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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY
AND OTOLARYNGOLOGY:
ORAL HISTORY RECOLLECTIONS OF PAST
AND PRESENT LEADERS**

Volumes 1 – 3

Interviews with

Wendell L. Hughes, M.D.
W. Howard Morrison, M.D.
Daniel Snyder, M.D.
John W. Henderson, M.D.
Clair M. Kos, M.D.
Frederick C. Blodi, M.D.

David J. Noonan
Stanley M. Truhlsen, M.D.
Lawrence A. Zupan
Bradley R. Straatsma, M.D.
Bruce E. Spivey, M.D.
H. Dunbar Hoskins Jr., M.D.

With a Series Introduction by
William H. Spencer, M.D.

Interviews Conducted by
Sally Smith Hughes, Ph.D.
1990–1997

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THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY: ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS, 1998, 564 pp.

Retrospective interviews about the American Academy of Ophthalmology and Otolaryngology (AAOO), and the American Academy of Ophthalmology (AAO) with 11 past and present leaders, and with a former executive of the American Association of Ophthalmology. Characteristic administrative styles of successive Executive Secretary-Treasurers and Executive Vice Presidents; Annual Meetings at the Palmer House hotel; pioneering Continuing Education Programs and Instruction Courses at the Annual Meetings; the Home Study Course; Academy organization and the Committee of Secretaries during the Benedict administration; the *Transactions of the American Academy of Ophthalmology and Otolaryngology*; AAOO organizational changes during the Kos administration; appointment of David Noonan; movement toward separation into two Academies; voting on separation; division of funds; the AAO move to San Francisco; AAO reorganization during the Spivey administration; switch from a bimonthly transactions to the monthly peer reviewed journal *Ophthalmology*; creating the *Basic and Clinical Science Course in Ophthalmology*; the Ophthalmic Knowledge Assessment Course; ethics and the AAO; Federal Trade Commission approval of the Academy's code of ethics; the AAO assumes a political role; the Washington office; merger of the AAO with the American Association of Ophthalmology; women and the Academy; the Foundation of the AAO; the National Eye Care Project; the endowment fund; growth of women members; organizational redesign at the outset of the Hoskins administration; changes in the decision-making process and planning mechanisms; public members on the Board of Trustees; the Academy's advocacy role and its response to the growth of managed care; the Surgical Care Specialty Coalition; outcome studies, cost-effectiveness and quality of care; the Website and communications with the public; the growth of international membership; relationship between Ophthalmology and Optometry; the Work Force Study.

Interviews with Wendell L. Hughes, M.D.; W. Howard Morrison, M.D.; Daniel Snyder, M.D.; John Warren Henderson, M.D.; Clair M. Kos, M.D.; David J. Noonan; Frederick C. Blodi, M.D.; Stanley M. Truhlsen, M.D.; Lawrence A. Zupan; Bradley R. Straatsma, M.D.; Bruce E. Spivey, M.D.; and H. Dunbar Hoskins, M.D.

Preface by William H. Spencer, M.D.

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SERIES INTRODUCTION

Since its inception, the American Academy of Ophthalmology and Otolaryngology (AAOO) has been in the forefront of the movement toward specialization in American medicine and in the development of innovative continuing education programs. During its fledgling years, when quality educational opportunities for budding ophthalmologists and otolaryngologists were few and far between, the Academy's Annual Meeting provided its members with a much-needed national forum where information could be exchanged about the diagnosis and treatment of diseases they encountered on a daily basis.

The AAOO also participated in the establishment of the first and second medical specialty examining boards (the American Board of Ophthalmology in 1916, and the American Board of Otolaryngology in 1924), and pioneered several educational and quality assurance programs subsequently adopted by other branches of medicine. Its groundbreaking meeting format, which mixed auditorium presentations with small group instruction courses, inaugurated the concept of a Continuing Education Program under the aegis of a national specialty society. This innovative program introduced Academy-sponsored medical correspondence courses (the Home Study Course); pioneered the use of scientific exhibits at an annual medical society meeting; collaborated with the Army Medical Museum to build a permanent collection of ophthalmic and otolaryngologic pathology (the forerunner of the Registries of Ophthalmic and Otolaryngologic pathology and the inspiration for the current American Registries of Pathology at the Armed Forces Institute of Pathology); originated the production of medical specialty society publications in the form of course synopses, manuals, atlases and textbooks, and launched an in-service examination designed to provide educational feedback to ophthalmologists in training and their faculty (the Ophthalmic Knowledge Assessment Program).

Sharon Bryan's lively chronicle of the AAOO's formation and growth provides the most comprehensive published account of the early Academy's internal organization, as well as its relationship with medicine as a whole and with federal and state agencies.¹ Bryan skillfully utilized original source materials, such as the minutes of Academy Council meetings, programs of Annual Meetings, the *Perceiver* (the society's early news bulletin), the *Transactions of the American Academy of Ophthalmology and Otolaryngology*, the Wherry scrapbooks, and William Benedict's correspondence. In 1989 the Foundation of the American Academy of Ophthalmology published Dr. William Felch's detailed synopsis of important events leading to the decision to divide the AAOO into separate academies.² Felch acquired much of his data from a combination of archived documents and personal interviews with Academy of Ophthalmology (AAO) leaders and staff. Additional valuable resources include back issues of *Argus* (now *Eyenet*, the society's current news magazine), essays read by members of the Cogan

¹ Bryan, Sharon A. *Pioneering Specialists: A History of the American Academy of Ophthalmology and Otolaryngology*. American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982.

² Felch, William C., M.D. *Decade of Decision: American Academy of Ophthalmology 1979–1989*. San Francisco: Foundation of the American Academy of Ophthalmology, 1989.

Ophthalmic History Society for the History of Ophthalmology during the Centennial Meeting of the Academy in Chicago,³ and vignettes presented at annual meetings of the Cogan Ophthalmic History Society. All documents are archived, either at the Museum of Ophthalmology of the American Academy of Ophthalmology in San Francisco or the museum of the American Academy of Otolaryngology in Alexandria, Virginia. The reader is also referred to Dr. Stanley Truhlsen's chapter, "The American Academy of Ophthalmology," in Albert and Edward's book *The History of Ophthalmology*.⁴

In 1986, the AAO's Foundation, in collaboration with the Regional Oral History Office of the University of California at Berkeley, initiated a series of ophthalmology oral histories consisting of in-depth interviews with senior ophthalmologists and others who had made significant contributions to the specialty. The eight indexed and bound transcripts of the interviews, published between 1988 and 1994, were intended to preserve the memories, experiences, and insights of extraordinary ophthalmologists and visual scientists who had lived through, and participated in, the impressive changes that occurred in ophthalmology during the years before and after World War II.⁵ Together, and separately, these volumes add a personal dimension to our understanding of America's ophthalmic heritage and preserve a fund of historic information that might otherwise have been lost (at this writing, five of the eight participants in the project have died).

The present work differs from the oral histories noted above. Focused on the Academy, it is composed of a compilation of interviews with past officers of the AAOO, and with past and present officers of the AAO and related organizations. The interviewees were nominated by the AAO Board of Directors and the Board of Trustees of the Foundation of the Academy. The collected histories are intended to supplement previously published information about the Academy and to help characterize the "flavor" of Academy activities. The discussions encompass the personal recollections of the participants concerning a gamut of pivotal events, ranging from the era when Academy leadership was paternalistically controlled by one individual, and AAOO efforts were almost exclusively directed toward the education of American ophthalmologists and otolaryngologists, to the present era where decision making and planning is a broader process and the AAO is committed to an agenda that still emphasizes educational issues, but includes societal and political issues as well.

³ "A Century of American Ophthalmology." A combined symposium on the history of ophthalmology given by the American Academy of Ophthalmology and the Cogan Ophthalmic History Society. Presented jointly at the American Academy of Ophthalmology Centennial Annual Meeting, October 30, 1996.

⁴ Albert, Daniel M., Edwards, Diane D. Editors. *The History of Ophthalmology*. Cambridge, MA: Blackwell Science, Inc., 1996.

⁵ *Ophthalmology Oral History Series, A Link With Our Past*. Conducted by Sally Smith Hughes, Regional Oral History Office, University of California at Berkeley, in cooperation with The Foundation of the American Academy of Ophthalmology.

During the years embraced by the reminiscences of the participants, the AAO moved its headquarters from Rochester, Minnesota to San Francisco, California and underwent significant leadership, staffing, and organizational changes. Wider participation by members in AAO governance was encouraged, and limits were placed upon terms of office (thus minimizing hierarchical entrenchment). Concurrently, a dramatic expansion took place in national and international membership, and substantial revisions were made in the scope of the educational program (e.g., publication of *Ophthalmology* as a monthly peer-reviewed scientific journal to supersede the *Transactions*; modification of the Annual Meeting format to replace the single daily plenary session with multiple programs and symposia primarily composed of subspecialty topics; presentation of an annual display of posters providing clinical and research data; broad growth of continuing education offerings to include “hands-on courses” and a plethora of written materials directed toward lifelong education in ophthalmology). In addition, the AAO sponsored the establishment of a professional liability program (the Ophthalmic Mutual Insurance Company) and created the Foundation of the American Academy of Ophthalmology to support and develop Academy public service programs (e.g., the National Eye Care Project, Diabetes 2000, Glaucoma 2001), and to preserve ophthalmic heritage through support of the Museum of Ophthalmology and its public outreach programs.

Eleven interviews were conducted between 1990 and 1993 with the intention of completing the editorial and production process in time for the Academy’s 1996 centennial celebration. For logistical reasons, and because there was uncertainty about how the materials would be used, this did not occur during the Centennial Meeting.

During the short five to seven years since these interviews took place, the American healthcare system has rapidly undergone fundamental changes that have imposed significant regulatory controls on physicians and others who deliver our nation’s medical care and educate our future physicians. Medical specialties, including ophthalmology, have been particularly affected by these changes, and individual ophthalmologists have increasingly relied upon the AAO to express their concerns to Congress and healthcare agencies. For this reason, and to place these memoirs into perspective, the FAAO’s Archives and Oral Histories Committee and the Editors have added a twelfth interview with Dr. H. Dunbar Hoskins Jr., the AAO’s current Executive Vice President, in which he expresses his views about the Academy’s role in assisting ophthalmologists to meet these challenges.

The individual oral histories are divided into four groups, each designated by the name of its chief administrative officer (Executive Secretary-Treasurer, Executive Vice President). Overlap between groups, as well as continuity, is provided by interviewees, who have witnessed successive administrations.

The “Benedict Administration” interviews with Drs. Hughes, Morrison, Snyder, and Henderson focus on their recollections of the ambiance and governance of the AAO during the relatively quiescent years when the AAO was headquartered in Rochester, Minnesota, when the impelling force was solely educational, and when virtually all ophthalmologists and otolaryngologists were generalists who looked upon the annual AAO meeting as an opportunity to learn about each and every aspect of their respective fields. Subspecialization

was in its infancy, and discussions about related topics took place in small groups at individual instruction courses, rather than the single daily plenary session.

The “Kos Administration” interviews with Dr. Kos and Mr. Noonan acquaint the reader with the perspectives of otolaryngologist members of the AAOO, touch upon reorganization of AAOO administrative procedures initiated by Dr. Kos in Rochester, and present the views of otolaryngologists about separation into two academies. As the only former employee of the AAOO who moved to San Francisco with the newly formed AAO, Mr. Noonan provides the reader with his unique observations of the Academy’s organizational growth during the past quarter century.

In the “Spivey Administration” interviews, Drs. Blodi, Truhlsen, Straatsma, and Spivey, as well as Mr. Zupan, recall their participation in the events leading to separation of the AAOO and establishment of the AAO in a new headquarters city with a completely new organizational structure. They also discuss merger of the AAO with the American Association of Ophthalmology, growth of the continuing education program, establishment of a refereed monthly Journal (*Ophthalmology*), formation of the AAO’s Foundation, relations with other organizations, development of a Washington Office of Governmental Relations, creation of an Academy Code of Ethics, and changes in Academy demographics—with increasing numbers of women and international members.

As noted earlier, the interview with Dr. Hoskins highlights the AAO’s activities at a time when managed medical care groups have limited patients’ access to specialists, and the Academy has become ophthalmology’s central advocate to private and governmental healthcare agencies regarding patient access, reimbursement, and practice expense issues.

William H. Spencer, M.D.
August, 1997

INTERVIEW HISTORY—Sally Smith Hughes, Ph.D.

In 1989, the American Academy of Ophthalmology (AAO) began to discuss an oral history project to document Academy history through interviews with some of its oldest living members. The idea evolved from a series of lengthy oral histories, sponsored by the Academy and the University of California, Berkeley, with eight prominent ophthalmologists.¹ The original idea was to produce an oral history volume for the Academy centennial celebration in 1996. That deadline proved to be untenable because neither an author nor adequate financial support was readily obtainable.

From the start, the project was conceived primarily as an historical endeavor, an effort to preserve important historical information, much of which would remain undocumented unless the memories of individuals playing salient roles in the AAO's history were elicited and recorded. After many vicissitudes regarding sponsorship, finances, project staff, format, selection of interviewees, and so on, the following volumes of twelve interviews are finally ready for research and—we hope—enjoyment. They also serve as a lively and personal way to preserve Academy history, particularly when used in conjunction with Sharon Bryan's *Pioneering Specialists*² and documents available in the Academy archives.

The fact that oral history records the personal and subjective is both its strength and weakness. It plumbs memories, anecdotes, details—the multidimensional context of events—in a manner unmatched by other historical methods. Yet the reader must be aware that oral history expresses the thoughts and opinions of individuals who, like all of us, see the past through the twin lenses of personal experience and perception. It is precisely this personal aspect that makes oral history uniquely informative and, to most of us, engaging. But deductions to be drawn from it must be weighed against the written document. Fortunately, the archive maintained by the Academy Foundation contains records on the history of the AAO and its predecessor, the American Academy of Ophthalmology and Otolaryngology (AAOO). In addition, each of the lengthy individual oral biographies mentioned above contains information on the AAOO and the AAO.

The interviewer prepared for the interviews by thoroughly researching relevant documents in the Foundation's archives, Bryan's history, other historical publications related to Academy history, and by talking with Academy members, particularly Dr. William Spencer. Four interviews were conducted in October 1990 at the Annual Meeting of the American Academy of Ophthalmology in Atlanta, Georgia, and four on a whirlwind tour of the midwest in July 1991. Interviews with David Noonan, who served on the administrative staff of both the AAOO and the AAO, were conducted on July 22, 1991. In an effort to capture recent history, an interview was recorded at Academy headquarters in San Francisco with Dr. Bruce Spivey on July 2, 1991, at the time AAO

¹ Oral histories of Drs. Paul Boeder, David Cogan, Thomas Duane, Dupont Guerry, Edward Maumenee, Dohrmann Pischel, Harold Scheie, and Phillips Thygeson are available for research at the Academy and at the Bancroft Library, University of California, Berkeley.

² Bryan, Sharon A. *Pioneering Specialists: A History of the American Academy of Ophthalmology and Otolaryngology*. American Academy of Ophthalmology, San Francisco, American Academy of Otolaryngology—Head and Neck Surgery, Rochester, Minnesota, 1982.

chief executive, and with Dr. Bradley Straatsma at UCLA [June 1993]. To bring the history up-to-date, and to reflect the Academy's response to contemporary changes in health care, Dr. Dunbar Hoskins, the current chief executive, was interviewed in San Francisco on September 16, 1997.

We have Dr. William Spencer to thank for this project's seeing the light of day. At a time when most of us had moved on to other obligations, he revived the project and carried it to completion. The series preface and helpful introductions to each oral history are solely his. In addition, he pursued funding, garnered approval from Academy officials, and collaborated with the historian/interviewer.

Edited transcripts of the interviews sent to the interviewees for review and approval were returned with only minor additions and changes. The interview with Dr. Clair "Mike" Kos was reviewed by his son, Michael. A chronology of selected events related to Academy history is located in the appendices.

Sally Smith Hughes, Ph.D.

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ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Wendell L. Hughes, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
October 28, 1990, Annual Meeting of the
American Academy of Ophthalmology,
Atlanta, Georgia

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Wendell L. Hughes, M.D.

Wendell L. Hughes, M.D.

Introduction¹

Wendell L. Hughes was born February 26, 1900 in Thorndale, Ontario, Canada. The son of a general physician, he followed his father into medicine and graduated from the University of Western Ontario Medical School in 1922. His residency training in ophthalmology was obtained at New York University—Bellevue Hospital from 1923 to 1926. Between 1930 and 1968 he practiced ophthalmology in New York City and Hempstead, Long Island, where he pioneered the development of microneedles and sutures, combined surgery for cataract and glaucoma, and ophthalmic plastic surgery. His interest in ophthalmic plastic surgery was stimulated by his association with Dr. John Martin Wheeler, the first really serious oculoplastic surgeon in this country. Dr. Hughes introduced and reported a number of ophthalmic plastic reconstructive procedures and taught many of the early leaders of this subspecialty. Several books on the subject of ophthalmic plastic and reconstructive surgery were dedicated to him in appreciation of his teachings and leadership.

Dr. Hughes was highly regarded by general plastic surgeons and became a founder and one of the first diplomates of the American Board of Plastic Surgery. He served as Clinical Professor of Ophthalmology at New York University Medical Center, and was president of the New York Ophthalmological Society and the Nassau County Ophthalmological Society. In 1955 he was presented with an honorary Doctor of Science degree by his alma mater, the University of Western Ontario Medical School, which also instituted a yearly lecture and instructional day in his honor.

In 1942, Dr. Hughes was a co-author of an Academy monograph on *Anomalies of the Extraocular Muscles*.² He chaired the Academy's Plastic Surgery Committee from 1952 to 1968 and was largely responsible for writing and editing the first edition of the Academy's manual, *Ophthalmic Plastic Surgery*³ in 1961. Dr. Hughes was President of the American Academy of Ophthalmology and Otolaryngology in 1967, when proposals to divide the AAO into separate academies were initially debated publicly.

In 1969, Dr. Hughes served as the first president of the American Society of Ophthalmic Plastic and Reconstructive Surgery. The Wendell L. Hughes lecture, established the same year, is delivered each year at the Academy. He became a member of the American Ophthalmological Society (AOS) in 1941. His AOS thesis, *Reconstructive Surgery of the Eyelids*, was

¹ Sources: 1. Beard C, Wendell L. Hughes, M.D. *Trans Am Ophthalmol Soc* 1994; XCII: 16-18.
2. "Wendell L. Hughes, M.D. Dead at 93." *Argus* 1994; (Apr): 38.

² Aebli R, Hughes WL, Dunnington JH, White JW. *Anomalies of the Extraocular Muscles*. American Academy of Ophthalmology and Otolaryngology, 1942.

³ Hughes WL et al*. *Ophthalmic Plastic Surgery*. American Academy of Ophthalmology and Otolaryngology, 1961. (* 24 contributors)

subsequently published as a text in 1943 and enlarged into a second edition in 1954.⁴ Dr. Hughes actively participated in the scientific, social, and athletic programs of the AOS for many years. He was an avid tennis player and for 11 years donated tennis medallions to winners of the women's tennis doubles tournament (in 1983 the yearly medallions were replaced by the Permanent Wendell Hughes Bowl). In 1971, he moved to Florida, where he also enjoyed boating. (When this writer met him in Tunisia, on a two-month volunteer stint on the SS Hope hospital ship, he blithely wore one green and one red sock "to help me remember port from starboard.")

Dr. Hughes died February 10, 1994 in Highland Beach, Florida. He is survived by his wife, Mary H. Hughes; two daughters, Nancy Taylor, a nurse in Midland, Texas, and Margaret Smith, a college accounting professor in Melville, Long Island, and a sister, Helen Tamblyn of Alto, Georgia.

William H. Spencer, M.D.
August 1997

⁴ Hughes WL. *Reconstructive Surgery of the Eyelids*. St Louis: C.V. Mosby, 1943 and 1954.

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WENDELL L. HUGHES, M.D.

[Date of Interview: October 28, 1990, Annual Meeting,
American Academy of Ophthalmology, Atlanta Georgia]

Member and President of the Academy

- Hughes:* *How far back do your memories of the Academy go?*
- Wendell Hughes: I joined the Academy in 1929. I've been a member, of course, ever since. That means about sixty years.
- Hughes:* *Do you think you maybe have a record there?*
- Wendell Hughes: Maybe; I don't know. Anyway, I'm ninety now, and from '29 it would be sixty-one years.
- Hughes:* *That's quite a spell of time.*
- Wendell Hughes: I was born in 1900. At first, the Academy was the American Academy of Ophthalmology and Otolaryngology. I was President at the time that it was the combined Academy.
- Hughes:* *Do you remember the year?*
- Wendell Hughes: In '67. It was about two or three years after that when ophthalmology and otolaryngology separated. I'm not sure when the first year of the American Academy of Ophthalmology was.
- Hughes:* *It was 1979.*
- Wendell Hughes: Oh, I thought it was earlier than that.
- Hughes:* *The discussion about splitting went on long before it actually occurred.*
- Wendell Hughes: It was going on during the early seventies, anyway.
- Hughes:* *But not when you were President?*
- Wendell Hughes: Well, I don't remember whether it was or not. I had assumed that it was. But I don't think it was, really. I don't think it was until after I was President.

Hughes: Do you remember any particular issues that were current when you were President?

Wendell Hughes: Well, no; it was just a general increase in attendance at the Annual Meeting of the Academy. We used to meet in the Palmer House in Chicago, and we outgrew that, so we went to places where they would handle big conventions. There were only three or four convention centers at that time throughout the country that could handle that number of people, seven to eight thousand.

Hughes: Was it well before you became President that you left the Palmer House?

Wendell Hughes: Yes. I think we were meeting in a large convention center at that time.

Executive Secretary-Treasurers of the Academy

Hughes: Do you remember any of the old guard of the Academy? I'm thinking of people such as [Drs.] Henry Gradle, William Wherry, and Bill Benedict.

Wendell Hughes: William Wherry was the Secretary for many years, and then Bill Benedict followed him. When I was President, Bill Benedict was very seriously ill, and I had to pinch-hit for him. I had to fly out to Chicago to sign checks for the staff and take up some other matters. Bill died a year or so after that, in 1969. He was the Secretary for quite a while. In those days the President was from ophthalmology one year, otolaryngology the next. We alternated that way.

Hughes: I understand that it was an unwritten rule, that it wasn't actually in the constitution.

Wendell Hughes: Oh, no, it was just fairness between the two organizations, that's all.

Hughes: Well, tell me a little about these people, both in terms of their personalities and also their management style—how they ran the affairs of the Academy.

Wendell Hughes: Bill Benedict really ran the affairs. He was a good administrator when he was in his prime. [Dr. Clair Michael] Mike Kos, otolaryngologist, followed him. William Wherry was an otolaryngologist, and then Bill Benedict was an ophthalmologist. Mike Kos was the last of the combined Executive Secretary-Treasurers. I think he had been secretary of the

otolaryngology section. [Dr.] Bruce Spivey came along after that, and he's been there ever since.

Hughes: Can you say anything about the differences in the way these different men handled affairs of the Academy?

Wendell Hughes: Bruce is a very astute administrator. So was Bill Benedict. Bill Benedict managed things very well. He was sort of the dictator in the Academy. I think Bruce pays attention to some of the other professional men a little more and has a good board of directors, which is in charge of the Academy in general.

Hughes: Would you say that Bill Benedict was a one-man show?

Wendell Hughes: Yes, I think so. Of course, Bruce is pretty much that way. He manages things very well. He does adopt some suggestions of others, and others adopt suggestions of his.

The Academy's Political Involvement

Hughes: The primary goal of the Academy in the early days was an educational one, and political and economic affairs were not considered part of the Academy's responsibilities.

Wendell Hughes: That's right. Political and other aspects of the Academy are more prominent now.

Hughes: How do you explain that? Is it due to the changing face of medicine?

Wendell Hughes: It's a necessity. Since third-party payers have stepped into the medical picture, [political action] has been a necessity to keep the medical aspect in the foreground rather than just the political. Third-party payers have quite an influence in the Academy and in general medical practice, not only in ophthalmology.

Hughes: Was there any debate about the Academy expanding its duties?

Wendell Hughes: No. No, it became a necessity, that's all.

Hughes: So political involvement was generally supported by the membership at large?

Wendell Hughes: Oh, yes. The American Association [of] Ophthalmology is particularly concerned with the political aspects. That has increased considerably.

Hughes: There was an effort made to bring the American Association of Ophthalmology into the Academy after the Academy split from otolaryngology.

Wendell Hughes: It is sort of an ancillary division, you might say, of the Academy.

Hughes: Does it retain its name?

Wendell Hughes: Oh, yes, and with individual meetings and officers.

[Dr.] John Martin Wheeler proposed me for the Academy, and he was really my mentor in the old days. I was associated with him in my residency at Bellevue Hospital. He was President at one time [1934].¹

More on the Executive Secretary-Treasurers

Hughes: Did you have any personal contact with William Wherry?

Wendell Hughes: Not so much with Wherry. Bill Benedict was my main contact with the Academy.

Hughes: Anybody else of the early people that we should mention?

Wendell Hughes: Bill Benedict and Mike Kos were the two secretaries who had to do with the Academy. Mike was Bill Benedict's understudy, you might say, and he went on to be the secretary of the otolaryngology section later on [1960–1968].

Hughes: I understand that Dr. Benedict was the first full-time Executive Secretary Treasurer.²

Wendell Hughes: I thought William Wherry was.

Hughes: He was part time.

¹ Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982, p. 136.

² *Pioneering Specialists*, p. 147.

Wendell Hughes: I know Wherry was only part time, and he served at first without any salary.

Hughes: I read that Benedict only became full time when he retired from the Mayo Clinic,³ and that Wherry was always part time.

Wendell Hughes: That may be so, but I know that Wherry gave his time just because he wanted to foster the Academy.

Hughes: Do you remember how many people were involved in the Academy staff that year you were President?

Wendell Hughes: There were about eight girls. The headquarters was in Rochester, Minnesota.

Dr. Wheeler was interested in ophthalmic plastic surgery, and it was he who stimulated my interest in the plastic work.⁴ I followed him as chief of the plastic surgery group in the Academy when Dr. Wheeler died in 1938, and plastic surgery was expanding remarkably. We used to have our meetings in the main ballroom of the Palmer House, and we even had a dinner for the first few years.

They used to have small plastic [surgery] meetings in Room 14 of the Palmer House, and it got so that people were hanging on the outside of the doors trying to get in, with a big crowd outside, because the room wasn't anywhere near big enough. So finally they had it in one half of the ballroom. They'd have one half for ophthalmology and one half for otolaryngology; they'd both be having meetings that way. Dinner meetings were also held in the ballroom of Palmer House in the '60s. Then, of course, we got into different convention centers later on.

The plastic group has mushroomed, so now they have a special organization, what they call ASOPRS: American Society of Ophthalmic Plastic and Reconstructive Surgery, which has about three hundred members now. I was the first in '69.

Hughes: It's a relatively new organization?

Wendell Hughes: Oh, yes. We have our meetings in conjunction with the Academy [Annual Meeting], and then another meeting in the spring—two meetings a year for the ASOPRS group.

³ *Pioneering Specialists*, p. 147.

⁴ See Wendell L. Hughes, "The Development of Ophthalmic Plastic Surgery." Undated typescript.

Hughes: *Getting back to Dr. Benedict, I understand that his real interest was in education and that he was one of the people who was strongly opposed to the Academy branching out into politics.*⁵

Wendell Hughes: Yes, he was very much against that. I wanted to have the president of the United States come out as a guest speaker when I was President, but [Dr. Benedict] was very much opposed to that because it was political. Well, I was just a neophyte compared to him, so of course his policy predominated.

Hughes: *Why was he opposed to any political involvement?*

Wendell Hughes: I really don't know. I wanted to get some of the bigwigs interested in [the Academy], but I was overruled there.

Hughes: *Is it that the Executive Secretary, now the Executive Vice President, is the power behind the throne?*

Wendell Hughes: That's true.

Hughes: *For one thing, he has continuity, and the President changes every year.*

Wendell Hughes: The President is only there for a year, yes. That's basic that the Executive Secretary really has control or has major influence, especially in the politics of the Academy.

Hughes: *Dr. [Stanley M.] Truhlsen has written a little history on the secretariats of the Academy.⁶ He describes an "old boys' club" at the top of the AAOO hierarchy which "passed secretaries and officer posts around to each other." Do you have any comment to make about that description?*

Wendell Hughes: I hadn't heard that before, but it sounds relevant.

Hughes: *You were aware as President that there was a "club," so to speak, of the Academy hierarchy?*

Wendell Hughes: I had no idea of a club at all, or of any particular group having got together. I wasn't a politician myself, and I didn't delve into the politics of the group at all.

⁵ *Pioneering Specialists*, p. 145.

⁶ Stanley M. Truhlsen. "The History of the Ophthalmology Secretariats of the American Academy of Ophthalmology." Typescript, revised April, 1987, 32 pp., p. 11.

Hughes: *Why is a given individual chosen as President?*

Wendell Hughes: Because he has given service to the Academy over the years.

Instructional Courses in Plastic Surgery

Wendell Hughes: I had been in charge of the plastic instructional courses. We had two panels of instruction to give these courses, and I was instrumental in forming those groups and also in suggesting [topics] for each of the men. We'd have meetings each year to decide what we'd present next year in the instructional courses. Then we'd get together with the group, and we'd give each man a certain subject to prepare for next year for his instructional course. Dr. Alston Callahan was my right-hand man in that organization, so he had charge of one panel, and I had charge of one panel. We got together with all the instructors in the current year to choose courses for new instructors for the following year.

Hughes: Was there a theme that ran through the courses?

Wendell Hughes: It was all plastic or reconstruction surgery. The courses were not designed for personal aggrandizement and were intended to provide procedures that surgeons could use in their practices at home. We showed slides and movies of exemplary procedures.

Hughes: *How did you decide which topics should be presented each year?*

Wendell Hughes: We asked the presenters themselves what procedures they were particularly interested in. They would be able to present that subject much better than if somebody said, "Here, you take such and such a subject."

Hughes: *So you picked the individual, and then the individual chose what he wanted to talk about?*

Wendell Hughes: Oh, yes. We tried to get it so that people who were particularly interested in, say, ptosis or strabismus or various lid reconstructions and so on, had their chance to develop a good course in that subject. Courses increased so that now well over a hundred are given at the time of the Annual Meeting each fall.

**The Combined Operation for Cataract
and Glaucoma**

Wendell Hughes: Another one of my interests was cataract and glaucoma. I think I probably did the first combined operation for cataract and glaucoma back in 1929. I was severely criticized at the American Ophthalmological Society meeting by Dr. [Frederick] Verhoeff, who said that this type of operation should never have been done, severely criticized as only Verhoeff could. [laughs] He had a very vitriolic tongue when he wanted to use it.

Hughes: You were a young man at that point.

Wendell Hughes: Oh, relatively so. I was a neophyte.

Hughes: Do you remember his reasons for not combining those procedures?

Wendell Hughes: He said there was no reason for it; take the cataracts out, and sometimes the glaucoma will disappear. That was perfectly true for the occasional case, but usually the glaucoma had to be treated later on, and it was a much more difficult operation to do the glaucoma after the cataract was removed. The results were not nearly as good as doing the glaucoma when the cataract was present. The combination of the two was so easy to do.

Dr. [Robert N.] Shaffer of California criticized me on that same subject very severely at the American Ophthalmological Society meeting, where I presented papers. Later on Bob told me, "I remember the times I used to get up and castigate you for this, and now we're all doing it." The combination procedure is routine now.

Hughes: How long did the combined procedure take to catch on?

Wendell Hughes: Gradually, over fifteen or twenty years.

Hughes: Did you continue to do the combined operation?

Wendell Hughes: Oh, yes. I reported over three hundred cases of combined operations for cataract and glaucoma.

Freedom of Expression

- Hughes:* This was a controversial idea of yours in the early days, and if you wanted to give a paper or a course at the Academy, would you have been told that you couldn't talk about this?
- Wendell Hughes: Oh, no.
- Hughes:* It was completely left up to the individual?
- Wendell Hughes: I was able to get courses on care of cataract with glaucoma going at the Academy.
- Hughes:* And you said exactly what you liked?
- Wendell Hughes: Oh, absolutely. There was no hindrance in any way.
- Hughes:* Did anybody review a course outline or an abstract?
- Wendell Hughes: We'd send in an abstract, just a small outline that laid out the things that would be covered in the course. Then in more detail we'd have a further course summary to give to each of the men at the time of the course. There'd be thirty or forty men in the classes, and we'd give an outline to each of them.
- Hughes:* The outline was mainly to tell prospective students what the course was going to cover?
- Wendell Hughes: Absolutely.
- Hughes:* So it was not to give the powers-that-be some knowledge of what you were going to cover?
- Wendell Hughes: No, they didn't censor in any way what anybody wanted to give.
- Hughes:* Did the Academy ever enter into the debates that always go on in medicine? Did they come down on one side or another?
- Wendell Hughes: Not particularly, no. There were papers on one side, and there were papers on the other, given independently of the Academy hierarchy. Eventually it melts down into something that is concrete, that is generally accepted over the years.

