



# SCOPE

## Serendipity and Service

Bruce E. Spivey, MD

I have been asked to write about myself because I had the honor of receiving the Laureate Award from the AAO last November 2015. With an open agenda, I thought I would share something of the often serendipitous 61 years I have traveled through ophthalmology.

### How I wound up in medicine

The mother of my best friend in high school, who was a nurse, was absolutely hell-bent on her little Billy becoming a doctor. I had no ideas of my own, and that seemed like a very good option. So I followed Billy and two other close pals into pre-med as we entered college and later went onto medical school.

### ...and then became an ophthalmologist

The summer before I entered the University of Iowa medical school, I worked as a section hand laying new rail track and I had a nearly fatal railroad accident. In addition to some fractures, I also had an eye injury that no one in Cedar Rapids, Iowa could figure out. Soon after entering medical school, I got an appointment in the eye department with a faculty member, who said "I have no idea what you have, but do you need a job?"

Phil Ellis, subsequently Chief at Colorado, took me across the hall and introduced me to Herman Burian, a European who was a noted strabismologist and electrophysiologist. I began doing electroretinography in 1955 and have been involved with ophthalmology since.

### My interest in global health

After I entered the United States Army in 1964, following my residency deferment by the Berry Plan, I was sent to Fort Polk, Louisiana. There was no equipment, no hospital and no need for an ophthalmologist, as it was a training center. I

complained bitterly to the assignment officer for ophthalmologists, beginning my letter, "Dear Sir, you are in dereliction of your duty." I wanted to make sure he read the entire letter, during which I made the same statements plus a horrendous boast that I was the best-trained ophthalmologist in the Army, and they were not utilizing my skills appropriately. Based on this immature and undoubtedly inaccurate challenge, I was sent to Fort Dix, New Jersey, which actually did have instruments, a hospital and even elevators. BUT, soon after, guess who was the first ophthalmologist sent to Vietnam? That was the most intense and greatest learning year of my life, particularly understanding myself. Besides becoming the triage officer for the 85th Evacuation hospital, I was the first ophthalmologist for 1100 lepers nearby Qui Nhon, South Vietnam. This year in South Vietnam left me with an understanding of developing countries needing ophthalmic care and physician education, a Bronze Star and a career dilemma.

### A pivot to medical education

Not being sure I wanted academic medicine, I returned to the faculty at the University of Iowa to test this career direction and rapidly realized that those in academia need a niche to identify them in their ongoing careers. There were many subspecialties



that I liked, and just as many that I did not. I observed my more senior faculty and realized that they were magnificent preceptors, but not really educators. I then focused on medical education and obtained a Master's degree in medical education at the University of Illinois, traveling weekly to Urbana and Chicago while maintaining an ROI grant. I believe I was the first ophthalmologist to obtain an M.Ed. While not truly serendipitous, this was considered a bit crazy and unusual by all but me.

### **How I (and the newly-formed AAO) ended up in San Francisco**

In 1971, I felt I needed to test the world outside the cocoon of Iowa City. There were some marvelous opportunities in various places, but I selected Chairmanship of a small but historic residency program in San Francisco. This program was the oldest residency program in the West, having started in 1873. It is now California Pacific Medical Center (CPMC). Again, while not completely serendipitous, it was risk-taking and unusual. As the American Academy of Ophthalmology and Otolaryngology

divided into two organizations, it was clear that the new American Academy of Ophthalmology would need a CEO. This was the only time in my life I applied for a job and was lucky enough to receive it. This was a non-serendipitous event that was a tremendous 17 year experience. Living in San Francisco, I moved the new AAO to my city from Rochester, Minnesota. At the same time, I had been appointed as President and CEO of CPMC. It was a challenging time balancing the direction of two evolving organizations while continuing to practice ophthalmology.

### **Introduction to ophthalmology's global stage**

In 1982, Ed Maumenee became President of the International Council of Ophthalmology. He found the Council to be occupied by very senior, quite passive ophthalmologists and wanted a younger group to stimulate a seemingly moribund board. Ed appointed me Chairman of this junior ICO. Thus began in 1985, my 33 year relationship with the ICO, during which time I served 12 years as Secretary General, 8 years as President and will end in 2018 when my

service on the Board is completed.

### **Expanding my management horizon**

I was traveling 46 weekends a year as CEO of the AAO and during the week, serving also as CEO of CPMC and a hospital system (California Healthcare System). I have an observation that a CEO institutionalizes his/her errors after 7 years, and doubles them after 14 years. Having been 17 years in the first two roles, I needed to make a decision to pursue one or the other. Out of the blue, an offer came to develop a hospital system in Chicago, related to Northwestern University, which I accepted.

After five years in Chicago, I was recruited to New York as CEO at the combined Columbia and Cornell clinical medical school faculty for a five year period. At that point, having options to live in New York, Washington, Chicago or San Francisco, my wife Amanda and I selected San Francisco, where we have lived to this day.

### **Lessons learned and my leadership philosophy**

Being an educator by training but later assuming various management roles, though I never had any formal management training, has afforded me a continuous learning experience. Management requires common sense, liking people, and a great support team. I have served as a CEO for 73 aggregate years and have developed my own philosophies. Today I am not sure I would have been afforded so many opportunities for on-the-job training.

### **Always be open to a new idea or new challenge**

Your family, contemporaries, colleagues and students will lead you in a helpful manner.

