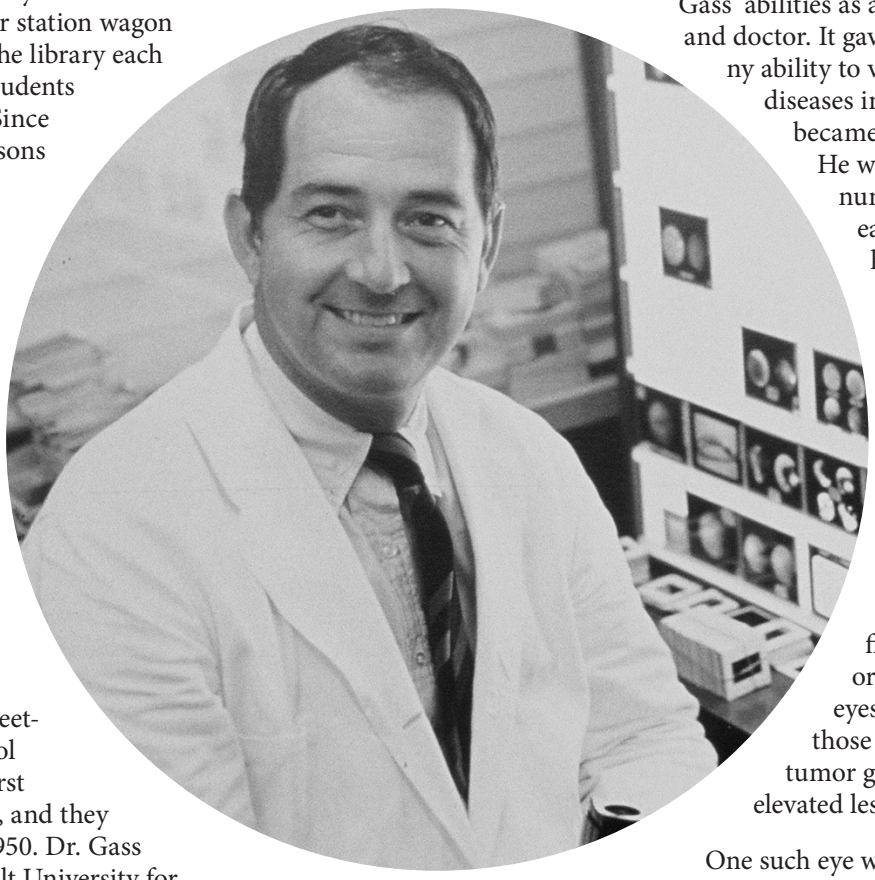
J. Donald "Don" M. Gass, MD, is one of the most influential ophthalmologists of the 20th century.

Dr. Gass was born on Aug. 2, 1928 on Prince Edward Island, Canada to a physician father and an attorney mother. His father was the head of tuberculosis hospitals in Tennessee at that time. He rode a train with his mother at age of 2 weeks to Nashville, where he grew up and attended the two-room Grassland primary school. It housed three grades in each room.

He credits his love for reading and learning to a primary school teacher who used to fill her station wagon with books from the library each week so that the students could read them. Since three grades of lessons were taught in the same classroom, Dr. Gass was easily proficient in the higher-grade lessons that left him a lot of time to read and learn outside his schoolwork. This was the foundation for his super abilities.

Dr. Gass met Margy Ann Loser, his high school sweetheart, on the school bus. She was his first date and only love, and they were married in 1950. Dr. Gass attended Vanderbilt University for his undergraduate education. His plan was to enroll in engineering school at Vanderbilt, and when he arrived for admission, there was a shorter line for arts and science. If the engineering line was shorter, we may have only known him from a distance as a brilliant engineer. He graduated with high honors in 1950 and soon after was enlisted in the Navy and served in the Korean war.

On his return from the war, Dr. Gass and his wife lived for a short while in San Diego, Calif., where their first child John was born. Finishing his tenure in the Navy, he entered medical school at Vanderbilt and graduated with the highest honor, the founder's medal. Dr. Anderson Spickard, his medical school classmate and professor of internal medicine at Vanderbilt recalls, Dr. Gass had the best notes in their medical school class, and everyone wanted to borrow them. Their second son Carlton was born in Nashville while Dr. Gass was in medical school.



J. Donald M. Gass, MD, pictured with his slides on the view box.

Dr. Gass completed an internship at the University of Iowa and moved to Johns Hopkins for his ophthalmology residency. Media, their daughter, was born during his time in Baltimore.

At Johns Hopkins, he idolized Frank Walsh, MD, the most distinguished neuro-ophthalmologist of the time. As a resident, Dr. Gass wrote many papers, ranging from corneal iron lines to Waardenburg's syndrome. He was chosen chief resident at Johns Hopkins and completed an ocular pathology fellowship at Armed Forces Institute of Pathology (AFIP), between his residency and chief residency.

This ocular pathology fellowship was the perfect blend to young Dr. Gass' abilities as a clinician, scientist and doctor. It gave him the uncanny ability to visualize retinal diseases in layers and he became a 'master' at that. He went on to describe numerous new diseases throughout his career with his knowledge of ocular pathology. An early example is choroidal osteoma. Fundus cameras were not common in the early '60s and people handmade drawings of clinical findings with elaborate notes. Many eyes were enucleated those days for fear of tumor growth when elevated lesions were seen.

One such eye was sent to the AFIP during Dr. Gass' fellowship. He learned that the lesion had thin cancellous bone in the choroid, the Haversian system of canals with blood vessels were also present and these vessels emerged on the surface resembling spiders. In the mid-1960s, as a young faculty member