- Hughes:* *The Academy in those days did not issue statements about the validity of new procedures? I'm thinking of the recent case of radial keratotomy, where the Academy got into considerable problems by recommending against the procedure.*
- Wendell Hughes: There are always new procedures being devised, especially in the early days of my work. And there are all sorts of different procedures that are more or less common now.
- Hughes:* *From what you are describing, it sounds as though the Academy meetings were really quite an open forum.*
- Wendell Hughes: Oh, there's no question about that.
- Hughes:* *And you could debate back and forth either way?*
- Wendell Hughes: Oh, absolutely.
- Hughes:* *Did a young man feel welcome to stand up and say whatever he wished?*
- Wendell Hughes: He could stand up and say what he wished, but the people in the audience certainly could analyze whether they thought it was reasonable or not.
- Hughes:* *Do you think meetings are as open nowadays?*
- Wendell Hughes: Oh, yes, I think so. Certain papers have to be accepted and placed in the proper pertinent forum. Time is limited, so there is some selection if too many papers are proposed.
- Hughes:* *People will stand up and say, "Why, I think you're absolutely wrong."?*
- Wendell Hughes: Oh, yes. For instance, in the Academy program right now there are all sorts of different propositions. Some of them will hold up over a period of time, and others will be discarded.
- Hughes:* *There were two main officers in the Academy, the President and the Executive Secretary-Treasurer. We talked about how the Executive Secretary-Treasurer was the person . . .*
- Wendell Hughes: He was the fundamental person who carried the continuity of the Academy along.
- Hughes:* *What did the Board of Councillors do in the early days?*

Wendell Hughes: They met around the table to discuss subjects—and politics, too, began to be discussed, but particularly subjects that would be taken care of and how the instructional courses would be conducted. There are some five or six hundred courses now, and in those days they were just starting to increase.

Instruction Courses

Hughes: Of course the Annual Meeting now is dramatically larger, but aside from size have you noticed other changes?

Wendell Hughes: The three big ballrooms [at the convention center in Atlanta] are attended each day, and hundreds of instructional courses are going on at the same time. Seven hundred courses, usually with thirty to forty men in each group, is a tremendous project.

Hughes: I've been told that education has been very much an interest of yours. Is there any more that you have to say about your role in the Academy's educational endeavors?

Wendell Hughes: I don't know if I was very much of an outstanding man at all, but I suppose I have stimulated some of the men. My reputation is entirely due to the work of the group with whom I have been associated.

Hughes: You're talking about the plastic group?

Wendell Hughes: Particularly, yes.

Hughes: I read that Dr. Wherry was never enthusiastic about Dr. Gradle's idea of the Home Study Course.⁷ Did you ever hear that?

Wendell Hughes: Yes, I think Dr. Gradle was instrumental in starting the instructional courses in the Academy, if I remember correctly.

Hughes: The instructional courses came before the Home Study Courses?

Wendell Hughes: That is correct.

⁷ *Pioneering Specialists*, p. 137.

Medical Ethics

Hughes: Do you have anything to say on the subject of the Academy as an arbiter of medical ethics?

Wendell Hughes: The ethics problem is a very difficult one for any group, because if you try to lay down some sort of principles, then you're open to limiting a person's activities. There's an antipathy to limiting the parameters [of anybody's practice]. It's very difficult for the Academy to set down principles that don't limit the practices of certain people. There's something in general politics about limiting the activities of certain people in certain groups. I can't think of the name of it.

Hughes: Oh, there's restraint of trade.

Wendell Hughes: Yes, that's exactly it, because you're restraining some people's activities because of ethics, and then the Academy gets into trouble. It's extremely difficult to put down your proper ethics in relation to your practice.

Hughes: What kind of sanctions does the Academy have at its disposal for members that it thinks are acting improperly?

Wendell Hughes: They can expel them from the Academy.

Hughes: Is that indeed done?

Wendell Hughes: Yes, but again they're liable to be criticized because of restraint of trade.

Academy Relations with Other Medical Organizations

Hughes: Is there anything to say about the Academy's relationships with other organizations within ophthalmology? I'm thinking, for example, of the Section on Ophthalmology of the AMA, the AOS [American Ophthalmological Society], and the American Board of Ophthalmology.

Wendell Hughes: The Academy has a representative on the Board, of course, and they have representatives that go to the AMA, the American College of Surgeons, the Ophthalmological Society, and the Pan-American Association of Ophthalmology.

Hughes: *What are those representatives expected to do?*

Wendell Hughes: Attend the meetings and see what's going on, and then report back to the Academy.

Hughes: *Is it a two-way flow of information?*

Wendell Hughes: I would expect that. Now, of course, I haven't been in close contact lately at all, so I'm just assuming that it is so.

Separation into Two Academies

Hughes: *Do you remember anything about the debate, pro and con, in regard to separation into two different academies?*

Wendell Hughes: Oh, yes. There were people who were grossly opposed to it. I was mildly opposed to it myself.

Hughes: *Why was that?*

Wendell Hughes: Because I thought it would lessen the influence of this group with various other groups and also would make it difficult to get commercial exhibitors who had interest in both sections to come to each individual section. That might be a money matter. It wouldn't be economical for companies that have surgical instruments for both nose and throat and eye to exhibit at the ophthalmologists' meeting and also at the otolaryngologists' meeting. That would divide their influence. But, anyway, it turned out that I was entirely wrong.

Hughes: *[laughs] At least you freely admit it.*

Wendell Hughes: Oh, well, good gracious. I've made plenty of statements that have turned out wrong in my life. [laughs]

Honors

Hughes: *Do you have anything to add?*

Wendell Hughes: I don't know how much of personal things we want. I brought this along, a couple of pages of honors that have been bestowed on me. The Wendell Hughes Lecture was instituted in 1969, and then there's another one, the Hughes lectureship and instructional day in ophthalmologic plastic surgery at my alma mater, The University of Western Ontario, 1985.

I believe you have a list of publications that I gave you.

Hughes: *Thank you, Dr. Hughes.*

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY:
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

W. Howard Morrison, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
July 13, 1991 at Dr. Morrison's Home in
Omaha, Nebraska

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W. Howard Morrison, M.D.

William Howard Morrison, M.D.**Introduction¹**

W. Howard Morrison was born in Bradshaw, Nebraska on May 1, 1909. His grandparents had been Nebraska pioneers, and his father the town's first family doctor. He graduated from the University of Nebraska College of Medicine in 1934 and remained in Omaha as an intern at the College of Medicine Hospital until 1935. Upon completion of his residency training in ophthalmology at the University of Illinois Eye and Ear Infirmary with Dr. Harry Gradle (1935–1937), he joined Drs. W. P. Wherry and W. P. Haney in practice in Omaha. Concurrently he was appointed to the faculty of the University of Nebraska College of Medicine. Dr. Morrison remained actively involved in teaching until 1976, when he retired from active practice and became Professor Emeritus.

Through his association with Dr. Wherry, who was Executive Secretary-Treasurer of the American Academy of Ophthalmology and Otolaryngology, he actively participated in the affairs of the Academy. He was appointed associate editor of the *Transactions* of the Academy in 1940, and in 1969 (when Dr. W. L. Benedict relinquished his editorial position) Dr. Morrison was named Editor-in-Chief of Academy Publications. He retired from this position in 1975; during the next year, he supervised the transition to separate *Transactions* for ophthalmology (edited by Dr. Stanley M. Truhlsen) and otolaryngology (edited by Dr. D. Thane Cody). He received the AAOO Honor Award in 1953 and was selected to be Guest of Honor of the American Academy of Ophthalmology in 1983. Dr. Morrison served as a delegate to the American Medical Association House of Delegates, representing the Academy from 1958 to 1964.

Dr. Morrison died on February 13, 1996. His wife, Evelyn, preceded him in death in 1991. He is survived by a daughter, Ellen Gigliotti, and a grandson, William Morrison.

William H. Spencer, M.D.
August 1997

¹ Sources: 1. Truhlsen SM, William Howard Morrison, M.D. *Trans Am Ophthalmol Soc* 1994; *XCIV*: 13-14.
2. *Pioneering Specialists*, p. 22.

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WILLIAM HOWARD MORRISON, M.D.

[Date of Interview: July 13, 1991, Omaha, Nebraska]

Family Background

Hughes: Dr. Morrison, let's start with your parents and early education.

Morrison: My parents, George Andrew and Nellie King Morrison, were early settlers in Iowa and Nebraska around 1870. My paternal grandparents, William Frederick and Virginia Morrison, came from Pennsylvania in a covered wagon and first lived in what was called a dugout, where they dug into the side of the hill, and they lived there until they could erect a sod house. My father, who was their ninth son, was born in 1877—and they were not Catholic. They lived in this sod house for eight years. Then they built a frame house and bought a farm in 1878, which is still in our possession. They paid \$10 an acre for it. That may not mean much to many people, who might think that was a very inexpensive farm, but in those days \$10 was more than you would think.

My father was the ninth and youngest son. He studied medicine and graduated from the University of Nebraska College of Medicine in 1905.

Hughes: Was that unusual, for a family to send a child to college?

Morrison: Oh, my, yes. In those days an eighth grade education was common, and some probably didn't go that far.

My father attended York College, which was in the county where he lived, and taught high school for several years. My father was a little older than most students entering medical school. After he finished medical school, he went back to where he was born at Bradshaw, Nebraska, and practiced there until he died in 1934. In 1907, he married my mother, who was an Iowa elementary school teacher. She had gone to school at Cedar Falls and then at Drake University for a while.

In our family I was the older son. My younger brother by two years eventually became a gynecologist. Before that he was a geologist, but the geologists were no longer employable because of the Depression, so he went to medical school and practiced in the St. Louis area.

Hughes: Did you stay in touch?

Morrison: Pretty much so, but as you get older your correspondence isn't kept up to date. We kept up more through wives.

Education

Hughes: What about your early schooling?

Morrison: Well, I went to the local school at Bradshaw and then to the University of Nebraska at Lincoln, where I did my premedical work. Then in 1930 I came here to the University of Nebraska College of Medicine.

Hughes: Had you always wanted to be a doctor?

Morrison: That's hard to determine. You see, my father was a general practitioner, a family doctor, and of course you develop a little hero worship, although you did know what you were getting into. Maybe that's why I went into ophthalmology, which would be a little more sedentary. But yes, I presume so. My brother eventually did, too, although none of our family since then has gone into medicine. My brother has two sons. Both of them are lawyers. We have a daughter who is neither a doctor nor a lawyer, although many women are lawyers now.

Hughes: And more and more women are doctors, as well.

Morrison: Yes, I think almost 50 percent of our medical school classes are women now. In fact, one of my former associates, [Dr.] Rusty Crossman, is married to an anesthesiologist.

Hughes: The University of Nebraska had a pre-med course?

Morrison: That was at Lincoln, where the university is.

Hughes: Two years?

Morrison: Two years. Some spent four years, which I'm grateful I didn't.

Hughes: Why didn't you?

Morrison: These were tough times, and the quicker you got out, the sooner you could start earning a living.

Hughes: It was the Depression.

Morrison: If you had an M.D. degree, you probably would not have starved to death. And that's not saying it lightly. I had a classmate, for example, who just died way up in his nineties. He was the oldest one who came into our class. He had been in the First World War in the balloon school out here at Fort Omaha. He was an x-ray salesman who struck hard times. His wife said, "Why don't you take the bonus that you got and go to medical school?" [General Douglas] MacArthur broke up the veterans' protest back in Washington, D.C., but they eventually got a bonus. So he went back and prepared himself with some courses so he could attend medical school. I think he was nearly forty when he graduated. But he has outlived most of us. [laughter]

The Academy under Dr. William Wherry

Hughes: Were there outstanding faculty at the University of Nebraska?

Morrison: We thought so, of course, but I don't know of many with a national reputation.

Hughes: Anybody who particularly influenced you?

Morrison: No, I don't believe so, except Dr. [William] Wherry. When I was a senior in medical school, I got to know Dr. Wherry's associate, Dr. [William] Haney, who, by the way, was the father-in-law of Dr. Stanley Truhlsen.

Hughes: Is that so?

Morrison: Yes. Dr. Haney had a heart attack, and before that he had a retinal detachment that Dr. Harry Gradle repaired.

Dr. Wherry was in school at the same time my father was, and they knew each other. He had a son, Walter, who was a fraternity brother of mine. We knew each other very well, of course. Dr. Wherry asked his son and me if we would come down and help in the office part time while Dr. Haney was recuperating, which we did, and that was my entree as far as Dr. Wherry was concerned.

At that time, 1933, Dr. Wherry was Executive Secretary-Treasurer of the Academy, and we saw a great deal of activity in the office, because that was the headquarters of the Academy: 1500 Medical Arts Building in Omaha.

Hughes: What kind of staff did he have for the Academy business?

Morrison: Well, Dr. Wherry had Miss McGovern, who was his personal secretary. Then there was Miss Jacoby, who was a personality person and went to all of the Academy meetings, and they all liked her. She arranged the banquets and so forth. Then he had another woman by the name of Helen Avery, who was a stenographer.

Hughes: That was it?

Morrison: That was the sum total of it. At the headquarters there at 1500 they kept a large box that looked like a coffin. That contained all the material they needed at the Academy meeting—perhaps not all, but the nucleus of it. So that box was always sent to the place where the Academy met. Two of the women went, Miss McGovern and Miss Jacoby. The stenographer didn't get to go, much to her dislike.

But there were a lot of goings-on as far as the Academy was concerned. Representatives came from various hotels. They held the Academy [Annual Meeting] in hotels, and there were only two hotels at that time that could take the number of people who came to the Academy meeting. These were the Waldorf Astoria and the Palmer House.

Hughes: Did it alternate?

Morrison: Pretty much so, yes. I think one time they had the meeting in Washington, D.C. I don't know how it went; that was before my time. There was another one up in Montreal.

But the hotel representatives, the people who had to do with conventions, spent a lot of their time in the office currying favors.

Hughes: That was big business for them, wasn't it?

Morrison: Oh, yes, it was.

Hughes: About how many attended the Annual Meeting when you first became associated with the Academy?

Morrison: I can't tell you the number, but the hotels were full. Some members had to stay at other hotels. Of course, at the headquarters hotel they had everything arranged as to where they had the banquet and the various rooms where courses were given.

Dr. Wherry was quite a person. As you'll notice when you go back to his history, he made his way from being almost an orphan, raised by his sister. He sold papers and popcorn, edited a magazine for the college of medicine, and was a stamp collector. In fact, he had a tremendous stamp collection. He told me at one time that he would have to live on that when he retired.

Hughes: Did he?

Morrison: No. He died before that time. Unfortunately, Mrs. Wherry and his son paid very little attention to the collection, so they boxed it up and sent it back to Atlantic City for auction. I often wondered how the thing came out. But I'm sure it was worth a lot of money. Dr. Wherry delivered papers at the time when the Spanish-American War broke out. He said he sold newspapers for a dollar apiece. In those days, that was a lot of money.

Hughes: Tell me a little about Dr. Wherry as a personality.

Morrison: Dr. Wherry was an outgoing individual and enjoyed organizing things. For example, when we would go on a trip, he would arrange for several cars on the Union Pacific Railroad for his secretaries or people in the Academy. Dr. Wherry was a surgeon for the Union Pacific Railroad. He would buy all the tickets, pay for all the drinks and everything else. Then he would send the Academy a bill at the end of the meeting. He just loved to do those things. And he enjoyed cards, so he would arrange several card games as a matter of relaxation. He was a big man, and in his later years he was quite a bit overweight. I think that might have been part of his problem, because he developed cardiac disease. He was kind and very thoughtful.

Hughes: How was he as a physician?

Morrison: He carried a large practice, and as a young man he wrote a number of papers which were published. In his later years, of course, his whole life was the Academy, even on Sundays. As an ear, nose, and throat man, I think he was excellent, but in later years he spent more time on the Academy than he did on his practice.

Hughes: Had he been trained in eye as well?

Morrison: He had. Typical in those days, they did eye, ear, nose, and throat. The eye work was mostly refraction; he tested for glasses. Surgical procedures he left to people who made ophthalmology their main specialty. He brought me in, after my residency, to take over the ophthalmological portion of the practice.

Hughes: Did you do more than refraction yourself?

Morrison: Well, I had had my residency by that time.

Hughes: Yes, but was his practice more than just refraction?

Morrison: Oh, yes, definitely. When you bring people in for refraction, you bring in cataracts and everything else. This was the story there. He was on the staff at several different hospitals. When he died, all the secretaries of the Academy, many of the officers, and several schools of nurses came to his funeral. The attendance there was—I hesitate to use the word spectacular—very impressive, I'll tell you that.

Hughes: How had he come into contact with the nurses?

Morrison: He was the chief of staff at two or three hospitals at one time or another.

Hughes: How did he keep all these irons in the fire?

Morrison: He was a man of many hats. He loved cards, as I mentioned. We have a group we call The Offnite, which was organized in about 1900, that consists of about fifty doctors. Once a month on Thursdays we would get together and play cards. We had a bar, and then we had dinner with a lot of stories, a little off-color. He would always get to the Offnite early so he could get the card games organized. [laughter] He loved to do that.

Hughes: So there was always a social aspect to the Academy?

Morrison: A great deal. He emphasized that. Where he had his Academy headquarters office, he always had oyster stew and sandwiches, so anybody who came in could have lunch while they were talking to him. Hotel waiters really paid him a lot of attention, because he always tipped them well at the end of the meeting.

Then he had a parlor with rooms off certain floors for the various officers of the Academy. They would go up there at night and visit and play cards. At that time I think the Annual Meeting was more of a family type thing, even though there were many hundreds of members. Nowadays to me it seems impersonal.

Hughes: Did Dr. Wherry receive a salary?

Morrison: Yes, he did, and I don't know what it was. It wasn't a big salary, not any more than probably covered the time he would lose in the office.

Hughes: There was money put aside for the social events?

Morrison: Yes.

Hughes: That certainly did not come out of his pocket.

Morrison: No. Banquets were big things. We had a British ophthalmologist as a guest of honor during the Second World War.

Hughes: Was that [Sir Stewart] Duke-Elder?

Morrison: No, it was not Duke-Elder. I have forgotten what this man's name was, but Duke-Elder was there in later years. This man got up and said that the food wasted at the Palmer House could feed half of London. Of course, they were on restricted rations at that time.

This is a little off the subject perhaps, but Dr. Ned Ellett, who practiced in Memphis, Tennessee, was a big, handsome man but rather quiet. When he was the [Academy] President, he got up and talked about how when he was in the medical corps during the war, they put him in orthopedics. "But," he said, "I complained. I have had nothing to do with the knee except in a social way for many years." [laughter] Everybody about dropped over, because of all people . . . And that wasn't too bad at that.

The Academy under Dr. William Benedict

Hughes: Did Dr. Benedict continue the social aspect of the Annual Meeting in the same way?

Morrison: Yes, to some extent, but he was a different person. He was a hard driver and a little intolerant, but a wonderful person. In later years, when he was dying, he would call me and say, "Now, you've got to take over everything as far as the publications are concerned." I would go up to Rochester, and [Dr.] Wendell Hughes, who was the President at that time [1965], would start talking to the girls and so forth. Then Dr. Benedict would get better and come in, and he would shoo

us all out and take over. He didn't want to quit, but he had to eventually. In fact, I think some of the girls went and looked at the coffin to be sure he was in there. [laughter] He was a big man physically and had a tremendous voice, a booming voice. You could hear him all over the headquarters office when he was talking on the phone.

[Dr.] Fred Cordes was a friend of his, a professor of ophthalmology at the University of California. Dr. Benedict was Cordes' guest at the Bohemian Grove. Dr. Benedict was very much impressed because Herbert Hoover was there and stopped on his way back to regale us with stories about the Bohemian Grove. At that time we were organizing the *Transactions*, so he spent a couple of days going over the anticipated publication.

Hughes: How did Dr. Benedict's administrative style compare to Dr. Wherry's?

Morrison: Oh, it's a little hard to say, because the Academy grew so rapidly under Dr. Benedict, and it had to be handled in a more businesslike way. I don't mean to say that Dr. Wherry was not businesslike, but I don't think Dr. Benedict was close to his [Academy] in the way that Dr. Wherry had been. I think that would have been impossible, as large as the Academy was.

Hughes: How large was the office under Dr. Benedict?

Morrison: It occupied the third floor of one of the bank buildings at Rochester, Minnesota, quite a large space. Dr. Benedict had a number of employees. We had two manuscript editors and a proofreader running the *Transactions*, and we had mailing people and advertising people; so we probably had about ten people. Dr. Benedict had a right-hand employee by the name of Miss Thompson. She was a female Simon Legree. If he didn't put you in your place, she did.

Hughes: And she knew his thinking?

Morrison: She was just a mirror image of him. So we knew that what she said had his backing. There was no trouble, don't get me wrong; but you knew where the directions were coming from. Unfortunately, she developed a stroke in her later years but wanted to continue. At that time I was Editor-in-Chief of all Academy publications, and I just couldn't employ a person handicapped as badly as she was—not so much physically but vocally, and I'm sure her mental processes weren't quite accurate. She wanted to get back in the swing, and we had to deny her.

*Transactions of the American Academy
of Ophthalmology and Otolaryngology*

Morrison: I thought the organization for the *Transactions* might be of interest to you. When I was in medical school, and that was about 1930 to 1934, I was helping out in the office, as I mentioned. Dr. Wherry liked to do things in a rather flamboyant way. He would get his material together and go out to the Field Club golf course, sit under one of the trees, and edit what we called the bulletin, which was kind of a newsletter at that time.

Hughes: *Was it the counterpart of Argus, the monthly?*

Morrison: No, not exactly, because it had so much about the courses and activities in it. This bulletin predated the *Argus*.

Hughes: *But it didn't have papers in it?*

Morrison: No. We had Miss Evans and another librarian at the university who helped put the papers given at the Academy meeting in a bound volume, and then the Douglas Printing Company here in Omaha would print them. But very few people would look at the bound volume.

Hughes: *Were these papers just as they had been submitted by the speaker?*

Morrison: Yes.

Hughes: *Unedited?*

Morrison: They were edited to some extent. As I recall, they weren't edited in a strict sense, so they were kind of willy-nilly. I hesitate to be on record about that.

Dr. Wherry, together with Dr. Gradle and Dr. Benedict, decided that they would recommend a bimonthly publication. So Dr. Wherry had all of them come to Omaha, where he put them up at the Omaha Athletic Club. For two days they had meetings about what they were going to do about the *Transactions*, picking out the cover, type of paper, two columns or one column, typeset, et cetera.

Hughes: *This was pre-war?*

Morrison: This was 1940, I think.

Hughes: *You were the associate editor for the Academy Transactions?*

Morrison: Not at that time. Later, when they decided to make this a bimonthly publication, then they had to have an editorial board. So the editorial board consisted of Dr. Benedict as Editor-in-Chief, and I was associate editor for ophthalmology. Dr. Henry Williams at the Mayo Clinic was the associate editor for otolaryngology, and the various secretaries were also editors, so-called. They didn't enter in too much.

Hughes: Who put out the bulletin?

Morrison: Douglas Printing Company printed it, but Dr. Wherry put it together.

Hughes: On his own?

Morrison: Yes. How much help he had from various secretaries, I don't know. I know that Wherry did most of it.

Hughes: Were papers presented at the Annual Meeting included in the bulletin?

Morrison: Not that I recall. I don't recall any mentioned by title.

The *Transactions* caught on in a hurry. I think many people enjoyed seeing in print the paper they had read at the Academy meeting.

Hughes: Who did what on the editorial board?

Morrison: When I got to be Editor-in-Chief, my chief function after the [Annual] Meeting was to get the papers all together, leaving out about one hundred. I would separate them by topic so I could see how they related to each other, and [then] select the issue in which they were to be printed. Of course, you always had a fight, because somebody would want to be in the first issue, not the December issue. Then I would rather roughly edit them and send them up to the two manuscript editors.

Hughes: What were you editing for?

Morrison: Mostly scientific mistakes. You would be surprised how many people put things in a manuscript that were kind of screwed up. They mean to say something, and they don't.

Hughes: So it was content rather than style?

Morrison: Yes. When it got to the manuscript editors, they put their teeth in it.

- Hughes:* Now, how did you check the facts? Sometimes the information would be in your head, but sometimes . . . ?
- Morrison:* That's about all of it. When it came to something that I was puzzled about, I would go to the library or look at my own texts.
- Hughes:* Was Dr. Williams doing the same thing?
- Morrison:* Yes. He was a real brain, a very unusual person. He had a severe arthritic condition. Then he developed emphysema. I was in a meeting one day, and I smelled cigarette smoke. I turned around and said, "My God, Bill, you're not smoking, with that oxygen tank sitting beside you?" "Oh," he said, "I've got it turned off. Don't worry." Here he had so much emphysema that he had to have oxygen, and he was still smoking cigarettes.
- Hughes:* Why had he been chosen as an editor for otolaryngology?
- Morrison:* Because Dr. Benedict knew him really well. He was at Rochester, at the Mayo Clinic. So they knew each other.
- Hughes:* Is that the way appointments usually went—Dr. Benedict knew the person?
- Morrison:* I think that's the way you would select people. Don't you think the President selects his cabinet members because he knows them?
- Hughes:* Oh, yes. Did Dr. Benedict's appointments have to be nominally approved by the Council?
- Morrison:* I presume they did, and that brings up another thing. Dr. Wherry always had the Council meet at 7:30 in the morning, before breakfast. Some of the men didn't like to get up at 7:30, and they were greatly relieved when Dr. Benedict had the Council meetings in the afternoon.
- Hughes:* Well, let's finish with the Transactions before we get into a discussion about the Council meetings. Did you and Dr. Williams operate independently as Transactions editors?
- Morrison:* Pretty much so, except that he would send me books such as the *University of Chicago Manual of Style*. I knew about it, too, but he would send excerpts from that. He was a bird dog.
- Hughes:* It sounds as though he were making stylistic changes as well.

- Morrison: Oh, yes. He was far superior to me as far as that was concerned.
- Hughes: Why had you been chosen as editor for ophthalmology?*
- Morrison: Well, because I had been in Dr. Wherry's office.
- Hughes: Yes, but a lot of people had been in Dr. Wherry's office.*
- Morrison: Maybe he took a liking to me. I don't know.
- Hughes: He must have thought, too, that you had some skills for the job.*
- Morrison: Being associated with him rather closely, he knew that I usually delivered what I was supposed to do. He knew I had a fair intellect, and he knew I would perform.
- Hughes: I would think the position would require a wide-ranging knowledge of ophthalmology.*
- Morrison: Of course, I wasn't chosen until after I had my residency. A resident doesn't know everything, but he thinks he does. [laughter]
- Hughes: Did you have difficulty sometimes with papers that were outside your field of expertise?*
- Morrison: Not too much. We had to have permission to print illustrations or pictures. There was a well-known ophthalmologist, and I am not going to mention his name, who would not get permission. We finally had to withdraw his paper. You see, if we were going to print a picture from Duke-Elder, he had to get permission from Duke-Elder.
- Hughes: Why wouldn't he?*
- Morrison: He was just one of these fellows who knew everything, and he wasn't going to get mixed up in nitty-gritty. He had a textbook. [With this attitude] I wonder how he got his textbook printed.

Academy Presentations

Hughes: What was the selection process for having a paper presented at the Academy?

Morrison: The secretaries met several times a year. The Secretary of Ophthalmology was [Dr.] Kenneth Roper. He was kind of an old maid. Everything had to be precise. In fact, when he got to be President of the Academy, if we had a meeting in the afternoon and he was going to present something in the evening, he went back to his hotel and changed his clothes so that he would have a suit that was pressed and looked right. He was meticulous.

To come back to your question, the secretaries would start talking about people they knew around the country and various subjects they thought they were fairly familiar with. Then they would figure out whether they were going to put these people on the program.

One year we had a symposium on glaucoma, for example. They selected [Dr.] Bob Shafer from California; [Dr.] Bernie Becker of Johns Hopkins, who was at that time the head of the department of ophthalmology at Washington University; [Dr.] George Haike from New Orleans, at the University of Louisiana; and myself. They selected us to give this symposium—why, I don't know. [Dr.] Bruce Fralick from the University of Michigan was also on the panel. We met in Denver, then in San Francisco, then in St. Louis, and then at Ann Arbor—in all, four times to get this panel worked out. It had to be well prepared, because you were up before the entire Academy. I think the whole ballroom was full of people. It looked like 10,000 when you got up there. But it was well done, I think. Not because I was in it, but because we prepared it properly.

Hughes: Do you think the amount of preparation was typical?

Morrison: I think most did it, because that is a big job. You don't get up there and make a fool of yourself.

Hughes: Do you think that in general people took a presentation at the Academy very seriously?

Morrison: The only thing I can say is that they certainly had a good attendance. They had standing room only for most meetings.

Hughes: I realize there was a social aspect, but was the primary reason for attending the Academy to learn what was happening in ophthalmology?

- Morrison: I would say probably 75 percent learning and 25 percent social.
- Hughes: Attending the Annual Meeting of course meant leaving your practice. Was that difficult for people in solo practice?*
- Morrison: Oh, I presume, yes. But you have to do it, or you are going to die. You can't work 365 days a year.
- Hughes: But was the meeting also important for keeping up with what was going on in ophthalmology?*
- Morrison: I believe so. Perhaps in a specialty it's a little different, but I'll bet you that some people in internal medicine and general practice very seldom look at a book. They don't have time. When you go to something like the Academy, you're a captive, you see. You have to listen to the presentations. Then they had all these new instruments and exhibits. One whole section of the Palmer House and the Waldorf was given over to exhibits and new instruments. So that gave a person the means to keep up with what was happening. Some people get a great deal out of an exhibit, and some people don't.
- Hughes: Were there guidelines for the exhibitors?*
- Morrison: One of the secretaries was in charge of the exhibits. They always had a great deal of trouble because of the labor problem. When exhibits were delivered at the Palmer House, one labor union handled the exhibit from the truck to the sidewalk, another would take it into the building, and another to its assigned space. Each one had to be paid off. It was a bad situation, but you had to do it.
- Hughes: Did the Academy solicit exhibitors, or did they apply?*
- Morrison: I think it mostly went through departments. If you have a young man in the department, and he wants to bring to notice what he's doing and get some Brownie points, he knows that the exhibit is an opportunity. Or perhaps the secretary in charge of the exhibits had contacted the head of the department to see if they had a man who would like to exhibit. Of course, they would have to send a skeletal outline of what they were going to exhibit. Awards were given for the best exhibits—A, B, and C. So that was quite a stimulus.
- Hughes: Getting an award had significance?*
- Morrison: Oh, yes, if you were an academic. You know.
- Hughes: How were commercial exhibitors selected?*

Morrison: I'm not aware of just how that was done. But there were a number of displays for surgical instruments—Bausch & Lomb and others.

Hughes: They had to be reputable?

Morrison: I presume so. I never was very close to it. A secretary handled it.

Then there was a secretary who was in charge of the banquets. That was Dr. [Earling] Hanson of the University of Minnesota.

Hughes: Just the banquets?

Morrison: Well, entertainment, too. That was a heavy job.

Hughes: Did everybody come to the President's banquet?

Morrison: I don't know what you mean. The annual banquet?

Hughes: There was a social occasion that the President hosted at the Annual Meeting.

Morrison: That was for the secretaries and the people who were almost the official family.

Hughes: Oh, so Dr. Benedict or Dr. Wherry would give that. Nowadays the President of the Academy has a reception. Was there anything comparable?

Morrison: No, I don't believe so. There was also a luncheon, and the man who was President, Dr. Fred Verhoeff, was honored. They gave him a big plaque. He said, "I've got so many of these, I can't hang them. No one pays any attention to me at home except the dog, and he can't read." [laughter] I remember that he wasn't happy about getting another plaque.

Hughes: Oh, yes. He always had something acid to say, didn't he?

Morrison: I remember him. He had a tremendous sense of control. He stumbled one day when going up to the podium. The pages just went everywhere. Any other fellow would have been unhinged, but Verhoeff got up to the lectern, got his papers sorted out, and gave a real good talk.

Hughes: I have heard stories that his comments could be very devastating.

Morrison: He and Dr. Benedict had something in common there. If you were on the ball, Verhoeff respected you. But if you were trying to fake a little bit, why . . .

- Hughes:* *He saw right through it, and he called you on it?*
- Morrison: Yes. Now, understand that I just knew him through visiting Massachusetts Eye and Ear.
- Hughes:* *Would Dr. Benedict routinely comment on papers at the meeting?*
- Morrison: No, he and others always selected people to discuss the papers. For example, I was selected one time to discuss cross-cylinders.
- Hughes:* *After a paper had been delivered?*
- Morrison: Yes. You knew exactly who was going to discuss a paper—one or two or three people. Then you could have spontaneous discussion about some of them, but you couldn't have too much of that or it would have gone on and on and on.
- Hughes:* *How much time was there for free discussion?*
- Morrison: I think papers usually ran anywhere from ten to twenty minutes and discussions probably just several minutes. We kept them pretty short.
- Hughes:* *Were people pretty unhappy with that as time went on?*
- Morrison: When Fred Cordes was President, he kept things right down to the second. If anybody went over that, he almost hit them with the gavel. Dr. [Alan] Woods, who was the head of the department at Johns Hopkins, got up and wandered on and on, and Fred did not interrupt, because he was Dr. Woods. He went about ten minutes over. [laughter]
- Hughes:* *Did that set a precedent?*
- Morrison: No. Another time, when Dr. Benedict was President, we were out at Glacier National Park, and [Dr.] Wilbur Rucker, who was Dr. Benedict's right-hand man, gave a paper. Benedict thought Rucker was going overtime, and he stood up (he was about twice as big as Rucker), and Rucker got the message; he sat down. I came back on the train with Wilbur, and he was so upset about that. He said, "I know I wasn't over time, but when he stood up, I had to quit." So that was it.
- When I was at the Institute of Ophthalmology in London, I visited with the librarian. I said, "I suppose Duke-Elder has a stable of people who help him." The librarian said, "No. He comes in here on a Friday, will check out three or four books, stay awake all Saturday and Sunday, and come back and check them

in.” He’s written a chapter for his book, all by himself, although his wife, Lady Duke-Elder, helped him to some extent. He was a one-man show, apparently.