Recruit people better and brighter than you are, entice them and trust

Laureate ceremony during AAO 2015 in Las Vegas. (Pictured Left to Right) David J. Noonan; Russell Van Gelder, MD, PhD; Bruce E. Spivey, MD; David W. Parke, II, MD



## From the Editor's Desk



### Summertime!

Susan H. Day, MD  
Guest Editor

And the living is easy, they say. But what impact does this season have on how doctors care for patients? On medical errors? On morbidity and mortality data? Years ago, ophthalmologist Robin Cook, fresh off his success as author of best-selling thriller *Coma*, quipped that his next suspense novel might be named *July*. After all, hospitals are full of interns brimming with theoretical knowledge but lacking in experience; new senior residents are eager

to hone procedural skills; faculty are finally leaving with their families for a well-deserved break.

Medical literature is replete with articles delving into the science of the “July effect” it is only natural to sense there is something risky about being admitted at the same time new trainees are coming on board. In large part, the published studies debunk this myth. Credible articles amass experience in the tens of thousands of patients, comparing month of admission over multiple years. One article, authored by Harvard critical care specialist Jarone Lee, MD and others, assessed nearly 60,000 patients over a 5-year cycle. This patient population easily could be thought of as representing the sickest of the sick patients. This analysis was performed at 2 academic centers. Morbidity and length of stay in an ICU setting were the outcomes. July had no deleterious effect on the outcomes. A second study from the Mayo clinic noted that surgical patient satisfaction (N>10,000) was actually better in the months of July and August.

Lest Dr. Cook have no material to substantiate a new book, there have been other published data showing higher rates of preventable com-

plications in trauma, more post-op morbidity/ mortality, and more complications from shunting procedures in pediatrics patients. Others cite obvious limitations to blaming a July effect squarely on physicians, such as seasonal influences including, more people on the roads, more alcohol intake with barbecues and warm long days, and higher rates of trauma of all sorts. In fact, other July factors would support better outcomes, including closer supervision, orientation sessions for entering house staff regarding reduction of medical error, and an environment where more questions are asked by beginners.

I would personally see a few take-home points from this evidence-based approach to the July effect. First, we need not cocoon ourselves at this wonderful time of year in order to avoid a trip to the ER. Secondly, resident education has shifted from the see-one, do-one, teach-one mentality to a patient-centric model designed to protect against medical error and consequences of a training environment. Finally, living is easy (and I won't say the negative corollary) in part when we do what we can to avoid testing the July mythical effect! Happy (and safe) summer to all!

them, give them true responsibility and authority. They will make you better and more successful than you could be alone.

### Don't burn bridges or hold a grudge

Don't be afraid to take on a task or committee or activity – and especially one that others believe is impossible – if you understand a way to success. These are breakthrough opportunities for career development.

Try to understand yourself and don't assume roles that are not a fit for your talent, knowledge or interests.

Be grateful for what comes and be happily astounded by good fortune in health and service. Always count your blessings!

My years in ophthalmology have been blessed in so many ways, including wonderful children and grandchildren, an unbelievably supportive wife, marvelous opportunities, spectacular friendships, inspiring mentors, seemingly grateful trainees, more travel than wise, and an idyllic specialty in which to work. I consider myself one of the very luckiest people.

### Still active

My wonderful journey through

ophthalmology is not completed. Back in SF, I have become Chairman of Pacific Vision Foundation. Our commitment is to develop a new Eye Institute, including the CPMC Residency Program, based on many tenets of the Aravind Eye Care system. This is focused on providing a major amount of uncompensated care. We will open the first phase in August of 2016 and while a challenge, it is an exciting and unique venture in the United States.

I am certain many of you have lived a serendipitous life experience. I hope yours has been as rewarding as mine.

Thank you Ophthalmology!

# The Man Who Almost Invented the Ophthalmoscope

M. Bruce Shields, M.D.

If the name, Charles Babbage, means anything to you, it is most likely within the context of his pioneering contributions to the history of computer science. It is less well known that he also invented the ophthalmoscope. Or, at least, he almost did.

Babbage was born in Devonshire, England, around 1791 to the family of a well-to-do banker, who emphasized early education for his children. As a result, when the young man entered Cambridge in 1810, he knew more mathematics than his university tutor and, by 1828, had become the Lucasian Professor of Mathematics at Cambridge (a chair once held by Isaac Newton). However, teaching seemed to be neither his strength nor his passion (he apparently never gave a lecture), and he resigned from his position in 1839 in order to devote all his time to his true calling as a mathematician and an inventor.

His interests and inventions were eclectic, ranging from a cow-catcher for locomotives to actuarial theories and tables. The biggest problem he sought to address, however, was that mathematical tables of the day, which were key to navigation, science, engineering and mathematics, were all calculated by hand, which led to frequent errors in transcription and calculations. Babbage reasoned that these human errors could be overcome by mechanization, which led to his formulating the concept of mechanical computation.