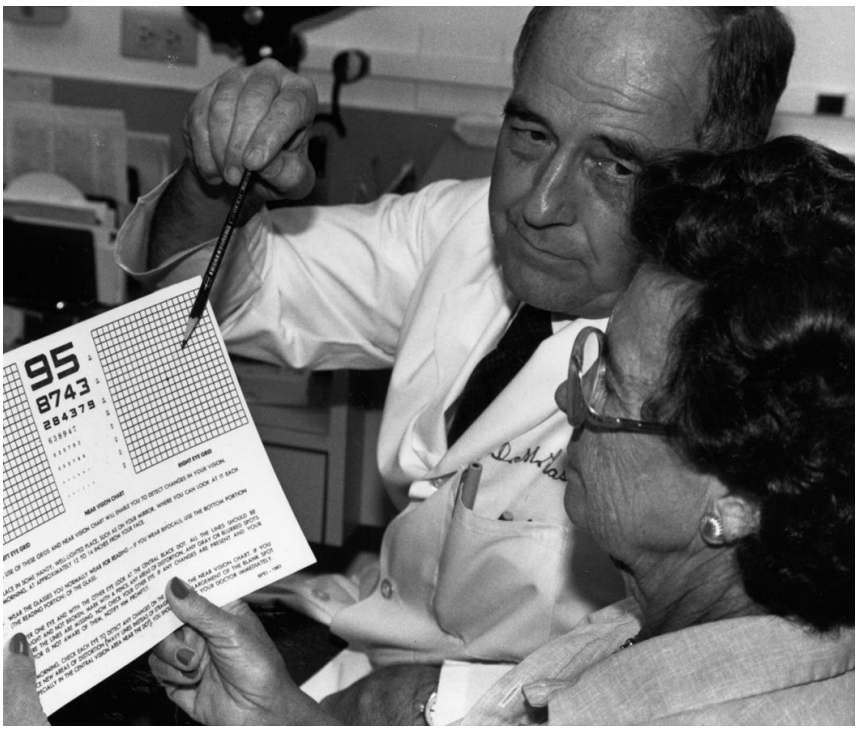
J. Donald M. Gass, MD

at Bascom Palmer Eye Institute, he saw a patient with a yellow- orange elevated lesion, on the surface of which he noted spider vessels. He sent the patient to the radiology department for a plain X-ray of the skull looking for bone in the orbit. When the radiology report returned as normal, he walked over to review the X-ray himself and saw the fine, eggshell-like cancellous bone within the eye socket. Such were his clinical skills and ability to recall features in different patients and connect them up later.

Dr. Gass was recruited to the faculty of the University of Miami in 1963 by Dr. Ed Norton as a comprehensive ophthalmologist. He performed all types of intraocular surgery ranging from cataracts to glaucoma, lid and orbital procedures. Fundus and fluorescein angiography (FA) cameras were new additions to the eye department, along with Johnny Justice, a photographer who had spent a couple of years at the North Carolina Veterans Affairs hospital, (which also had housed a FA camera).

Pictured left to right: Drs. Alan Bird, Don Gass and Pierre Amalric reviewing a fluorescein film, 1968.

Dr. Norton suggested to Dr. Gass to see if the fluorescein camera could be used to study retinal diseases. Thus, was born his incredible journey into deep and masterful understanding of retinal diseases. He used his superior clinical examination skills; knowledge of ocular pathology and interpretation of the FA features to fully understand the clinical appearance and the pathogenesis of many retinal diseases. He went on to describe for the first time at least three dozen diseases and further understanding of many other previously recognized conditions.



Dr. Gass instructing a patient the method of using an Amsler grid.

When he described new retinal diseases, he named them with long descriptive names such as acute posterior multifocal placoid pigment epitheliopathy (APMPPE) or acute zonal occult outer retinopathy (AZOOR) that made it easy for the novice reader to know part of the disease process just by learning the title alone. He drew many illustrations and cartoons, as he called them, with details of his understanding of pathology within the retina and choroid. His drawings from more than three decades ago are now being substantiated by modern-day OCTs.

In 1984, he wrote a paper on his understanding and interpretation of Type 2 juxta foveolar telangiectasia with blood vessels dipping from the retina and growing through the photoreceptor layers towards the sub retinal space, thinning of the inner retina with loss of inner retinal cells, partial outer retinal holes or spaces; all of

which can be confirmed on present day OCT and OCTA images.

Dr. Gass' ability to completely focus on the problem at hand and delve into it wholly, made him successful in solving many clinical issues and conditions. His uncanny ability to find the minutest changes in the patient's fundus and the ability to remember similar features in other patients and to tie them together meaningfully has benefitted innumerable patients and physicians.

In addition to his brilliance in diagnosing and managing medical retinal diseases, he was a skillful surgeon and an innovator. He was practical and looked for simple ways to make surgical instruments more useful. He flattened the tip and made a hole in the "lens hook" that was used to hook extraocular muscles and pass the bridle sutures all in one sweep. When he was trying to decompress the vortex veins in an eye with idiopathic uveal effusion and ended up sacrificing the vein in very thick sclera, he came up with the idea to remove a significant layer of the sclera and make scleral windows that resolved the uveal effusion.

Gass family: John & Carlton (Top row) Media, Margy Ann, Donald Gass & Dean (bottom row).

Dr. Gass building a Model ship.

He spent three decades at the Bascom Palmer Eye Institute in Miami, from 1963 until 1995. His youngest son Dean was born in Miami. Dr. Gass along with Drs. Edward Norton, J. Lawton Smith, Victor Curtin and John Flynn were considered the five pillars of Bascom Palmer. Together they contributed to a significant fund of our knowledge of ocular diseases. Dr. Gass credited Dr. Norton for his unusual vision for the institute and its future. Dr. Norton's ability to raise funds and the foresight to acquire property around the institute, along with trusting his faculty and "giving them the ball to run with" made Bascom Palmer the most successful ophthalmic institute in the country.

Dr. Gass and Mrs. Gass moved back to Nashville, his home town and his alma mater Vanderbilt in fall 1995. He continued clinical practice and described and added to our understanding of retinal diseases while at Vanderbilt. Fellows and residents were attracted to the department with his arrival. To quote Dr. Denis O'Day, the chairman of ophthalmology at that time, "The image that will forever endure for me is the one I saw every week. It is of a man sitting, surrounded by colleagues, residents, students and fellows. All are peering at photographs of the retina and the conversation is animated; all are engaged. As I walk by, I recognize our singular good fortune in having such a true academician in our midst."

Dr. Gass credits his parents Mary and Dr. Royden Simpson Gass and his parents-in-law, Pearl Dean and J. Carlton Loser, for inspiration, support and help during their early days. Dr. Gass was not only a fabulous husband and father, ophthalmologist and teacher; he was creative and enjoyed his pastimes immensely. He loved fly fishing and river fishing, built many wooden toys for his grandchildren and other kids in his workshop attached to the garage. His attention to details while building model ships exemplifies his core nature. A kind and easygoing personality came naturally to him. He never delayed acknowledging any present or gift with a handwritten note to the giver: I witnessed this on innumerable occasions.

He was funny and could pull a trick or two on his fellows or compatriots. He once told me this: "In the days when we didn't know much about many retinal diseases, photos and [fluorescein angiography] were done often at every visit trying to figure out what the patient's diagnosis could be."

During a fluorescein conference when such a patient was presented,

and the presenter went on showing several fundus photographs and fluorescein images done at multiple times, up jumped Dr. Gass with a fluorescent green Halloween mask over his face and announced, "And then the patient began to look like this." Such was his humor. In another episode, while walking through the gift shop, he found a stick with a voodoo toy/skull attached to one end. He bought this and stuck it under his lab coat and went to grand rounds. When the patients with unknown diagnoses were presented, two older ophthalmologists at Bascom Palmer often said that they had a similar patient and that the patient went on a cruise or an exotic trip or had some obscure treatment and were cured. The next time they said something similar, Dr. Gass stood up with his voodoo stick and said that when he had a similar case, his voodoo doctor friend sent him this special stick and asked him to perform a dance that cured the patient. His eyes filled with laughter and enjoyment recalling those moments.