Hughes: *It’s wonderful English as well, isn’t it?*

Morrison: Oh, yes.

Hughes: *Why were you in London?*

Morrison: I just happened to be there, and of course the eye institute is a world-renowned place. Interestingly, at that time they were taking pictures of the freshman class coming into the University of London, and I think they were almost 50 percent Indians from India.

Hughes: *What year was this?*

Morrison: Probably 1957, something like that. I didn’t see them, but that was what the photographer told me.

Illinois Eye and Ear Infirmary, 1935–1937

Residency

Hughes: *We didn’t talk about your experience at Illinois Eye and Ear Infirmary.*

Morrison: That’s one of the older eye institutes. I think Massachusetts Eye and Ear [Infirmary] is older, but Illinois Eye and Ear is probably second as far as age is concerned.

Hughes: *Who founded it?*

Morrison: It was founded primarily, I think, by the city fathers. Then the university took it over as part of the University of Illinois. At the time I went there, in 1935, Dr. Harry Gradle was the chief of staff. He and Dr. Wherry were very, very close. Dr. Gradle used to fly; he was a colonel in the U.S. Air Corps, retired, but he could hitch a ride on the air force planes. He came to Omaha frequently and always stayed at the Omaha Athletic Club. He and Dr. Wherry would have a real conversation for a day or two.

Hughes: *They were friends as well as colleagues?*

Morrison: Yes. When I decided that I wanted to go into ophthalmology, Dr. Wherry wanted me to have a residency, which I also wanted. He asked Dr. Gradle to put me in. At that time [Dr.] Dan Snyder was also starting, so we spent our time at the Illinois Eye and Ear Infirmary pretty much together.

Hughes: Tell me a little bit about the schedule.

Morrison: It was interesting. At the time I started in surgery, we had two different means of operating on the eye and closing the wound. Now you see advertisements all the time on television: “Go to these people. No stitches,” or “One stitch.” We had two men at the infirmary who didn’t put stitches in at all. They just opened the eye and hoped it would heal before it ruptured. Some men put in a couple of silk sutures, which were of no help at all if a tight squeeze occurred. At that time corneal-scleral suturing was just coming in, where they would suture the cornea and the sclera together. That was a closure that was technically quite difficult at that time, we thought, but it saved a lot of ruptured wounds.

Hughes: Why would some of the men not suture or suture very slightly?

Morrison: That was the way they did things in those days. They didn’t want to embrace the newer procedures.

Hughes: Were the sutures . . . ?

Morrison: Silk sutures.

Hughes: And were they fine enough?

Morrison: They were fine, though not like they are now, where you insert them under a microscope; but they were quite fine sutures.

Cataract Surgery

Morrison: In the days preceding that—not in my time—they would do a cataract operation in two stages. They would do an iridectomy first and then a few weeks later remove the cataract itself. In those days they would just squeeze the lens out. I have two stories about that.

An English surgeon by the name of Colonel Henry Smith would do up to (I may be exaggerating) seven hundred cataracts a day. You see, English surgeons went to India to do two things: urology, because many people had stones, and to

remove cataracts. A lot of people had cataracts in India. Why, I don't know. All Dr. Smith would do was open the eye, squeeze the lens out, tell them to get up and walk, and go on to the next one. So ophthalmic surgeons went to India to develop their technique.

Duke-Elder had a story about a farmer who went off to feed his cows. A cow flipped her head around and caught the farmer's eye with her horn and popped the lens out. The interesting thing is that about two years later the farmer went back, and the same cow hit him in the other eye. So he popped both lenses. The senior student I was telling the story to in the dispensary found it hard to believe. I spent a whole day looking for that report of Duke-Elder's, but I found it.
[laughter]

We didn't do cataracts under general anesthetic. It was all done under a local anesthetic. Of course, the squints and crossed eyes were done under general.

Hughes: *Why?*

Morrison: It's pretty hard to deaden an eye sufficiently so that you can pull on the muscles without pain. Many of the patients are children, you see.

We had a big general clinic at the infirmary. Patients would come in almost by the hundreds and sit in rows. You would segregate patients as to need.

Trachoma Treatments

Morrison: At that time we had a trachoma clinic. The people who had trachoma were the [American] Indians and the wrestlers. Wrestlers' eyes get rubbed into the mat, you see, and transmit trachoma from wrestler to wrestler. Trachoma was a terrible disease in those days. We would squeeze the lid and slit its surface.

Hughes: *The lid follicles.*

Morrison: Then touch up the lid surface with blue stones, a copper sulfate type of caustic. That would burn the lid pretty badly.

Hughes: *That was very painful, wasn't it?*

Morrison: I happened to have the pleasure of listening to Dr. Fred Lowe up at the Rosebud Indian Reservation. He was the first one who started using sulfa drugs for trachoma. He had a miraculous response.

Hughes: That was pre-war?

Morrison: Yes. I've forgotten what year this sulfa drug came out, but its use was popularized by Mrs. [Eleanor] Roosevelt. One of her sons was a patient at the Massachusetts Eye and Ear, and he had a severe sinus infection, I believe it was. I'm a little sketchy in my memory. There was this new drug coming out, prontosil, which is a sulfanilamide. So they used it on one of the Roosevelt boys. She put it in her newspaper column, and then you had people standing in line wanting that new drug. Fortunately, they were able to get it on the market pretty quickly. And so it was used for many things.

Hughes: What was the purpose of segregating clinic patients?

Morrison: Some of them needed glasses, some of them needed treatment for an infection, some of them needed cataract surgery, some of them had glaucoma, some of them had a crossed eye; so you segregated them.

Hughes: And you did a little bit of everything?

Morrison: Yes. As a resident.

Hughes: Were you allowed to operate?

Morrison: Oh, yes. You had to stand with the chief surgeon for a while until he thought maybe you could handle it. Then he would start you doing a few things and gradually work you into it.

Hughes: How long was the residency?

Morrison: Two years.

Dr. Gradle's Ophthalmology Practice

Morrison: Mine was just short of two years, because at that time Dr. Gradle took some of us into his office. He had a very large practice in Chicago. He took Dan Snyder, [Dr.] Ted Zeckman, [Dr.] Jack Cowin, and myself. We would refract, run fields of vision, and various things. All Dr. Gradle would do was write the prescriptions for glasses. He never touched a lens. He was interesting.

Hughes: But he operated, did he not?

Morrison: He lived up north of Chicago, in Highland Park, I believe. Snyder and Gradle were neighbors. Snyder's father was on the board of the First National Bank of Chicago.

Hughes: *I thought he was an ophthalmologist.*

Morrison: He was. He had money. When he died, the First National Bank supposedly sent a bank car out to pick up Dan and take him down to the bank. That was quite impressive. [tape interruption]

Dr. Gradle came down from his home to the office by train, steam in those days. He had office hours in the morning only. Then he had his chauffeur pick him up in his Packard car. He had this Packard fixed up in the back with a desk and light so that he could read and write. The chauffeur drove Dr. Gradle to Michael Reese Hospital, where he did most of his surgery. He always did his surgery in the afternoon. Then he would get in his car, and the chauffeur would take him home, an hour or two ride. He didn't waste time while he was riding home.

Hughes: *He had a full day of work, it sounds.*

Morrison: Oh, he had a tremendous surgical practice. In the afternoon, Dr. Sanford Gifford came in. He had more of an exclusive practice. He would see only a fraction of the patients Dr. Gradle would see.

Hughes: *Why was that?*

Morrison: That's hard to answer, because he was also up at Winnetka. He even had office hours in the evening, but I think that was to satisfy the top-drawer people who wanted to be seen by Dr. Gifford and didn't have time during the day. They thought they were more important than he was.

Hughes: *But it wasn't because he was only interested in certain types of problems? He didn't subspecialize, in other words?*

Morrison: I don't think so. In those days people played the field, except Dr. Gradle, who was pretty much interested in glaucoma. He wrote the section on glaucoma in [Dr.] Conrad Berens's book. Dr. Gifford became well known because the Duchess of Windsor came through Chicago, and she had something [wrong with her eye]—probably nothing, but she complained loudly about it. So Dr. Gifford got on the train and crawled up into the berth where she was and treated her eye, so they said. Of course, that got a lot of publicity.

Hughes: *I can imagine.*

Glaucoma Treatments

Hughes: *Did your interest in glaucoma stem from Dr. Gradle?*

Morrison: I think so. We saw a tremendous number of patients with glaucoma.

Hughes: *What was being done for glaucoma in the pre-war years?*

Morrison: We had drugs, but some of them were very harsh. Eserine, for example, was used, and that produced such a spasm of the iris sphincter that the patients often rebelled, usually rightfully so. Then pilocarpine was used. It wasn't nearly as harsh.

Hughes: *Was it effective?*

Morrison: It was effective, but not quite as effective as eserine. In Africa there is a river called the Esera River, and there the natives had an herb that was later known as eserine. They would take it, and if they died, they were guilty; if they didn't die, they were innocent. Of course, the people who didn't die vomited it up, you see. At least, that's the folklore story.

Hughes: *Did you operate for glaucoma?*

Morrison: Yes. We did an Elliott operation, where we would expose the sclera—that's the white part of the eye—down to the cornea. A little drill that we called a trephine was used to drill a hole in that area to produce an opening between the anterior chamber of the eye and the conjunctiva. The conjunctiva was pulled back over the opening and sutured. It would produce a big blister of aqueous as an exit for the fluid from the eye.

Hughes: *And that opening would remain patent?*

Morrison: In many people. That was the trouble. The operation wasn't successful in every case, because some would close, and sometimes the anterior chamber wouldn't reform. There were lots of complications, but it was about the only thing we had. There were some different operations that we used, but none of them were quite as effective as a trephine.

Dr. Gradle

Hughes: How long did you stay in Dr. Gradle's office?

Morrison: A month or two was all.

Hughes: Tell me about Dr. Gradle as a personality.

Morrison: He was a very precise, kind of a strict individual. The only thing he would get mad about was if you left the slit lamp light on. He'd come buzzing in there. He didn't want the bulb to burn out. He'd really dress you up and down. His father was an ophthalmologist in Chicago.

Hughes: Did his money come from his practice?

Morrison: Oh, yes; he had such a big practice. He operated on some of the top people. For example, the breakfast food people: Dr. [William K.] Kellogg used to come into the office. Then Dr. Gradle operated on [Dr.] Simmons for retinal separation. Simmons was attached to Marshall Field. Dr. Gradle did a lot of retinal detachments early on, when people weren't doing many of them. The fellow from Marshall Field complained about the bed being uncomfortable, so Gradle said, "Why don't you do something about it?" Simmons called his men together, and they developed a bed that would go up and down and tilt and so forth, and that was the start of that type of bed.

Dr. Gradle went to Prague and was trained by [Dr. Anton] Elschmig, who was a famous ophthalmologist in the 1920s. He was there a couple of years and then came back to Chicago. At that time Dr. Gradle was probably by far the best trained man in Chicago. He was skillful surgically and very intelligent, so he developed a tremendous practice. He would see as many as one hundred patients in the morning.

Hughes: He had academic attachments as well, didn't he?

Morrison: Oh, yes, he wrote a lot of papers.

Hughes: Did he have a university appointment?

Morrison: Supposedly. He was supposed to be extramural at Northwestern for a while, which I don't think meant much. His main appointment was at the University of Illinois. That's when he headed up the Eye and Ear Infirmary.

Hughes: How could he do so much?

Morrison: Well, he didn't do any operating. He would have a conference about once a week. Then he gave lectures at the infirmary. That's another interesting thing. Washington University gave courses on ophthalmology, and Dr. Gradle used this as a pattern. We had a whole series of lectures on histology, surgery, etc., so you came out having pretty well covered the waterfront.

Hughes: That was unusual at that time, wasn't it?

Morrison: It was, and he organized it. He gave a few of the lectures himself.

Hughes: Do you suppose that was the genesis of this idea for the Home Study Course?

Morrison: I don't know about that. I was on the ground, but I don't remember it. He and Dr. Wherry kind of whipped that out, and it took off. I think they were a little afraid that they wouldn't get the papers graded properly or on time, but it worked out very nicely.

Hughes: Somebody told me that they thought the inspiration for the Home Study Courses might have been the European study plan.

Morrison: I'm not familiar with that.

Dr. Gradle also instigated the Pan-American Ophthalmological Society. I knew some of the boys at Wilmer [Ophthalmological Institute] at Johns Hopkins. In fact, [Dr.] John McLean roomed with me for a while. He was the first five-year man out of Hopkins. When the resident got up to third or fourth year, they farmed him out to various institutions. John was farmed out to the Illinois Eye and Ear Infirmary. When they developed the annual Wilmer residents' meeting, they were permitted to have guests, so John asked me to come to Wilmer, and I attended the second meeting. For many years I would go back to Baltimore each year. It was inspirational to attend them.

Hughes: What was the reputation of the Wilmer in those days?

Morrison: Oh, very high. Of course, Alan Woods really put it on the map. You see, Dr. Wilmer had practiced in Washington, D.C. When he came down to Baltimore, he brought a very fine clientele. When Alan Woods came in, he organized a pyramid type of residency. He would appoint five or six men for the first year, then pick three or four the second, and so on for five years.

Hughes: Was that the European system?

Morrison: I don't know.

Hughes: People dropped out along the way?

Morrison: Yes. Most had a two- or three-year service. But the top cookie was the five-year man. John McLean and Bernie Becker were two of the five-year men.

Hughes: Who stayed was the chairman's choice?

Morrison: I presume he may have consulted [Dr.] Jonas Friedenwald, who was in that department.

Friedenwald worried me when I was asked to write a thesis for the American Ophthalmological Society [AOS]. You are required to practice ten years, I believe, before you can be proposed for membership, and you are supposed to have somebody second you. Then you are required to write a thesis, which can be based, and usually is, on some basic research problem. When I got my thesis together, I found out that Friedenwald headed the thesis committee. Of course, you don't send your name on the thesis.

Hughes: Was your thesis on glaucoma?

Morrison: Yes, on the stability of miotics. At that time, ophthalmic drug solutions were made up by the pharmacist. You didn't know how long the drug would last, whether it had frozen or gotten too hot in the summertime, and what this did to the effectiveness of the drug. So I heated some, froze some, and some were kept for various lengths of time. We dissected out the sphincter of the iris of the albino rabbit, bathed it with these drugs, and had an oscilloscope record the amount of contraction.

We had killed rabbits by injecting air into the hearts, and we would dissect out the sphincter of the iris.

Hughes: Would you do that under a microscope?

Morrison: No. I put on a loupe.

Home Study Courses

- Hughes:* I would like to hear you talk about the Home Study Courses, which, as I understand it, were very much a Harry Gradle innovation.
- Morrison: That's right, but I had very little to do with them except to know what was going on.
- Hughes:* Can you tell me how they worked?
- Morrison: No, I really can't.
- Hughes:* But were you ever involved with grading?
- Morrison: No. Dan Snyder was.¹

Rejecting the Offer to Move the Academy to Dallas

- Morrison: As I think I mentioned earlier, the Academy [Annual Meeting] was usually held in just two hotels, the Waldorf Astoria and the Palmer House. They had alternate years for the meeting. Some time after that we began getting a lot of pressure from Dallas. They wanted us to move everything down to Dallas, headquarters and all, and have every meeting down there, year after year after year. They were just building the big convention center. So they took the officers of the Academy down there, the secretaries and President and all, and we spent four or five days there and were royally treated. They had a fleet of white Cadillacs and beautiful girls chauffeuring us. They took us around to the various hotels, and we'd have lunch at one place and dinner at another. They really rolled out the red carpet to try to entice us to come down there. The boys who were on the inside were the greatest salesmen I've ever seen. But we didn't bite.
- Hughes:* That was the same convention center where eventually the Academy had some input into how the meeting rooms were structured. And they were building it when you went down there?
- Morrison: Yes. We walked through mud to get up to the center.

¹ See the oral history in this volume with Daniel Snyder.

Hughes: *Why didn't the Academy move to Dallas?*

Morrison: Well, we were fearful of putting the meetings in one spot, year after year. That's what Dallas insisted on.

Hughes: *Dr. [Clair M.] Kos thought there were some advantages, for example that a lot of the material could be stored and wouldn't have to be transported year after year.²*

Morrison: I think they had Kos hypnotized. [laughter] I'm sure Academy members like to have variation in the cities to go to for Annual Meetings.

We were all wheeled around in golf carts. One night Dr. [Dean M.] Lierle of the ear, nose, and throat department at the University of Iowa, Iowa City, who always smoked a cigar, was in the cart ahead of [Dr. Albert D.] Ruedemann, and Al Ruedemann was catching all the sparks and ashes. They had a regular fight about that.

I have another story about Ruedemann. He came to give a paper in Omaha, and I was delegated to pick him up at the plane. He had stopped over to spend the night with C.S. O'Brien, who was head of the department of ophthalmology at the University of Iowa. O'Brien was quite a drinker, and Ruedemann participated a little more than he should have. He ran off the plane in Omaha and said, "My God, is this Denver or Omaha?" He didn't know where he was. [laughter] He still had a hangover.

Annual Meeting Courses

Morrison: Dr. [Kenneth] Roper at one time was the Secretary who had charge of selection of Academy courses. We would meet at the hotel [where the Annual Meeting was going to be held] to arrange it. He would pick each of our brains about who we knew who was interested in a particular subject to be used as an instructional course. Then he would contact either the individual or the head of the department where this person was on the staff.

Then Ruedemann became very active with the courses. He would pick up the entrance tickets to find out how many attended a course. I started out giving a course on tinted lenses. Then I gave a course on the malingering [patient] and courses on glaucoma for a long time. If you got the reputation that you gave a

² See the oral history in this volume with Dr. Kos.

pretty good course, all your tickets would sell out. If they didn't, why, you had few people there. That was kind of a letdown.

Hughes: And you might not be invited to teach next time?

Morrison: That's right. But most of the courses were pretty well attended, because there were so many people trying to get tickets that they all couldn't get [their first choices]. If they couldn't get a ticket for one subject, they would go to another one. If one didn't particularly interest them, they would take it anyway.

Hughes: Were the instruction courses in a lecture format?

Morrison: Yes.

Hughes: Was there any opportunity for discussion?

Morrison: Oh, yes, always, but discussion was mostly at the end of the course. Then Ruedy would come around to try to get the room free for the next course, and he didn't want a lot of hangers-on.

Hughes: How were lecturers chosen for the instruction courses?

Morrison: You picked out a man to talk about the subject that he was interested in.

Hughes: Who did the selecting?

Morrison: Ruedemann and Roper.

Hughes: What were they looking for?

Morrison: For example, they would invite [Dr.] Mike Hogan to give a course on ocular pathology, or Dr. Gradle on glaucoma.

Hughes: So they were looking for people who were experts in their particular field?

Morrison: That's right.

Hughes: How did the Academy handle innovation?

Morrison: I don't remember specifically, except one case when I was a student in Dr. Wherry's office. [Dr. Julius] Lempert, I believe his name was, developed an operation for otosclerosis, and the old-time otolaryngologists didn't buy it. They thought it was horrible. I remember the phone just about rang off the wall.

They were going to kick Lempert out of the Academy. The operation finally caught on, but they were slow to pick up his procedure.

The Academy's Political Stance

- Hughes:* *Would you say that generally speaking the Academy was a conservative organization?*
- Morrison: Oh, I would say so. But one thing the Academy didn't get into was politics. We stayed away from that completely.
- Hughes:* *Who espoused that philosophy?*
- Morrison: I think that just evolved. It was kind of a no-no; they never discussed anything in the way of politics.
- Hughes:* *Did the Academy set standards within ophthalmology?*
- Morrison: Yes, pretty much so. The Academy worked very closely with the [American] College of Surgeons and the American Ophthalmological Society. Those three organizations seemed to pretty much set standards.
- Hughes:* *I know there was a representative from the AOS to the Academy.*
- Morrison: Yes. I think there was one from the College of Surgeons, too.
- Hughes:* *What were representatives expected to do?*
- Morrison: To spread out [the responsibility for setting standards] and have fresh ideas.
- Hughes:* *Could one look to the Academy for a judgment about specific procedures or advances in ophthalmology?*
- Morrison: I don't quite understand. They would have publications or give courses if members wanted information about some particular procedure. How anybody would answer that question, I don't know.
- Hughes:* *I was thinking of subcommittees set up on occasion to consider specific issues within ophthalmology.*

Morrison: I don't think there were too many of those when I was involved. But I don't recall.

Hughes: Dr. Benedict was very much against the Academy taking any political stances at all.

Morrison: I'll say so.

Hughes: Do you have any comments to make about that?

Morrison: None, except that he brooked no transgressions.

Hughes: What was his argument for the Academy not being involved in politics?

Morrison: I think he thought politics would probably dilute the thrust of ophthalmology. Of course, he was imbued with that sentiment at the Mayo Clinic. The clinic didn't get involved in politics, either. A man was supposed to stay in his rut and hold it.

Hughes: Some of the membership was not happy with this stance as years went on, particularly in regard to the optometrists. I think that was some of the impetus for the formation of the American Association of Ophthalmology.

Morrison: Could be. Ophthalmology had to have something to confront them with or neutralize them, that's right. But that [confrontation with optometry] is still going on.

Hughes: Now the Academy has taken on that fight.

Practice of Ophthalmology, 1942–1976

Hughes: Dr. Morrison, I understand that you inherited Dr. Wherry's office and that until very recently Dr. [Stanley] Truhlsen, the third generation of ophthalmologists, was in the same office.

Morrison: Yes, that's true. Dr. Wherry, I believe, died in 1942, and I continued on with the practice of ophthalmology. We discontinued the otolaryngology portion.

Hughes: And you were the only one in the office?

Morrison: Yes. Then Dr. Truhlsen became interested in ophthalmology, I think primarily because his father-in-law, Dr. W.P. Haney, was a part of our office until his death. Dr. Truhlsen had a splendid background. He interned at the University of Albany in New York and stayed on in pathology for a year. Then he went to Washington University under [Dr.] Lawrence Post. He became so interested in motility that he was asked to stay on and head up the motility portion at Washington University, because the ophthalmologist had died who had been heading that subspecialty.

Hughes: He was a very young man.

Morrison: Yes, but very astute.

Hughes: Had you known him before?

Morrison: I went to his wedding. I knew him as a medical student and, of course, I knew him through the Haneys. He was certainly able to handle himself. By the way, he lives next door to me. Did you know that?

Hughes: Yes, he told me that you shared a wall.

Morrison: A common wall. I said, "What about my moving next door?" He said, "Well, we got along for thirty years. I think we can stand it a little more." [laughter] We first were in the Medical Arts Building, and that's where the headquarters office was.

Hughes: After the Washington University experience, you invited him to join your practice?

Morrison: Yes. It wasn't a formal invitation, but it just happened. That's one of the nicest things I think I ever did, because in all our years of association, I don't think there was ever a harsh word, and I don't think I ever asked him to do something that he didn't do. Of course, I was kind of careful. I didn't ask him to do impossible things.

Hughes: Did you divide up the work in any logical manner?

Morrison: No. We just had the patients come in, and as I had an overflow, which I had, he would pick them up. Before long, he had a going practice of his own. I was in the Medical Arts Building for twenty years.

Then in 1957 we moved out to the Doctor's Building, which is in the medical school complex, right near the Clarkson Hospital, which is a general hospital. Dr. Truhlsen at that time was with me. I stayed there for twenty years.

Interestingly, at that time Dr. Byron Demorest came into our office after his internship. He spent a few months with us before taking up his residency at Washington University in St. Louis.

Hughes: Had he been trained at the University of Nebraska?

Morrison: His medical school was there, but I'm sorry, I just can't tell you where his internship was. Then Dr. [Rex] Latta was with us. His father, John Latta, was the head of the anatomy department and taught embryology at the University [of Nebraska]. That was a course that scared everybody to death. The first eight weeks was embryology. Some of the boys hardly took a bath or got a haircut, because in those days it wasn't like it is today. I was talking to a classmate of mine, Dr. Edward Holyoke, who had headed up the department of anatomy. He is still close to the university. The university selects over one hundred students, and they graduate over one hundred students. There is little attrition anymore; if you get in, you're in to stay.

My class started out with one hundred and eight students, I think, and graduated eighty-four. A lot of people didn't make it. Embryology was an eight-week course; you either [passed and] went on, or you didn't.

Hughes: But you could get dropped afterwards as well?

Morrison: Oh, yes. In fact, that's one of the reasons we got married when we did. We had known each other for a long time. My wife was a stenographer, secretary, and a good one. In those days, you couldn't be married and hold a job, so you had to do these things secretly. My father died in 1934, five days before I graduated in medicine. In those days, there wasn't much money around. I knew if I had my second semester tuition paid, they probably wouldn't kick me out, and I probably wouldn't fail. So then we got married on December 30, 1933. That was fifty-seven years ago.

Hughes: And you didn't try to keep it quiet?

Morrison: We had to. Oh, my, yes. Even a breath that you were married, and out your wife went.

Hughes: What was the reason?

Morrison: Jobs were so hard to get, terribly hard to get. They felt that a woman was taking the place of some man who needed a job. That was before [women's] "lib" came along.

Hughes: *We were talking about the office. Did Dr. Truhlsen stay in the Doctor's Building until very recently?*

Morrison: Yes, up until about a year ago. You see, Omaha has moved west. It has to move west, because South Omaha is where they used to have the stockyards. There aren't very many stockyards anymore. East is the Missouri River, so you are funneled into the west side. This is where the population is now.

We built our home in 1941 on 93rd Street. There were alfalfa fields around, and people said, "Why did you want to move out into the country?" During the war we only had one car, and we had a bus that came along. They called it the Rockbrook Rocket. My wife would wear a pair of walking shoes and walk up about a half a mile to where the Rockbrook Rocket stopped, put her shoes in the trunk of a tree, put on her "go-to-meeting" shoes, and get on the Rockbrook Rocket. [chuckles] We moved into our home just before Pearl Harbor. The war came and, of course, no building [took place] then. So we were isolated there.

Dr. Gradle came by one day. He said, "That's a nice little cottage." I thought it was a great big house, which it was not. But it was pretty good-sized.

Lightning rods came out shortly after we built our home. Some lightning rod salesman came through, and I said, "I thought that went out with Benjamin Franklin," so I didn't buy. Well, it wasn't more than two or three months until lightning struck the house to the south of us and knocked all the shingles off, and about two weeks later it hit the house to the north of us and knocked a bed apart. So then we had lightning rods in the neighborhood. [laughter] We saw the sign.

Dr. Truhlsen has moved out here to Regency, which is a very exclusive residential area with some stores and businesses. You people don't know about the harshness of the winters in the Middle West. It's hard for older people, particularly, to walk on icy walks. Now his patients can park underneath his office in a carriage-type practice. Of course, his office has all the newest things as far as equipment and so forth are concerned. You don't realize that until you compare it to what you had. It's beautiful.

And they have expanded the office. At the time Dr. Truhlsen was with me, we were alone for several years. Then Dr. Latta came in, and now they have five doctors and two offices, one in the old office in the Doctor's Building and one out here in Regency.

We worked at one time a great deal at the Immanuel Hospital, which is a Swedish Lutheran hospital that is far north. It is a beautiful hospital run by the sisters. They ran a tight ship. But when we moved into the Doctor's Building, it was within about one hundred yards of Clarkson Hospital. So rather than driving five or six miles through heavy traffic, you could just walk across the street and be in Clarkson Hospital. And the College of Medicine is also right there. So most of our practice at that time started going to Clarkson.

I don't know if the ophthalmologists today have a hospital practice anymore. It's all outpatients. Stan Truhlsen said he hadn't been in the hospital for a long, long time. Of course, in the past we almost lived in the hospital. We kept patients in the hospital for seven days after cataract surgery. We had to let the wound heal, because we didn't have firm sutures. I started using firmer sutures when I came back to Omaha.

There was a paper given years ago at the American Ophthalmological Society by a fellow who was touting doing cataract surgeries in his office. You should have heard the discussion about that. He was believed to be way off the beam, but now he is a pioneer.

The Council of the American Academy of Ophthalmology and Otolaryngology

Hughes: Let's talk about the Council, which we only mentioned in passing. You were elected to the Council in 1939?

Morrison: I was never on the Council. I was an ex officio member and had quite a title.

Hughes: Maybe that's what I read. You were a member because of your editorial position?

Morrison: Yes, I think so, and there was a little backbiting perhaps. I don't think I made any enemies, but I don't think they wanted some people to come up too fast and take over some of their priorities.

Hughes: You were too young then to be . . .

Morrison: Possibly. Dr. Wherry always included me, and it was always kind of a stressful thing. You had to get up, no breakfast, and sit in there. Here are these fellows,

hungry, and finally they brought in breakfast, most of them complaining because they didn't like early morning hours.

Hughes: Ex officio meant that you could attend but not vote?

Morrison: That's right.

I don't remember too much about Council meetings except that they discussed where they were going to have the next Annual Meeting. We didn't discuss who would be President, because if you were on the Council it was kind of scratching your own back. One Council member went up to become President, and the next one went after that.

Dr. Benedict had a secretary, and he didn't know she was an alcoholic. She just couldn't take the minutes of that meeting at all. It was disturbing. We had a microphone to record the meeting. When somebody started talking, it became my job to say, "Well, that's Dr. [Dean] Lierle talking," and get it on the tape. Then the secretary could follow suit and take the minutes much better, but the old man barleycorn caught her. Dr. Benedict fired her after he found out.

Hughes: That became your job just because you were there and available?

Morrison: But I didn't attend all the meetings, by any means. I was an adviser to some of them.

Hughes: The minutes were published in the Transactions, of course. Were they verbatim minutes?

Morrison: Almost. They were scrubbed up a little bit, but they were pretty much extemporaneous.

Hughes: Who did that?

Morrison: Dr. Benedict's secretary and some of the manuscript editors.

Hughes: Somebody implied that in the early days Dr. Benedict edited the minutes, not just for style but for content.

Morrison: Yes. In fact, I shouldn't say this, but he changed them a little bit.

Hughes: That's what I was trying to get at.

Morrison: Did you hear that from anybody else?

- Hughes:* Yes, I did. In what way would he change them?
- Morrison:* He didn't make any really drastic changes, but he changed the tenor of the thing a little bit.
- Hughes:* You mean he cut down the controversy, for example?
- Morrison:* Well, changed the effectiveness of it.
- Hughes:* Dr. [John] Henderson told me that he had a way of tabling an issue that he didn't approve of, that he just wouldn't act on it.
- Morrison:* No. If they got ahead of him, he would get up and talk. He could talk by the hour. You didn't know what he was talking about. I shouldn't say that, but he would take up all the time, and nobody would have a chance. [chuckles]
- Did John Henderson say that, or was he afraid to?
- Hughes:* I don't want to quote him. I can't be absolutely sure. Certainly that was the tenor of the conversation.
- Morrison:* I had a lot of admiration for Dr. Benedict, and he was still the boss. In fact, they didn't think he was dead until they looked in the coffin. [laughter]

Moving Toward Separation into Two Academies

- Hughes:* Was there growing unrest? The Academy was growing at such a fast rate.
- Morrison:* The unrest was the breaking off of the ophthalmologists. The otolaryngologists didn't think they could swing it by themselves, and I didn't want the ophthalmologists to break off. So we had several meetings and finally decided that the two specialties would separate. But there was a quite bitter—I wouldn't say exactly resentment, but questioning why we should leave them in the lurch. But the otolaryngologists have done all right.
- Hughes:* Dr. Benedict, I understand, was totally against separation.
- Morrison:* Yes. That couldn't have happened when he was Secretary-Treasurer.
- Hughes:* Why was he so against it?

Morrison: Well, he wanted a big meeting. He figured he could get more attention. But the meeting was getting so big that the hotels couldn't handle it. We had to do something, and separation seemed to be the most logical thing. I think the biggest membership when I was in the Academy was 14,000. What is it now, do you know?

Hughes: My memory is that it is about 22,000. In the end, do you think separation was a good thing for ophthalmology?

Morrison: I'm sure it was, but at the time I was mostly against it. I felt the Academy was a going concern, and it did very well; but I could see where the size of the membership was getting out of hand. I was smart enough to see that, but I had enough emotional ties that I just liked to have the status quo go on. You knew that if they had 14,000 at that time, you were going to have 22,000 tomorrow. You couldn't get hotel space even in large cities to handle a combined meeting.

You dislike having things change, particularly as you get older. My emotional response was that the Academy should be split, but I hoped it wouldn't be. You are embarking on a new field. You don't know exactly how it will go and who will be in charge of it, how they will run it, and how well it will do.

Anybody who knew Ed Maumenee knew that he was a good organizer. He's at Wilmer, you know.

Hughes: Are you thinking of his role as President of the Academy?

Morrison: I think he was just an interested dissident at that time. I don't think he had any official position. But he was a rabble-rouser, articulate, and had a tremendous background, being at Wilmer's—like God taught him, you see.

Hughes: So people listened?