His first attempt at a computer began in 1822 with a “difference engine,” which was intended to automatically compute values of polynomial functions. The device was mechanical and unwieldy (if finished, it would have approximately 25,000 parts and weigh 15 tons), but the basic architecture

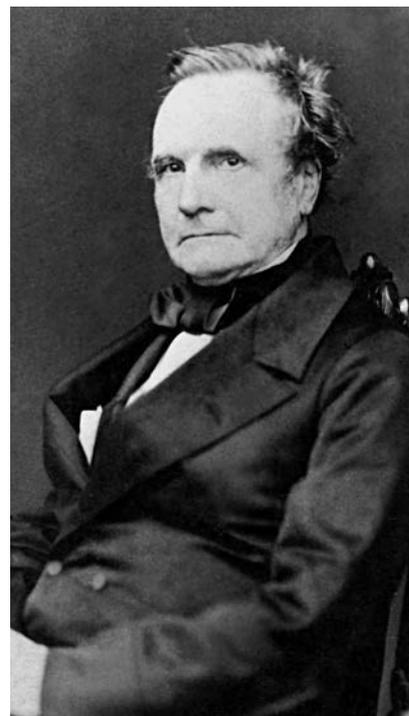
was similar to modern computers. With various colleagues, he labored for more than a decade, exhausting much of his personal wealth, as well as public funding. He achieved some success with a steam-powered device, demonstrating that calculations could be mechanized, but government confidence and support finally ran out, and he never completed his difference engine.

He did not give up on the concept, however. In later life, he designed an “analytic engine,” which was more complex than his difference engine and represented a transition from mechanized arithmetic to full-fledged general purpose calculations. It was programmed with punched cards and used several features that are found in modern computers. It was never completed, but he tinkered with it until his death in 1871. In 1991, a team of British researchers completed construction of Babbage’s difference engine from his original plans and showed that it worked.

Babbage’s interest in the eye stemmed from his affliction with bilateral monocular diplopia, which he was able to partially correct with the use of a pinhole or a concave lens. His study of the eye led him to design a device for viewing the posterior aspect of the globe.



Although no model or drawings apparently exist, it has been described as consisting of a tube with a mirror that was angled to reflect external light into the eye. There was a central opening in the



Charles Babbage, 1791-1871

mirror (silver removed) through which the observer could view the internal ocular anatomy. In 1847, Babbage presented his idea to the distinguished British ophthalmologist and physiologist, Thomas Wharton Jones, who was apparently unimpressed and offered no encouragement to the inventor. And that was where it ended, until about seven years later, when the German physicist, anatomist and physiologist, Hermann Helmholtz, described a somewhat similar device, and the rest is history.

Jones admitted his error by acknowledging Babbage’s contribution in an 1854 article in “British and Foreign Medico-Chirurgical Review,” and Babbage included it as one of his accomplishments in his 1864 autobiography. Although he lost his chance to be included in the pantheon of ophthalmic history, he is considered by many to be a father of modern computer science. In 2011, a team of British researchers began attempting to build Babbage’s analytical engine, despite lacking the complete original design, and hope to have it finished by 2021, in time for the 150th anniversary of the inventor’s death.

# Sushruta

Thomas S. Harbin, MD

Who started us on the path of cataract surgery? We're probably familiar with the remarkable number of pioneers in the past 70 years, beginning with Sir Harold Ridley and continuing to present times with a large group who have pushed cataract surgery into becoming one of the most successful operations of present times. Giving due credit to those living and dead to whom we owe thanks is beyond the scope of this article. But who deserves credit for being the first to perform any type of cataract operation?

Many ophthalmologists, especially those familiar with the history of medicine in India, give credit to Sushruta (also spelled Susruta). Most historians place the time of his life to 600 BC and he lived in Benares, a city on the banks of the river Ganges. He wrote a treatise on surgery called the *Sushruta Samhita*, only one copy of which is extant today. It was written in Sanskrit and largely unknown to medical historians of the 19th and early 20th centuries.

According to Dr. Shridhar Dwivedi, the *Sushruta Samhita* contains 184 chapters with descriptions of over 1100 illnesses, 700 medicinal plants and numerous other medicinal preparations. He described diabetes and angina, linking angina to obesity and recommending exercise for diabetics.<sup>1</sup>

Dr. V.K. Raju, Clinical Professor of Ophthalmology at West Virginia University, notes that the *Samhita* had eighteen chapters devoted to the eye and described seventy-six different ocular diseases, many of which required surgery. Most notably, Sushruta was the first to perform cataract surgery by couching.<sup>2</sup>

Consider this scenario. What would you do? The family leads a bilaterally blind person to you. The vision is likely hand motions at best, and the patient can neither get around independently nor see food

on the plate. Life expectancy is severely limited. You see two white reflexes through undilated pupils. What can be done?

You have no slit lamp, no tonometer, no anaesthetic or dilating drops and no surgery center. Do you let this patient go home to die or try to do something?

We know that Sushruta advocated for learning medicine in part by dissecting the human body, and that he developed and described a number of surgical tools while teaching that the human hand was the foremost surgical instrument.

Historians credit Sushruta as being the first with the courage to help such patients. One of his instruments was used to enter the eye and push the cataract into the vitreous space. Think of the challenges presented by performing this in the absence of anaesthesia and dilation. But he did so and if the patient did not develop an infection, the vision recovered to count fingers with the restored ability to ambulate and see to eat food.

His accomplishments did not stop with eye surgery. D.P. Agrawal, quoting from a book published by the government of India,<sup>3</sup> credited Sush-

ruta with developing the basic principles of plastic surgery—release of the skin to cover defects, rotation of flaps and pedicle flaps with attention to proper wound apposition.

Sushruta also addressed ethics, warning that improper intervention with surgical maneuvers due to ignorance of the disease process, greed for money, or lack of judgment will lead only to complications. A conscientious surgeon considers the patient as a whole.

Sushruta's emphasis on ethics has led Dr. Raju to sponsor Sushruta and Charaka Lectures at West Virginia University as well as Sushruta Lectures on History and Ethics at the Wilmer Institute and the University of Pittsburgh. Dr. Raju wants to keep alive the lessons propagated by this remarkable man.