Whatever he was doing he immersed himself completely and enjoyed every minute of it. To quote his son John Gass, "One could see the twinkle in his eye and a satisfied smile in his face for a job well done."

Dr. Gass enjoyed sports, both playing and watching. He was known to hit the ball outside the park while playing softball at Bascom Palmer. The Baltimore Orioles were his favorite team. Many Monday lunches were spent discussing weekend sports events ranging from basketball to football and golf. He loved Michael Jordan and Tiger Woods for their capabilities and achievements. As a fellow, I was invited to his home in Nashville for every major sporting event – Super Bowl Sunday, college football finals and many others where we watched the game eating dinner and playing Super Bowl pool for minimal stakes, along with his daughter's family and grandkids. He was a great cook and enjoyed barbecuing and using slow smoking cooker. I spent many weekend evenings at their home enjoying the hospitality of Margy Ann and Dr. Gass.

Margy Ann Gass and Donald M. Gass at their home in Nashville.

Dr. Gass was a special gentleman with multifaceted skills and abilities. He contributed much to science and medicine at the same time devoting time to his family and pursuing his favorite past times. Whatever he was doing he immersed himself completely and enjoyed every minute of it. To quote his son John Gass, "One could see the twinkle in his eye and a satisfied smile in his face for a job well done." More than anything else, Dr. Gass contributed most to our knowledge and understanding of medical retinal diseases. He won every award and accolade that is known in ophthalmology and retina.

Dr. Gass was diagnosed with pancreatic cancer in June 2003, and his clinical practice had to be halted prematurely. In spite of the ravages of the illness and the effects of chemotherapy, he continued writing, rendering his thoughts and opinions of cases that colleagues from across the country and the world sent him and attending teaching fluorescein conferences. His enthusiasm for a new case, a novel finding or writing a letter to the editor about an article was unchanged; all of which he did during this period. He made it to the Academy's annual meeting in New Orleans in November 2004, where he was bestowed the Laureate award. Sadly, soon after, his health took a downturn, and he passed away on Feb. 26, 2005.

It is an honor to write about a man who was unusually brilliant and truly generous in many ways; he had great knowledge and skills and freely shared his thoughts and opinions. Most of all, he was a healer and a teacher who made each one of us a better doctor, a better teacher and a better human being.

Editor's Note: We are grateful to our History of Ophthalmology editor, Daniel M. Albert, MD, MS, and his editorial assistant, Ms. Jane Shull, who contributed to the editing of this article.

Algernon B. Reese, MD: A 5-foot-9 Giant in Ophthalmic Oncology in the 20th Century

By David H. Abramson, MD, FACS

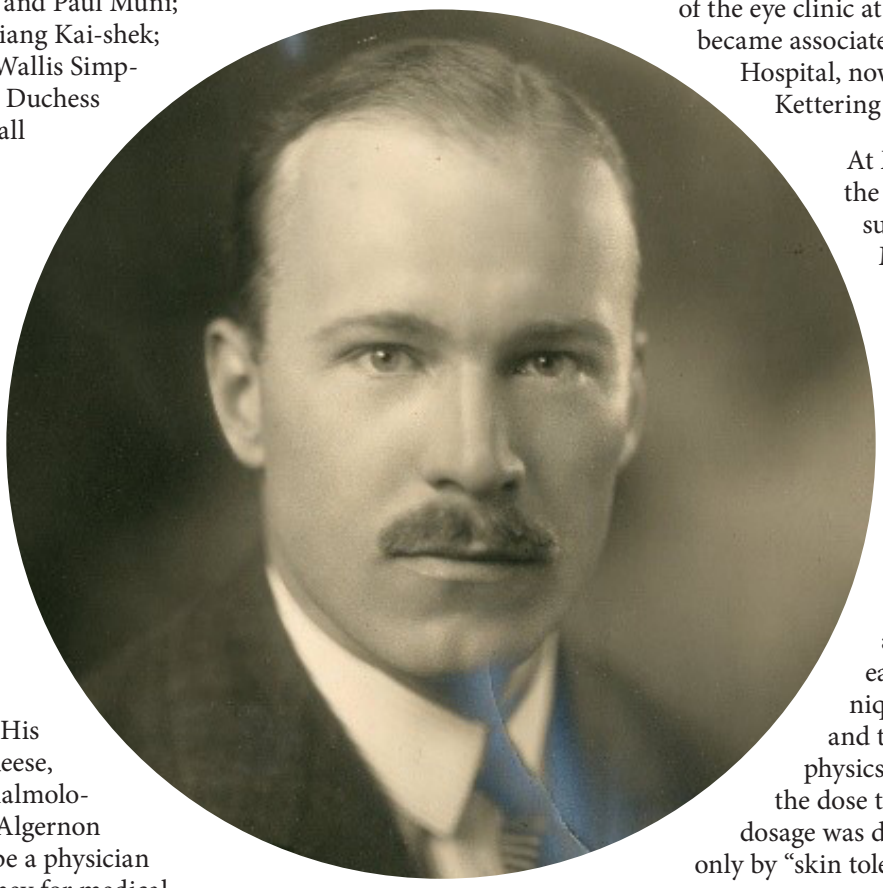
Algernon B. Reese, MD, dominated the world of ophthalmology in the 20th century, but his legacy lasts in the 21st century.

Dr. Reese believed in staying busy, working hard, always perfecting whatever he did, sharing thoughts and experience and being open always to new ideas and approaches. When he died at age 85 in 1981, everyone in ophthalmology knew him (or of him). His obituary in The New York Times emphasized his contributions, career and some of his most famous patients (no HIPAA then), including actors John Wayne, Bob Hope and Paul Muni; Chinese leader Chiang Kai-shek; Edward VIII and Wallis Simpson, the Duke and Duchess of Windsor; baseball legend Babe Ruth; composer George Gershwin and novelist Ernest Hemingway.

In some ways, Dr. Reese's life was planned for him, but despite the planning, it didn't go exactly as envisioned. He was born and raised in North Carolina where his father was a pharmacist. His uncle, Robert G. Reese, MD, was an ophthalmologist in New York. Algernon always wanted to be a physician but lacked the money for medical school so his family made a "deal" with his uncle: His uncle would loan them money for the cost of medical school in return for Dr. Reese joining him in practice in New York when he completed training.

After graduating from Davidson College in North Carolina in 1917 and Harvard Medical School in 1921, he did a surgical internship at the Roosevelt Hospital in New York (1922-23) followed by a residency at the New York Eye and Ear Infirmary in 1924-25.