Morrison: Oh, yes. We got together several times. He would smoke big cigars. My father smoked constantly, except when he was seeing patients. Smoke never seemed to bother me, but as I got older, I didn't care for the cigar smoke. But Maumenee would blow it on you.

Leadership of the Academy

Hughes: Dr. Truhlsen wrote a paper on the secretariat.³ He speaks of an old boy's club that passed the secretariats around to each other. In your experience, were the offices passed around within a very small group?

Morrison: Yes, indeed. If someone was getting old or sick, why, he was just passed over.

Hughes: The Academy made a pretense of being a representative body, did it not?

Morrison: Yes, but it wasn't, and it still probably isn't.

Hughes: Do you know why Dr. Benedict was chosen when Dr. Wherry died?

Morrison: I think he probably was the logical man. He had the place [Mayo Clinic] at Rochester. Up there, you can get things done that you can't do in private practice. For example, one of our great hassles in the practice of ophthalmology or any other practice is employees. You have an office full of patients, and all of a sudden three or four employees would light on you and say, "I want a raise." What are you going to do? You've got to see patients. Dr. Benedict told me that his women got into a row, and he said, "I called down to the business office and said, 'I'm firing everyone; send me a whole new crew.'" That's the way they could do it in Rochester. You couldn't do that in private practice.

So he could handle the Academy, and he was retired by that time. He had to give up his chairmanship [of the department of ophthalmology] at the Mayo Clinic.

Hughes: Well, he wasn't retired initially. He served from 1942 to 1950 before he became full-time Executive Secretary at the Academy. He retired from the Mayo in 1950.

Morrison: The story about that is that [Drs.] Charlie and Will Mayo were brothers, and Will Mayo developed a tremor at about age sixty-five. Charlie, his brother, had a couple of little fainting spells; they thought them minor strokes. So the brothers thought they better retire at sixty-five and make it mandatory. You could retire as head of the department at sixty-four, and you could continue working until sixty-seven.

³ Stanley M. Truhlsen. "The History of the Ophthalmology Secretariats of the American Academy of Ophthalmology." [n.d.] 32 pp.

So Dr. Benedict had to get out, and that's when John Henderson said to Dr. Benedict, "Now, you are sure you're going to have to obey that rule?" Dr. Benedict said, "Yes." And he did.

Hughes: The Academy had grown by 1950, but the creation of that full-time position must have been partially because Dr. Benedict was now available full time.

Morrison: Yes, that's right. In fact, when he died we had a rump session in Hot Springs, Virginia. They got after me that I should be the Secretary-Treasurer. First of all, I'm not that caliber; secondly, I had a private practice. I couldn't possibly have developed an organization to come down to Omaha from Rochester. It was better for it to stay where it was.

Hughes: And yet the Academy had always moved with the Secretary-Treasurer.

Morrison: No. Kos went to Rochester.

Hughes: Kos did, but he came after Benedict.

Morrison: Yes, that's right. But they wanted me to move it from Rochester to Omaha.

Hughes: Why do you say that you weren't the caliber?

Morrison: Oh, that takes a strong person. I have a lot of inferiority complexes.

Hughes: I haven't noticed. [laughter] It was a compliment that you were asked. Do you have any regrets?

Morrison: None at all. No, because I think I would have fallen on my face. It was just beyond me. I couldn't see giving up a very lucrative practice, and I was on the staff at the university. I would have had to sever all that and get involved in things I wasn't too familiar with.

Hughes: Until Dr. Benedict became full time, people had done private practice and run the Academy.

Morrison: I saw Dr. Wherry, who had a very fine practice, get involved so much with the Academy. He had an interesting habit. He didn't want anybody to know he was going out of town for a meeting. He would just leave. All his patients would wonder. They would come in and say, "Where's Dr. Wherry?" "He's gone." "Well, he was supposed to take care of me."

Hughes: How could it be that you were asked to follow Dr. Benedict?

- Morrison: Well, this happened in an informal rump session.
- Hughes: Yes, but it would have been two ophthalmologists in a row as Secretary-Treasurer.*
- Morrison: There was nothing firm. Dr. Wherry was an otolaryngologist, and Dr. Benedict was an ophthalmologist. I think that was happenstance more than anything else. In fact, I'm sure it was.
- Hughes: It's not happenstance with the other officers?*
- Morrison: To be President, that's right. But the Executive Secretary-Treasurer was, I think, sacrosanct.
- Hughes: Dr. Benedict was Executive Secretary for twenty-six years, 1942-1968.*
- Morrison: Yes.
- Hughes: Was there any unrest amongst the otolaryngologists that an ophthalmologist had been Secretary-Treasurer for so long?*
- Morrison: I don't think so. They were glad to see him run a tight ship. Really, he did a beautiful job.
- Hughes: Do you remember any talk of separation?*
- Morrison: None whatsoever that I ever heard.
- Hughes: Even amongst the otolaryngologists?*
- Morrison: I think they were very grateful that he was able to do what he did.
- Hughes: Why was Dr. Kos eventually chosen?*
- Morrison: Really, I don't know.

Editing the Transactions

- Hughes: I gather that when there were two associate editors, you were exclusively responsible for ophthalmology, and Dr. Williams was exclusively responsible*

for otolaryngology. What about the arrangement of the papers from the two specialties in the Transactions? How did that get decided?

Morrison: I think it was all clear-cut. All of the papers given at the section on otolaryngology and all on the section of ophthalmology would be included.

Hughes: There was a segment on ophthalmology and a segment on otolaryngology?

Morrison: Well, they had one segment in the back of the *Transactions* for otolaryngology, and ophthalmology in the front, and then we would alternate them.

Hughes: You already talked to me about prioritizing the papers within ophthalmology.

Morrison: Dr. Benedict handled a lot of that. I did some of it. I didn't have full command until he died. Then I had to sort them out myself. I suppose Williams did the same thing for otolaryngology.

Hughes: You sorted according to topic?

Morrison: Yes, I think that's right. If you accept two or three papers on glaucoma, you put them together. As I said, the heat you would get was not pleasant, because some would write or call and want their paper in the January issue.

Hughes: What were the guidelines for advertising in the Transactions?

Morrison: It had to be ethical advertising by a firm that was acceptable. Nothing by these fly-by-night people. Nothing that would be advertising for individual profit. You could not run an ad and say, "Tonsillectomies: Ten dollars," or something like that. The advertising was a great source of income.

Hughes: How much of the cost of publication did it cover?

Morrison: This is just a ballpark figure, but I would say probably a fourth to a third.

Hughes: And what supported the rest of it?

Morrison: Dues. There wasn't too much outgo. Now, for example, I spent all these years as editor without any salary at all. When I went to a meeting, I had a suite, and my travel expenses were paid. But that was all I got. I didn't want to take a salary, because the secretaries weren't getting a salary. I didn't feel that I should be getting something when I wasn't much different than they. Then some of them rebelled, and they got a salary. They gave me \$500 a month after that, which was about 10 cents an hour. I was pleased to get that, not that I needed it.

Hughes: Did you have a certain set number of pages that were allotted to advertisements?

Morrison: Not that I recall. I think you took about everything you could, because that was a revenue-producing thing. We had a little problem, as I recall. All the advertisers like to have it at the front of the journal; they don't want to be in the back. But you had to rotate the ads, too. I forget which one of the girls handled the advertising. They did a pretty good job.

Hughes: Did you read every paper that was submitted in ophthalmology?

Morrison: Yes, well over a hundred each year. But I did it rather crudely. I found out one thing; I couldn't be a proofreader. My wife could pick up misspellings and everything else. I would just skip over those, because I do fast reading, by paragraphs almost.

Hughes: Did she sometimes help you?

Morrison: I retired, and I said, "What am I going to do about a secretary?" I didn't want to be running back and forth to the office. Besides, the girls weren't working for me then. So I said, "What about my wife? She is an expert secretary." She had been a secretary for the president of the Omaha Commerce Clearing House, a big legal publishing concern in Chicago on Wabash Avenue.

So we started out. You should see her type. She said, "I'm not going to take any more shorthand. I can't remember it too well anymore. You talk, and I'll type." But she just about drove me crazy. The noise of that typewriter! You were trying to get your thoughts together, and whirrr! So we soon stopped that, and I had to learn to hunt and peck myself. She helped me out on the big things.

A lot of hours were spent on telephone conversations. I had almost a direct line to Rochester. Mrs. Michaelson was the one who handled that part of it, but she wasn't very popular with some of the other girls, particularly Miss Thompson.

Hughes: Why was that?

Morrison: Well, she was kind of flighty and talkative.

Hughes: You must have acquired a tremendous knowledge of ophthalmology from having read all the papers.

Morrison: I suppose. You're not aware of that, because in practice you make a point—I did—to read the *American Journal of Ophthalmology* and the *Archives of Ophthalmology*.

Hughes: From cover to cover?

Morrison: Cover to cover. I'm a great reader. I've been handicapped a little bit, not being able to play tennis and such, so my avocation is reading.

Hughes: How large was the circulation of the Transactions?

Morrison: I think every member got it.

Hughes: Probably also some libraries and advertisers.

Morrison: Libraries got it. I think they gave them gratis to companies which sold instruments. Other than that, I don't think there was too much outside business.

Hughes: What exactly did the Transactions contain other than the minutes and the papers?

Morrison: It contained a lot of things. It had the Council minutes, as you know, and the briefing of the instruction courses. Each instructor had to write a synopsis of about fifty words, which had to be printed. All these synopses of the instruction courses were printed ahead of time.

Hughes: That was sort of advertising, to attract students?

Morrison: It wasn't advertising. It was notifying people who wanted to take the course. You could sign up for this or that course and send a tear-out sheet with whatever amount of money was required. Then they gave you tickets at the Annual Meeting. Ruedemann or someone else would pick up the tickets when you went into this little instruction room. At one time we printed the course directory in the *Transactions*, but it finally got so big we had to publish it separately.

Also, it contained a write-up about the various instruments that were going to be shown by the various companies at the Annual Meeting. There were also some articles about the Home Study Course.

Hughes: Vacant positions?

Morrison: Yes, we carried those for a while.

Hughes: How time-consuming was it when you were associate editor?

Morrison: Well, I'm a peculiar person. I can't go to bed and rest easily unless I have everything taken care of, so I spent a lot of nights—not complete nights, but I would come home from the office and couldn't go to bed and have the editing

hanging over my head. But, you know, if you keep up, you don't get behind. That's the solution to a lot of things.

Editor-in-Chief, 1969

Hughes: In 1969 you became Editor-in-Chief. That was because Dr. Benedict was ill.

Morrison: As I told you, this happened repeatedly. He would call me and say, "I'm so sick I can't function. You've got to take over." Then in about three days, "I am better," and he'd take over again.

Hughes: That was difficult for you, wasn't it?

Morrison: Wendell Hughes was the one who really caught it.⁴ When he was President [1967], he came to Rochester and attempted to reorganize the Academy. Benedict got out of a sick bed and took care of Hughes in a hurry.

Hughes: Benedict wasn't about to give up the reins, was he?

Morrison: Not to Wendell Hughes.

Hughes: What did being Editor-in-Chief entail?

Morrison: It concerned all of the publications. We also published the directory and the *Perceiver*. We published the instruction courses in separate handouts. When you would go to a meeting, you would pick up a whole packet of material. We also published an orthoptic journal.

Hughes: When you became Editor-in-Chief, did Stan Truhlsen become editor of the Transactions?

Morrison: Yes.

Hughes: So you didn't have direct responsibility?

Morrison: I knew Stan would perform, so he did.

⁴ See the oral history in this volume with Wendell Hughes.

Hughes: You no longer had to worry about the ins and outs of the publication of the Transactions?

Morrison: This was more of a directive thing. At that time you didn't handle the everyday things so much. You couldn't.

Hughes: Did it end up being less time-consuming than being editor of the Transactions?

Morrison: I think it was more pleasant and less time-consuming, because you weren't on the battle line all the time.

Hughes: You mean with the complaints from people about their papers?

Morrison: That's right.

Hughes: Why did you step down as Editor-in-Chief in 1976?

Morrison: I retired from the university. When you're sixty-five, you have to retire.

Hughes: Yes, but you probably didn't retire from practice until later.

Morrison: I retired from practice in 1977.

Hughes: At about the time when you stepped down from being Editor-in-Chief. Had you just had enough?

Morrison: Well, you probably think I'm after Benedict all the time. I'm not after him, but he wanted to continue on way beyond when he should have. You should cut the strings somewhere. When I was going into practice, the only way a doctor retired was when he died. Now retirement is popular. Some retire at fifty. So it's a different ball game entirely.

My roommate in medical school, Fred Schlumberger, had urologic training at the Crile Clinic [in Cleveland, Ohio]. Old Dr. [George W.] Crile I believe was the first one to successfully do a blood transfusion. Crile had glaucoma, and he lost his vision to the extent that he couldn't even tell time. Fred told me that Dr. Crile would say, "Dr. Schlumberger, what time is it? My watch has stopped." Schlumberger knew he couldn't see the watch to tell time, but still he was doing gangliectomies. Schlumberger said he would often cut the aorta, and they couldn't kick him out because he was it—Dr. Crile.

Hughes: That sounds dangerous to me.

Morrison: I remember that Dr. Pointer, our dean, once told me that if Dr. Crile, the Mayo brothers, and Dr. Frank Lahey had gone into the circus business, you would never have heard of Barnum & Bailey and the Ringling Brothers. I think that's about right.

Hughes: *That's wonderful.*

Beginning in 1973, the Transactions was divided into an ophthalmic section and an otorhinolaryngologic section. Whose idea was that?

Morrison: I can't tell you. I think it was a gradual schism that developed when we were going to have to divide convention-wise. I think the ophthalmologists wanted to wean themselves away from otolaryngology. There was no reason for a man to pick up a journal that had a lot of things in it that he wasn't interested in at all.

Hughes: *When did the Transactions decide to publish voluntary papers, not just papers that had been presented at the Academy?*

Morrison: That was after my time.

Hughes: *Do you know why that decision was made?*

Morrison: No.

Early Associations with the Academy

Hughes: *Dr. Morrison, I was wondering what your first associations with the Academy were.*

Morrison: My first association was just listening to what was going on and seeing activity in the headquarters office. I think my first Academy meeting was in Cleveland. I got in late on a train. The hotels were sold out. But through Dr. Wherry's instigation, I got a room in a ladies restroom. [laughter] I had a terrible time, because the women would rattle the door all night. I was in there all alone. That was the only room left at the hotel.

Hughes: *Were you a resident at the time?*

Morrison: No, I was in practice with Dr. Wherry. I knew very little about the actual workings of the Academy as a medical student; you had no first-hand information.

But there were a tremendous number of calls that came through. There were Council calls where you would have two or three people on the same line, particularly talking about finances. The Academy had a stockbroker in Omaha and apparently did all right. But they wouldn't do anything unless they had two or three recommend a stock.

Hughes: Did it do well by the Academy?

Morrison: They made some money on it. Of course, that was after the 1929 plunge, when things were starting to come back. They bought blue-chip stocks. That didn't make too much money for them.

Dues

Hughes: Did the dues stay stable for many years?

Morrison: Until the last twenty-five years, I would say.

Hughes: I know they went up when Dr. Kos had just come in.

Morrison: I remember that definitely. We wondered whether the members were going to hold still for that. I have forgotten how much we increased them.

Hughes: Well, dues had been thirty dollars per year, and they went up to one hundred. Did that cause a furor?

Morrison: We thought it would, but I don't know; I had no follow-up. I remember the meeting we had at Rochester about that hundred dollars. I about dropped over backwards. But Kos thought it would go, and it did.

Hughes: You're not aware of losing members?

Morrison: As I remember, we lost a few, but nothing like they thought they might. We had quite a tax advantage. You could take it off your taxes. So people aren't going to holler too much.

More on Early Academy Meetings

Hughes: Can you remember your first Annual Meeting clearly enough to describe it?

Morrison: No, except it was the usual Academy meeting. But to me, seeing it for the first time, it was just tremendous. There were so many people, and the instruction courses were all crammed, almost standing room only, and the scientific exhibits were wonderful, I thought. And of course the program was fascinating. I don't remember any papers, but I am sure they were interesting.

Hughes: Were you able to get tickets to the instruction courses?

Morrison: I didn't try to obtain tickets.

Hughes: You came too late?

Morrison: Yes. At the Palmer House they would have instruction courses in rooms on an upper floor. You would be in narrow hallways; you could hardly get through, and people would be coming and going. You would just have to crowd your way through between courses. There were a great number of people there.

Hughes: Was it important to go to the Academy for other than medical reasons, to socialize and to meet prominent people in the field?

Morrison: I'm sure there are some people who do those things.

Hughes: Why did you go to the Academy year after year?

Morrison: I think because I would always gain a great deal, and you had a lot of companionship. You saw people you hadn't seen for years, you saw new advances in scientific instruments, and you heard papers that stimulated you. And I attended a few of [Dr.] Dohrmann Pischel's instruction courses. I remember Dr. Pischel's course on detached retinas, which was very interesting. I always liked Dr. [Peter] Kronfeld's courses, too. Oh, by the way, the sister of Dr. [Michael] DeBakey, the great vascular surgeon, is a Ph.D. and wrote medical articles for her brother. So she and I, and there were some others, gave a course on medical writing a couple of times at the Academy, which was quite interesting.

Hughes: Was the attendance good?

Morrison: Yes. We had a sold-out course. Everybody wants to write about medicine without any effort.

Hughes: Did you tell them exactly how to do that?

Morrison: Yes, that's right. [laughter] I had a great ghostwriter.

Membership in the Academy

Hughes: When did you become a member of the Academy?

Morrison: In 1938.

Hughes: What was the procedure for becoming a member?

Morrison: Well, you made an application and put down your money. I don't remember if it was the Academy meeting or the American Board of Ophthalmology and the American Board of Otolaryngology—they were meeting in San Francisco, and I went out to take my board [examination]. We stayed at the Fairmont Hotel. I remember I was so impressed by the nurses wearing sweaters at the hospital. I had never seen nurses wearing sweaters before. It was cold there, you know. We had a wonderful time. I passed the board. You had to pass the board before you could become a member of the Academy; it was contingent upon that.

Hughes: Do you remember any of your examiners?

Morrison: Oh, yes. This fellow [Dr. Clifford] Walker, he was a great retinal detachment man.

Hughes: Oh, yes. He designed some retinal pins, didn't he?

Morrison: Yes, Walker pins. I have forgotten exactly what the question was, but he wanted me to state how many nerve fibers crossed the lamina cribrosa, or in the pit in the optic nerve. Of course, I had never counted them. I couldn't have. I never heard of anybody else who did. I've forgotten who the examiner was who came in and saved me. He said that wasn't the kind of question you should ask. Walker was a crazy guy. He came down in his bathrobe. He hadn't shaved for a week. He was eccentric.

I remember one of the fellows went to Walker to have a detached retina repaired. After a few days, Walker came in and said, "Would you like to get up and sit in the chair, or do you want to have a bowel movement today?" This fellow said,

“I haven’t had a bowel movement for a week. I would like a little of both.”
[laughter]

Walker worked with [Dr. Harvey] Cushing on the perimetric studies of pituitary tumors. He was a brilliant person.

Hughes: Brilliant and eccentric.

Morrison: Oh, my, yes.

Hughes: Was he respected in the field?

Morrison: He was noticed. But most people couldn’t buy his coming down in a bathrobe and pajamas.

Hughes: Did you have to have a nomination by a member to get into the Academy?

Morrison: It might have been, but I don’t remember, because mine was pretty automatic, being right there in the Academy office.

Hughes: Do you remember the Diversion Club in connection with the Annual Meeting, which I believe Dr. Wherry started and Dr. Benedict continued?

Morrison: I don’t remember.

Associations of the Academy

Hughes: Perhaps you would like to talk about the AFIP, the Armed Forces Institute of Pathology, and its connection with the Academy.

Morrison: Dr. Gradle felt that the Academy should underwrite the AFIP to some extent. The AFIP would often make enough slides so that they could be used for the Home Study Course, so we people out here in the hinterland could send back there and get a set of slides and study them. It worked out very well.

Hughes: Eventually they did do that?

Morrison: Yes, and they had quite a number of duplicates made. I’ve forgotten how many. But it certainly served its purpose. The Academy didn’t go broke on it. I think the excess money went to the Armed Forces Institute of Pathology Museum.

Hughes: Wasn't Dr. Gradle also instrumental in setting up the ophthalmology museum that encouraged the collection of ophthalmic pathology?

Morrison: Yes, he was. Gradle was the spark plug that got it off the ground and kept it going.

Hughes: For a while the Academy gave a small sum annually to maintain Dr. [Lorenz E.] Zimmerman, who had another job offer and was threatening to go elsewhere. According to the minutes, the Academy stepped in to encourage him to stay at the AFIP, which is an indication, I think, of the importance of the AFIP to the Academy ophthalmologist.

Morrison: Yes, the Academy gave an annual \$500 contribution that continued on in the next decade.

They had twelve sets of slides, one hundred slides each.

Hughes: How would the slides have been used in the Home Study Course?

Morrison: At that time they weren't, because this started in 1929. There was no Home Study Course at that time. Most of the people were studying for the board [examinations]. Some didn't have a background in pathology. But I suppose later on if there was a course on pathology, you could get the slides and study them. I used them simply because I was studying for the board.

Hughes: Those were available in the Academy office?

Morrison: No, I think you had to write back to the AFIP.

Hughes: Also, Academy members could send specimens into the AFIP?

Morrison: Yes, that's right.

Hughes: Was the AFIP's diagnosis or analysis respected?

Morrison: Oh, yes. After Zimmerman came in, certainly.

Hughes: What about the other associations that the Academy had? There was always a liaison with the AOS and the AMA [American Medical Association], and I guess with the American Board of Ophthalmology and the College of Surgeons.

Morrison: Well, we had one group that they organized, and that was the secretaries of local ophthalmology or otolaryngology societies. The Academy funded a luncheon every year. I had the misfortune to become president of that one time. It was all right, but I didn't think it served too much purpose. Mostly it was a lot of fun (because we all had our local things to do, and we knew about what we wanted to do and what we couldn't do). Kenneth Craft from Indianapolis organized it. But the Academy was very nice to continue this every year. Everyone liked the luncheon.

Ethics

Hughes: What did the Academy do to try to maintain high ethical standards amongst its membership?

Morrison: I don't know that there was a publicized code of ethics, but of course you were expected not to do fee splitting. And then this matter of rebates on glasses came up, and that created a great problem.

Hughes: Could you explain that?

Morrison: Well, in the old days some ophthalmologists would have big surgical practices. They would be able to refract and almost give glasses away. Some of the people with smaller practices had to live pretty much by refractions to make a living. They kept their prices way down. So the optical companies would divide the price they would get for the glasses with the referring ophthalmologist. They called that rebating.

Many of the [ophthalmological] organizations came out very much against it. They brought a class-action suit, as they called it. In each locality they picked out one ophthalmologist to represent the others. I think because of my association with the Academy, I was chosen. It was not any fun, I'll tell you. I thought it would ruin me, but it didn't. In fact, the American Ophthalmologic Society was very strict in their ideas, but I was not criticized. Of course, it was settled, and they required an agreement to consent and desist or something of that sort, which all of us were glad to sign. It just required something like that to bring an end to rebating.

Later, rebating was done away with, but it created a lot of problems, because as soon as they no longer rebated, the price of glasses went up. This pair of glasses

[points to his own] cost \$150. They used to cost \$18. Of course, everything else was also cheaper in those days.

Hughes: Were you ever aware of a member being expelled?

Morrison: None of them were ever expelled to my knowledge.

Hughes: Very recently the Academy has come up with a code of ethics. Are you aware of that?

Morrison: Vaguely.

Hughes: It's a written code of ethics. It was mainly the work of Dr. [Jerome] Bettman and the Ethics Committee.

Morrison: Does the code say anything about whether you can own an optical company and be a practicing ophthalmologist?

Hughes: I don't know if it is that specific.

Morrison: To me that seems wrong. If you send patients to your own optical company, of course you're going to profit. I don't know if that's in the code of ethics, but ophthalmologists are doing it. Stan [Truhlsen] shook his head and said, "There is an optical shop in our new office building."

Hughes: You don't approve?

Morrison: Well, I'm an old fuddy-duddy. [laughter] For a while, they would hire a person to come into your office to adjust frames and so forth. But if the person became sick, and people came to you for glasses, you monkeyed around with a pair of pliers and didn't know what you were doing. So that became a difficult problem. Then when you sold them the glasses you had to give credit, and some of them paid and some didn't, so you might have a big credit loss. There were lots of ins and outs to it.

But there was a big stink. Alart Woods, who was at Johns Hopkins, and Lawrence Post at St. Louis led the fight to stop rebating and dispensing, [saying that] those who had been doing it should be put in jail. [chuckles] I'm using words liberally. But they were both protected by their institutions, so they didn't have to worry about [what they said].

Hughes: Apparently one of the problems with the Academy code of ethics is that it really doesn't have any teeth. Ophthalmology is now looked upon as a trade rather than

a profession. Restraint of trade can be invoked to quash any disciplinary actions that the Academy might want to take.

Morrison: All those things are fighting windmills. I was in the House of Delegates at the AMA for a number of years, representing the ophthalmologists in the United States. We would get up and pass resolutions about Medicare. We were just fanning the breeze, because the United States Congress didn't pay attention to what we did. We had no teeth. We just passed a resolution.

I would sit there and watch those fellows jump up and talk. That was the first time I ever saw a Teleprompter. A fellow tried to use it; he didn't know how to do it. He got all mixed up. The thing wouldn't come up as fast as he wanted it to. He had a difficult time.

Each state was permitted a number of delegates to the AMA, depending on its population. Nebraska only had two. California had two or three dozen. New York was the same way. They called the Nebraska delegates aces and deuces. But I wasn't in the Nebraska delegation. I represented the Section on Ophthalmology.

Hughes: So you were in addition to the Nebraska delegates?

Morrison: Yes. That was a great education. You would go up on the second or third floor of the hotel where the meeting was being held. Every room had a delegation from California, or somewhere else, with all sorts of drinks, sandwiches, and so forth, trying to persuade you to vote their way. It was the darnedest thing. And most things they voted on didn't have teeth.

Importance of the Academy

Hughes: How important has the Academy been to your career?

Morrison: I think because of the relationship with Dr. Wherry, a great deal. I think being on the editorial board, you had to cover a lot of fronts. You had to read a lot of things. It kept you very much on your toes. Prestige-wise, I don't think it meant too much. Most people didn't know anything about it. People very seldom opened the covers of the *Transactions*. Someone found that about three-fourths of the scientific magazines were never opened.

Hughes: Ophthalmologists?

Morrison: Yes. They get busy, just like everybody else, with other things to do. I was on the [University of Nebraska] College of Medicine faculty in the Department of Ophthalmology. If you're dealing with students, you've got to know what you're talking about. So I had to keep abreast.

Advances in Ophthalmology

Hughes: Could you comment on the changes that you noted in ophthalmology as you edited the Transactions over the years?

Morrison: Well, a difference in suturing came up. A different treatment of glaucoma, both surgically and medically, was, I think, very important. And diagnostic trends, I'm sure. Using the contact lens for better viewing of the interior of the eye. Very powerful ophthalmoscopes enabled you to search the retina for breaks better than you did with your ordinary ophthalmoscope. Mechanization—the tables go up and down, lean back and forth. The changes in anesthesia were great, although we didn't use too much general anesthesia. I very seldom operated on a cataract with general anesthetic. We were afraid of patients vomiting.

Hughes: Is there anything more you care to say about the Academy or anything else?

Morrison: No, except that I'm sorry I've been out of the trend pretty much, but you have to survive. You can't do everything. I remember Dr. Benedict gibing me one day. He said, "What's an ophthalmoscope?" I thought he was crazy. He said, "You know, I wouldn't know which end to look through any more." He had been retired a few years.

Hughes: That was a bit of an exaggeration.

Morrison: I remembered it, though. He was completely out of the swing of things.

Hughes: Do you still read in ophthalmology?

Morrison: I read. I'm still on the editorial board of *Survey of Ophthalmology*.

Hughes: Do they send you papers to review every once in a while?

Morrison: Yes. Why they keep me on, I don't know. I guess they don't know I'm this old and have retired.

Hughes: *You review papers on glaucoma?*

Morrison: Just general ophthalmology.

Hughes: Well, anything else you can think of?

Morrison: I think I've covered a lot of ground. I hope I haven't wandered too much.

Hughes: *I think it's been very interesting. Thank you.*

Morrison: You are nice to say so.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Daniel Snyder, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
July 9, 1991 at Dr. Snyder's Home in
Lake Forest, Illinois

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Daniel S. Snyder, M.D.

Regional Oral History Office
University of California
Berkeley, California

The Foundation of the American
Academy of Ophthalmology
San Francisco, California

ACADEMY ORAL HISTORY
BIOGRAPHICAL INFORMATION

(Please write clearly, don't type. Use black ink.)

Your full name Daniel Snyder

Date of Birth May 2, 1910 Birthplace Kenilworth IL

Father's full name Emanuel E. Snyder

Occupation Physician ENT Birth & Death dates 1870-1936

Mother's full name Ruth Fogle Snyder

Occupation _____ Birth & Death dates 1870-1961

Spouse's full name Bertha Stibbs Snyder

Children's full name Harry Snyder, Ruth S. Bregar

Daniel Snyder, Jr.

Where did you grow up? Kenilworth IL.

Present community Lake Forest, IL.

Education U. Wisconsin 1927-1930 Northwestern Med 1930-1934
(undergraduate, graduate, Medical School, internship, Residency)

Intern, Michael Reese Hosp. Resident Illinois Eye & Ear Infirmary.

Occupation(s) Ophthalmologist

Areas of expertise _____

Other interests or activities _____

Active in which medical organizations Am Acad. Ophthalmology.

Chicago Ophth. Soc. American Ophth. Soc.

Other organizations _____

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DANIEL SNYDACKER, M.D.

[Date of Interview: July 9, 1991, in Lake Forest, Illinois]

Family Background and Education

Hughes: Dr. Snyder, let's start with where you were brought up and educated.

Snyder: I was born and brought up in Kenilworth, Illinois, a suburb of Chicago. My father, Emanuel F. Snyder, was an ophthalmologist who practiced in Chicago. My son describes us as middle class. I had an ordinary middle-class upbringing. I went to public grammar school and high school. When it came time to go to college, I went to the University of Wisconsin, where I spent three years from 1927 to 1930. My record was far from distinguished.

Hughes: Why the University of Wisconsin?

Snyder: Well, my brother had gone there, and it was a popular college for people in the Chicago area. In those days the university was much smaller than it is now, and it was a very liberal school.

I belonged to a fraternity. I had fun in college, I guess. I worked reasonably hard, but, as I say, I was in no way distinguished.

Hughes: Were you headed toward medicine?

Snyder: Yes, I took a premedical curriculum, and in 1930 I transferred to Northwestern Medical School.

Hughes: Why Northwestern?

Snyder: That's kind of an interesting question that I haven't really thought about much. There was a man who was very prominent in the Academy, a very close friend of my father, who became almost a second father to me after my father died in 1936. It was Harry Gradle, I think, who really steered me toward Northwestern.

I finished school there in 1934, but in those days one did not get his degree and was not classified as having graduated until after he had spent a year's internship. Although I finished medical school in 1934, I graduated in 1935. After I finished my internship, a couple of things happened. One, I got married.

Hughes: *That's important. [laughter]*

Snydacker: And two, I started my eye training at a place called the Illinois Charitable Eye and Ear Infirmary, which later became part of the University of Illinois. In those days it was not known as a residency; it was an internship, and it was only a year's duration. So I worked there for a year [July 1935–July 1936] as an intern. I guess it would now be called a residency. Of course, later the residency period was expanded, so now it's three or four years.

Hughes: *Why did you choose ophthalmology?*

Snydacker: Because my father was an ophthalmologist, and my mother steered me in that direction. My mother was quite a remarkable lady. Unfortunately, she developed what is now called Alzheimer's disease, which in those days we called senile dementia. The last ten years or so of her life were pretty miserable.

Hughes: *That is too bad. Had you ever thought of taking up a specialty other than ophthalmology?*

Snydacker: Not really. My father died in 1936, just before we went to Vienna. As a matter of fact, it had been planned that my father and Harry Gradle, who were close friends but who each had his own practice, would join forces, and I would work for both men. When my father died, of course that changed things. We debated whether in fact we should go to Europe, and then we decided, yes, we would go.

Ophthalmology in Vienna¹

Snydacker: We spent six months in Vienna. I took courses and went to clinics and so forth.

Hughes: *Where?*

Snydacker: This was at the Allgemeines Krankenhaus in Vienna. There was in those days an organization that was called the American Medical Association of Vienna. It made arrangements mainly for Americans to study in a great variety of specialties.

¹ For more on ophthalmology in Vienna, see *Dohrmann Kaspar Pischel, M.D. Ophthalmology Oral History Series, A Link with Our Past*, an oral history conducted in 1987 by Sally Smith Hughes, Regional Oral History Office, University of California, Berkeley, in cooperation with the Foundation of the American Academy of Ophthalmology.

Hughes: Was Vienna still at the pinnacle of medicine?

Snydacker: It was between the wars. We were there in 1936. They still had outstanding men, but it was on its last legs. After World War II, training in this country became infinitely better, and infinitely better than it was in Europe.

Hughes: So there was no longer a reason for Americans to go to Vienna?

Snydacker: No longer a reason to go there.

Hughes: Were there famous names in ophthalmology connected with the Allgemeines Krankenhaus?