Today, we may not perform cataract surgery by couching, but we would do well to heed Sushruta's thoughts on ethics while we pay homage to a courageous and pioneering physician.

1 G. Dwivedi, S. Dwivedi, Indian J Chest Dis Allied Sci 2007; 49 243-244

2 V.K. Raju - Personal communication  
3 *Scientists*, Gov't India Publication (pp 44-720)

Oil Painting by Robert Alan Thom (1955)



# What Ever Happened to the French Foreign Legion?

William S. Tasman, MD

The romantic idea of joining the French Foreign Legion was often heard in the 1930's during the Great Depression. Since World War II, which got our economy going again, you rarely hear about joining a legion. There were also other countries that supported military legions. One that comes to mind is Spain who kept a close eye on Morocco.

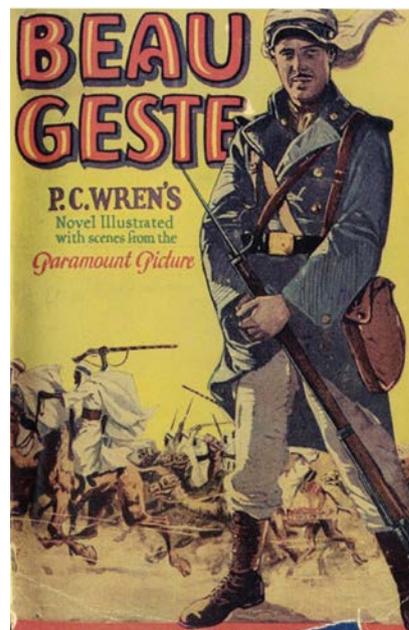
The French Foreign Legion was established on March 10, 1831 and was headquartered in Sidi-Bel-Abbes in Algeria. Until 1962, that was the main headquarters and training camp for the Legionnaires.

When the Legion was originally formed, the Legionnaires were not ever to be in France, itself. The purpose was to have them managing some of the other territories within the French Empire, such as Algeria and other countries in Africa and Asia. And as to the romantic aspects of the Legion,

many of them were fostered by such books as *Beau Geste*, (which means a beautiful gesture), a novel written by Percival Wren, a non-Legionnaire, by the way.

Enlistment required the candidate to be at least 17 ½ years old, and finally, allegiance was not sworn to France, but rather to the Legion itself.

*Beau Geste* is the story of a young man named Michael and his twin brother, Digby, along with another brother, John who get involved with the disappearance of a valuable family gem, the Blue Water. The brothers were questioned and then Michael (Beau), decides that he will join the Foreign Legion because they ask no questions about your background, and give up no information about you to other official authorities. If you are not French-speaking, and Beau was from England, that was a problem because



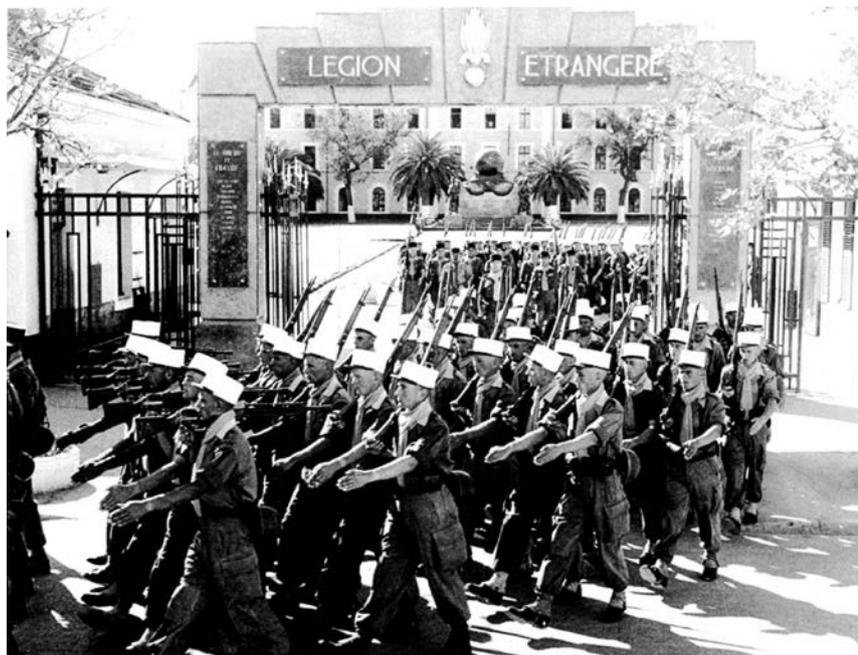
Cover of the illustrated novel, "Beau Geste," authored by P.C. Wren.

all orders are given in French by French Officers. Thus, a good portion of the first few weeks in the Legion concentrate on teaching recruits to parler français.

The original 1831 contingent was made up of disbanded Swiss and German foreign regiments of the Bourbon Monarchy. Components of the French Army that had occupied Algiers in 1830 were in need of reinforcements. Accordingly a French expeditionary force was transferred by sea from Toulon in Southern France to Algeria.

While many who look at the Foreign Legion think its main area of duty was North Africa, it is important to point out that the units of the French Foreign Legion have served around the world. They have been involved with several wars including the Franco-Prussian War, World War I and World War II (they were more involved in WWI than WWII). Later their duties were in French Indochina now Vietnam. During the first Indochina war a climatic battle between French and Viet Minh communist forces took place at Dien Bien Phu and the French defeat set the stage for later US involvement in the Vietnam War.