In those days, the science of ophthalmology was pathology. Dr. Reese had developed an interest in pathology (his uncle's plan had included studying pathology with the "greats") so he spent six months in Boston with Verhoeff, followed by a year with Ernst Fuchs in Vienna, where he received a degree from the University of Vienna. In the fall of 1926 he returned to New York as planned, where he joined the private practice of his uncle, but the plans soon fell apart.



Portrait of Dr. Algernon B. Reese, circa mid-1930's. Reproduced with permission granted by the Historical Society of Western Virginia.

In October 1926, just months after starting, his Uncle Robert, then 61, died unexpectedly. Dr. Reese took over the busy Manhattan practice. He was adept at running the practice and from then on, according to one of his later associates, he never stopped. For the rest of his professional life he merged a private midtown practice with hospital appointments/obligations/titles and a very active surgical practice, all while doing his own pathology. He joined the New York Eye and Ear Infirmary, serving as chief of clinic and pathologist until 1932. He then joined the staff at Columbia for a year, then resigned to become chief of the eye clinic at Cornell, where he became associated with Memorial Hospital, now Memorial Sloan Kettering Cancer Center.

At Memorial he met the head and neck surgeon, Hayes Martin, MD, and together they began exploring the use of radiation for retinoblastoma. Radiation had been first reported to work in retinoblastoma treatment about 30 years earlier, but techniques were crude and there were no physics to help gauge the dose to deliver. Often, dosage was determined only by "skin tolerance."

At the time, radiation sources and energy gave a higher dose to the skin than to the eye and had a large penumbra, causing significant local toxicity. Although some patients were cured, few eyes sur-

Algernon B. Reese, MD

vived and even fewer survived with vision. With Dr. Hayes Martin, Dr. Reese learned how to modify the beam and aim it to lessen toxicity to structures, and to measure dose, improving success rates for saving eyes, eyesight and for a few — restoration to normal vision. Drs. Reese and Martin not only performed the radiation treatments themselves, often they also served as anesthesiologists for their pediatric patients.

In 1931, Dr. Reese resigned from the New York Eye and Ear Infirmary and Cornell positions to begin a lifelong association with Columbia University College of Physicians and Surgeons and the Eye Institute, where he rose to professor of ophthalmology and director of eye pathology. At Columbia he established the first clinic dedicated to retinoblastoma and each week in a basement room, he would examine children under anesthesia.

Dr. Reese's fame grew. Patients and visiting physicians came, he soon realized how difficult it was for families to come and stay in New York for exams and treatment. At his own expense, he purchased a townhouse near the hospital, where families could stay while in New York. The families were never charged for lodging, and his friends would clean and maintain the townhouse.

He would split his time between his private office and Columbia Presbyterian where he did his retinoblastoma work. While he was a true pioneer, he was always open to new ideas.

It must be remembered that Dr. Reese did almost all of his melanoma and retinoblastoma work with the direct ophthalmoscope in a time when there was no ophthalmic photography. At Columbia, he worked with a medical illustrator, Emil "Gus" Bethke, whom he taught how to use the slit lamp, gonioscope and ophthalmoscope. Bethke documented many of Dr. Reese's cases and his illustrations fill his famous textbook on tumors. Later, I had the opportunity to appreciate how accurate these drawings were.

Algernon B. Reese knew from a young age that he wanted to be a physician. Image and permission to reproduce provided by Algernon B. Reese III.

While writing a treatise on retinoblastoma, I came across the record of a patient whose retinoblastoma had been successfully treated with diathermy by Charles Perera, MD, and illustrated by Bethke. I examined that patient 50 years after his previous treatment and — using modern ophthalmic imaging — I was able to photograph the eye and ora seratta. When I compared my photos with Bethke's illustrations 50 years later, I realized that he had depicted the ora precisely as it was … not as the usual "sawtooth" filled in by most other illustrators.

Even though Dr. Reese had great confidence in his skills, knowledge and abilities, he was always open to new things. For example, he immediately realized the benefits of the newly designed indirect ophthalmoscope. Dr. Reese was in his 60's when it became popular in the U.S., he quickly learned and perfected its use.

Columbia's mandatory retirement age of 65 for surgery required Dr. Reese to cease performing surgery in 1962. I entered the Eye Institute in 1970. In those days the entering residents began the residency in a rotating fashion: each on four months after the other. I was assigned the extra year. Fortunately, D. Jackson Coleman, MD, kindly invited me to join his pioneering work on ultrasound for a year.

Dr. Coleman encouraged me to explore what was afoot in the Eye Institute, and I met, Robert M. Ellsworth, MD, who was pursuing Dr. Reese's retinoblastoma work. One day, I walked past an open, unmarked door. There — stooped over a microscope — was an older man. He said he was working on a book.

"It's about tumors of the eye," he said. He was searching slides for material to use for the third and final edition of his legendary book, to which I still refer, "Tumors of the Eye." I told him about our work with ultrasound in the diagnosis of ocular tumors.

Algernon B. Reese, MD

"Would you like to write a chapter for my book?" he asked. I was stunned! He did not know me nor anything about ultrasound, but immediately recognized ultrasound's potential value to the work.

"I don't know anything about tumors," I said.

To which he replied: "You'll learn!"

He taught me about tumors and I taught him about ultrasound. When his book was finally published, I was shocked that he acknowledged me for my contribution to his book.

Dr. Reese received many honors and awards in our field and lectured extensively. He always worked to make organizations better and to help his fellow physicians. He was a charter member of the Verhoeff Society, president of the American Academy of Ophthalmology and Otolaryngology in 1955, chairman of the AMA Section of Ophthalmology in 1966-67, president of the American Ophthalmological Society (AOS) in 1960 and chairman of the American Board of Ophthalmology in 1960.

He sponsored countless American and international fellows, published more than 200 peer reviewed papers and published his first book, "Tumors of the Eye" in 1951. Dr. Reese never sat on his laurels. He revised and republished the book again in 1963 and the last edition — the one to which I contributed — in 1977.

Although Dr. Reese is best remembered for his work on uveal melanoma and retinoblastoma, he was a prolific surgeon who had extensive experience with surface ocular malignancies, periocular malignancies, orbital tumors and a fascination with PHPV (PFV). Interestingly his AOS thesis was "Peripapillary Detachment of the Retina Accompanying Papilledema." His Jackson Lecture was on PHPV.

Pictured from left to right: Dr. Ellsworth, Dr. Reese and Dr. Abramson. Image source and permission to reproduce by author, David H. Abramson, MD, FACS.

Prior to the use of radiation for retinoblastoma, the standard practice was to remove almost all eyes with retinoblastoma including bilateral enucleations. For most of the 20th century, the only way to save an eye with advanced disease (and vitreous seeds) was radiation. Children's lives were saved, eyes were saved and vision was often saved. In fact, retinoblastoma is the only solid tumor of childhood that can be cured with radiation alone!