Snydacker: Oh, sure. There was a man by the name of [Dr. Karl D.] Lindner, who at that time was quite well known. He was an early investigator into the treatment of retinal detachment particularly. He was outstanding. There was an outstanding surgeon by the name of [Dr. Joseph] Meller. When he operated, he had a pair of presumably sterile cuffs—he just wore his street clothes—that he put over his forearms and which extended maybe not quite up to his elbow. He operated barehanded without gloves and smoking a cigar.

Hughes: Did you take that technique back with you? [laughter]

Snydacker: It was after World War II that we started to wear gloves. Before that time we had always operated barehanded, the reason being that in those days surgical gloves were made of rubber, and they were so thick and heavy that they were cumbersome. It was felt that this deprived the surgeon of the delicate movements necessary in ocular surgery.

Hughes: It probably did, didn't it?

Snydacker: Sure, it did. For example, I don't think Dr. Gradle ever wore gloves when he operated. He had a severe stroke late in 1945, so that he was forced to retire, and he never worked again. But I don't think he ever wore gloves.

Hughes: Was there a problem with infection?

Snydacker: Not really. You must remember that this was in the pre-antibiotic and pre-steroid days, when treatment was limited. We had atropine, and we had pilocarpine and a few standard drugs of that nature, but we had very few specific drugs such as exist today. Infection, I'm sure, was more common then than it is now, but that was not necessarily a function of the fact that surgeons didn't wear gloves. It was a

question of the sterilization of instruments, the operating room surroundings, and the like of that.

Hughes: Were you seeing any signs of the coming war when you were in Vienna?

Snydacker: Oh, yes, of course. In the middle thirties in Vienna there was sharp division. There were some Nazis. I remember particularly a man by the name of Fischer, who was a Dozent in the eye clinic—that means he was like an associate professor—who was a Nazi. He was strongly in favor of the Anschluss, when the Germans took over Austria. There was a threat hanging over all of Europe at that time. Hitler was in the ascendancy. People thought there would be great economic advantage to Naziism. I guess there was also a good deal of prejudice involved, in that these people were probably anti-Semitic.

Hughes: Were you aware of people in the hospital or in the clinic being dismissed or leaving because they saw what was coming?

Snydacker: Not that early. Well, the Anschluss occurred in 1938. I suppose it was late 1937 or early 1938 that people began to leave. But earlier there was feeling, and there was a sharp division. Most of the people that I talked to were anti-Nazi. There was a man by the name of [Dr.] Pressburger who worked in what was called a Polyklinik. You see, in the Allgemeines Krankenhaus there were two clinics: there was the First Eye Clinic and the Second Eye Clinic. They were associated with the University of Vienna. Outside of the Allgemeines Krankenhaus and not very far away from it geographically was the Polyklinik. The Polyklinik was headed by a man by the name of [Dr.] Adelbert Fuchs. Adelbert Fuchs was the son of [Dr.] Ernst Fuchs, and Ernst Fuchs was a very prominent ophthalmologist in the early part of the twentieth century.

Hughes: So Fuchs wasn't associated with either the First or the Second Eye Clinic?

Snydacker: Adelbert Fuchs was not. The father, Ernst, had been. I think the father had headed the Second Eye Clinic. Pressburger worked at the Polyklinik. He was a very engaging man. What one did in those days was pay a man a certain amount of money, I don't remember how much, and take private work with him. So I used to go, I think from five to six in the evening, to this man's office in the Polyklinik, we would sit down one-on-one, and he would talk about any variety of things. I would ask him questions if I didn't understand; or the things he thought I ought to know, he would tell me. He was a very entertaining man who, along with ophthalmology, also told me about his career in the cavalry in World War I under Emperor Franz Josef and all the romance that went with that.

Hughes: Was he a good ophthalmologist as well?

Snydacker: Yes, he was a good ophthalmologist. He afterwards came to this country—he was Jewish—and I think he settled in San Francisco.

Hughes: But you never saw Dr. Pressburger after he came?

Snydacker: I think I may have seen him once after he came to this country.

Hughes: What were you doing with the rest of your time in Vienna?

Snydacker: I would go to the clinics, which were typical German clinics. Every morning patients would all be lined up, standing. Maybe forty, fifty patients. Lindner, the head of the First Eye Clinic, would stand up, look at the patients, do a very superficial and very quick examination, and decide which ophthalmologist should see that patient. There were some ophthalmologists, for example, who were interested in external disease. There were other ophthalmologists who were interested in strabismus. There were others doing cataract or retinal detachment. It would be very quick, and he would go through the forty or fifty patients in ten or fifteen minutes. Patients would then be apportioned out to the various physicians who would, of course, examine them more carefully and prescribe treatment.

Usually after that there would be surgery. I spent more time in the Lindner clinic than I did in the Meller clinic. The head of the clinic, Professor Lindner, would operate. He had first choice of all the patients. He would do whatever cases he wanted. If there were cases that he didn't want to do, the Dozents would do them, and they would go down the line like that. So there was not very much left for the younger men.

Hughes: Were you allowed to operate?

Snydacker: I never did any surgery there. I was only an observer. In the Lindner clinic there was a Dozent by the name of [Ludwig] von Sallman. Do you know that name?

Hughes: I know that name, yes. He was later at Columbia, right?

Snydacker: Yes, he was later at Columbia, and then he worked for a long time for the government. Before the founding of the National Eye Clinic, it was called the Institute of Neurological Diseases and Blindness, and he worked in connection with that.

So I would go watch surgery. By that time it was usually noon, and I would go home. My wife and I would always have our main meal at noon or slightly after. There was a beautiful little Gothic church near where we lived called Votif

Kirche. Behind that Votif Kirche, in the churchyard, there was a lovely little park. We used to go over there after lunch. One could rent a chair. Stools without backs were available for one Groschen—a Groschen was a fraction of a cent—and chairs with backs, or what were called Lehnssessels, maybe cost two Groschen.

Betty and I rented Lehnssessels, and we would sit in the park. I would have a textbook that I pretended to be reading. [laughter] We would sit there for a half an hour or an hour. Then afterwards I would go back to the clinic and have a private hour with von Sallman or with Pressburger. Or there might be something special going on at the clinic, or there might be a special lecture or something like that.

Hughes: *Were you allowed to choose the men that you saw in these private sessions?*

Snydacker: Yes. After I had been there a few months, I was designated to be the representative of the ophthalmologists who happened to be studying there at that time. So I organized a few courses. Most of us had had very little contact with the men who were famous—with, for example, Lindner or Meller. There were a few other famous men. There was a man by the name of [Dr. Karl] Safar, who gave us a course.

I arranged for each one to give a lecture. At first they were a little reluctant, but we persuaded them. So we could come home and say that we had heard Meller talk, we had heard Lindner talk, we had heard Safar and [Dr.] Adelbert Fuchs talk, and so forth. Von Sallman I think gave a lecture.

Hughes: *How much give and take was there?*

Snydacker: There was not very much give and take. The German and Viennese professors were very professorial and very strict.

Ophthalmology Practice with Dr. Harry Gradle

Snydacker: When I came back, as I say, I started in practice with [Dr.] Harry Gradle, who had a very large private practice.

Hughes: *In Chicago?*

Snydacker: In Chicago. There were five of us. He was the chief. His associate was a man by the name of Dr. Samuel Meyer, who died recently in his late nineties; he of course

retired long ago. There were three younger men, of whom I was one. A man by the name of Dr. Jack Cowen was the second, and a man by the name of Dr. Theodore Zekman was the third. Dr. Zekman is still practicing, mainly because he doesn't know what else to do. [laughter] He is a couple of years older than I am.

We worked hard then. We spent our mornings in the office. Now, I am talking about the three younger men particularly. The mornings included Saturday, by the way. Three afternoons a week we worked in the clinics at the Illinois Eye and Ear Infirmary. Two afternoons a week I worked at the clinic at the Michael Reese Hospital, with which I was associated. One afternoon a week I assisted Dr. Gradle in his surgery. If your mathematics are any good, you'll see that it comes up to six afternoons a week.

Hughes: Was that typical?

Snydacker: Sure. Six full days a week. My father, for example, even when he had given up hospital work, went to his office six days a week. He worked on Saturday morning.

Hughes: Were you developing any interest in a subspecialty of ophthalmology?

Snydacker: In those days this superspecialization was not really known. There were a few men who had particular interests and emphasized those interests, but they didn't specialize in them the way subspecialty people do now. As a matter of fact, I became interested in extraocular muscles, but I made a conscious decision after I had come back from the service that I didn't want to specialize. I always had the idea that to confine oneself to one particular narrow field might be kind of boring.

Military Service, 1942–1945

Snydacker: But to go back, we worked six days a week, and we worked hard. I did that until 1942. In 1942, as you may recall, we had become involved in the war. I put on a soldier's suit and went off to the service.

Hughes: To do ophthalmology?

Snydacker: To do ophthalmology, yes. At first I was with what was then called the United States Army Air Corps. My job was to examine the eyes of prospective pilots, young men who were known as cadets, who were in training to become pilots.

I was stationed at a lovely place called Blytheville, Arkansas. [laughter] Blytheville, Arkansas, was the pits. By that time we had two kids: [the one] you met this morning, and her older brother. After I had been stationed at Blytheville for a while, I was able to rent a house, which was very hard to do, and Betty and the children came down and joined me. We stayed there for about eighteen months. Then I felt that I was just involved with routine examinations of healthy young men all the time, and it was not very productive. So I requested a transfer, which finally came through, to the army ground forces. I was assigned to a general hospital, which at that time was in Palo Alto, California.

Hughes: *What was the name of it?*

Snydacker: Dibble General Hospital.

Hughes: *Ah, yes. So you must have known Dr. [Crowell] Beard and Dr. [Phillips] Thygeson?*

Snydacker: Not through that.

Hughes: *They were both there during the war.*

Snydacker: Well, it must have been after I was there, because I was assigned to Dibble before the hospital was opened. I started to organize the eye service.

One day the commanding general of that area came in to inspect the hospital. He went through the eye clinic. Then as we were walking down the hall, he put his arm on my shoulder and said, "Major, anybody you want to help you, just let me know, and I'll see if I can't arrange it." I was elated, because I thought that was an indication that maybe I was going to stay at this nice place. We called it our six golden months in the army.

But pretty soon a colonel from the Surgeon General's office came up with a big broom. He swept me right out into the South Pacific. I was assigned then to an evacuation hospital. Very shortly, in June of 1944, I went overseas. I took a well-known island tour, starting in New Guinea, going up through the Dutch East Indies, through the southern Philippines. Then we went to the general Philippines for rest and rehabilitation. During the time there, in late August or early September of 1945, the war was over. We were loaded onto an LST and proceeded from the Philippines to Japan, skirting a typhoon on the way, which is a very interesting experience. Do you know what an LST is? A landing ship tank. One of those great big, long boats, the bow of which opens up, and it carries tanks, trucks, and everything. It carried our whole hospital unit.

So we ended the island tour in Japan. We got there in early October, and I was there about six or seven weeks and then came home. While I was with the evacuation hospital, we were assigned to a town called Utsunomiya and stayed there for about a month or five weeks. Then I was transferred out to come home. I got home in December of 1945. Incidentally, I got home ten days after my chief, Dr. Gradle, had the stroke that I mentioned.

Hughes: You had been intending to practice with him?

Snydacker: I was uncertain, but I probably would have. This stroke was a right-sided stroke that deprived him of his speech. It became immediately clear that he would never be able to resume practice. So then I opened my own practice.

Harry Gradle

Hughes: Before we leave Dr. Gradle, I would like to hear a little more about him, because of course he is a big figure in Academy history. Tell me first of all what he was like as an individual.

Snydacker: He was a small man and not very handsome, but very dynamic. He had a great way with people. As I said, he had an enormous practice. People used to just crowd into his waiting room. They came, really, with an appointment, but an appointment didn't mean very much, and they frequently would wait for an hour or more and sometimes even longer. He had the ability when they walked into his private office to make them feel he had been waiting all morning just to see them. So he was great.

The Academy and the Armed Forces Institute of Pathology

Snydacker: He had many original ideas. The Home Study Courses were his idea. The Armed Forces Institute of Pathology [AFIP] was all his idea.

Hughes: He was responsible for associating the Academy with the AFIP, was he not?

Snydacker: Yes. I don't know the details of it, because that happened actually before I started to practice with him.² But I do know that although he himself was not particularly interested in pathology, he recognized its value. Throughout the country at that time there were very few eye pathology laboratories. There was one at the Illinois Eye and Ear Infirmary that was headed by a very famous lady by the name of Georgiana Dvorak Theobald. That was to my knowledge the only real pathology laboratory in the city of Chicago. I think there was some pathology being done at the University of Chicago. I don't think there was any pathology being done at Northwestern.

Hughes: Are you talking just about ocular . . . ?

Snydacker: Pathology, yes.

So the ocular pathology laboratories were far and few between. Dr. Gradle recognized the need for such laboratories so that pathological services would be available to ophthalmologists throughout the country. There were a few people who were associated with the Armed Forces Institute of Pathology who were knowledgeable about eye pathology. One was Helenor Campbell Wilder. Another was—and I may not have this name right—Courteny [Dr. Elbert DeCoursey. He was later Brigadier General.]. But those people were working with the Armed Forces Institute of Pathology, so they were competent to do ocular pathology. Harry Gradle put together the idea [of the Academy associating with the AFIP] and succeeded in getting the whole thing across.

Hughes: That was also a pathology registry, was it not?

Snydacker: Yes, that's right. I forget exactly what the title of that was. [Dr.] Lorenz Zimmerman really took over the registry and built it up. He also has written its history.³

² For the Academy's association with the Armed Forces Institute of Pathology, see Sharon A. Bryan, *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*. San Francisco: American Academy of Ophthalmology, Rochester, MN: American Academy of Otolaryngology, 1982, pp. 91-109.

³ Zimmerman LE. The registry of ophthalmic pathology: Past, present, and future. *Trans Am Acad Oph Otol* 1961; Jan-Feb, 51-113.

The Home Study Courses

Snydacker: I knew more about the Home Study Courses because they evolved while I was working with Dr. Gradle.

Hughes: Why did he think it was necessary to have the courses, and for whom were they intended?

Snydacker: It's important to realize that at that time, which was in the middle thirties, ophthalmic education was not what it is today. There were residencies, many of which were a year, as mine was, or sometimes two years [long]. They were largely clinical residencies with a minimum of formal instruction. This was throughout the country. There were of course some exceptions. There were some large teaching hospitals where there was more or less formal instruction, but that was not the rule. In order to fill the gap, Harry Gradle conceived the idea of having what he called a Home Study Course. The Home Study Course had a faculty generally of younger men who by and large were well known.

Hughes: Is that why they were chosen?

Snydacker: Yes.

Hughes: Well known for expertise in certain areas?

Snydacker: Frequently well known for expertise in a certain area, but sometimes they were the young men who had published articles on certain subjects.

The way the Home Study Course worked was that a list of questions was issued by mail to the students, along with reading lists. The students then would have a month to study. At the end of the month, a second list of questions was sent, and the students would write essay-type answers and return the answers to the Home Study Course headquarters. The Home Study Course headquarters would then send these answers to individual faculty members.

The various teachers in the Home Study Course would make up their own questions and their own reading list. It was a big job, because at first it was difficult to make up the questions. If you have ever tried to make up examination questions, you'll know that they can be easily misinterpreted, and the student can get off on the wrong track. So the questions have to be very explicit, and the answers then have to be graded with understanding. It was, as I say, a big job. This was long before the days of computers and computer-assisted answers and the like of that.

Hughes: Did the man who had made up the questions do the correcting?

Snydacker: Yes, he usually did. But frequently what happened was that the man who made up the questions would have a staff under him, residents or junior staff members, to whom he would assign papers for correction. But there were some very conscientious men who graded the papers by themselves.

Hughes: Were the questions intended to give the student an everyday understanding of ophthalmology? They weren't arcane?

Snydacker: No. And they were really intended as a stimulus for the student to read. In order to answer the questions, he must have read something about the subjects. So that was the theory behind the whole Home Study Course.

Hughes: So the student had to have access to quite a number of different texts?

Snydacker: Yes, that's right. But again, texts in those days were fewer than they are now. There were certain standard texts, and in general the reading lists that were provided referred students to those books which were commonly available. Not every student had access to a well-equipped medical library.

Hughes: Were these students exclusively in residency training programs?

Snydacker: No, some of them were out in practice. Again, it was directed to young men in general. Many residency programs advised their residents to take the Home Study Courses. But that was not always a prerequisite. Many young men who had finished their residency, who felt that they needed more work, took these courses. They were widely taken. There frequently might be 100 or 150 men taking the courses throughout the country. That meant that there would be 100 or 150 papers to correct.

Hughes: I can see how it was a big job.

Snydacker: It was a big job. It required a lot of time for the young men who took the course. They had to do a lot of reading. Having once done the reading, they had to take a lot of time to write the answers.

Hughes: Did most people complete the course?

Snydacker: Well, there was a pretty good dropout rate. I've forgotten; we figured that all out at one time. But I think as many as sixty percent finished the course. Very frequently what would happen would be that a man would start a course, drop out, and then resume it later on when he had more time.

Hughes: *Was the knowledge that was being conveyed at the cutting edge of ophthalmology?*

Snydacker: In those days, I don't know. The cutting edge was a little dull. [laughter] But it was current procedure, and the subject was divided into a number of specialties like refractions, external diseases, retinal diseases, and uveitis and internal ocular infections. Those were just some of the specialties.

There would be one faculty member in charge of each specialty section, and then, as I say, he would have one or several assistants who would help him, particularly in grading the papers.

Hughes: *You did this for a while?*

Snydacker: Yes, I did it for a while.

Hughes: *In refraction?*

Snydacker: In refraction. I learned a great deal about refraction. [laughter]

Hughes: *Did you find that you had to do some reading yourself?*

Snydacker: Yes. I had to do reading by myself, and I had to find out the reasons for certain things. It was a very educational experience.

Hughes: *Did you correct the papers?*

Snydacker: Sure, I corrected the papers. I guess I passed some of them on to some of the younger men and to some of my colleagues.

As is usually the case, some of the teachers were very conscientious. Bob Drews is a prominent ophthalmologist in St. Louis, and his father, Dr. [Leslie C.] Drews, was on the Home Study Course faculty. His father, I think, corrected all the papers himself and wrote very good, pertinent comments. What we used to do was write comments on the margins. He wrote fine comments to show that he had read these answers carefully. That wasn't always the case. A lot of times teachers didn't correct papers as carefully as they should have. A lot of times the teachers were very slow in correcting the papers, because it was such a big job.

Harry Gradle had been a member of the Board of Secretaries for a long time and had then been President of the Academy. He was reappointed as the Secretary for the Home Study Course, so he was intimately involved in the workings of it—intimately involved in the appointment of teachers and the like of that.

Hughes: I hear that Dr. [William] Wherry, when Dr. Gradle first proposed the idea of the Home Study Course, was not terribly enthusiastic.

Snydacker: I can't answer that. I knew Dr. Wherry, but only very casually. I've forgotten exactly when he died, but he died before World War II, I think.

Hughes: He died in 1942, early in the course of the war.

Snydacker: Dr. Wherry had been the Executive Secretary of the Academy and nurtured it along. His death was a great loss. After Dr. Wherry died, Dr. [William] Benedict was appointed as Executive Secretary. It was under his guidance that the Academy really took off. He was the Executive Secretary during the time that I served on the Board of Secretaries.

Hughes: Was it because of Dr. Benedict that the Academy took off, or would it have happened because of the explosion of knowledge within ophthalmology?

Snydacker: Well, I suppose a little of both, but Dr. Benedict was really a remarkable man in many ways. He was extremely well known and well liked. He had certain ideas about the Academy and the way it should be run. He had pretty good ideas about what the ophthalmologists in the country wanted, and he emphasized those things.

The Instruction Courses

Snydacker: Harry Gradle was also closely involved with the instruction courses of the Academy. Maybe not single-handedly and maybe in conjunction with the other secretaries, he decided that instruction of small groups would be very helpful—the idea of having these instruction courses in which there might be twenty or thirty students and someone particularly well qualified in any given subject who would talk informally to this small group of people.

Hughes: This was at the Annual Meeting?

Snydacker: This was at the Annual Meeting. This was subsequently organized during the time that I was on the Board of Secretaries by Dr. [Albert D.] Ruedemann, Sr. It was quite a logistic problem, because there had to be space provided for all the instruction courses, and there were frequently as many as sixty or seventy different courses. Rooms had to be provided, the courses had to be coordinated concerning time, instructional equipment, projectors, and the like. So it was a big job.

Hughes: Was the format when you were first active in the Academy similar to that of nowadays, so that there would be a series of different courses going on at the same time?

Snydacker: Yes.

Hughes: I understand that when the instruction courses were first instituted in 1921 they were held after the scientific sessions, and they were in large lecture settings.⁴

Snydacker: That may be true; I don't know about that. But at the time that I was active—this was during the time when it was the American Academy of Ophthalmology and Otolaryngology (AAOO)—the general sessions for ophthalmology would be held in the morning, and the general sessions for otolaryngology in the afternoon. As I recall, these alternated each year. One year ophthalmology general sessions would be in the morning, and the next year they would be in the afternoon. That meant, then, that if general sessions of ophthalmology were in the morning, the instructional program would be in the afternoon. For otolaryngology, if general sessions were in the afternoon, the instructional periods would be in the morning.

The instructional courses were very popular. It was amazing how conscientious ophthalmologists were in attending the sessions and the instructional courses. It was generally known who were the good teachers and who were not the good teachers. The good teachers would be sold out.

Hughes: Have you been to the Annual Meeting recently?

Snydacker: I haven't been to the Annual Meeting in some little time because I have problems with my vision.

Hughes: When you did go, did you find that the instructional courses were very similar to those you remember when you first became associated with the Academy?

Snydacker: Oh, sure. What I did, particularly later, was choose instructional courses largely on the basis of who the teacher was rather than what the subject matter was. Of course, I knew a great many of those people by that time.

Hughes: Who was responsible for choosing the instructors?

Snydacker: The man who was the Secretary for Instruction. During the time that I was on the Board of Secretaries, it was Dr. Ruedemann. At our meetings of the Board of Secretaries, he would ask everyone whether they knew of anyone who was

⁴ For the history of Academy instruction courses, see *Pioneering Specialists*, pp. 78-90.

particularly qualified or who was a particularly good instructor. But largely it was his decision alone.

Hughes: *Was he looking first and foremost for good teachers, or was he looking for people who were knowledgeable in certain areas?*

Snydacker: Well, he was looking for the combination. That was the idea.

The idea of rotating was instituted a little later. That is, a teacher might give a certain course for one or two or three years and then be retired. There were important advantages to that, because not only did it give the well-known people or people who were expert in any subject a chance to be an instructor, it also got rid of those who were less competent.

Hughes: *Could one be reappointed?*

Snydacker: Oh, yes, of course. There was no rigid rule, except that after a given number of years that person was relieved. He might in subsequent years be reappointed or he might not.

Hughes: *Did you have any association with the instructional courses?*

Snydacker: I gave courses for a while.

Hughes: *In what field?*

Snydacker: Mostly in refraction.

Hughes: *Did you enjoy that?*

Snydacker: Sure, that was fun. I gave some courses in extraocular muscles, because I was interested in that, too. As a matter of fact, the first courses that I gave were probably shortly after 1947 or 1948. There was a course in extraocular muscles that was headed by a man by the name of [Dr.] LeGrand Hardy, who was from New York and had a particular interest in extraocular muscles. There was a man by the name of [Dr.] Edmund Cooper of Detroit who gave part of that course.

Hughes: *For several years running?*

Snydacker: I think I gave it for two or three years.

The Palmer House, Chicago

Hughes: Was the Annual Meeting in the Palmer House?

Snydacker: For the late forties, during the fifties, and I guess even up to the early sixties, the Palmer House was one of the few hotels in the country that was geared to and so arranged that it could accommodate the Academy and all its activities. There was a hotel in Chicago at that time called the Stevens, since called the Conrad Hilton. It was larger than the Palmer House, but it didn't adapt, didn't lend itself to holding the meetings nearly as well.

Hughes: Because of the arrangement of the rooms?

Snydacker: Yes, and because of the arrangement of the lecture halls and space for exhibits, all of which were important.

Hughes: Did the Palmer House administration make special accommodation for the ophthalmologists and the otolaryngologists because of the year-after-year attendance?

Snydacker: Yes. There was a manager of the Palmer House, Dick Callison, who was a very nice man and very competent, and he became very involved with the Academy. He used to come to the Board of Secretaries meetings. He didn't stay the whole time, but he would come, and he knew everybody. So we would discuss all kinds of problems with him in terms of management of the hotel and the use of space. He was very intimately involved. Finally the Academy grew so large that even the Palmer House could no longer handle it.

As I seem to remember, at that time, in the fifties and sixties, in the combined Academy there might be as many as 6,000 or 7,000 members attending. Of course, that didn't necessarily mean the 6,000 or 7,000 came at the opening gun and stayed all the way through. The auditorium in the Palmer House held, I think, 2,000 or 2,500 people. It frequently was hard to find a seat. Something more than half the members of the Academy were ophthalmologists. I think that was probably 60/40 or even 65/35; there were fewer otolaryngologists.

Hughes: Do you know how the size of the combined specialty meetings compared to the size of other medical specialty meetings?

Snydacker: At that time it was one of the larger medical specialty meetings. Of course, we had a long and honorable tradition of big meetings. These eye, ear, nose, and throaters, as we were called, had been a specialty much longer than some of the

others. Even internal medicine, which had far more physicians, was a little slower to organize. Of course, in those days there were very few men who subspecialized in general medicine; there were relatively few cardiologists, gastroenterologists, and pulmonary specialists.

Hughes: Was there considerable attention from the press?

Snydacker: Yes, I suppose there was. Moderate. One of the members of the Board of Secretaries was the Secretary for Public Relations. But in those days we had to be very careful about press relations. The press was always interested in individual personalities, and they were also very interested in “breakthroughs.” Some well-known man might get special attention from the press, and that was deemed very unprofessional. The media, then as now, always liked to play up the breakthroughs and were then as now not always aware of what constituted a breakthrough or what was really significant and what was not. So we had to be much more careful about publicity then than now.

Hughes: How could the Academy attempt to control what the press reported?

Snydacker: As a matter of fact, the Academy had a rule that prohibited individuals from giving unauthorized interviews. So if the press wanted to interview some particular member of the Academy, it had to be done through the Academy and generally with the Secretary for Public Relations present.

Hughes: What if a member of the press attended a presentation?

Snydacker: They were not permitted. Admission was for members only, and you had to have a badge. You wore a badge, and that admitted you. If you didn’t have a badge, you didn’t get in. Badges weren’t issued to members of the press.

Hughes: I understand that certain ophthalmologists took advantage of the Academy meeting to drum up interest in the area in which they were practicing. Do you remember anything like that?

Snydacker: Well, I’m sure that was true, but I was never particularly aware of it.

The AAOO Board of Secretaries

Snydacker: I was thinking about the way the Board of Secretaries functioned. There were six members of the Board of Secretaries, not including Dr. Benedict. There was a Secretary for Ophthalmology, a Secretary for Otolaryngology, a Secretary for

Instruction in Ophthalmology, a Secretary for Instruction in Otolaryngology, a Secretary for Public Relations, and a Secretary for the Home Study Course. During the time I was on the Board of Secretaries, the Secretary for Ophthalmology and the Secretary for Otolaryngology changed a little bit. When I first started, Dr. Algernon Reese of New York was the Secretary for Ophthalmology, and Dr. Lawrence Boise of Minneapolis was the Secretary for Otolaryngology. Later, Dr. Kenneth Roper became Secretary for Ophthalmology, and he remained that for quite a long time.

Hughes: How did an individual assume the position of secretary?

Snydacker: That also relates to the way the Board of Secretaries was run. Dr. Benedict was the one who really decided. The members of the Board of Secretaries were appointed; they were not elected.

Hughes: Appointed by Dr. Benedict or appointed by the Council?

Snydacker: Appointed by Dr. Benedict and by the Council, but largely it was Dr. Benedict. Dr. Benedict ran the Academy almost single-handedly, although he relied heavily on the two senior members of the Board of Secretaries, who were at that time Dr. Ruedemann and Dr. Dean Lierle. Do you know those names?

Hughes: Yes.

Snydacker: The three of them really ran it. The man who became Secretary for Public Relations was Dr. Glenn Gibson from Philadelphia. Dr. Gibson had been one of Dr. Benedict's residents. I liked Dr. Gibson. He was a very nice man (he is long since dead), but he was not a very forceful kind of personality.

Hughes: Did that mean that the secretariat drifted?

Snydacker: It just meant that Dr. Benedict didn't pay a great deal of attention to what either Dr. Gibson or I had to say. [laughter] He was considerate. He would make suggestions to us. If we made suggestions, he would take them under advisement. One of the things that Dr. Benedict was very skillful at was when a question came up regarding any given action of which he disapproved, he would smother that proposal by inaction. He would just sit on it, wait for a year or two or three, and then gradually it would just disappear.

[For Dr. Snydacker's additional comments about the Board of Secretaries, see the appendices.]

William Benedict

Snydacker: Dr. Benedict was very much opposed to dividing the Academy. That question came up periodically during those earlier years. Partly because of his close association with Dean Lierle and Dr. Ruedemann, he thought the combined Academy was in a stronger position financially and in terms of its influence in the broad field of medicine.

Hughes: And he maintained that idea to the end?

Snydacker: He maintained that idea to the end.

The other thing he maintained was that he was absolutely opposed to the idea of small, ancillary groups meeting in conjunction with the Academy meetings. He refused permission time and again. There were groups like the Contact Lens Association, or there were groups, particularly in the later years of his reign, that were interested in retinal detachments; and there were groups interested in various other subspecialty areas that wanted to have meetings, and it would have been convenient. Dr. Benedict refused to let them meet in conjunction with the Academy.

Hughes: What was his reason?

Snydacker: The reason was, and I think it has been borne out, that he thought the Academy as a whole was important, and if the subspecialties held meetings, the only reasons people would come to the Academy meetings would be to come to those ancillary meetings. They wouldn't pay attention to the Academy, and the Academy thereby would be weakened. In some sense, I think that has come to pass.

Benedict had to give up some of his activities. He was talking about resigning, but he never did resign. But after his death he was succeeded by Dr. [Clair M.] Kos of Iowa City, and the philosophy gradually changed. These subspecialty groups whose meetings Benedict had so opposed were permitted to meet at the same time as the Academy. Those groups have gradually become stronger and stronger, with larger and larger memberships. As a result, one of the things that has happened is that some of those groups have been relied upon to provide some of the program of the Academy. For example, there is now an intraocular lens surgical group. I think they are called upon to have symposia, maybe not at every meeting but at some meetings, or to provide individual speakers on given topics. I can't say that the Academy is weakened. I'm not sure that it is. But some of the emphasis on the unity of the Academy has been weakened, I think, and the Academy has consequently maybe become less important.

Academy Membership

Snydacker: At the time that I was on the Board of Secretaries, the prerequisite to membership in the Academy was certification by the [American] Board of Ophthalmology or the [American] Board of Otolaryngology. As you may know, that was changed, and there was a separate category of membership allowed so that people who had not passed on those boards were allowed to have membership. I think initially that non-board-certified people were second-class members in contrast to fellows, but I am not sure what it is now.

Hughes: How do you feel about that?

Snydacker: I think probably it is a good thing. There had been at one time an ophthalmology section of the American Medical Association. That was open, of course, to all members of the American Medical Association. That Section on Ophthalmology has been abandoned. There is therefore no other group, I think, that includes all ophthalmologists, those board-certified and those not board-certified. I think the Academy of Ophthalmology since the split has maybe 12,000 members.

Hughes: I think I read 15,000.

Snydacker: It's a large number, much larger than it used to be. This is the only organization in ophthalmology that includes both board-certified and uncertified. I guess it is a good thing. It permits some unified organizational action in professional, social, and governmental affairs.

Hughes: Does it make it more difficult to maintain educational standards?

Snydacker: No, I don't think so. One thing that I'm not certain about is that if there are 15,000 members, what percentage of them are board-certified, and what percentage are not? I passed my boards in 1938. Through the years there have been more and more people taking the boards. I think a relatively small percentage of ophthalmologists who take the boards fail to pass. They may fail the first time, or maybe even the second time, but a surprising number persist and ultimately pass. Far and away the largest proportion who take the boards pass the first time.

More on the Board of Secretaries

Hughes: Let's go back to the Board of Secretaries. Could you describe what the overall purpose of the Board was?

Snydacker: The Board of Secretaries had a couple of functions. It was the basis for the Program Committee. In those days the Program Committee consisted of the Board of Secretaries plus the President, the President-Elect, and maybe a few other people, such as the councillors. I have forgotten. But primarily the Program Committee was the Board of Secretaries, since the Secretary for Ophthalmology and the Secretary for Otolaryngology were members of the Board of Secretaries. They were very important in determining what the program would be. I would say, in a sense, that was one of their most important functions.

The other function, as I have indicated, was the instruction courses. The Board of Secretaries included the Secretary for Instruction both in ophthalmology and otolaryngology. As I have already said, the Secretaries for Instruction were to a certain extent autonomous. They relied on the advice of the Board of Secretaries. They relied, of course, on the administrative activities of the headquarters of the Academy, which in those days was in Rochester, Minnesota. The Secretaries for Instruction communicated with the instructors and then gave them the time of their courses and so forth. They did all the logistic matter. There may have been a Secretary for Exhibits, although I think those were associate secretaries for exhibits in ophthalmology and in otolaryngology.