Members of the French Foreign Legion training in Sidi-Bel-Abbes, Algeria, which was their headquarters and training camp from 1831 until 1962. The white hats they wear are called Kepis.



The Legion is well-remembered for its incursion into Mexico between 1863 and 1867 when the French attempted to install Maximilian as the leader of Mexico. The Legionnaires had only small artillery and cavalry units and hoped that they would prove to be enough to maintain their toehold in Mexico. The Imperial Mexican Army, however, proved too much for the smaller Legion units and Juarez was able to maintain his leadership and Maximilian was subsequently executed.

The Legionnaires come from 140 different countries and over the years because of the number of campaigns they have fought there have been about 40,000 Legionnaire fatalities.

Some wonder if Americans joined the Foreign Legion. And the answer is yes, but rarely today. Back in the 30's and 40's it was common if you fell on hard times or if really depressed you might

walk out and say, "I'm going to join the Foreign Legion."

What kind of a living can you make in the Foreign Legion? Well, it's not Wall Street. Upon enlistment, you serve a 5-year hitch and this can be followed by another one of six years. However, the pay and the benefits are quite low.

There have been several Beau Geste movies starting with one in 1926, which starred Ronald Coleman and William Powell. The one that people remember most is the 1939 version with Gary Cooper, Robert Preston, and Ray Milland. All of these actors have died, but one that I have not yet mentioned is Brian Donlevy. Cooper obviously is Beau Geste, Digby played by Robert Preston, and John is played by Ray Milland. Brian Donlevy, who died in 1972, plays the sadistic Sergeant Major named Markoff. He ultimately gets command of the small garrison at Fort Zinderneuf, and it is only because of a Tuareg attack that

a mutiny is prevented. Beau and his brothers along with a few other loyalists were against the plot.

In 1966 another version of Beau Geste starring Guy Stockwell and Doug McClure was made and finally in 1982 BBC had a serial on Beau Geste. Two other films of Beau Geste were made, one starring Laurel and Hardy in 1931 entitled, "Beau Hunks," and the other starring Marty Feldman in 1957, I'll leave those to your imagination.

Finally, the answer to the question in the title, where is the French Foreign Legion now? It is still operational even in Afghanistan, but most of what they do is in their former colonies. P.C. Wren went on to write several other books, but none that had the appeal of *Beau Geste*.

For those of you who may have a yen for the romance of the Foreign Legion, as I've said before, fuhged-daboudit, the upper age limit for enlistment is 40.

---

## As I Remember It

### He Called You What?

George H. Kurz, M.D.

**D**uring my residency in the late 1950s and early practice years ophthalmologists commonly used the term "senile" for various conditions associated with advancing age. Cataracts in older persons were called "senile cataracts," as distinct from traumatic or other types. Likewise, the aging process at the center of the retina was called "senile macular degeneration," abbreviated "SMD." All this seemed perfectly normal to me.

One day my mother, then in her late sixties, asked me to recommend an eye doctor. I had great admiration for Dr. Francis Adler, department chairman at the University of

Pennsylvania. In addition to being a brilliant, nationally known figure in the world of ophthalmology, Dr. Adler was a gentleman. He was also an accomplished violinist. My mother was a music lover. I was sure they would get along just fine.

A couple of days after she saw Dr. Adler I asked her, "How was your appointment with Dr. Adler?" "Terrible!" she replied. "He called me senile!"

"He what?" I responded. "He called me senile! I heard it with my own ears! He said it to his secretary." "Are you sure? Whatever it was he said, I can't believe he would say you were senile."

"Well, I'm certainly never going back there again!" was her final word on the subject.

I was very disturbed. What could

the professor have said that made her think he was calling her senile? A few days later Dr. Adler's office sent me a report of his examination. It included a note that she had "senile scleral plaques." I wondered why Dr. Adler bothered even to mention these harmless, insignificant calcium deposits. In my mind I pictured Dr. Adler dictating the findings of his examination to a secretary. When he mentioned "senile scleral plaques," the only word my mother recognized was "senile." She latched onto it and couldn't get it out of her mind. I determined from then on to try to avoid using the word "senile" in the presence of a patient.

My mother's experience surely was not unique. Eventually the ophthalmologic community caught on. In two or three decades the term "senile" disappeared from our vocabulary.

## SpEye in the Sky

W. Banks Anderson, Jr., MD

**S**ydney Cotton, an Australian businessman, and professional pilot, was recruited in 1938 by MI6 to photograph Europe and the Mediterranean from the air. Although he had done aerial surveying in Newfoundland, Cotton's most recent business was marketing Dufay-color film in Europe. This Fred Winterbotham realized was perfect cover. With MI6 funding, Sydney became the proud owner of a Lockheed 12A. This Bentley of private planes was a twin-engined smaller and faster version of the Lockheed Electra using the same engines as its cousin and boasting a heated cabin. Sydney put his brain and MI6 money to work in maximizing its photoreconnaissance capabilities. And he was inventive. During WWI while flying for the Royal Navy he had developed windbreaker flying coveralls that he modestly named Sidcot suits. They rapidly became the gear of choice for pilots.

Aerial reconnaissance in 1938 had hardly progressed since the low altitude photos of WWI trenches. In the cold of higher altitudes lenses fogged. Sydney was not about to fly over Germany at low altitude. His three military five inch format cameras, one straight down and the others to right and left, were mounted in a fake extra gas tank with a sliding panel on the bottom of the aircraft that made them almost invisible. He diverted heat from the cabin across the cameras and lenses to keep them from fogging. He replaced the side cockpit windows with tear drop bubbles to make scouting his rear for "escorts" and contrails easier. The cabin was not pressurized and he and his crew breathed oxygen above ten or twelve thousand feet. His first few runs to Tempelhof were without cameras and his Lockheed was inspected by the Luftwaffe.