Dr. Reese had perfected the techniques, established the dose, fractionation and portals and delivered some of it himself, but in 1955 he reported that — years after treatment — two of his patients had developed fatal cancers in the radiation field. In 1972, he and Bob Ellsworth, MD, encouraged me to spend time at the Armed Forces Institute of Pathology (AFIP), with Lorenz Zimmerman, MD, exploring these curious second cancers.

As a result, we realized that children with retinoblastoma had a genetic defect (this was more than 10 years before the gene was sequenced), which made them prone to developing subsequent cancers (we called "second cancers"). We also identified the exquisite sensitivity these children experienced to the harmful effects of radiation. In effect, we showed that radiation was a double-edged sword and that more children were dying from the second cancers than from the retinoblastoma itself. Reese immediately appreciated the dire consequences of radiation.

There was a nonophthalmic side to Dr. Reese, too. In college he played basketball and was the team captain. Throughout his life he enjoyed tennis, hiking and water sports. In his later years he took up golf with enthusiasm and used home movies to help his swing.

Perhaps because of his time spent in Europe he appreciated good food, wine, dancing — and then there was bridge! He loved bridge, read books on it, studied it and played regularly. He hosted parties for the staff at the Eye Institute and included a yearly golf tournament. He was a southern gentleman who never cursed, never boasted, was polite and respectful of all people.

And yes, he completely repaid his uncle's widow for the loan he received for medical school.

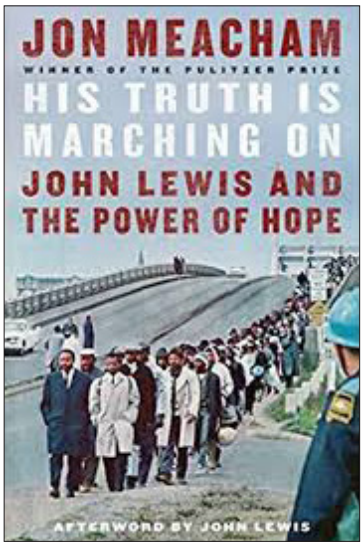
I stand on the shoulders of this giant who made me look taller.

Editor's Note: We are grateful to our History of Ophthalmology editor, Daniel M. Albert, MD, MS, and his editorial assistant, Ms. Jane Shull, who contributed to the editing of this article.

What We're Reading This Winter 2021

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

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



His Truth is Marching On: John Lewis and the Power of Hope
By Jon Meacham
Reviewed by M. Bruce Shields, MD

The tumultuous year of 2020 will go down in history for many reasons. One of those will be the passing of the civil rights icon and longtime U.S. congressman Rep. John Lewis, on July 17, 2020.

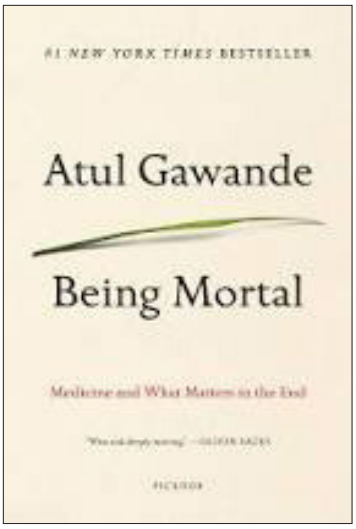
The significance of his contributions to racial justice in the twentieth and twenty-first centuries makes this account of his life by Pulitzer Prize-winning author Jon Meacham one of the most important books of the year.

Lewis was an advocate of nonviolence, a philosophy he learned from Martin Luther King Jr. and others. He also aspired to be a minister. As a child on his family's Alabama tenant farm, he preached to the chickens. In fact, his first act of nonviolence was refusing to eat them. At age 25, he participated in the march over Pettus Bridge in Selma, Ala., where he was beaten and taken to the hospital with a concussion. But he and the others returned two weeks later and completed the march from Selma to Montgomery (54 miles) in three days.

It is hard to imagine what it must be like to allow another person to beat you without retaliating and to even convince yourself that you love that person. But that is what Lewis and many others like him did repeatedly. He was jailed 40 times, five during his time in Congress, where he served with distinction for 34 years. In 2011, he received the Presidential Medal of Freedom.

It is hard to imagine what it must be like to allow another person to beat you without retaliating and to even convince yourself that you love that person. But that is what Lewis and many others like him did repeatedly.

If and when our country achieves true racial equality, it will be to the credit of men like Lewis. For those who hope for that day, I highly recommend Meacham's book.



Being Mortal
By Atul Gawande
Reviewed by Alfredo A. Sadun, MD, PhD

I am afraid of dying. And why not? I'm 70 and need to come to terms with that eventuality.

When I was younger, the issues of life and death had deep philosophical and psychological implications that I felt were overwhelming. Now, as I've learned more about life, it's less about these theoretical concerns and more about the ugly process.

This New York Times bestseller by practicing general surgeon Atul Gawande, MD, MPH, argues the point we've often heard: Quality of life should take priority over quantity of life. He offers models for assisting the infirm and the elderly, but more importantly, demonstrates that a person's last months can be elevated to maintain value and dignity.

The first half of "Being Mortal" was good, but it was largely sociology. It asked what's wrong with our society and health care systems and what remedies could be considered to better handle the challenges of people too old and too sick to take care of themselves. But it was the second half of the book that was profound as it ranged from philosophical to practical. The anecdotal stories were deeply moving but also grounded in evi-

What We're Reading

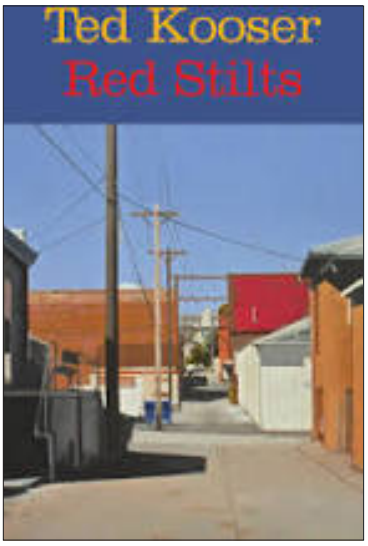
dence. I was surprised to find the answers to some problems that I had pondered much of my life.

For example, Gawande described the difference between transactional loyalty (which is bad, at least in excess) and loyalty to something grander than ourselves (church, community, country, idea). "Loyalty to causes that have nothing to do with self-interest …" is its own reward. And this gives life meaning, even when confronting the pain and loneliness of the final months of terminal illness. Gawande argues that the key to facing our mortality is to have a voice in facing it.

Orson Welles famously said, "You are born alone, and you die alone." This need not be true in the physical sense. The dying can and should feel their family connected and condensing around them. Yet maybe it is true in the deeper spiritual sense. You can hold hands, but at the end of the day, only one of you is gone, so it can't be a completely shared experience.