The Council met just prior to the Annual Meeting and, I think, once during the meeting. The Council consisted of the Board of Secretaries, the officers of the Academy, and three councillors. I can't remember how the councillors were chosen.

Hughes: Were they chosen by region?

Snydacker: No, I don't think so. I think maybe they were appointed. Whether they were appointed or elected didn't make a great deal of difference, because if they were elected they had always to be nominated, and they were always nominated by the Executive Secretary, either Dr. Benedict or Dr. Kos or, more recently, Dr. [Bruce E.] Spivey. Their names would be brought up at the Annual Meeting. It was always a . . .

Hughes: . . . rubber stamp?

Snydacker: A rubber stamp. There was only, I think, one election in the history of the Academy that I remember anything about in which there was an opposition slate.

Hughes: When was that?

Snydacker: That was at the time that [Dr.] Bradley Straatsma had been suggested by the Council for the presidency. He was opposed by a group headed by [Dr.] Whitney Sampson from Houston. Whitney Sampson got together a group of people, including [Dr.] Joe Dixon and young [Dr.] Al Ruedemann, Jr., who was not generally liked very well. There was a real opposition ticket, and I remember that [Dr.] Fred Blodi was in charge of organizing the regular slate. I guess Fred Blodi was on the Council at that time, and he was in charge of organizing the pro-Council forces. He got me to speak at the meeting in favor of Bradley Straatsma, and other people were primed to get up and speak.

Hughes: What was the basis of the opposition?

Snydacker: The basis of the opposition was just that it was a power grab. I think the Academy probably did the right thing. Instead of remaining divided, they brought Whitney Sampson in, appointed him to the Council, and gave him a job. He was afterwards President.

The American Association of Ophthalmology

Hughes: There was a problem about the time of the separation of the academies with what to do with the American Association of Ophthalmology.

Snydacker: As I remember, the American Association of Ophthalmology was a group of ophthalmologists, both board-certified and non-board-certified, who banded together primarily to fight optometry. At the time of the separation, as I indicated earlier, in order to unite ophthalmology as a whole it was decided to offer membership to those non-board-certified ophthalmologists, most of whom—or at least many of whom—were members of the Association. That was the way that problem was solved.

I'm sure that Whitney Sampson, whom we were discussing a moment ago, was a member of the Association, but he was also board-certified. Whitney Sampson is a very smart man, and I think he is an ambitious man. In any case, he joined the ruling part of the Academy and ultimately became President.

Hughes: Do you have anything to say about what led up to the separation of the Academy? I'm interested particularly in your earlier remark that there had been talk about a separation for a long time.

Snydacker: There had been talk. As I indicated, Dr. Benedict thought the joint Academy of ophthalmology and otolaryngology was a stronger organization financially, politically, and professionally. It was stronger as a unified group than it would be if the two specialties separated. I think that concern was not well founded, because the association of ophthalmology and otolaryngology came from the end of the nineteenth century and the beginning of the twentieth century, when it was very common for doctors to be eye, ear, nose, and throat specialists. That no longer is the case. There may be, I suppose, a few who practice the combined specialty, but I don't know of any. So most professionals are either ophthalmologists or otolaryngologists. I'm not sure how the Academy of Otolaryngology has progressed, but the Academy of Ophthalmology has a larger membership of just ophthalmologists than it ever had of the combined group. So it has been able to stand on its own feet.

Having been a member of the Academy since 1938, I have long since become a life member. As a life member I haven't had to pay dues, but I understand that the dues are appreciable. I don't know how much they are now, but I know it used to be \$20 a year or something like that.

Hughes: I think it is something like \$500.

Snydacker: Quite likely. But, of course, the Academy does all kinds of things now that it didn't do . . .

Hughes: . . . in the old days. [laughter]

Snydacker: As my children used to say, "Father, in the olden days . . ." [laughter]

Hughes: Well, in the "olden" days, when you were a young physician, could an ophthalmologist get along very nicely without being a member of the Academy?

Snydacker: Oh, yes.

Hughes: So the Academy membership was not really crucial to success as an ophthalmologist?

Snydacker: No.

Hughes: Why did people belong to the Academy?

Snydacker: People belonged to the Academy because it was a stimulating thing. It was a constant source of information. Even the most learned people in various subspecialties still got information from membership in the Academy, as they do through membership in their own subspecialty groups.

More on the Home Study Courses

Hughes: I want to ask a few more things about the Home Study Courses. Were they imitated?

Snydacker: There were no other ophthalmology groups that were involved.

Hughes: I was wondering about other countries.

Snydacker: I don't know that.

Hughes: I read that in 1953 you were nominated by Benedict—who else?—and elected Secretary of the Home Study Courses. You served for seven years, until 1960. Do you know why Dr. Benedict nominated you?

Snydacker: Not really, except that Harry Gradle had been a very close friend of Dr. Benedict, and with my close association with Harry Gradle, I guess they thought that would work out. I think it did for a while. Maybe I carried the Home Study Courses over a period of time, but sometime after I left they were dramatically changed and modernized and made much more comprehensive, and in some ways maybe more complicated but, I'm sure, improved. I really don't know much about what they are doing now. I presume that a great deal is done on the basis of computerized activities. I suspect that rather than essay-type questions (which are a headache to grade and to write) they are using the true-and-false and multiple-choice format. I suppose that's good.

Hughes: There were two components of the Home Study Courses. The first one to be instituted was the course in basic science [1940]. Then in 1942, Dr. Gradle started the course in clinical science—or clinical medicine, I guess, is what he called it.

Snydacker: Clinical ophthalmology.

Hughes: Did those two courses remain separate, at least during your tenure?

Snydacker: No, they were merged.

Hughes: Before you came on the Board?

Snydacker: I think even before I came on the Board. Of course, I worked as an instructor in the Home Study Course program for some time before I became a member of the Board of Secretaries. In those days the program was so arranged as to combine basic and clinical science. Really, the basic science part of it included optics, refraction, pathology, and physiology. But all of those subjects were easily absorbed into and made part of the overall Home Study Course that included both basic and clinical ophthalmology.

Hughes: In those seven years that you were Secretary of the Home Study Courses, do you remember anything significant happening? Was there any particular issue or problem that arose?

Snydacker: All those problems that arose were handled by Dr. Benedict, sometimes in consultation with Dr. Lierle and Dr. Ruedemann. But things went along really smoothly in those days.

Hughes: I read that in 1955, which was the fifteenth anniversary of the Home Study Courses, you and Dr. Ben H. Senturia—he must have been an otolaryngologist?

Snydacker: He was an otolaryngologist. He was an associate secretary for otolaryngology.

Hughes: Well, both of you wrote a report on the present status of the courses.⁵ Do you remember that?

Snydacker: Did I really? [laughter] If it says that, I guess I must have. I don't remember that.

Hughes: It was an analysis of the attendance over the years. I was going to ask if your report led to any changes. I'll just ask in general: Did you make any changes in the course?

Snydacker: I didn't make any major changes. I made a few changes. Dr. Benedict was not very enthusiastic about any changes. He thought things were rocking along pretty well and that we were better off just to stay the way we did. I think there was a time when I envisioned some changes, but nothing ever came of them.

⁵ Daniel Snydacker and Ben H. Senturia. "Home Study Courses Report for 1954–1955," October 1955, Council Minutes, 1955.

Hughes: Was that the famous Benedict procrastination technique?

Snydacker: Yes, in a sense. The question of just not doing anything, and eventually things quieted down.

Hughes: Do you remember what you hoped to do in the way of changes?

Snydacker: Only to expand, I think. I don't think I had the vision the others had later, nor the facilities to expand as it has expanded. The concepts of education and examinations to determine the degree of education have changed rather markedly. Those changes have come subsequently.

Hughes: When you say expansion, do you mean in terms of the numbers of types of courses that were offered?

Snydacker: Well, yes, in the expansion of the subject matters that were offered.

Hughes: Did you feel that there was any problem in keeping the courses up-to-date?

Snydacker: No. Probably one of the major problems was to get faculty members, because it was an onerous job with a lot of work involved. Men would be glad to serve for a few years, but at the end of the few years they frequently wanted out, and it was necessary to find someone else.

Hughes: And that was your job?

Snydacker: That was my job. It was difficult, and all the selections I made had to be approved by Dr. Benedict. He was pretty good about that. He always emphasized the necessity of having well-known educators as faculty members, and I agreed with that. That was a good idea, but it was sometimes difficult to get those well-known educators.

Hughes: Was that your main criterion for selecting faculty?

Snydacker: That and my personal knowledge and personal friendships.

Hughes: Is that who they usually ended up being? Were they friends or associates of yours?

Snydacker: Oh, no. But, of course, during that period in my life, my acquaintanceships and friendships expanded considerably, because I came in contact with a lot more people than I would have otherwise.

- Hughes:* I read about an exhibit in connection with the Home Study Course which was shown at the Annual Meeting of the Academy and at other ophthalmology meetings.
- Snydacker:* At each Annual Meeting of the Academy there were exhibits. There were what were called technical exhibits, which were put on by the various manufacturers and opticians and the like. Then there were scientific exhibits dealing with various scientific projects and experiments the members were doing, which were put on by members of the Academy.
- The Home Study exhibits were part of those scientific exhibits, and they were designed to publicize the Home Study Courses and get people interested in them. There was a paid professional lady, Maude Crivens, who worked for the Academy and who would organize that exhibit. It consisted primarily of the best answers to questions that had been written. Those were displayed so that they could be read by anyone who wanted to see the answers. A lot of times people who had taken the courses and had trouble with one or more questions would come and look at those papers that had been well written and that had the correct answers to any given questions.
- Hughes:* Were you expected to stand in attendance at the exhibit?
- Snydacker:* No. That was the responsibility of the lady who was employed by the Academy. She was the one who was in attendance.
- Hughes:* Was that a good way of drumming up interest in the courses?
- Snydacker:* I guess so. Particularly in the early days, the exhibit attracted pretty good interest. As I say, many of the people who either had taken the course or were planning to take the course studied those papers to see what was being done, how it was being done, and the type of questions that were being asked.
- Hughes:* How else did you get the word out that the Home Study Courses were available at the Academy?
- Snydacker:* We had little brochures. One of our main thrusts, as I indicated earlier, was to try and coordinate the Home Study Course with various residency programs. It was very helpful, I think, particularly in those residency programs that were mainly clinical in content. It offered some kind of instructional program that the residents could take. In some instances the residents were required to take the Home Study Course. That was good.

Hughes: In those cases, did the department or hospital take some responsibility for seeing that a resident actually completed a course?

Snydacker: That was the idea, and that would have been ideal. I don't know that it always happened. There was no way we could control that.

Hughes: What did a student get at the end of a course? Was there a certificate?

Snydacker: I guess there must have been a certificate. I've forgotten.

Hughes: Did a young ophthalmologist need that certificate to move ahead in ophthalmology?

Snydacker: No. If you made application to the American Board [of Ophthalmology] to take the board examination and could show that you had passed the Home Study Course, sometimes that was helpful in that regard. The American Board paid some attention to those people who had passed the Home Study Course.

Hughes: But it didn't mean that it absolved the person from having to take the board exams?

Snydacker: No, not at all.

Hughes: Did you make any attempt to gear the Home Study Course to the board?

Snydacker: Yes. I was what was called an associate examiner. I never was a full board member, but I examined at a great many board examinations. In the 1950s and '60s, boards frequently were given in Chicago in conjunction with the Academy meeting. Dr. Benedict had no objection to that. The boards would be given before the Academy meeting, and they usually would be given at the Illinois Eye and Ear Infirmary or sometimes at the Cook County Hospital. The people who took the boards were given patients to examine. Patients would be available at those large charitable organizations.

As you know, the board, in those days at least, was divided into two sections. There was a section on refraction, a section on external disease, a section on glaucoma, etc. Our Home Study Course was also divided in that same kind of a way, so there was a definite attempt to correlate the Home Study Course and the board. We made the attempt on the Board of Secretaries to make sure that correlation took place. The board didn't have anything to do with it.

Hughes: Did the student taking the Home Study Course do it partially as a means of preparing for the board?

Snydacker: I'm sure that's true. We had no way of knowing about that, of course. And there were a fair number of people who took the Home Study Course who had already passed the boards.

Hughes: As a means of updating?

Snydacker: As a means of updating and adding to their knowledge.

Hughes: Do you remember what the breakdown was between the resident student and the man out in practice?

Snydacker: I don't. I'm not sure we kept any record of that.

Hughes: You were unaware of any great change in who was participating in the Home Study Courses?

Snydacker: I don't remember any change.

Hughes: Do you remember as residency programs became more formal and, I assume, more scientific?

Snydacker: More didactic.

Hughes: Did that cut into the potential audience for the Home Study Course?

Snydacker: I think so. But whether that has persisted or not, I really don't know. I must confess that I don't have any information about the status of the various courses that are offered by the Academy today.

The Academy and Politics

Hughes: Did anybody object to what nowadays would be considered Dr. Benedict's high-handed way of running the Academy?

Snydacker: I suppose there were some objections, but maybe they weren't very forceful. Dr. Benedict, as I say, was universally liked. He was skilled at handling people. If and when any problem arose, he usually could handle it without too much difficulty. I don't remember any major contentious problems arising.

Hughes: The Academy under Benedict, and before that as well, was a strictly educational institution?

Snydacker: Yes, sure.

Hughes: It was "hands-off" politics, is that not correct?

Snydacker: Yes, that's right. Dr. Benedict was very reluctant to become involved in any kind of politics.

Hughes: What was his reason?

Snydacker: I don't know that he had any. That was just his feeling about the matter. You must remember, really, that certainly up to and including the twenties, and I guess even the thirties, medicine and politics didn't mix. There was very little intrusion either one way or the other. There was a little, but very little. It was only later, particularly with the advent of Medicare, that politics really became important in medicine. So I think Dr. Benedict's feeling was in a sense a hangover from the earlier days and earlier feelings.

Hughes: Yet I noticed from the Academy meeting minutes that the Academy did occasionally take a stand on federal legislation that directly impinged on medicine.

Snydacker: Could be. I don't remember that, nor do I remember any specific things. If there were anything, it was usually an attempt to get the politicians to lay off with interfering with medicine.

Hughes: Was the Academy pretty successful?

Snydacker: I think it was. Politics was much less important to medicine than it is today. There were just the beginnings of rumbles about socialized medicine, but those rumbles were terribly new. I can remember my father talking before I went to medical school about the dangers of socialized medicine and the changes that might take place in medical practice. Of course, some of those changes have taken place, but many of them didn't take place during my almost fifty years in practice.

Social Aspects of Serving the Academy

Hughes: Was there a social dimension to serving with the Academy?

Snydacker: The only social thing was the question of our relationships with members of the Council and the other members of the Board of Secretaries. We of necessity became much closer friends than we had been before. But, for example, Dean Lierle and Al Ruedemann—who was, incidentally, always called Ruedy—were half a generation older than I; I think they were maybe fifteen years older than I was.

Hughes: So that was somewhat of a barrier?

Snydacker: A little [bit] of a barrier, but that barrier was bridged fairly well. I can remember one incident. The first meeting of the Board of Secretaries that I went to was held in Minneapolis. We went out to dinner at a country club. I don't remember the name of the club or much about it, except that I do remember that there were drinks. Ruedy was very conservative. I have forgotten all the details, but his brother was in some kind of a position where he had been exposed to mistreatment by communists, and Ruedy was bitterly anti-communist. I was much more liberal than he, I'm sure. We got into a kind of political argument. He was very vociferous. I remember coming back after this argument and saying, "God, I'll bet you I'll not be on the Board of Secretaries very long." But the next morning he had forgotten all of it, and we got along just fine.

Hughes: But it could have worked that way in those days? It wouldn't take much to have Benedict dismiss you?

Snydacker: I think you would have had to have more than one minor political argument. I think we all got along pretty well.

Hughes: Did you see each other as a board other than at the Annual Meeting?

Snydacker: Yes. Let's see. There was a meeting in January that was a program committee, as I said before. In the summertime, three or four months before the Annual Academy Meeting, which was in October, the Board of Secretaries always got together and usually went out of town. For example, I remember that we met several years at the Broadmore Hotel in Colorado Springs. In a sense, that was the only pay. I never derived any pay from the Academy, but the Academy did pay for our travel expenses and our expenses for that meeting. It usually was a three- or four-day meeting in which we combined business with pleasure. We used to meet every morning and discuss matters and problems in the program,

appointments, and the like of that. Then there was entertainment in the afternoon, usually golf. These men all played golf; some of them were miserable golfers, including myself. I played at it.

Hughes: Did you play only on these occasions?

Snydacker: I started playing golf when I was a child, but I was never very good at it. I never belonged to a club, so I didn't play very much except at those meetings. There is another organization, called the American Ophthalmological Society [AOS], which most of us belonged to. We played golf at that.

Hughes: Golf and tennis seem to be the sports of ophthalmologists.

Snydacker: There was a lot of tennis at the AOS meeting, but the Board of Secretaries did not play tennis. They were too old. I think I had probably given up tennis by that time. I used to play tennis when I was young, but two things happened. One, I turned forty. Once you've turned forty, you're going downhill, you know. [laughter] Then my principal tennis play friend left town, so I had no one to play with.

More on the Instruction and Home Study Courses

Hughes: My impression is that the present instruction courses are not so much geared to the resident but are a way for the practicing ophthalmologist to keep up-to-date.

Snydacker: Well, I think probably that is what the major emphasis is now. I'm not sure.

Hughes: That's a change, isn't it?

Snydacker: Yes, it is. You see, that's tied in with the fact that residency programs now are much more didactically oriented than they used to be. In almost every residency program there is a certain amount of didactic teaching that goes on. Part of the residency program at Michael Reese [Hospital] was to take the Lancaster Course. Sometimes that course was taken before the resident started his clinical period, sometimes it was midway in the course of the residency, and sometimes even toward the end of the residency. That was, I think, a fairly common part of the residency program amongst institutions which didn't have a strong didactic base.

At the University of Chicago, which was where I was associated for a while, we gave a course to the residents. But those courses given during the residency

training frequently were completed with difficulty, the reason being that the resident was so very busy. For example, if you scheduled a lecture to be given at a certain hour of the day, you picked that hour based on when the resident was most likely to be free. But the fact that he was most likely to be free did not mean in fact that he always was free, and very frequently he might be involved in surgery, or it might be his day off, or there might be a variety of reasons why a resident was unable to get to that lecture. So there was a certain advantage in having a concentrated course at a certain prescribed time during the residency program when the resident had nothing else to do but go to the lectures in that course. Those would be all-day programs and might go on for a month, two months, three months.

Hughes: You're not talking about the Home Study Course but about a course within the department?

Snydacker: Yes, that's right.

Hughes: Did such courses develop postwar?

Snydacker: Yes. Almost all the big advances in training in this country have occurred since World War II.

Hughes: When was it appropriate in the Home Study Courses and instruction courses to include surgical innovations or technological breakthroughs?

Snydacker: We always left that up to the judgment of the individual instructors. Generally that was well handled, I think. A breakthrough hardly ever occurs so suddenly that it dramatically changes the course of treatment or the course of events overnight. Any really dramatic breakthrough, and they are very few and far between, would usually be over a period of time—months. Then gradually, as information is disseminated about that breakthrough, it would be included in any course that we would begin.

Hughes: Would it be accurate to generalize that the subject matter included within the Home Study Course was pretty much tried and true?

Snydacker: Yes, I think that's true. There was certain information that was important. In pharmacology and therapeutics, there might be some new things that were taught, but the basic principles of ocular disease were really in a way the same as they have always been for years and years. There are changes, for example, in the way cataracts are treated, but the causes of cataracts, the question of when to operate, and the various types of cataracts are more or less standard. Even the latest breakthroughs have not changed those things particularly.

Ethics and the Academy

Hughes: A controversial topic of recent years has been radial keratotomy, which, of course, was a real problem for the Academy.

Snydacker: Oh, yes.

Hughes: Can you think of any analogous situations?

Snydacker: No.

Hughes: As I understand, the problem there was that a number of ophthalmologists espoused radial keratotomy, and the Academy stated that this was not a proved technique.

Snydacker: Yes, that's right. Fortunately, during the time that I was on the Board of Secretaries there was no very radical group. In a sense, I suppose there were megasurgeons, but not as there have subsequently come to be. That is a change. Again, not a breakthrough; that's a gradual change that has happened, where certain aggressive surgeons have developed enormous practices, sometimes legitimately, sometimes for what some of us might say are illegitimate reasons.

For example, there is a man here in Chicago who advertises on television that senior citizens can have their cataracts removed, and he won't charge them anything. He accepts what Medicare pays, and he'll send cars out to get the patients and bring them to his hospital. And the cars take them home after they are operated on as outpatients. Those are all modern methods.

Hughes: In the old days an ophthalmologist with that sort of history applying to the Academy for membership would not get very far?

Snydacker: That's right.

Hughes: Is that still the case?

Snydacker: I have no idea. Even advertising now is ethical. Advertising in the olden days used to be entirely unethical. There were people like Harry Gradle, who did a great deal of surgery, but he might have done, I suppose, during his heyday, maybe five or six cataracts a week. Nowadays there are people who do five or six cataracts a day and do them three or four times a week, so the volume of surgery has increased enormously. One of the things that has happened is that patients are being operated on a great deal earlier than they used to be. That's another story.

Hughes: You don't approve, I gather.

Snydacker: No, I don't approve. I was very conservative when it came to surgery.

Hughes: Do you have any comment to make about the Academy and the increasing trend toward litigation and how that has affected the Academy's operations?

Snydacker: I have no idea about that. When I had anything to do with the Academy, the question of malpractice had really not arisen in any serious proportion. Although there was such a thing as malpractice, it was not a serious threat. Malpractice insurance was not very expensive. It seems to me that when I first started I had malpractice insurance which cost \$25 a year or something like that. [laughter]

Hughes: Not anymore.

Snydacker: But there were very few suits. I think there are two causes for most malpractice claims: one, if the patient feels deserted by his doctor, who maybe doesn't pay as much attention to him as he wants; or, two, malpractice is confused with a poor result. If a doctor makes extravagant claims about the prospect of success, and he gets poor results, he's liable to be in trouble.

Hughes: What about the Academy as an arbiter of ethics in ophthalmology?

Snydacker: Well, you know, ethics in ophthalmology is exceedingly difficult to define. Long since I was on the Board of Secretaries, there was a committee on ethics chaired by a San Franciscan, [Dr.] Jerome Bettman, Sr.

Hughes: Oh, yes. I know him.

Snydacker: He did a tremendous job and was very conscientious, and he evolved a code of ethics which I think is fine. I think it's a shame that doctors should not instinctively appreciate what ethics are. I suppose it involves a question of honesty.

Hughes: You are saying, to paraphrase, that you think a code of ethics should be necessary?

Snydacker: Yes, that's right.

Hughes: I think Dr. Bettman also found that because of litigation, or the threat of litigation, it was very difficult to enforce the code of ethics. This was a standard to which he hoped ophthalmologists would aspire.^{6,7}

Snydacker: Voluntarily. Quite so. One of the great problems, and I don't think the Academy has solved that problem really, is the question of what to do about transgressors—people who do not perform in as ethical a way as they should. To my knowledge there is no way of disciplining such people. I know that in Chicago an attempt was made to discipline one of our colleagues by dismissing him from the staff of a certain hospital. He went to court and won a decision, and the hospital was not allowed to kick him out. So the question of discipline is a difficult one.

Hughes: How was it done in the old days?

Snydacker: It never really came up in the old days to my knowledge. I know there were people who were dishonest. There was an attempt early on by the University of Illinois to take over the Illinois Charitable Eye and Ear Infirmary, which ultimately it did. But that attempt was blocked for many years by one rather powerful man who had ulterior motives. His ulterior motives were certainly not discovered during his lifetime. I think they were only discovered after his death.

Hughes: It was personal aggrandizement, then?

Snydacker: I think so, yes. I think nothing was ever done about it. This was in the twenties and early thirties, so unethical behavior did exist in those days. I guess physicians were maybe more discreet about misbehaving.

Hughes: Didn't the Academy take a stand on the issue of rebates from opticians?

Snydacker: Yes, but that was a very common thing. In general it was frowned upon, but there were certain situations in which it was almost necessary. For example, I had a friend who practiced in central Illinois in a small community where there was no optician. It was necessary for him to dispense glasses. Otherwise there was no way his patients could get glasses. If you gave them a prescription, they might have gone sixty miles into St. Louis or a couple of hundred miles to Chicago, but that was really asking too much. So this man dispensed glasses, but he happened to have been a very honest man, and he didn't exploit the patients. On the other

⁶Jerome W. Bettman, Sr., "Ethics and the American Academy of Ophthalmology." Draft manuscript, October 4, 1989.

⁷Bettman Sr. JW. The Pressures on Our Standards of Ethics, *Arch Ophthalmol*, 1986; 104:497.

hand, there are, unfortunately, many ophthalmologists who dispense glasses who derive a substantial income from the glasses they dispense. That is generally considered to be improper.

Later Career

Hughes: Dr. Snyder, we abruptly left your career somewhere in the middle of your Academy office. Why don't you bring us up to the present time.

Snyder: Well, my career was very satisfying to me. I always thought that I had the best of both possible worlds. I was associated for about twenty-five years with the Illinois Eye and Ear Infirmary. I was an associate professor of ophthalmology. I enjoyed my contact with the residents very much. I had a service at the infirmary. It was very rewarding.

I never was particularly involved in administrative work. In about 1966 I left the infirmary and had an appointment at the University of Chicago Medical School. That was a little unique, because the faculty at the University of Chicago was all full time, and I still was in private practice, so I didn't go there full time. I worked there from 1966 until about 1980. Then I retired and actually am emeritus at the University of Chicago. Again, I enjoyed my contacts there with the residents. I wasn't the only one, but my principal job was to have contact with the residents. I enjoyed that.

Hughes: You like teaching?

Snyder: I like teaching, but I like teaching on a very informal basis.

Hughes: One to one, or small groups?

Snyder: One to one or one to a few. There was a certain amount of lecturing that I had to do, but generally what I enjoyed doing was having a resident examine a patient and then discussing the patient and discussing the findings.

I retired from that position, because by 1980, I was seventy years old, and I had always had a strong feeling that old men should move out and make way for the younger men. By that time I was old.

Then I kept on in private practice. I gave up surgery in 1976 and just had an office practice, and I enjoyed that. By then I had no hospital duties and no

teaching duties, so I continued that way until 1984, when I retired. I retired, as I told you, because I had developed this macular degeneration, which probably was not senile but the exact cause of which is only speculation.

Retirement Activities

Snydacker: After I retired, I became interested in botany.⁸ I'm largely self taught, but I've become interested in the Illinois prairie and in the flowers and grasses which grow on the prairie. We live quite close to some of the best prairie remnant in Northeastern Illinois, under the management of the Open Lands of Lake Forest, for which I am a volunteer. I have made a two-year survey and collection of all the various specimens that grow on these prairies. I have collected about four or five hundred specimens. Floristically it is very rich, and it has given me great pleasure.

I bought a little herbarium cabinet for the Open Lands, and my specimens are all over in that herbarium in the office of the Open Lands of Lake Forest. Then also I work as a volunteer in the botany department at the Chicago Field Museum of Natural History, where I have now reached the stage where they let me do what I want, and I have great pleasure there. I go there once a week.

Hughes: Did you take instruction at the Field Museum?

Snydacker: No, I've never had instruction. But I have reviewed various families and various genera of plants there. I read up about them, and then I go and look at them. I am studying the goldenrods. [chuckles] Anyone who studies the goldenrods is considered a little crazy.

Hughes: Because they are so complicated?

Snydacker: Because they are so complicated.

Hughes: You told me off tape that you had developed your own key.

Snydacker: Yes, I developed a key, and it seems to work; but my final report is not in.

Hughes: Does it differ significantly from the previous key?

⁸ See "Retired doctor's interest in flowers in the prairies," *Chicago Tribune*, April 28, 1991.

Snydacker: Well, I hope it's less complicated and easier to use, but I'm not perfectly sure of that.

We travel quite a bit, and we take continuing education courses at Northwestern University, usually two days a week in wintertime. This Thursday was the start for the summer session, which meets once a week. It starts at 9:30 in the morning and lasts until quarter of three in the afternoon.

Hughes: Intense.

Snydacker: We take two courses that are offered in that period. We've had great pleasure from that. We have a subscription to the theater and to concerts and the like, so we keep out of mischief.

Hughes: Sounds like a very good life.

Snydacker: It is a good life. I have been very lucky.

Hughes: Well, I thank you.

Snydacker: Not at all.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

John Warren Henderson, M.D.

Conducted by

Sally Smith Hughes, Ph.D.

July 11, 1991 at the Mayo Clinic,
Rochester, Minnesota



John W. Henderson, M.D.

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name John Warren Henderson

Date of birth Sept. 11, 1912 Birthplace Sidney, Nebraska

Father's full name Edgar Forrest Henderson

Occupation Civil Engineer Birthplace Piconis, Iowa

Mother's full name Lillian Lending

Occupation Housewife - seamstress Birthplace Centerville, So Dakota

Your spouse Madine Downing

Occupation Housewife - Office Manager Birthplace Fallan, Iowa

Your children Sally Lou Henderson

Sally Jane Henderson

Where did you grow up? Omaha, Nebraska

Present community Rochester, Minnesota

Education M.S. University of Nebraska 1937; Intern Cincinnati

General Hosp '37-'38; Residency + fellowship at Mayo Graduate School 1938-1943

Occupation(s) Ophthalmologist

Areas of expertise Orbital + ocular adnexal surgery; Cataract surgery;

Corneal transplantations surgery; Author of textbook on orbital

tumors, 3 editions (1970 - 1994)

Other interests or activities Jazz piano; Construction of double

acrostic word puzzles; Model railroads; Ophthalmic history;

Poker.

Organizations in which you are active Cogan Ophthalmic History Society.

Memberships: American Academy of Ophthalmology.

American Ophthalmology Society

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JOHN WARREN HENDERSON, M.D.

[Date of Interview: July 11, 1991]

Family Background and Education

Hughes: Dr. Henderson, let's start with your family background and early education.

Henderson: I was born in Sidney, Nebraska, in a little four-room house in the pastures and cornfields on the outskirts of town. (I think it was in 1983 that I stopped in Sidney, Nebraska, and looked up the old place, which is now a part of the city, and the house is still standing.) My father, Edgar Forrest Henderson, was away at the time. He was a surveyor on the Union Pacific Railroad and working on a new branch line out in western Nebraska.

Within nine months of my birth, my family moved to Omaha, because my father was transferred to the Union Pacific headquarters there. My mother, Lillian Sending Henderson, had been a schoolteacher. They were married in 1910, and I was their first-born. I went to elementary school and high school in Omaha. I was a paperboy for five years, from ages twelve to seventeen. I saved up a good deal of money as a paperboy so that I could go to college. My father had had two years of college education to become a surveyor. He was a farm boy from Iowa, and he scrounged around to get the money to go to school. It was his thought that I should do the same.

My mother was more agreeable to helping in some way if possible, and I think she was all for my going to college. My mother was early on someone who wanted a niche for women. She wanted to be a doctor, but in earlier years, let's say around 1908, 1909, women just didn't do that. It was not proper, and they weren't accepted. But even as a boy, I remember her saying when I would hear her talk to other people, "My boy is going to be a doctor" [laughter], whether I had any say-so or not. But I think she was instrumental in getting me a scholarship to pre-med school at the University of Nebraska for my first semester.

Hughes: Had you been a good student all along?

Henderson: Yes, I had been a good student, so I don't think it was very difficult to secure me a scholarship. But you had to show financial need. As I recall, the tuition for the first semester at the University of Nebraska at Lincoln was forty dollars. And my scholarship provided twenty-seven dollars of that. [laughter]

I also worked in Lincoln in my two years of pre-med. I had a delightful experience, in that five nights a week (not Saturday and Sunday) I worked with a crew of three other young men carrying a big basket full of homemade sandwiches and a jug of hot chocolate around to the fraternity and sorority houses. We were the only sales crew who were granted entrance to the sorority and fraternity houses. Those of us who went to the sorority houses would stand at the foot of the stairway, and somebody would yell upstairs, "The sandwich man is here!" Then the girls would all come down in various arrays of hairdos stuck in curlers, robes and gowns, and no makeup. In the fraternity houses I would travel from room to room. It was a popular way of making some money. I worked from about seven-thirty in the evening until around eleven.

Hughes: Somebody else made the sandwiches?

Henderson: Well, it was managed by the mother of one of the young men who lived in Lincoln. She made the sandwiches in the afternoon, and I think she also was the business manager. She was the one who paid us. She was a nice woman. Her son, of course, was one of the crew.

We had two cars, one furnished by the lady who ran the business, and her son drove that car; then one other young man had his own car. There were four of us with two cars; one crew of two made the fraternity houses, and one crew of two made the sorority houses. I made the friendship of many students and often listened to a discourse of their future careers.

College Medicine, University of Nebraska, 1932-1937

Research Fellow and Teaching Assistant, Department of Anatomy

Henderson: Then after two years I went to Omaha, Nebraska, for medical school. Early on, I was interested in some teaching. I made the acquaintance of Dr. John S. Latta, professor of anatomy and histology, who gave me a chance to stay out a year between my sophomore and junior year to work in his laboratory as a teaching assistant. This also entailed doing a piece of basic research, writing a thesis, and passing an oral exam leading to the master of arts degree in histology (1935). I worked a year in this laboratory. That was quite an experience in research and teaching. My research project was "The Effect of Insulin Injections on the Hematopoietic System and Suprarenal Glands of White Rats." I received a stipend of fifty dollars a month.