Sidney Cotton in the cockpit of Lockheed 12A G-AGTL "Caprice."

He then began regular "business" trips to Berlin flying there and back by different routes but always fast and high with his cameras running. He had chutzpah.

On July 28, 1939 the Nazis staged an air rally at Frankfurt and Sydney was invited. For this trip he installed the new format 35mm Leicas in each wing. Military dignitaries like Albert Kesselring and Luftwaffe officers wanted rides and Sydney was happy to oblige. Flying at low altitude in forbidden air space his Leicas were clicking away with Nazis on board.

During photoreconnaissance missions his assistant was often Patricia Martin, 20 years his junior. She shared not only his cameras but also his bed. She takes credit for the "bubble" window idea. At home in England was his second wife whom he had courted in Newfoundland when she was 15 and he 28. He had promised her father he would marry her at 18 when she came of age and had done so. From Malta he photographed North Africa and Italian and Greek harbors and military installations. On such trips he would pose as an amateur archeologist or airline executive or movie director. His and Pat's photos of the North African coast were later the basis of the allies' invasion maps.

He did not neglect photo processing, enlarging, and mosaic making. His images and their interpretation were superior to anything Bomber Command or the Royal Navy had ever seen.

With 60% overlaps they could be viewed in stereo. But RAF "Bomber" Harris wasn't happy. Shortly after the war had begun, the Luftwaffe bombed Scapa Flow. A few days later in March of 1940 Harris' squadron launched a fifty bomber retaliatory raid against a German seaplane base on the island of Sylt. It was a media sensation. Crew members described burning hangers. Some were awarded medals by the King. But when Sydney presented his post raid photos there was no damage to be seen. Indeed it seemed that Harris' bombers had missed the entire island. Although Bomber Command sulked, Churchill was impressed and Cotton's unit was provided Spitfires modified to Sydney's specs: No guns, no ammunition, no dark paint, no dents, no skin blemishes but with added fuel tanks. His meticulous exterior prep including plaster of Paris smoothing added 20 to 30 knots of speed. Flying high unarmed and faster than Bf 109s meant that his pilots usually returned. His group grew from 29 to 316. His unit, now in uniform, flew to France to provide photoreconnaissance during the German blitzkrieg. Thoughtfully he provided his men with their own brothel and flew in British ale for their mess. The RAF was livid especially as earlier Sydney had offered to transfer his operation to the Royal Navy. His negotiating and drinking partner had been naval intelligence officer Ian Fleming. The RAF had steamed and balked and Churchill had settled the fight ruling that the unit belonged to the RAF. Accordingly when Paris fell and they returned to Britain on June 17, 1940 Wing Commander Cotton was fired. But his men and women, his reconnaissance techniques and his many thousands of images continued to help win the war. That next January on the royal honors list, Frederick Sydney Cotton was awarded the Order of the British Empire. Some say that with his fast vehicles and fast women, he is with us still as Bond — James Bond.

# EyeCare America Discount Drug Card

C. Pat Wilkinson, MD  
Chair, EyeCare America

Since 1985, EyeCare America has been matching medically underserved individuals with local volunteer ophthalmologists to provide eye exams and care. Over 90 percent of this care is provided at no out-of-pocket cost to the patients by more than 6,000 volunteer ophthalmologists who have dedicated themselves to their communities and patients through this program.

In recognition of rising prescription drug costs, EyeCare America, in partnership with NeedyMeds, now offers a new drug discount card to all ECA patients we refer. Every penny saved is a welcomed relief, particularly to those in need. We are additionally offering this card to individuals, physicians and groups that wish to distribute it to

their patients, friends or family. The card offers up to an 80% discount on prescription drugs, and it is accepted at more than 65,000 pharmacies nationwide, including all major chains. No membership or registration fee is required and the card never expires.

NeedyMeds, a non-profit organization that provides up-to-date pharmaceutical assistance program



information, has actively worked with ECA for more than a decade. This year, NeedyMeds approached us to partner with them through an EyeCare America-branded drug discount card. EyeCare America receives monthly usage reports indicating pharmacies used, drugs purchased and discounts received.

To place your complimentary EyeCare America laminated Drug Discount Cards order, email [eyecareamerica@aao.org](mailto:eyecareamerica@aao.org).

The need for eye care continues to grow as the population ages. And ophthalmologists have the opportunity to take part of the largest public service program in American medicine. To date, EyeCare America has helped nearly 1.8 million people by dedicated volunteer ophthalmologists. For over 30 years, the program continues to stay committed to preserving sight and helping patients.

## As I Remember It

### A Lesson on Side Effects

George H. Kurz, M.D.

A bricklayer of German extraction, whom I shall call Richard Kohl, was in his late sixties when I saw him in the mid-1960s. I established a diagnosis of glaucoma and treated him with the customary drops of that time. I increased the strength of the first medication and then added a second drop.

At one point, I informed him, "Mr. Kohl, we've reached the maximum strength of your drops, and still I'm not satisfied with the control of your eye pressure. I would like to add a medication called Diamox that you take by mouth. Then let me see you in a couple of weeks to check the pressure again."