There is inherent loneliness in dying but that can be partly mitigated. As Woody Allen said, "It's not death I fear. It's the dying." Gawande did a masterful job explaining how we dread the loss of dignity, of control, of no longer being the author of our own narrative — that's all worth fearing. But much can be done to address this. And having read the book, I think I'll do a better job talking to my seriously ill patients. I'll stop to ask them what they hope for, what they fear, and what their priorities are. These are the three key questions for us to ask of them. And for us to ask our family members and, most importantly, to ask ourselves.

This is a good read for all, but especially for those who have family approaching their last decade and especially for physicians who may be called upon to help with difficult decisions. But it is also a guide and comfort for ourselves.



Red Stilts
By Ted Kooser
Reviewed by J. Kemper Campbell, MD

At 81, Pulitzer Prize-winning poet Ted Kooser seems as firmly rooted in the Nebraska landscape as the Bohemian Alps in which he resides.

Despite his recent second retirement from his teaching position at the University of Nebraska and as editor of his syndicated newspaper column, "American Life in Poetry," he continues to write daily. His 15th book of poetry, "Red Stilts," demonstrates that poets, like fine wines, continue to improve with age.

Poetry, perhaps more than any type of written communication, relies upon that invisible bond formed between author and audience. The emotions evoked by the poet in each reader are unique and result in a shared intimacy between the two.

Fittingly, this book begins with a letter from the poet to his readers. As the sights, sounds and ambiance of a summer night in a small town are carefully assembled, the reader discovers that the scene has been conjured entirely from the poet's nostalgia for an imaginary time. Fortunately, as his childhood footsteps fade into the night, he leaves the hint of his future return.

With his opening three-page letter the longest poem, the remaining short poems are divided into four sections corresponding to Midwestern seasons, beginning with those appropriate for Winter and ending with Autumn. Those familiar with Kooser's work will recognize his skill at connecting the ordinary events of daily life to the sublime.

His observations of a dead vole or a field mouse struggling in the talons of a red hawk will lead to meditations on the transitory nature of existence. A neighbor watering her petunias can remind readers of the beauty available in any of the mundane moments which, when connected, form our lives.

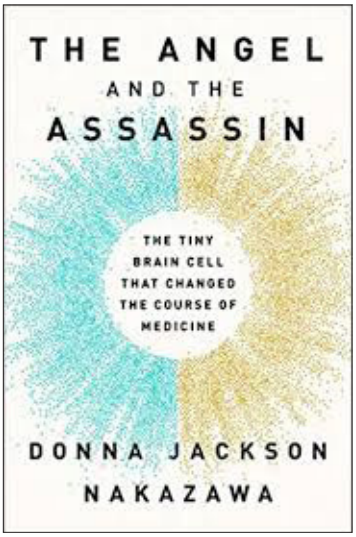
As the sights, sounds and ambiance of a summer night in a small town are carefully assembled, the reader discovers that the scene has been conjured entirely from the poet's nostalgia for an imaginary time.

An old man's mind, as this reviewer can verify, is able to recreate vanished scenes with a miraculous clarity. The footprints left in the morning snow by a father seventy years ago will remain untouched by the sunlight and a long gone, familiar Sherwin-Williams signboard retains its brilliant red hue. Rummaging through Kooser's memories is like visiting an antique store in which every corner yields a fresh delight.

As one of the truly accessible poets, Ted Kooser is the ideal com-

What We're Reading

panion for those plagued by the anxieties of the pandemic. Keeping this slim volume at bedside for re-reading will soothe the jangled nerves unleashed by the daily news. Rather than a dictionary, readers need only bring a welcoming heart.



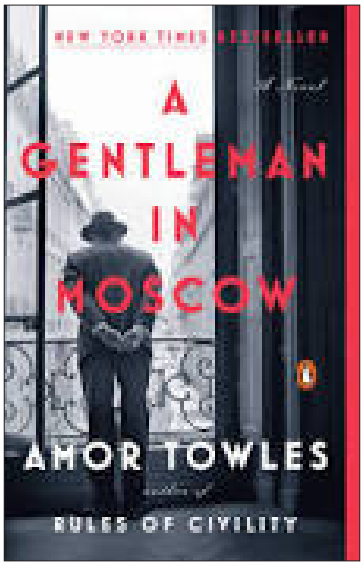
The Angel and the Assassin: The Tiny Brain Cell that Changed the Course of Medicine
By Donna Jackson Nakazawa
Reviewed by Thomas S. Harbin, MD, MBA

Microglia- Who knew? We were taught that microglia were inert and the brain was immunologically privileged with no connections to our systemic immunology reactions and processes.

Research in the last few years has refuted this dogma and provided potential avenues for diagnosing and treating many brain disorders.

Microglia constitute 10% of brain cells and are neither glial cells nor nerve cells. Instead they are immune cells, not inert but actively pruning and reshaping the synapses in our brains, usually for the good, but sometimes for the bad. Just as our systemic immune calls almost always protect us but can sometimes become destructive and cause the various autoimmune diseases, so can microglia.

The author discusses the research that has led to the new knowledge of microglia both in imaging and diagnosing problems, but possibly in treating a number of diseases including dementia. Sometimes a bit repetitive, but always interesting.



A Gentleman in Moscow
By Amor Towles
Reviewed by Laurie Gray Barber, MD

Amor Towles, author of The New York Times bestseller "Rules of Civility," penned this marvel of a life elegantly lived.

Released in 2016, a "Gentleman in Moscow," is a study in emotional discovery while forcibly losing contact with the outside world. The introspection and the wonderful treasures that can be found while limited spatially is correlative to 2020, our pandemic year.

Our protagonist, Count Alexander Rostov, appears before the Emergency Committee of the People's Commissariat for Internal Affairs in 1922. His life prior has consisted of, as he mentions in his tribunal, "Dining, discussing. Reading, reflecting. The usual rigamarole." Because the apparently rudderless count had written a poem construed by the Emergency Committee as insurrectionist and elitist, he was sentenced not to the firing squad, but to a lifetime of house arrest. The Metropol, a grand hotel facing the Kremlin, would be his jail and his awakening.

Count Rostov proceeds to press his indelible mark into surroundings of opulence while ensconced in an attic space, as well as into his newfound friends who previously served him and into other hotel guests that saw his potential before he realized it.

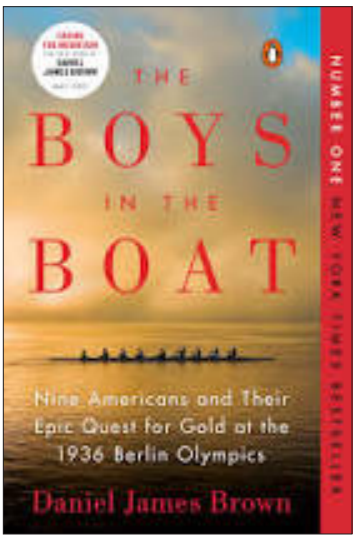
A piece of historical fiction, the book informs readers of the many dark years Russia suffered before and during the count's incarceration. Before, Russia suffered through a world war, a civil war, two famines. During his incarceration, Russia began "collectivization," where farms served the "common good," the elite were brought low or killed, organized religion shuttered, and the Great Purge, followed by World War II. Throughout the historical events, the count could only watch through the window of the Metropol and hear through the conversations of other hotel guests that which was transpiring.