Hughes: *Were you thinking that you wanted to combine research with practice?*

Henderson: I suppose somehow, but at this time a major concern was to earn enough money to continue school. I was married at the end of my freshman year of medical school [1933], and finances were a recurring problem thereafter.

Hughes: *Was it unusual to be married in medical school?*

Henderson: Yes, very unusual, particularly in the freshman year.

Hughes: *Did you run into any problems?*

Henderson: Yes. My wife, Nadine Downing Henderson, was office manager at the Woodsman of the World Life Insurance Company. They would not employ a married woman. So we kept our marriage a secret for the first years so that she would not lose her job. Subsequently she found other jobs and continued to work through the remaining years of medical school.

It was her support and her earning ability that kept me in medical school. Otherwise I'm sure I would have had to drop out.

Jobs

Henderson: I continued working in my junior and senior years and had several off-hour jobs all at the same time. One job was at six-thirty in the morning to make toast at the hospital. The hospital had 110 beds, and I made all the toast—two pieces of toast for every patient every morning except on Sunday. On Sunday they would have pancakes, and I didn't have to go to the hospital to make toast.

Also, one of my duties at that time in the morning was to get all of the cans of milk out of the walk-in freezer and pour the milk into pitchers so that glasses of milk could go up to the patients' trays.

Hughes: *Which hospital?*

Henderson: It was the University of Nebraska Hospital, right on the campus of the medical school in Omaha. I earned three meals a day for working that hour in the morning.

When school was over in the afternoon around four, I caught the streetcar and hurried downtown to the medical laboratory of the Union Pacific Railroad. Here it was my job to process the urinalysis specimens and perform the blood counts. This brought in a little money. I worked until about 6:30 and then hurried back to the hospital so I could eat my free supper.

Then I would go home and maybe study an hour or get some sleep, because I worked the night shift on the telephone switchboard at the hospital. My shift was eleven until about six in the morning; I had to get off at six to make the toast. Sometimes I fell asleep. The nurses would awaken me by pounding on the locked door of the little building housing the switchboard across the street from the hospital.

Hughes: How did you find time to study?

Henderson: Well, looking back on it, I just don't know. It seemed like I was working all the time. I got a fourth job, I think in the last part of that senior year. That was the one night I didn't have to work on the switchboard, and that night I worked at the Kresge Dollar Store downtown as the night custodian and stockroom clerk. It was hard to go to school the next day, when you'd worked during the night. I found that I was sleeping through lots of classes, but I had nice classmates who knew of my night work and often would show me their lecture notes.

But apparently I was quick on the take. If I heard it once, if I wasn't sleeping, I could remember. I managed to get through medical school and finished seventh in my class of eighty-eight.

We began to run out of money near the end of medical school, I think because of inflation. I managed to borrow money from the Knights of Columbus. They helped us with fifty dollars a month for that last year, and I was able to pay them back in my internship.

Hughes: Had they ever done anything like that before?

Henderson: I think they had some kind of a student loan program, and I happened to qualify for a loan. I had no connection with the Knights of Columbus at all. We weren't of Catholic faith.

Hughes: That was the Depression, wasn't it?

Henderson: Yes, that's right.

Hughes: The Depression didn't make life any easier.

Henderson: No. Few people nowadays, with our fine lifestyles in general, and even our poor, can realize how widespread was the Depression. Grown men who had been executives were out on the corner selling apples. I hope we'll never have that again.

In the summers between medical school semesters, I worked on the Union Pacific Railroad. I was a combined bridge and building painter. Most of the painting was on the mainline, painting depots and bridges over rivers. We lived in a bunk car on a siding near the workplace. We did our own cooking. We lived that way through the summer, moving from place to place along the railroad mainline.

I made good money in the summer, about sixty-five cents an hour. But it did keep me away from home. The paint crew had an old Buick touring car. Most of them were alcoholics and rough characters. Everybody got paid on Saturday night. They all wanted to go into Omaha and get drunk and go to bawdy houses. I was delegated to be the driver of this old Buick touring car and to stay sober so that I could rout them out of the red-light district around midnight and get them back to the bunkhouse [laughing] by Sunday morning. That was an experience.

I would let them out at the various places they wanted to go in the red-light district, and then I'd go out and spend the evening with my wife. I think I was the only married man in the crew.

Intern, Cincinnati General Hospital, 1937-1938

Henderson: I graduated from medical school in June 1937 and then went to Cincinnati General Hospital as an intern.

Hughes: Why Cincinnati?

Henderson: Well, I wanted to leave Nebraska. I had lived there all my life. I thought I ought to have a touch of the way they practiced medicine elsewhere. I wanted to go to a larger institution, perhaps to the East Coast. But the dean of the medical school, Dr. C.W.M. Poynter, said, "Competition among the eastern schools for an internship will be very tough." So I said, "Well, why not Cincinnati?" He said, "I have never sent a student to Cincinnati. Why would you want to go to Cincinnati?"

I gave him the above reasons for studying at a big country-city hospital. I also said, "Cincinnati has a major league baseball team, and I'd like to go where they

play major league baseball.” He looked at me and said, “You’re out of your mind, but I’ll write a letter of recommendation.” I was accepted at the Cincinnati General [Hospital], and my wife secured a very nice job at a printing company affiliated with Procter and Gamble Company, which had their headquarters in a suburb of Cincinnati. She was the switchboard operator for this Procter and Gamble affiliate.

Her boss was an avid baseball fan and had season tickets to the Cincinnati games. When his wife wanted to go out to the Cincinnati park to see the ballgame and he couldn’t go, he would arrange it so that my wife would go in his place, and he would find somebody else to run the switchboard. So my wife saw the ballgames that I intended to see but was prevented from attending by the long hours at the hospital.

We finished our year at Cincinnati General. By that time I was pretty certain I would like to do ophthalmology, although I had had only a very short month of it on the outpatient service.

Hughes: *Why did you want to do ophthalmology?*

Henderson: Well, it was a clean surgical field, it was delicate surgery, it provided patients with sight—sometimes very rewarding—and provided a window into the medical ills of the body. I thought it would be a fine specialty.

So the question then came up, where would I have eye training? I applied at the Massachusetts Eye and Ear Infirmary, which I thought would be the top-notch place because of its affiliation with Harvard. But I had never been to Boston. And then I also thought I probably ought to make another choice. I had heard about the Mayo Clinic, although I had never been out of Omaha to visit any of these places, and I also applied at the Mayo Clinic.

At that time, an interview was not necessary for an applicant. You could apply by mail, although an interview was desirable. But there again, it was a question of the money involved in traveling that far. I envisioned the Mayo Clinic as a sanitarium-like institution that would be a frame building of three or four stories on the outskirts of town, located in a sort of park-like atmosphere, with nurses pushing patients around in wheelchairs on the asphalt sidewalk. It was a surprise when I came to Rochester to find their big building downtown.

Fellow in Ophthalmology, Mayo Clinic, 1938–1941

Henderson: Anyhow, I applied for and received an appointment from the Mayo Clinic one day in January [1938]. I had heard nothing from either school until a telegram came: “This is to inform you of your appointment to a fellowship at the Mayo Clinic. Please reply immediately,” or something like that.

Well, a bird in the hand was probably better than one in the bush. I didn’t know anything about the Mayo Clinic, but it seemed to have a good reputation. So I sent my acceptance by Western Union, and that night after the telegram was sent, I realized, embarrassed, that I had misspelled ophthalmology. [laughter] I figured they would just think it was probably an error on the part of Western Union! I left out one of the h’s, as we all do.

The next day came the appointment from Massachusetts Eye and Ear Hospital.

Hughes: Was it a disappointment that you had missed it?

Henderson: Yes. I was disappointed that I had not waited a day longer to reconsider my choice. It would have changed my whole life if I had gone to Massachusetts Eye and Ear, and now that I look back, it was better that I stayed in the Midwest, where I had been raised. I subsequently visited Boston many times. I don’t think I would have fit very well in an eastern school.

I also had been offered a residency at the Cincinnati General Hospital in pediatrics. They had an excellent pediatric department at the time.

Arrival

Henderson: I think I made the right choice, but I started off at the Mayo Clinic on the wrong foot. I not only had misspelled ophthalmology, but my appointment was to commence on Monday, July 4, 1938. We arrived in town on Friday, July 1, by train. I asked where the Mayo Clinic was, and they pointed me to the tall Plummer Building. My wife wanted to know where the streetcars were. Broadway, the main street, was not entirely paved at that time. It was still a pretty small town.

We stayed at the hotel across from the railroad tracks, and then all day Saturday we walked and walked and walked, looking for a place to stay, something that we thought we could maybe afford. Finally by Sunday afternoon we found a small

apartment just a few blocks from the clinic: third-floor room with a pull-down bed, a little bathroom, one closet, and a kitchen.

We moved in, and we were just pooped after our two-day search for lodging. We collapsed in that pull-down [Murphy bed] and slept until ten or eleven o'clock of the following morning. This was Monday, July 4, a holiday, of course; at least it had been that way at the Cincinnati General Hospital.

I reported to work on Tuesday morning, July 5, to Dr. [William L.] Benedict's department. The first thing they asked me was, "Where have you been?" Come to find out they didn't have a holiday on July 4, so I reported a day late. Well, I thought, I'm in the soup already! And that worried me. Dr. Benedict was not very pleased about this new young man. I was the only appointee that particular quarter.

The Mayo Brothers

Henderson: I had my first assignment in the neuro-ophthalmology subsection, where I did visual fields and ophthalmoscopy. I was getting along all right until about two weeks later. I came to work promptly at eight o'clock on this particular morning, and the desk receptionist said, "Dr. Mayo wants to see you."

I said, "Which Dr. Mayo?" And she said, "Dr. W.J. Mayo." I said, "Where is his office?" They directed me down to the third floor of the Plummer Building, where we worked at that time. His secretary apparently knew I was coming, because she waved me down the hall to the next office.

Dr. William J. Mayo supposedly was a very stern man. He was sitting at his desk. When he looked up and saw me waiting at the door, he said, "Come in, young man." He didn't ask me to have a chair. I stood along the front of his desk, and he said, "Now, you're Dr. Henderson."

I said, "Yes, sir." He said, "You're new here." I replied, "Yes, sir." I suspected that he had heard about my reporting a day late. I thought, I'm probably going to get canned. He said, "Have you found a place to live?" I said, "Yes, sir." He said, "You're married, I understand." I said, "Yes, sir."

He said, "Now let's see. You're in ophthalmology." And I said, "Yes, sir." All my replies were just "Yes, sir; yes, sir." He said, "Well, we're pleased to have you here, young man, and I hope you have a good experience. It's nice to meet you." I said, "Yes, sir," and walked out! [laughter]

Well, I was so frightened of going for this interview, knowing that I had already done something wrong, that I had masked any other idea of why he wanted to see me. He just wanted to greet me. If I had only known this was the purpose of our visit, I would have felt at ease enough to have had a brief chat with him. But I muffed that chance. Later Dr. Mayo sent me his autographed picture, which I still have. I learned later that I was one of the lucky appointees randomly picked to meet Dr. Mayo.

Hughes: Was that one of the few times you met him?

Henderson: Yes. He died the next year [1939].

Hughes: And his brother?

Henderson: They died the same year. Now, it was Dr. Charlie [Mayo], the younger brother, who did the major share of ophthalmology in the Mayo partnership from 1888 to the time Dr. Carl Fisher came in 1908.

In those early years, Dr. Charles was a true generalist. In addition to eye patients, he took care of ear, nose, and throat patients and pulled teeth. He would operate on patients with skull fractures, and he did gynecology, obstetrics, orthopedics, urology. My, he was a versatile man, and with very, very little training. In medical school (Chicago Medical College), he made use of spare time to visit the hospitals and surgical clinics in Chicago and just watched physicians work. He learned from watching.

Hughes: Did you ever see him operate?

Henderson: No, I didn't have a chance to see him operate. I had a chance to meet him, but not under the circumstances of my meeting his older brother.

Hughes: Charlie was much more approachable, wasn't he?

Henderson: Oh, absolutely. Very, very friendly. My wife worked as a desk receptionist at the Mayo Clinic shortly after we came to Rochester. She had a very pleasant experience with Dr. Charlie that illustrates the man.

Frequently surgeons were called to the medical floors of the clinic to see patients in consultation. Some surgeons were very brusque with the floor receptionist, particularly if there was any delay in seeing the patient. My wife had worked only a few weeks as a receptionist when Dr. Charlie came to her desk and said, "I'm here to see a patient." She said, "Who are you?" Instead of being upset, he said,

“Don’t you know who I am? Why, I think you’re new here, young lady.” “Yes, I just started,” she replied.

He said, “Well, it’s nice of you to be working here. I’m Dr. Charles Mayo. It’s so nice to meet you. We will know each other next time. Would you tell Dr. So-and-So that I’m here?” This illustrates the outgoing, friendly, homey nature of this man. He couldn’t help but gain the faith and the respect of the farmers and other people in these Midwestern states. He was just what they thought a physician should be, somebody who would be interested in them, rather than a standoffish physician.

Hughes: Which his brother was, wasn't he?

Henderson: Yes, to some extent, except when he was meeting or working with professional associates. The personalities of the two brothers differed, but they got along very well. Dr. Will looked after the administrative details of the partnership and, seemingly, was the boss.

Rotations in the Department of Ophthalmology

Hughes: Well, what did you find in the department of ophthalmology? Was it a department or a division?

Henderson: By that time it was a department. It was divided into four sections: the surgical and external eye disease section, section of refraction and strabismus, neuro-ophthalmology (visual fields), and medical ophthalmology (chiefly ophthalmoscopy). It was the custom to rotate the new resident every three months through each of these sections during the first year. This would acquaint the new resident with the clinical parameters of all sections of the department by the end of the first year.

My first assignment was the section of neuro-ophthalmology. This meant working in a dark room, doing four to six visual fields a day. There was a certain everyday monotony connected with this type of work. By the end of three months, I was looking forward to an assignment in another section of the department.

Alas, through some oversight, I was again assigned to a three-month period of visual fields. I covered up my disappointment by thinking this three months would certainly be my last on this monotonous assignment over the three-year residency period.

Lo and behold, again through some program glitch, I was assigned a third three-month period in visual fields. As the end of the first nine months of my residency approached, I seriously thought of quitting and searching elsewhere for a residency with a broader clinical base.

Nevertheless, the teaching of the broader aspects of neuro-ophthalmology was excellent. The teachers in this section were Dr. Henry P. Wagener, Dr. Hugh L. Bair, and Dr. C. William Rucker. These men realized the misdirection of my training and often asked me to see some of their patients with more exciting eye problems when lulls occurred in the scheduling of visual fields. So I decided to stay at Mayo and, in retrospect, this proved to be the right decision.

In 1938, neuro-ophthalmology was just emerging as a subspecialty that, at present, is recognized as an important part of residency training. Visual field examinations in an office setting nowadays are almost universally performed by trained technicians. I daresay that, at present, I may be the only active ophthalmologist who spent nine months, full time, in the visual field room during a residency.

The remainder of my residency went off without further bungled assignments. It was a rich and rewarding experience. The clinicopathologic material at Mayo was vast and varied. At the end of the three years, I was made (July 1941) a first assistant, a position comparable to a present-day fourth-year fellow.

Major, Medical Corps, AUS, Pacific Theater, 1943–1946

Henderson: I was in the army reserve. I joined the Army Medical Corps Reserve in 1937 when I graduated from medical school. I thought war would break out sometime in the near future, and by joining the army reserve I thought I would acquire some seniority that might result in a better assignment than if I waited for the draft. Anticipating a call to active duty, I thought it to my benefit to remain a first assistant at Mayo rather than attempting private practice.

War began in Europe in [’39], and the Japanese attack on Pearl Harbor was in December of ’41. These events led to a very lucky break in my career. I received orders in early October of ’41 to report for active duty to a field hospital unit in Seattle, Washington, in two weeks. In the meantime, Dr. Charles W. Mayo (son of Dr. Charles H. Mayo) had been organizing a Mayo army hospital unit, with the expectancy of being called up for duty in Europe. They needed an ophthalmologist in this unit.

So Dr. Mayo suggested that I fill this vacancy. I told him I already had orders to report to Seattle in two weeks, but that my preference was to join the Mayo unit if possible. He called the adjutant general's office and arranged for an immediate transfer.

Subsequently the Seattle medical unit was sent to Corregidor in the Philippine Islands. If I had stayed in that unit, I would have been captured by the Japanese and probably put in the "death march" either to Cabanatuan or Billibid. I had a classmate in medical school who also joined the Army Medical Reserve and was sent to Corregidor. He spent his war years in the prison in Manila and acquired hepatitis. He survived the war, but died soon after from cancer of the liver.

So the serendipity of my transfer to the Mayo unit may have been a life-saving event for me. But the Mayo medical unit wasn't called up for two years! [laughs]

Hughes: Why was that?

Henderson: Some years after the war I learned that the physician in the army headquarters in Washington, D.C., who supervised the distribution of hospital units to the various war zones, had been an employee of Mayo prior to the war. He had been asked to leave the clinic after a falling out with one of the Mayo brothers. This ill will not only was responsible for the delay in calling the Mayo unit to active service, but also for the splitting of the general hospital into two smaller station hospitals and sending them to far-away outposts in New Guinea instead of active service in Europe.

The two station hospitals shipped out to New Guinea by way of New Zealand and Australia in January 1944. From New Guinea, my hospital gradually moved north along the Pacific Ocean islands as the armed forces cleaned out the Japanese. My unit was on the Philippine Island of Leyte when the atom bomb was dropped in August of 1945. We looked forward to going home, but I didn't have enough points; so I had to stay in the Philippines on demobilization duty until I returned home in May 1946, a total of two and a half years overseas.

Another lucky thing happened to me while I was in Leyte. Hoping to get two weeks away from hospital routine, I volunteered to serve as the medical officer on a cargo ship traveling to Okinawa with army supplies. I got down to the dock and learned that the ship's cargo was dynamite. I had a second thought about this travel and arranged to get the travel order canceled. The ship was sunk by a [Japanese] submarine one day out of the harbor.

Hughes: Two close calls!

Henderson: How our lives are changed by those little things!

Coming back from overseas, we settled in Riverside, California, where we wanted to start a practice.

Hughes: Why had you picked Riverside?

Henderson: Well, my wife through the war had moved out to that area and liked it. She lived in Redlands. There was a resort hotel in Riverside at that time, and I contracted for a room in that hotel complex for my office. But I couldn't get any office equipment, because of the war, for at least nine months.

**Faculty Member, Department of Ophthalmology,
Mayo Clinic, 1946-1977**

Henderson: At this time I had three and a half months of leave time, full pay, so my wife and I decided we would tour the western half of the United States by car. We set out, stopped everywhere to see people we had known years before, and just had a delightful time. During the course of the touring we stopped at Rochester, Minnesota, to see old friends. I thought, "Well, I'll go over to the Worrall Hospital and watch some eye surgery." I had written to Dr. Benedict a couple of times when overseas about my experiences but never received a return letter from him.

At the hospital I met Dr. Benedict. He said, "Where have you been?" I said, "Well, I just got out of the army." He said, "We've been expecting you." Well, he had never said a word when I left two years before of ever coming back, and he had never answered my letters. I think that on the spur of the moment he thought, "Gosh, here's a guy who's been trained here, and he is not busy." So he said, "Why don't you take your coat off, get on a gown and take over some of my list?"

Well, I was overwhelmed. I had really never made any plans to come back, because we had committed to Riverside. My wife would have no part of my coming to Rochester.

Hughes: Why was that?

Henderson: She wanted to live in California.

Well, Dr. Benedict talked to her, but she still was adamant. We had a great big argument. We were staying with some friends who were putting us up. I think sometimes at night they wondered if this couple would ever shut up, we were arguing so about whether to stay or go. And we almost had a divorce over this.

Hughes: Why did you want to stay?

Henderson: I wanted to stay because I thought it would be a fine institution to combine practice and teaching. I knew I was welcome. I knew that if I stayed, I would be working with Dr. Benedict in the surgery and external eye section. It would give me an opportunity to do that part of ophthalmology that I liked best.

So my wife and I settled our differences and stayed, and it just turned out over the years to be the right choice. We were happy to become residents of Rochester, Minnesota, and my subsequent time at the Mayo Clinic has always been very, very pleasant.

Hughes: And of course, eventually in 1961, you became chairman of the department.

Henderson: Yes.

Hughes: Benedict had retired by then. He had to retire at a certain age?

Henderson: Yes. But between us there was another department chairman, Dr. C.W. Rucker.

Hughes: That's right. Dr. Benedict retired in 1950.

Henderson: Yes. So Dr. Rucker was chairman until '61.

Hughes: And then he retired?

Henderson: He was nearing retirement.

William Benedict

Hughes: Had the department changed much in those years between Benedict's and your chairmanship?

Henderson: Yes, it changed from a department that was run by command to a department that was administered by consensus. There was more contact among the associates in running the department. Dr. Benedict ran his department like he ran the

Academy. He was, in a sense, almost an autocrat—a benevolent autocrat, but still an autocrat. There wasn't any, "What do you think," or "What's your opinion?"

Hughes: Was there unrest?

Henderson: Yes, underneath it all, but we were all afraid of him. Working with him, he could be very stern. But socially [laughs], Dr. Benedict was quite a party man. On a social occasion, he was approachable, conversational, interested in what you were doing, and having a good time. That was another side of him.

Dr. Benedict was elected Executive Secretary-Treasurer of the American Academy of Ophthalmology and Otolaryngology in June 1942. At this time his close friends represented a partial list of the "who's who" in ophthalmology. This list included Drs. Conrad Berens, Frederick C. Cordes, C.S. O'Brien, Grady E. Clay, Harry Gradle, M. Hayward Post, Lawrence T. Post, A.D. Ruedemann, Derrick Vail, Algernon Reese, and Alan C. Woods. These men worked well together, and at one time or another all were members of the inner councils which directed the activities of the various national ophthalmological societies.

These men played golf and socialized together in their spare time. Dr. Benedict was one of a quartet among this group who were easily persuaded to sing barbershop harmony after a few beers or martinis. The influence of these friends on the governing councils of other national ophthalmological societies helped make Dr. Benedict's prior work on various committees of the Academy a pleasant and relatively headache-free experience. Even so, this required more and more time away from his clinical practice and administration of the eye department at the Mayo Clinic.

Hughes: Do you want to say anything about the twelve years when you were chairman?

Henderson: I was chairman of the Department of Ophthalmology, Mayo Clinic, from 1961 to 1973. My appointment as professor of ophthalmology in the Mayo Foundation Graduate School of the University of Minnesota was superseded by the establishment of the Mayo Medical School in 1972. I continued as professor of ophthalmology until retirement in 1977.

Mayo Medical School

Henderson: This opened up another outlet for teaching. Many weren't too enthused at first about having a medical school; this just added more students.

Hughes: Who wasn't?

Henderson: I would estimate the Mayo staff was split about fifty-fifty concerning the need [for] or wisdom [of having] a medical school. I think many of us were hesitant about change. Could we do right by a medical school and still do our practice? Ultimately they did a wise thing; they limited the first class to just forty students.

Hughes: Who wanted the school?

Henderson: Well, it was a generation of men about my age and younger who wanted the prestige of a medical school.

Hughes: These were people on the faculty?

Henderson: Yes. Our relationship with the University of Minnesota Graduate School was very pleasant, but there was a wish to have some independence from the University of Minnesota in medical teaching and research, [and] not just [to be] an appendage.

Hughes: Did the University of Minnesota look upon the Mayo Medical School as a competitor?

Henderson: Yes. But the thing that I think eased the problem was that the two medical schools in the state of Minnesota would continue under the supervision of the Board of Regents of the University of Minnesota. Neither would the money given to the university or the Mayo for graduate education be affected.

University of Minnesota Graduate School

Hughes: Please explain the story of the foundation of a graduate school in Rochester.

Henderson: Dr. W.J. Mayo had recognized the advantages of advanced training in medicine beyond the medical school curriculum since his graduation from the University of Michigan in June 1883. To obtain such postgraduate training, the brothers Mayo annually traveled to the medical and surgical clinics in the larger cities to personally observe the work of other physicians. These short excursions were augmented by occasional longer travel to Europe to keep abreast of newer clinical discoveries.

In turn, in the early 1900s, physicians increasingly came to Rochester to observe and work in the growing medical and surgical practice of the Mayos and their

associates. These training periods soon were extended over periods of several months to several years. No formal recognition of such extended training was given, other than a certificate of internship at St. Mary's Hospital, where the Mayo partnership had exclusive staff privileges.

By the third decade of their rural practice, the Mayo brothers had accumulated considerable personal wealth, far beyond their current or future needs. They thought some of this money should be used to endow medical education and research under the aegis of the state university. To facilitate this plan, the Mayo Foundation for Medical Education and Research was incorporated in February 1915, and securities amounting to a million and a half dollars were transferred to three trustees. Another two years passed before the affiliation with the University of Minnesota was formalized and the endowment transferred to the control of the Board of Regents for the management and support of a graduate school of medical education in Rochester.

Hughes: *Well, you retired for the first time in 1977. Was that mandatory?*

Henderson: Yes. Retirement at sixty-five had been a long-standing rule here. The day before your retirement, you were full time; the day after your retirement, gone. This was the era of double-digit inflation, and I was reluctant to retire on a fixed income under such circumstances. About this time, national legislation was passed allowing men to work until they were seventy, effective six months after my scheduled retirement. Mayo wouldn't let me stay another six months to be eligible for the continued employment.

Professor of Ophthalmology, Louisiana State Medical School,
1981-1987

Henderson: In 1981 I found a job at the Louisiana State Medical School at Shreveport.

Hughes: *How did that come about?*

Henderson: I replied to an ad in one of the eye journals for an ophthalmologist at the medical school in Shreveport, Louisiana, and was accepted. They were glad to have me.

Hughes: *Did you go down there with the idea of not only doing ophthalmology, but also doing some reorganizing?*

Henderson: No, I just went down to do ophthalmology. It was a chance to teach residents and do clinical ophthalmology and ophthalmic surgery—and augment our shrinking income.

Hughes: And then you retired a second time in 1987?

Henderson: Yes.

Hughes: Was it your decision to retire?

Henderson: Yes. Originally I went with the idea of being in Louisiana two or three years, then coming back to Rochester. Because of my assignment to the VA affiliation with the medical school, I learned that if I would stay five years I would be eligible for a pension because of my previous active duty in the armed forces and time in the army reserve. Not very many people can retire after five years with the government!

We stayed in Louisiana six years, and that helped to make us more financially secure. The pension system at the clinic in those years was adequate, but it didn't allow for inflation. We returned to Rochester in November 1987.

More on William Benedict

Hughes: Let's go back and pick up in more detail on the Academy. I think the place to begin is with Dr. Benedict.

Henderson: It's not generally known that Dr. Benedict's first interest in education was because of his experience as a schoolteacher. He taught school two years after graduation from high school. Now, whether he ever had a teaching certificate, I have never been certain. He didn't hold the same teaching job the full two years.

The fact that he did not have significant college credits from an accredited school was a problem when he went to apply for medical school at the University of Michigan. I think they finally waived the requirement of two years of college education for Dr. Benedict in view of his teaching experience. However, this lack of college credits subsequently was the reason he was refused reciprocity for medical licensure in the state of Minnesota when he came to Mayo in 1917. To obtain the required credits for Minnesota medical licensure, it was necessary for him to return to the University of Michigan.

It was interesting to hear Dr. Benedict tell about his experiences in the psychology course in which he had enrolled at the University of Michigan. The professor of psychology was enthused about trying to photograph the movement of eyes. He used the cat for his experiments. Because of his interest in ophthalmology, Dr. Benedict was selected to assist in these experiments.

A movie camera such as we now know it was not available at that time (1920). Since the cat's eyes move very rapidly, how were you going to be able to catch the motion? Well, they made a white chalk mark on the front of the cat's eye and illuminated the eye by reflected light. The professor handled the cat. I don't remember what the stimulus was, whether it was to ring a bell or whether the professor who had hold of the cat did something so that the eyes would move.

Off where the camera was, Dr. Benedict was standing on a stepladder, up about ten feet off the floor [laughing], with some kind of a carrier they'd rigged up full of film plates. His job was to drop them in sequence down a chute attached to the camera just as fast as he could. Each plate would record a picture of the cat's moving eyes. When the single frames were projected rapidly, the trajectory and velocity of the moving eyes could be measured. Dr. Benedict once said to me jokingly, "You know, John, that's the only time I ever got to do basic research!" [laughter]

He never said anything to me about the other course in sociology in which he was enrolled. He stayed four months and received the credits necessary for his Minnesota licensure.

Dr. Benedict was responsible for the educational program of the department at Mayo. He set up the three-year residency and urged students to complete the full three-year study. Prior to that time, graduate training was sort of hit-and-miss, depending on the time that the student wished to devote to the subject. Many physicians were interested in eye, ear, nose, and throat training, but did not wish to devote three years' study exclusively to ophthalmology.

We had some problems with the residency program. Initially there was a succession of men who had not quite grasped the idea of graduate education, who still were looking for something temporary between their internship and practice, or who had been in practice a year or two and wanted to try to learn a little more ophthalmology, but only wanted a short course. One such man, who came soon after the graduate school started, stayed only twenty-two days. When asked why he wanted to leave, he said he wasn't getting enough surgery. [laughs] This is the shortest time on record in the ophthalmology program at Mayo.

Hughes: Nowadays you couldn't arbitrarily stop a residency program, could you?

Henderson: No. You would not be eligible to take the examination of the American Board of Ophthalmology.

Early Faculty, Department of Ophthalmology, Mayo Clinic

Henderson: When Dr. Benedict took [a] leave of absence to acquire further credits at the University of Michigan, Dr. Avery D. Prangen was the first addition to the eye department staff in 1920. Dr. Prangen was also a graduate of the University of Michigan Medical School, two years after Dr. Benedict. Dr. Prangen's interest in ophthalmology stemmed from a lifelong severe bilateral strabismus, a marked hyperopic astigmatism, and defective depth perception. Previous efforts to correct his own visual handicap led to Dr. Prangen's particular interest in patients who presented with similar problems. His care of such patients allowed Dr. Benedict to concentrate on patients with external eye disease and those requiring ocular surgery. Thus the subsections of external eye disease and ocular surgery, and strabismus and refraction evolved. This was the first subspecialization within the department.

The second addition to the staff of the department was Dr. W. Ivan Lillie. When he first came to the Mayo Clinic for postgraduate training in 1918, his interest was in neurology. After six weeks he was called to active duty in World War I. His older brother, Dr. Harold "Pete" Lillie, had been on the staff of the Mayo Clinic in the Department of Otolaryngology for several years. Pete Lillie had preceded Dr. Benedict on the staff and was partly responsible for Dr. Benedict's appointment in the eye department through a recommendation to Dr. W.D. Mayo.

Upon his release from army service, Ivan Lillie enrolled as a fellow in ophthalmology with a request that he be allowed to see patients with neurological disorders related to the eye. Dr. Benedict and Dr. Prangen were very supportive of this idea because it would relieve them of the time-consuming tasks of ophthalmoscopy and visual field examinations, which were necessary on these sometimes difficult patients. Thus the subspecialty section of neuro-ophthalmology was founded. Mayo was one of the first medical centers, or perhaps *the* first, to recognize neuro-ophthalmology as a distinct clinical subspecialty. Ivan Lillie's staff appointment was effective January 1921.

The last addition to the department's staff in these formative years was Dr. Henry P. Wagener. Dr. Wagener initially enrolled as a fellow in ophthalmology at the University of Minnesota under the tutelage of Dr. Frank C. Todd in May 1917. (Dr. Todd, a recognized ophthalmologist, was the secretary of the

first Joint Examining Board of the American Academy of Ophthalmology and Otolaryngology formulated in 1915.)¹

After one year of study, Todd and Wagener—both single—were drafted for World War I service and sent to Camp Dodge in Des Moines, Iowa. While working in the camp hospital, Dr. Todd died in the first wave of the influenza epidemic of that era. The war was over soon thereafter. On release from active army duty, Dr. Wagener's request to transfer his postgraduate training to the Mayo Foundation and Mayo Clinic was granted.

At Mayo, Wagener was urged by Dr. Benedict "to look at (patients') eyes with the ophthalmoscope." This was in keeping with Dr. Benedict's proposal to perform routine ophthalmoscopy on patients undergoing general examinations at the Mayo Clinic, particularly those with disorders of the blood cells, high blood pressure, and diabetes. In pursuing this assignment, Dr. Wagener often would spend off-duty hours, particularly at night, doing ophthalmoscopy on hospitalized patients with the above medical disorders, as well as other non-ophthalmic medical problems. Wagener also worked closely with Ivan Lillie. Dr. Wagener's work was the foundation for the medical ophthalmology section, the last of the four subspecialty sections within the department in the 1920s. These sections continued to serve both clinical and educational functions well beyond the period of my training.

After a long period as a first assistant, Dr. Wagener joined the staff as full consultant in January 1926.