"But, Dr. Kurz," he replied, "I'm leaving next week for Europe to visit

relatives, who I haven't seen in many years. I will be gone the whole summer. Can you prescribe enough to last me until September?"

"Of course, but I want to see you as soon as you get back," I told him. I wrote a prescription for the full strength of Diamox, 250 milligrams four times a day, just as I had been taught.

September came and Mr. Kohl returned. His eye pressure was just fine.

"How was your trip to Germany?" I inquired. "Not very good," Mr. Kohl responded. "You see, for some reason I lost my appetite. Everywhere I went to visit my relatives, they went out of their way to make wonderful meals for me, but I just didn't feel like eating. And they got out their finest wines, but I couldn't enjoy them. It was really terrible. Even though I tried to force myself to eat, I still lost nearly 20 pounds!"

"Oh, my goodness! What a

shame!" I told him. "The reason you lost your appetite was probably the Diamox tablets. You'll have to stop them and see if your appetite comes back." I knew full well that loss of appetite was a common side effect of Diamox, but I had not warned him about this. And since the decrease in appetite came on gradually, he hadn't thought of a possible connection with his medication. I had told him to take his pills four times a day and that was that! It never occurred to him to do anything but precisely what the doctor ordered.

Mr. Kohl had put up with an unpleasant side effect for more than two months, and the trip he had so eagerly anticipated had been spoiled. I felt very bad about that. Before a week passed, he called to say that he was feeling better and his appetite was nearly back to normal. A much smaller dose proved to be the solution to the patient's problem, and the doctor was reminded of a very important lesson in managing our patients.

# Join us in Chicago, a City that Innovates

Neesah Azam

**A**AO 2016 meeting registration is now open! Come join the Academy in one of our favorite meeting locations and explore what is new in the ever changing city of Chicago.

Innovate with your colleagues and meet long-time friends or make new ones with more than 15,000 ophthalmologists from over 120 countries. Enjoy a cup of coffee in the SO Lounge, take a Poster tour to speak directly with those

working on the latest breakthroughs,

or join a Breakfast with the Experts discussion.

The networking and educational opportunities at AAO 2016 are endless.

**AAO 2016**  
In conjunction with APAO  
**INNOVATE**

Registration for AAO 2016 includes, Symposia and spotlight sessions; Papers, posters and videos, Exhibition; Endless learning opportunities at the Academy Café, Learning Lounge, Poster tours and Technology Pavilion. Purchase separate tickets for Skills Transfer labs, AAOE Master classes and coding workshops. Plus, register for any of the eight Sub-specialty Day meetings.

Make your meeting experience easy and purchase your Academy Plus Course Pass when you register. The Academy Plus Course Pass offers convenience and flexibility, with unlimited access to more than 350 instruction courses.

## Senior Ophthalmologist (SO) Featured Events and Resources

The Senior Ophthalmologist Special Program and Reception in Chicago is free for all attendees and guests and is scheduled on Monday, October 17 from 2:30 p.m. to 5 pm. The program will feature Doug Carlson, JD, who will present “*Lincoln, Chicago, and Convention Politics.*”

The session will include the presentation of the Academy’s 2016 EnergyEYES Award to honor one of our SOs who has been an inspiration to young ophthalmologists. It will conclude with a reception for everyone to enjoy.



Doug Carlson, JD

## SO Symposia

**Patient Engagement (SYM25)**  
Oct. 17 from 8:30 a.m. to 10 a.m.  
Patient engagement is the term used for the increasingly empha-

sized need for physicians to address health needs from the patient’s perspective. As patient satisfaction and outcomes grow in importance, this concept becomes incorporated into policies



and services. This symposium will review the evolution of this movement; the current impact on patient access as well as physician payment; the specific issues applicable to ophthalmologists; and the role the Academy is taking to provide appropriate patient educational materials and resources for its members and the public.

**Global Ophthalmology: Opportunity for SOs? (SYM48)** Oct. 18 from 10:15 a.m. to 11:15 a.m.

Retiring ophthalmologists are not aware of how their unique skills can be utilized after they leave their practice. In this symposium, panelists will discuss opportunities for retiring ophthalmologists looking for meaningful ways to contribute and serve others. Attendees will be presented with a variety of options, including provision of clinical care in underserved areas, teaching surgical techniques, and resident education.

Chicago’s innovative spirit can be seen in its architecture, award-winning restaurants, and world-renowned museums. For more information on AAO 2016 and SO member events, please visit the Academy’s Website: [aao.org/so](http://aao.org/so).



## New Uveitis and Immunology Lecture at AAO 2016

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

I'm proud and excited to share that C. Stephen Foster, MD, and his wife, Frances, have made a generous \$250,000 endowment to establish the C. Stephen and Frances Foster Lecture in Uveitis and Immunology. This annual 30-minute lecture will debut at AAO 2016 in Chicago with a presentation by Douglas Jabs, MD, MBA, professor and chair emeritus of the Department of Ophthalmology at Mount Sinai School of Medicine.

The lecture is designed to share the latest medical and surgical innovations, enabling ophthalmologists to more effectively prevent vision loss due to anterior, intermediate and posterior uveitis, panuveitis, and other ocular inflammatory conditions.

"As longtime scholars and teachers of ocular immunology and uveitis, Frances and I have felt indebted to the Academy for the forum and support for our efforts in education. We felt that this lectureship would further solidify our efforts in this relatively underappreciated area," said Dr. Foster, founder of the Massachusetts Eye Research and Surgery Institution. Mrs. Foster directs its infusion center.

The Foundation is deeply grateful to the Fosters for their leadership in promoting education to protect sight.