Because the apparently rudderless count had written a poem construed by the Emergency Committee as insurrectionist and elitist, he was sentenced not to the firing squad, but to a lifetime of house arrest.

What We're Reading

Both incarcerated and sheltered in the magnificent Metropol, the count observes and describes intricate details of his small space, magnifying significance and beauty. Amor Towles deftly weaves a tale of a man who flourished, searching for a "deeper understanding of what it means to be a man of purpose." Humor, romance, cuisine and wine appreciation are woven into the tale of a man who relishes, regardless.

This book has inspired my husband to research and then prepare Latvian stew (which uses dried plums and apricots, as well as fine cuts of pork). It encouraged me to smell fennel in the spice drawer, sip a fine brandy and gaze around the immediate world rather than glimpsing quickly. May the book, and the stew, bring richness and life flavor as well!



The Boys in the Boat
By Daniel James Brown
Reviewed by Samuel Masket, MD

For those who relish nonfiction, love to read of triumph over tragedy, appreciate that work ethic and team play still matter and enjoy the juxtaposition of world history with sporting events, Dan Brown's book will thrill you.

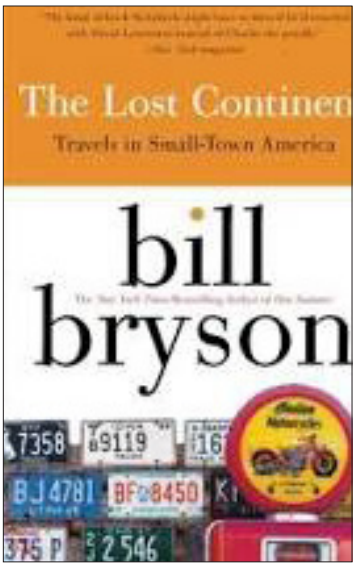
The story is based on the University of Washington's crew team in the mid-1930s and their quest to reach Hitler's 1936 Berlin Olympic Games. But underneath the vicissitudes of training, racing, qualifying, etc., is the personal and difficult story of the protagonist, Joe Rantz, a child of the Great Depression who was left to his own abilities after being abandoned by his family at a young age.

The UW team was considered ragtag, comprised of the sons of loggers and other blue-collar workers of the Pacific Northwest; they competed against the scions of the very rich at meets across the country, with remarkable success.

Although his story is a remarkable tale of will and survival, he forged a bond with his teammates, coaches, and a young sweetheart; those relationships propelled him to achieve his potential.

The UW team was considered ragtag, comprised of the sons of loggers and other blue-collar workers of the Pacific Northwest; they competed against the scions of the very rich at meets across the country, with remarkable success against the "smart money."

Each competition is described with such verisimilitude and excitement that the reader will literally turn the pages in anticipation. But this story is far more than racing competition; it is a metaphor for the struggles of the Great Depression and the virtues of perseverance. This book remains among my all-time favorites.



The Lost Continent
By Bill Bryson
Reviewed by John Stechschulte, MD

2021 Will be a good year in which to read "The Lost Continent", by Bill Bryson. The book will help the reader laugh while bringing back childhood memories (some awful) of long family vacations taken by automobile to distant places. This is a funny, insightful, and touching book about the author's search for the heart and soul of America.

Bryson drives across the U.S. visiting 38 states looking for the perfect town. He tries to retrace some long road trips he took with his father to tiny towns. He remembers how cheap his father was and his father's "ability to get hopelessly lost without ever actually losing sight of his target."

On his own solo journey, Bryson vividly explains his opinions of the people he meets and the places he encounters. He is seldom polite or positive, but he did like the genuine feel of Leadville, Colo. He drove 14,000 miles in search of the ideal city he called "Amalgam," whining about nearly every state that he entered.

What We're Reading

The author ends his drive and concludes the book by returning to his hometown where he finds that he is finally "almost serene". Brian Bryson grew up in Des Moines and begins his trip in Iowa. For 10 years prior to this book he lived in England. He obviously adopted too much of the dry British wit, but that makes the reader chuckle on nearly every page of the book. If you grew up in a small town, you'll

Bryson vividly explains his opinions of the people he meets and the places he encounters. He is seldom polite or positive, but he did like the genuine feel of Leadville, Colo.

turn the pages quickly hoping to find that he visited your hometown and discovered a "pleasantly acceptable" Howard Johnson's meal there. *Newsweek* described his book as a "snide travelogue".

Bryson describes most towns as hypnotic and devoid of stimulus, but he says one city, Charleston, is enchanting. He says people in the Midwest are friendly, farmers never feel any pain, and that all Americans are "slow but overall good". He claims these facts - Maine grows more potatoes than Idaho, nearly every Nevadan was born elsewhere, RV's are life-support systems on wheels, and that England has more hikers than the U.S. Bryson has written other humorous books about backpacking across Europe, the small island (England), and the English language. "The Lost Continent" may make us more adventuresome in the New Year.

WHAT WE ARE WRITING

Practical Ethics in Ophthalmology: A Doctor's Guide to Medical Ethics in the Surgical and Medical Practice of Ophthalmology By Thomas S. Harbin, MD, MBA

Reviewed by M. Bruce Shields, MD

In 2009, Dr. Harbin published "Waking Up Blind: Lawsuits Over Eye Surgery," which immediately established him in our profession as a premier writer of nonscientific medical literature, as well as a leader in the field of medical ethics.

Dr. Harbin followed that success with two well-received books: "The Business Side of Medicine: What Medical Schools Don't Teach You," and, with M. Duffy Jones, DVM, "The Business Side of Veterinary Medicine: What Veterinary Schools Don't Teach You." Now Dr. Harbin has returned to his zeal for medical ethics with his latest contribution to our profession, "Practical Ethics in Ophthalmology: A Doctor's Guide to Medical Ethics in the Surgical and Medical Practice of Ophthalmology."

As Dr. Harbin notes in his prologue, all ophthalmologists believe they conduct ethical practices and agree that this should be a fundamental goal of our profession. And yet, with the way that the business of medicine is changing, even those with the best intentions are at risk of ethical slips that they may never recognize. Dr. Harbin does a great service to our profession by clarifying these potential pitfalls, telling us how to watch for them and how to avoid them.

Dr. Harbin breaks his book down into logical sections, with easy-to-read and understand examples of the ethical challenges that lurk in every aspect of the ophthalmic practice. For example, in Part I, Practice Activities, he considers ethical issues related to prescribing medications, performing surgery and introducing new devices and procedures. In other sections, he addresses the physician's relationship with industry, the academician's quest for ethical research and publishing, personal behavior, as with substance abuse, and much more.

The book has already received praise from many of the leaders in our profession. Dr. George Bartley stated that, "Dr. Harbin has done a service by reminding us to keep the welfare of the patient preeminent at all times." Dr. Ruth Williams correctly notes, "Dr. Harbin translates the lofty ideals of ethics into the everyday practice of ophthalmology." Dr. Paul Lichter observes that, "In his matter-of-fact and easy-to-read writing style, Dr. Harbin draws on his extensive experience with ethical issues in medicine and ophthalmology." And Dr. Susan Day makes the cogent point that, "Practical Ethics in Ophthalmology" is a highly pragmatic view of the importance of ethical behavior by physicians: good ethics makes good business."

I fully agree with each of my colleagues and strongly believe that Dr. Harbin's book should be required reading for every ophthalmology resident (and probably every medical student) and one with which every physician should be familiar.

Editor's note: If you have written a book or know of a colleague who has, let us know so we can share it with our readers. Send your recommendation to scope@aao.org

News from the Foundation

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

With 2020 in our rear-view mirror, I'm optimistic for 2021 with high hopes for the new COVID-19 vaccines and a steady recovery for the U.S. and the entire world.

GOAL ACHIEVED: 2020 ORBITAL GALA ATTENDEES BROUGHT THE MUSEUM CAMPAIGN TO A CLOSE

Three years ago, the American Academy of Ophthalmology Foundation established an audacious goal to raise $12 million to build a physical museum at Academy headquarters in San Francisco. At the virtual 2020 Orbital Gala in November, we reached the campaign finish line, thanks to our members' generosity! Even with the campaign officially over, we still need your support as we add exhibitions and programs.

Orbital Gala chair Ron W. Pelton, MD, PhD (aka "The Notorious R-O-N"), welcomed hundreds of supporters to Zoom and YouTube, where they watched cocktail demos for perfect mint juleps (Woodford "Woody" S. Van Meter, MD) and Manhattans (George A. Williams, MD, and Tamara R. Fountain, MD) and a preview video of the new Truhlsen-Marmor Museum of the Eye®. The 17th annual virtual fundraiser offered opportunities to bid on vacations, ophthalmic equipment, wine and conversations with legends such as Atul Gawande, MD, MPH, Jane Goodall and Peter Alexander as well as legendary ophthalmologists. In all, $400,000 was raised for the museum and endowment. We couldn't have done this without the passionate, kind hearts of all of our generous donors! See the fun we had.

Scenes from the 2020 Orbital Gala: Woody Van Meter, MD educates his colleagues on the perfect mint julep and attendees bid during the virtual fundraiser.

A TRIO OF EVENTS HELPED SUPPORT OUR MISSION

The foundation's work is never done; there are always Academy programs that need our support. Three recent events — Giving Tuesday (Dec. 1), Year-End Giving (December) and Valentine's Day — offered opportunities for tax-smart contributions and gifts in memory or honor of loved ones. Altogether, over $50,000 was raised in support of the Academy's educational, quality of care and service programs. We thank our donors for backing our mission to educate ophthalmologists and prevent blindness worldwide and ensuring that the programs vital to these efforts continue to thrive.

The Academy Foundation offers a variety of opportunities and ways to give, from named gifts and pledges to legacy gifts and Donor Advised Funds. From the ONE® Network, IRIS® Registry research and risk-management studies to Minority Ophthalmology Mentoring, EyeCare America® or Global Outreach, there's a program that needs your help. Kick off this hopeful new year with a gift to our profession.

As always, thank you for your support of the Academy's many innovative products and programs. I wish you all the best for a healthy, successful 2021 as we return to a "new normal." Feel free to contact me any time at gskuta@aao.org.

Notable Dates in Ophthalmology

By Daniel M. Albert, MD, MS

5 YEARS AGO (2016)

One year after receiving a single injection of AAV2-hRPE65v, two patients with RPE65-mediated inherited retinal degeneration, or Leber's congenital amaurosis, were able to easily navigate a poorly lighted maze and had improved light sensitivity.

25 YEARS AGO (1996)

An internal review by the National Institutes of Health concluded that "gene therapy had not yet proved clinically successful and that significant problems remain in all basic aspects of gene therapy."

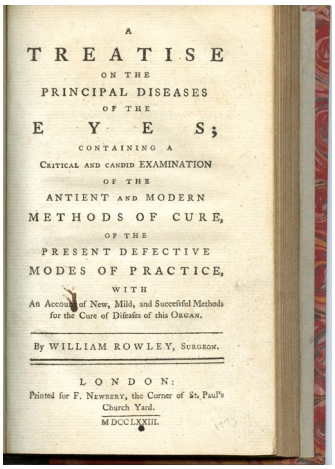
Robert Machemer, MD, 1968. Courtesy of the Truhlsen-Marmor Museum of the Eye®.

50 YEARS AGO (1971)

Dr. Robert Machemer, (1933-2009), in Miami developed a vitreous infusion suction cutter, which proved to be a major breakthrough in the area of closed vitrectomy surgery.

100 YEARS AGO (1921)

Dr. Otto Barkan, (1887-1958), trained in ophthalmology in Vienna and Munich and returned to his birthplace of San Francisco, where he focused on understanding the causative mechanism and treatment of glaucoma.


A
TREATISE
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ANTIENT AND MODERN
METHODS OF CURE,
OF THE
PRESENT DEFECTIVE
MODES OF PRACTICE,
WITH
An Account of New, Mild, and Successful Methods
for the Cure of Diseases of this ORGAN.
By WILLIAM ROWLEY, SURGEON.
LONDON:
Printed for F. NEWBERY, the Corner of St. Paul's
Church Yard.
MDCCLXXIII.

"A Treatise on the Principal Diseases of the Eyes," by William Rowley, 1773. The M. Wallace Friedman, MD, Rare Book Collection. Courtesy of the Truhlsen-Marmor Museum of the Eye®.

250 YEARS AGO (1771)

William Rowley, (1743-1806) of London, published his work, An essay on ophthalmia or inflammation of the eyes. He also published a general work on eye disease in 1773. Rowley issued a plagiarized translation of Plenck's Doctrina de morbus oculorum in 1790, which was considered in England to be an important work and was not recognized as a plagiarism for nearly half a century.

500 YEARS AGO (1521)

Averroes, (Abu Al-Walid Muhammad Ibn Ahmen Ibn Rushd Al Maliki) published, Paraphrasis De partibus et generatione animalium nuper ex hebraico in latinum translata per magisterium jacob mantinum. It reviewed Aristotle's work on vision and opposed the Greek emanation theory of sight that was prevalent at the time.

SCOPE

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