Check out the current issue of *EyeNet*<sup>®</sup> Magazine for our new donor ad featuring Jane C. Edmond, MD, a noted pediatric ophthalmolo-



C. Stephen Foster, MD, and Frances Foster

gist and member of the Academy's Board of Trustees. "The Academy Foundation supports initiatives that help ophthalmologists to improve surgical outcomes and medical treatment of eye disease worldwide. I support the Foundation because it's the right thing to do," said Dr. Edmond.

We'll be spotlighting different donors throughout the year. Want to be featured in an upcoming ad? Contact Karen Duke at [kduke@aaao.org](mailto:kduke@aaao.org) or 415.447.0356 and share why you support the Foundation!

I'm pleased to welcome Thomas W. Burns as our newest member of the Foundation Advisory Board. Mr. Burns is president and CEO of Glaukos, a leader in new technologies for micro-incisional glaucoma surgery (MIGS). He has more than 25 years of management experience across a broad range of ophthalmic medical devices and pharmaceuticals.

Mr. Burns' vision and expertise will undoubtedly help the Foundation to continue to advance the Academy's mission.

Tickets are now on sale for the Foundation's 13th annual Orbital Gala on Sunday, Oct. 16 at Chicago's renowned Field Museum. Our special honoree is Richard P. Mills, MD, MPH, who has been a cherished friend and colleague to many of us over the years. Visit [aaoo.org/foundation](http://aaoo.org/foundation) to purchase tickets and make a tribute gift in Dick's honor. Those making a gift of \$250 or more will be able to place a congratulatory message in his tribute book.

Also happening at AAO 2016 is our first annual donor reception on Saturday, Oct. 15 from 3 to 5 p.m. at the Hyatt Regency McCormick Place. We look forward to thanking our valued donors at the Partners for Sight (\$1,000+) and Leadership Council (\$2,500+) levels. More information to come soon.

Please feel free to drop me a line any time with questions or comments at [cmorse@aaoo.org](mailto:cmorse@aaoo.org).

Longtime donor Jane C. Edmond, MD, is featured in the Foundation's new promotional campaign





## As I Remember It

### Mystery Chef

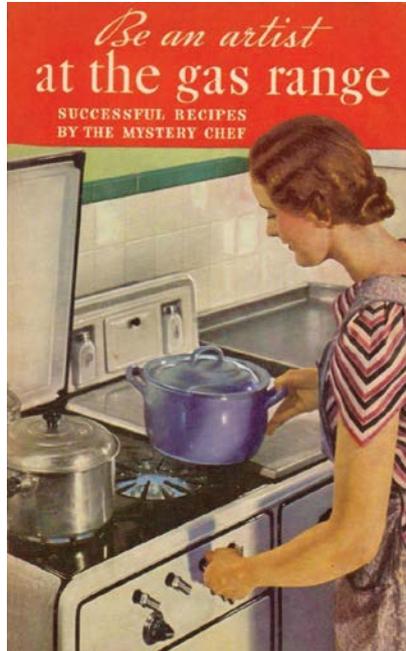
Ira I. Eliasoph, MD

Long before television existed with all its cooking and iron chef shows, when the U.S. was in the throes of a great depression, there was the “Mystery Chef” radio show which ran from 1932-1945. The “Mystery Chef” was a man named John MacPherson who was a chemical engineer that arrived in the U.S. in 1906 from England. He started on the radio in the 1930’s and his cooking quote was, “Be an Artist at the Range, Not Just a Cook.”

He gave recipes that were easy to follow, nutritious, and economical. He published several cookbooks and after I removed his cataracts, he gave me a large and delicious cheesecake that he had made, and inscribed one of his books for me.

An important cooking lesson from the book was, in preparation to cook rice or pasta, to take a large pot, put in the necessary water, and then an inch or two inside below the rim “paint” a wide stripe of cooking oil. This prevents the foam created when the water boils from rising up and spilling over the edge.

Back then, no one seemed to know what the Meibomian secretions were good for. We now know that the oil gives a better optical front surface for vision, retards evaporation of water in our tears,



but also the oil is a barrier at the lid margins to tear spillover.

I knew this from the “Mystery Chef” back in 1958.

## As I Remember It

### Vignettes of the days of training and early practice

SCOPE solicits interesting and entertaining vignettes of readers’ days of training and early practice.

Please limit your submission to about 500 words.

Send submissions by email attachment to [scope@aaao.org](mailto:scope@aaao.org)

## 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.

#### Editor

David W. Parke, MD  
North Branford, CT

#### Associate Editors

W. Banks Anderson Jr., MD  
Durham, NC

M. Bruce Shields, MD  
Burlington, NC

William S. Tasman, MD  
Philadelphia, PA

#### Assistant Editor

Neeshah Azam  
AAO, San Francisco, CA

#### Senior Ophthalmologist Committee

Susan H. Day, MD, Chair  
Chicago, IL

Richard L. Abbott, MD  
San Francisco, CA

Tamara R. Fountain, MD  
Secretary for Member Services  
Chicago, IL

Thomas S. Harbin, MD  
Atlanta, GA

Samuel Masket, MD  
Los Angeles, CA

David W. Parke, MD  
North Branford, CT

M. Bruce Shields, MD  
Burlington, NC

Gwen K. Sterns, MD  
Rochester, NY

C.P. Wilkinson, MD  
Baltimore, MD

#### Staff

Gail Schmidt  
Neeshah Azam

#### Design

Lourdes Nadon