Hughes: *Was it unusual at this time to have subspecialization in ophthalmology?*

Henderson: Yes, unusual to subdivide a department into these particular subspecialty sections. Also, seventy-some years ago it was unusual to have such a variety of clinical material and such a volume of patients to support, full time, an ophthalmologist in a subspecialty field. Here were four men who were allowed the privilege of seeing chiefly patients in their major field of interest. Dr. Wagener, for example, preferred working in a consulting capacity rather than being directly responsible for therapy. Occasionally he would encounter a patient with a sore eye. He would say, "John, what do you think we ought to do about this?" [laughter]

¹Bryan, Sharon A. *Pioneering Specialists: A History of the American Academy of Ophthalmology and Otolaryngology*. San Francisco: American Academy of Ophthalmology. Rochester, MN: American Academy of Otolaryngology, 1982, p. 63.

This was a satisfactory division of labor until Dr. Ivan Lillie expressed a wish to do something other than neuro-ophthalmology, particularly cataract surgery. There was no opportunity to do cataracts as long as Dr. Benedict was here.

Hughes: Because he took all the cataracts himself?

Henderson: Yes. Except that Dr. Lillie got to do a few cataract operations when Dr. Benedict was away because of political commitments. The minute Dr. Benedict returned home, such cases were cut off.

Later Dr. Ivan Lillie, because of his neuro-ophthalmology background and his evolving skill as a surgeon, caught on as the head of the department at Temple [University]. He left Mayo in the middle thirties. Dr. Wagener then took over the neuro-ophthalmology department, and for medical ophthalmology they brought in Dr. C.W. Rucker. Dr. Rucker made a career of medical ophthalmology.

William P. Wherry

Hughes: Do you have any concept of what the Academy was like under Dr. Wherry?

Henderson: Dr. Wherry was an excellent administrator. He was well liked among his professional associates. I think Dr. Wherry best demonstrated the concept that the administration of the Academy could be performed by one person. I heard it said that he required less sleep than average and would arise early to complete correspondence and administrative duties connected with the Academy prior to seeing patients. He had a very large and busy private practice in Omaha. I believe he had more interest in patient care than Dr. Benedict.

Hughes: Before Dr. Wherry took over, it was strictly a volunteer operation?

Henderson: Yes, to the extent that seldom did the elected secretary volunteer to serve beyond a year- or two-year term because of the time required away from a private practice. Prior to Dr. Wherry, there was less continuity in the administration of the Academy. It did not seem that Dr. Wherry needed coaxing to serve additional terms or take on additional responsibilities.

Dr. Wherry was an overall father to the Academy. He would look after programs, handle correspondence, take care of dues, serve as a sounding board for dissatisfied members, and keep everyone happy. He died in 1942.

More on William Benedict

Henderson: One of Dr. Benedict's goals, when he succeeded Dr. Wherry, was to expand the instructional courses, which had been a supplement to the annual scientific program for some time. These instructional courses were initiated by the continued efforts of Dr. Harry Gradle and Dr. Wherry. The courses were a means for the member physicians to update their educational level in selected subjects. These instructional courses were a prelude to the present-day continuing education programs offered at many medical centers. Two years after his appointment, the Home Study Courses for residents in ophthalmology were initiated.

After World War II, there was a marked increase in membership, which brought about many new problems, including the finding of meeting facilities that had sufficient room in one place to handle the increasing membership, scientific and instructional programs, and commercial exhibits. In addition, there were inroads in ophthalmology by the optometrists, the encroachment of federal legislation on ophthalmic practice, the impact of Medicare and Medicaid plans on ophthalmologists' income, and a growing number of "buccaneer" surgeons who were advertising and marketing newer ophthalmic surgical procedures for monetary gain.

Hughes: Was there unrest amongst the membership?

Henderson: Yes! There were small groups within the membership who clamored for strong opposition to federal policies affecting the conduct and fee schedules of the practice of ophthalmology, others who thought the Academy should play a more active part in opposing the expansion of optometry at the expense of ophthalmology, and still others who believed the Academy should be the principal agent for disciplining those who were stretching the ethical boundaries of eye surgery. Dr. Benedict opposed in some degree all those who wished to rock the time-honored boat of Academy policy. Many of these problems were never resolved to Dr. Benedict's satisfaction during his tenure. Lastly, factions were agitating to split the Academy into two separate corporate entities.

Hughes: How did Dr. Benedict administer Academy affairs?

Henderson: Very diligently. He carefully read every piece of correspondence and was very protective of his assumed right to make all decisions. There was no executive office manager comparable to the later position of Mr. David Noonan in the office of Dr. Benedict's successor. Nevertheless, he had excellent and responsible personnel working in his office. There were separate offices for the editors of

the *Transactions*, a secretary-typist, a clerk each for processing Academy dues, membership roles, Academy programs, and a large room for the wrapping and posting of Academy publications and pamphlets.

The Academy office was located on the second floor of a bank building on Second Street South/West, a block east of the Mayo Clinic.

Hughes: *Did he run back and forth between the Mayo and the Academy office?*

Henderson: Oh, yes. Often times he would leave the eye department early in the afternoon and go over to the Academy office, leaving his patients to the care of [Dr. Hugo Bair or me].

Department Chairman

Hughes: *Do you think he preferred the work at the Academy?*

Henderson: Yes, I'm quite sure he preferred it.

Hughes: *Why?*

Henderson: I think the varied and complex problems of the Academy were a more exciting endeavor to him than the humdrum of seeing patients. I suspect his clinical practice had reached a plateau. He seemed satisfied with the clinical status quo of his practice and was progressively less inclined to embrace new procedures and therapies related to ophthalmology. For example, after World War I, more delicate needles and smaller diameter sutures became available. The swaging of these needles to the suture was a boon to the closure of cataract incisions, and the suturing of limbal incisions became routine. However, Dr. Benedict's cataract incisions remained unsutured, resulting in a higher complication rate. Neither did he embrace the round pupil cataract operation that was cosmetically and functionally more acceptable to the patient when compared to the older iridectomy procedures. In addition, he opposed the transplantation of corneal tissue into the eyes of patients with corneal opacities. This operation, which restored the patients' eyesight in selected cases, was largely developed in the United States by Dr. Ramon Castroviejo of New York City. Dr. Castroviejo once had worked in the early experimental aspects of this operation at the Mayo Clinic through the sponsorship of Dr. Benedict.

Ramon Castroviejo

Henderson: Dr. Castroviejo had an interview with Dr. Benedict at the Academy meeting in the fall of 1930. Castroviejo was anxious to find a hospital, school, or medical center where he might find support and facilities for experimental research that would lead to the performance of corneal transplantation on humans. He had received his medical degree from the University of Madrid in 1927 at the age of twenty-three. A year later he came to the United States, where he worked at the Chicago Eye, Ear, Nose and Throat Hospital for two years in a clinical setting.

Dr. Benedict was impressed with Dr. Castroviejo's credentials and arranged an appointment as an assistant in ophthalmology in the Mayo Graduate School, commencing April 1931. This appointment differed from the usual residency appointment in that Castroviejo was assigned to work at the "farm." The latter was a facility of several buildings located several miles beyond the outskirts of Rochester that housed the animals and provided a space for experimental research. During the seven months at the farm, Castroviejo perfected the instrumentation and procedure of corneal transplantation on 112 animals. He commenced his private practice in New York City in 1932, and corneal transplantation operations on humans soon followed.

By the late 1930s, corneal transplantation was recognized as a safe and acceptable procedure for selected cases of corneal specification by many ophthalmologists. However, even after World War II, patients inquiring about such an operation were sent elsewhere by Dr. Benedict. When I returned to Mayo at this time, I was disappointed that Dr. Benedict disapproved of the operation.

Henderson's First Corneal Transplant

Hughes: Did you want to do them yourself?

Henderson: Yes, but I was reluctant to have a confrontation with Dr. Benedict on the subject. In the meantime I had watched movies of the transplant operation at several of the Academy meetings in the period 1947–1950. This made me more determined than ever that such operations should be done at Mayo.

During this time, Dr. Benedict's list of surgical procedures was gradually decreasing in proportion to his increasing commitment of time to Academy affairs and guest speaker invitations. In turn, Dr. Bair and I were increasingly responsible for the operative care of Mayo patients.

In 1950, during a prolonged absence of Dr. Benedict, I saw a patient with severe bilateral keratoconus who I thought would be an ideal candidate for a transplant procedure. Coincidentally, I knew of a satisfactory donor cornea. So I went ahead and did the transplant. I was so worried about what Dr. Benedict would say when he returned and learned about this breach in policy. But I decided I would have to just face the music, particularly if the graft failed.

But the patient did just fine. When Dr. Benedict came back [laughs], I went in one morning and said, "Say, you know, we had an interesting patient while you were gone." Often I would go in his office for such a visit to review the patients of his that had been left in my care. "This patient, a young man with keratoconus, couldn't see anymore to work. I thought he would be ideal for a corneal transplant. He wouldn't go anywhere else and insisted we have it done here, and so I did it."

Benedict looked at me. He was astounded. I said, "Gosh, would you like to go over and see him? He's over in the hospital; he's just doing fine." Dr. Benedict's face changed. What could he say? He didn't say no, and he didn't say yes; he didn't say, "You're fired," or "Why did you do it?" He just sat there, looked at me a few minutes, and sort of shook his head. That was it. He never said another word about it, and subsequently we started doing transplants. But it took so long to get up [the] nerve to do the procedure.

Running the Academy

Hughes: *Mr. Noonan told me that when there was a Council meeting, there was one sheet of paper with the agenda, and it was in front of Dr. Benedict.² Nobody else had an agenda or any reference materials to prepare for the meeting in advance.*

Henderson: That I think is true, but it was partly the custom at that time. Some presidents of the Academy seemed to take little part in formulating what was going to be on the agenda; they deferred to Dr. Benedict.

Hughes: *Had Dr. Wherry done that, too?*

Henderson: Yes. He made himself the needed person. And the presidents rightly relied upon him. The President was really a sort of a figurehead. I think other officers now have much more to say, and they can get up publicly and say, "What are our goals?" I think the Council also has more say than it did at one time.

² Interview with David Noonan, July 22, 1991.

Hughes: The Council being the present Board of Directors?

Henderson: Yes.

Henderson's Chairmanship,
AAOO Public Relations Committee

Hughes: Were you ever on the Council?

Henderson: No. I was a public relations committee chairman for several years in the 1960s. My job was to meet the press at the meetings, to be the liaison officer between the program speaker and the press, to evaluate the thrust or meaning of some report for the press, and minimize sensationalism that might be attached to some new discovery. I also did live, impromptu, daily summaries of the Academy scientific programs for the TV medium. At that time I was hoping that our committees could improve public relations by sponsoring short question-and-answer programs on the public radio stations, covering concerns about glaucoma and cataract. I was also thinking in terms of perhaps a five- or ten-minute spot on the radio on "What's new in ophthalmology."

I went through several successive presidents of the Academy, but none of them wanted to venture into TV or radio promotions, saying, "Well, there isn't enough budget money."

Hughes: Do you think it was really just the money?

Henderson: No. I think money was being used as a reason for not wanting to pursue these outlets for improving the public's image of ophthalmologists.

Hughes: Who chose the stories that were going to be reported to the press?

Henderson: We offered the press representatives a wide selection of program essayists and a wide variety of topics. They would choose the subjects or essayists which were of interest to them and prepare several abstracts. Their editor would review these abstracts and select one or two that seemed most newsworthy.

Hughes: Did the stories ever get out of hand despite your attempts?

Henderson: Yes. We had amongst us physicians who were wanting to be known quickly and others who already were well known through subtle promotion of some new

drug, new therapy, or new ocular surgical procedure. The phacoemulsification procedure for the removal of cataracts was just evolving. Several surgeons were vying to report the preferred techniques and the best results. Instrument companies were competing to manufacture the best phacoemulsifier.

Hughes: Were you given free reign?

Henderson: Yes, within the narrow parameters of the committee at that time. No, in regard to exploring other outlets pertaining to public relations. Now, of course, the Academy has a Washington office [Office of Governmental Relations]. They're going the full route of keeping in contact with legislators and state boards. They're very politically oriented, because that's maybe where the future lies. But it took the Academy so doggone long to get to that point.

Hughes: Well, some of the delay was because of Dr. Benedict.

Henderson: Not entirely. Other officers of the Academy, hand-picked by Dr. Benedict, shared the same limited viewpoint.

Hughes: Did the Academy have a Washington lobby when you were on the public relations committee?

Henderson: I don't believe so.

Hughes: Why were you appointed to the public relations committee?

Henderson: I don't know. Perhaps Dr. Benedict was trying to allay the criticism that the Academy was not sufficiently democratic by appointing men outside the inner administrative circle. You appoint somebody to a committee, and they think they're doing something.

Hughes: Were the appointments to some extent a reward for loyalty to the Academy?

Henderson: Yes, but I don't think that was a factor in my appointment. I had had no previous connection with the Academy other than grading basic science course papers submitted by residents.

Basic Science Home Study Course

Henderson: I was one of the first ones to get the job of grading papers for the Home Study Course.

Hughes: How did you get that job?

Henderson: Well, because I just happened to be on the spot. Dr. Benedict would come in with a pile of papers and say, "Here." This must have been about 1939 or '40.

Hughes: So it was very early on, because the basic science Home Study Course was founded in 1939.

Henderson: Almost from the beginning. I don't think they had it yet organized as to who would do what. It was a great idea. They sent out their study course, and when the answers were returned, I don't think anybody thought of who was going to grade the papers. I remember spending many evenings grading the initial Home Study Course papers.

Hughes: What were you looking for?

Henderson: Well, the answers were pretty straightforward.

Hughes: So it was pretty clear when somebody was right or wrong?

Henderson: Yes. After all, it really didn't matter so much. Nobody knew what the grade was except for the person who wrote the paper. It didn't matter whether he answered right or wrong except to know what was an acceptable answer.

Hughes: Was there a cumulative grade for the whole course?

Henderson: Not at that time. They didn't even have to complete the questions. If they didn't like the questions or thought the course was too hard, there was no requirement that the questionnaire be returned. There were no credits established at that time for taking the course. Later a certificate was issued for successful completion of the course. The taking of the course remained voluntary.

Hughes: The Home Study Course was simply an educational vehicle for the resident in training and the physician in practice?

Henderson: Yes, but I think the residents thought it was a preliminary to the American Board [of Ophthalmology] examination. That was the crux of it. Some of the men

who made up the basic science course were also on the American Board of Ophthalmology. The Home Study Course gave some idea of what might be asked, what those people, your seniors and peers, were thinking of as the important features of ophthalmology. There was a good chance that one of the questions in the Home Study Course would show up on the written examination of the American Board of Ophthalmology. In those years, many teaching centers did not have full-time instructors in all the basic sciences related to ophthalmology.

- Hughes:* *This was a new venture for the Academy, to get into education in such a concentrated way. I guess before that the Academy's educational efforts were mainly through the scientific program and instructional courses at the Annual Meeting.*
- Henderson: It was mostly at a clinical level, we'll say.
- Hughes:* *Was there any feeling that the Academy was straying too heavily into an area that was supposed to be the purview of the departments in the teaching centers?*
- Henderson: No, I don't think so. I think most department chairmen thought it would help standardize what should be taught and what the student was expected to acquire in the way of basic knowledge. I think the American Board of Ophthalmology helped to stimulate the attitude that a residency is not only to see patients and learn clinical facts but to acquire a basic fundamental knowledge of the subject, to demonstrate that the young man who wants to be certified has acquired this knowledge.
- Not all young men who took the basic science study course were trained in a university center. Some were preceptors in a physician's office. The Home Study Course allowed them to find out what was being taught to residents in the medical schools.
- Hughes:* *Did those students who were not associated with residency programs have problems with access to the texts that were required?*
- Henderson: Yes, particularly if they were in a community that did not have a medical school. For example, a preceptor in Santa Rosa, California, would probably have to go to San Francisco to obtain the necessary texts. Working with a private practitioner, you were not being taught book knowledge; you were being taught clinical knowledge. Those are two quite different things.

Clinical Home Study Course

- Hughes:* Since the clinical training was ensconced in the training programs, why did Dr. Gradle in 1942 think it was necessary to institute the clinical Home Study Course?
- Henderson: I think this was an effort to standardize what would be required or expected of a clinician who wanted to pass the certifying American Board. In retrospect, I don't think I realized what helter-skelter curricula existed. Each school had its own way of teaching what they thought was important. The quality and content of these teaching programs varied widely. I'm sure it must have helped some of the teachers and maybe made others mad that they had to teach two very difficult areas, physiologic optics and geometrical optics.

Physiologic Optics

- Henderson: Now, many young men who want to be ophthalmologists are not interested in the path of light rays through a system of lenses, how rays focus on the retina, and aberrations of light that occur in an optical system such as the eye. That's sort of dry stuff. The Home Study Courses brought to their attention that this information was important. One problem with physiologic and geometrical optics was being able to find a teacher. [laughs] You usually had to go to a department of physics, to someone who wasn't at all interested in ophthalmology and who would present the subject in such a difficult, mathematical, theoretical way that the student physician would fall asleep.
- Hughes:* Did you ever come across Paul Boeder, who taught physiologic optics to ophthalmologists?
- Henderson: Yes. I'm very fond of Paul Boeder. He was one of the very, very few whom I knew in my time who could teach optics and make it interesting to physicians who were primarily clinicians.
- Hughes:* Did he teach at the Mayo?
- Henderson: He was often a visiting lecturer, but did not teach the full structured course in optics, as was his custom in many other teaching centers.

We also had our problems in finding a teacher. We had a physicist on the Mayo staff who taught our students, a likable man who certainly knew the subject, but had difficulty adapting it to the practical level of the student resident.

Hughes: Was that Sheard?

Henderson: Yes, Dr. Charles Sheard. His lectures were highly mathematical and tiresome. In the course of the lecture he would fill two blackboards with strange symbols and complex equations. Midway in the course of the lecture he often would find that a hypothetical p squared did not correctly equal the hypothetical cube root of r . If, on retracing the steps of the equation, the error was not easily found, he would erase a few symbols and add the constant k , saying "That will make it come out right." He would turn around, look at us, and say, "See?" The drowsy student likely would not know the meaning of the equations, let alone what was a constant.

[Dr.] Kenneth Ogle succeeded Dr. Sheard. Ogle, Boeder, and others were close associates in the evolution of the Dartmouth Eye Institute. Dr. Ogle had good rapport with the students. He tended to de-emphasize the theoretical aspects of optics. Instead, he took the individual student to the laboratory and illustrated the optics of light on an experimental optical bench. This was a practical approach to the refraction of light and its application to refraction of the patient's eyes.

He was a biophysicist with a particular interest in aniseikonia, the difference in the image sizes between eyes. He spent half days in the eye department seeing patients with what at that time was thought to be problems with aniseikonia. It was a very popular subject at one time. At one time, Bausch and Lomb was even making special lenses for aniseikonic patients. Dr. Paul Boeder also was interested in this field.

Hughes: Did the eye department ever do anything concrete with aniseikonia?

Henderson: No. Dr. Ogle wrote several papers on the subject, and a few patients were given aniseikonic lenses.

Hughes: Why did aniseikonia come and go?

Henderson: Well, it was not so common as first assumed, aniseikonic lenses were difficult to wear and costly, and overall the correction of aniseikonia proved not to be very practical.

Hughes: And yet it was supposed to be the answer to most eye problems.

Henderson: Yes, aniseikonia was thought to be the basis for many cases of eye strain and eye-related headaches. If ordinary eyeglasses did not correct these problems, and if the addition of prisms did not help, then the correction of aniseikonia was probably the answer. Sometimes the more a treatment costs, the greater the therapeutic benefit: "Oh, doctor, I had trouble with my eyes until you found that I had aniseikonia." [laughs] A great psychological effect, possibly.

More on the Home Study Courses

Hughes: Getting back to the Home Study Course, were the clinical component and the basic science component operated as two separate entities?

Henderson: I think so, to start with. Subsequently the components of these courses were merged into what is now known as the Ophthalmic Knowledge Assessment Program (OKAP). In general, the home study type educational courses were more oriented toward textbook study as opposed to, say, clinical practice.

Hughes: Did you have any particular contact with the evolution of the Home Study Courses into what now is called continuing education?

Henderson: No, except to serve a couple of times on committees that discussed which direction to take. But really I never had any part in the policy making.

Hughes: Was that by choice?

Henderson: I suppose I didn't seem to have enough enthusiasm to stay on the committee. [laughter]

Annual Meetings

Palmer House, Chicago

Hughes: What are your memories of your first Annual Meeting?

Henderson: Well, I don't think I had ever attended such a large meeting of professionals. The Palmer House awed me.

Hughes: It was elegant?

Henderson: Yes, it had a certain éclat. The jewelry store next door had the largest array of precious-looking gems that we'd ever seen. Chicago itself had many attractions for a conventioneer—good stage shows, museums, and restaurants. The only quarrel about the Palmer House was the elevators. [laughs] There were too many people to transport than they had elevators [for].

You learn tricks about traveling on elevators in a crowded hotel. If you want to go down from, say, the seventh floor, and the building has sixteen stories, you're not going to get down from the seventh floor, because the elevator coming down will already be filled. So what would happen at the Palmer House? If you were stuck with a room on the seventh floor, you'd get on the elevator and go up. By the time you got to the sixteenth floor, it would be filled with people who got on at floors eight, nine, ten, eleven; so for people on the sixteenth floor, there wasn't any room to go down! [laughter]

With so many men in the eye department, we could not all attend the meeting in the same year. As a rule we went every other year, except for Dr. Benedict, and we looked forward to it. The big meeting of the year was the Academy.

Hughes: And in the alternate years you stayed home and minded the practice?

Henderson: Yes. There was no other meeting quite like the Academy, and I don't think to this day there is a meeting quite like the Academy. You might think of it as a little child going to a circus. It just has everything. It has commercial displays, socializing, professional learning, and a big-city base.

Las Vegas

Henderson: Looking back on all the fuss about going to Las Vegas, how silly that all seems now. But at that time Las Vegas was a sin city. "And to think that the American Academy would ever have a meeting at Las Vegas. . . . And those men would all be out looking at bawdy girls all night."

In Las Vegas I recall presenting a paper at the morning session of one of the satellite programs of the Academy. My wife and I had stayed up all night with convivial friends. I thought, "Boy, this is going to be a sad, sad turnout." [laughs]. And I was amazed how many men came to that morning lecture, many of whom I had seen just an hour or two before! To think they would haul themselves out of bed because of the professional quality of the meeting—

of course, we were all young. You can't stay up all night every time you go to a meeting. But that showed the high regard for the professional aspect of the Academy meeting.

Hughes: Was it throughout its history a high quality meeting?

Henderson: Yes!

Hughes: How did it compare to the American Ophthalmological Society and the Section on Ophthalmology of the AMA?

Henderson: Well, none of the other societies had a scientific program of such scope and depth as that of the Academy. The meeting of the Section of Ophthalmology of the AMA was shorter than the Academy, and its attendance was more regional. The membership of the American Ophthalmological Society was limited, and its meeting was a mix of scientific papers, socializing, sports events, banquets, and leisure time pursuits.

Another feature of the Academy meeting that is easily taken for granted is the dependable support services. Seldom do the lights go out in the assembly hall during the meeting, fuses do not blow out, switches work, the sound system does not fail, the correct slides are projected, a hand-held projection light is available, and the meeting auditorium is free of extraneous noises such as another assembly in an adjoining room. This is indicative of premeeting planning.

I recall a meeting of the Section of Ophthalmology in Atlantic City many years ago where the support services were not installed until fifteen minutes prior to the scheduled start. The start of the meeting was thereby delayed another hour.

The Diversion Club

Hughes: I read of the Diversion Club, which I believe was started by Dr. Wherry and encouraged by Dr. Benedict.

Henderson: I didn't realize that it had a formal name. It was the social offshoot that followed the Academy meetings. Dr. Wherry I think had in mind some kind of a diversion in a nonscientific setting that would allow members to know one another better. I think it included wives. I don't know how long these post-meeting trips continued.

My wife and I went to Bermuda on one such excursion. But the expected turnout for these post-meeting excursions gradually decreased. As the membership of the Academy increased, so did the length of the Annual Meeting. I suspect many members did not wish to take the time away from their practices to participate in the combined functions. On the diversion to Bermuda, everybody got seasick. We had some rough weather.

Separation into Two Academies

Hughes: Talk about separation had been going on for some time, and Dr. Benedict had pretty much put an end to it or at least had not allowed it to get to a level where something could be done. What changed? Why did talk of separation resume and increase in the seventies?

Henderson: Well, there was no longer any anatomical or clinical need for the societies to be joined. There was no common thread. The men who were coming up for training no longer were interested in a combined specialty. There no longer are EENT [ear, eye, nose, and throat] men. Training programs in the combined specialties disappeared. It seemed natural that physicians of a given specialty should have their own meeting, at their own time, and among their own group. I think the pressure for separate meetings continued to build. As the membership of the combined society continued to grow, there also was a question of a meeting location or facility that could adequately handle such a group.

Even though we might say that Dr. Benedict was against separation and wanted to continue just the way things were and might be resisting change, you have to also think factually of the background that he was working in. I think he was not sure how it could be split and still be fair to each group. Should the monetary assets be divided on a sixty-forty ratio according to the membership, or should [they] be divided equally? If so, would it then become taxable under federal incorporation law? And could it be split legally? What about state taxes resulting from a split? The Academy was incorporated under the laws of the state of Minnesota at that time.

Hughes: Was the agreement all along that the kitty should be split sixty-forty?

Henderson: No. Should the money be split on the basis of membership or just split straight down the middle? You can argue that point many ways.

Hughes: How was it eventually split?

Henderson: I don't remember.

Hughes: When Benedict, an ophthalmologist, was in power for so many years, did the otolaryngologists think maybe they weren't getting their share of the pie?

Henderson: Possibly such thoughts were entertained by some otorhinolaryngologists privately, but I don't believe they were publicly expressed. After all, Benedict had been legally elected following a longstanding policy of the Academy to rotate the office of secretary between the two specialties. Dr. Wherry also served under that provision.

In retrospect, it probably would have been better if at the time of Benedict's election some fixed term of service would have been decided. If it had been decided to alternate the secretaryship, say, every five years or so, much ill will might have been avoided. Such a proviso would have promoted the feeling of equality in the minority specialty. But those are all retrospective thoughts.

Hughes: The situation I would think would have intensified in 1950, when Dr. Benedict became full-time Executive Secretary-Treasurer.

Henderson: Perhaps Dr. Benedict had come to the conclusion that no one else could adequately manage the myriad details associated with Academy administration nor fully comprehend the many ramifications of policy changes that were besetting the organization.

Free of his duties at the Mayo Clinic, he plunged full time into the management of the Academy. He was at the Academy offices early and enjoyed the prestige of the secretaryship and all the perks associated with the office. He traveled a lot on railroad passes. On many occasions Mrs. Benedict also traveled free. He had gold cards from almost every hotel associated with an Academy meeting. He was showered with gifts at the holiday seasons and after a successful Academy meeting. A particular favorite was the frequent gift of a jeroboam of bourbon.

Hughes: Was alcohol a large part of the socializing?

Henderson: Yes, indeed. That might seem out of place to our present generation, which finds its pleasures in other stimulants. Alcohol is not looked upon with favor anymore. But at that time, that was the way to have a party. For a cocktail party, the Benedicts would be the consummate hosts.

Hughes: Getting back to the separation, what tangible difference do you think it has made?

Henderson: Having a separate Academy of Ophthalmology has made it possible to concentrate the Annual Meeting on one subject (ophthalmology) into a four-day period. You can't attract people in private practice to a meeting that lasts much longer than three or four days, because the overhead is too great in their idle offices. They want to get back, and their attention drops. The separate sections also are less unwieldy in securing housing and appropriate meeting facilities.

Hughes: Do you think the split encouraged the political focus of the Academy?

Henderson: Yes, it allowed the separate sections to focus on the political problems peculiar to the individual specialties. Coping with the regulatory legislation at the state and federal level is now a way of life in most private practices, and the separate Academy sections can now respond more quickly to the clinicians' request for help than was possible in the old combined setup.

Hughes: Ophthalmology has always been threatened by optometry. I'm not familiar enough with otolaryngology to know if it faced a similar threat.

Henderson: No, I don't think so. Otolaryngologists at one time were worried about the people who were fitting and selling hearing aids. That was not so much a threat as an effort to discipline a quasi-professional group that was sometimes selling poor quality hearing aids to the gullible public.

Hughes: Do you think the separation of the Academy focused more attention on the problem with optometry?

Henderson: Only to the extent that the increasingly aggressive encroachment of optometry on the parameters of ophthalmology has required a more active defense. Optometry has been an ongoing problem for the Academy for many years. Optometry is slowly gaining favor, particularly at the legislative levels of some states, in spite of the Academy's opposition.

Hughes: How long has the Academy had paid lobbyists in Washington?

Henderson: Not very long.

The American Association of Ophthalmology

Hughes: Do you have anything to say about the American Association of Ophthalmology and its eventual incorporation into the Academy?

Henderson: I was never a member of this society, and I do not believe I can be objective about the unrest that eventually brought about the merger into the Academy. I was in a group-type practice that was quite different from the practice of those ophthalmologists who were supporting the aims of the American Association of Ophthalmology. Right or wrong, I was not facing the realities of direct competition from optometry. I didn't have to worry about the financial impact of Medicare, and I didn't have to worry about paying the help and overhead. I had to stand and just watch the conflict of aims and policy.

I never wanted to be in politics, having to ask people for favors and then finding that I must return the favor. I think ophthalmologists in private practice needed help in some areas, and the American Association of Ophthalmology answered that need. At times the group angered many professionals who were satisfied with the status quo. But all in all, over time the merger seemed to broaden the scope of the Academy. I think it was needed. I don't think the Academy otherwise would have gone into fields other than education and scientific programs.

Hughes: How good has the Academy been over the years in keeping in touch with the rank and file members?

Henderson: I think it has certainly tried. They have widened the membership of the Council, for example, to include men not affiliated with teaching institutions.

Hughes: Was that a complaint in the early days?

Henderson: Yes, I think so. But the private practitioners were never able to organize themselves.

Hughes: They were all in different offices?

Henderson: Right. And then along came the Association of University Professors of Ophthalmology. This was a very tight little group. Their concern involved the methodology of grants and extramural funds to help finance their departments, the search for above-average residents, the standardization of teaching curricula, and a unified system of resident selection. The scope of their activities had little impact on the problems of the private practitioner. So I think the American Association of Ophthalmology served a purpose.

The Armed Forces Institute of Pathology

Hughes: Do you know anything about the special relationship between the Academy and the AFIP [Armed Forces Institute of Pathology]?

Henderson: The Academy early on assumed a paternalistic attitude toward the Institute of Pathology and realized its great educational potential. I think the Academy was one of the first professional groups to recognize the Institute as a resource for the collection and study of pathological eyes from sources nationwide. The Academy provided material support, particularly for the early Registry of Ophthalmic Pathology, although that was not always universally acceptable. Some members objected to giving, say, two hundred dollars in 1920 to a facility that housed a bunch of specimen jars. There was one particular person in the Academy, it seemed to me . . .

Hughes: It was Harry Gradle³ who particularly fostered the Academy's relationship with the AFIP.

Henderson: Yes. The AFIP has been a benefit, not only to mankind but to all ophthalmologists. Many ophthalmologists send specimens to the Armed Forces Institute pathologists for diagnosis. Like many government agencies, sometimes it gets involved in red tape and paperwork, but by and large, it has been a tremendous help in standardizing pathology. [It's a service] that might not have ever come about otherwise.

Hughes: The AFIP sends back a written report?

Henderson: Yes. It may take a while. The patient may die before you get the report. [laughter]

Hughes: Is there anything else you care to say?

Henderson: Oh, I don't think of anything. My, we've covered such a lot of ground!

Hughes: Well, you've done a wonderful job, Dr. Henderson. I thank you.

³ For the Academy's relationship with the AFIP, see Sharon A. Bryan. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*. San Francisco: American Academy of Ophthalmology. Rochester, MN: American Academy of Otolaryngology, 1982, pp. 93-109.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Clair M. Kos, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
July 12, 1991 at Dr. Kos's Home in
Iowa City, Iowa

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Clair M. Kos, M.D.



Clair Michael Kos, M.D.

Introduction¹

“Mike” Kos was born August 6, 1911 in Washington, Iowa, where his grandfather had settled in 1865 after immigrating from Bohemia. Raised in Atlantic and Des Moines, Iowa, and Lincoln, Nebraska, he received his BS (1933) and MD (1937) degrees from the University of Nebraska and interned at Bishop Clarkson Memorial Hospital in Omaha (1937–38). Dr. Kos received a diploma in otolaryngology from the Postgraduate School of Medicine at Harvard University (1938–39). His residency training in otolaryngology was at the Massachusetts Eye and Ear Infirmary (December '39 to October '41) where his chief, Dr. Harris P. Mosher, recognized his unusual abilities and encouraged him to have an academic career.

On completion of his residency, Dr. Kos entered the military as a first lieutenant flight surgeon and served as Director of Otolaryngology at Randolph Field, Texas, and Consultant in Otology to the Air Surgeon in Washington, D.C. until 1946. He retired as a lieutenant colonel. After a year in the Division of Otolaryngology at Duke University (January '46 to January '47), he studied fenestration surgical techniques for an additional year with Dr. Julius Lempert in New York City. At this time he was recruited by Dr. Dean Lierle as an Assistant Professor in the Department of Otology at the University of Iowa (1947–1951), where he later became Professor and Chairman of the department. In 1960, Dr. Kos left full-time academia to enter private practice in Iowa City and establish the Iowa Foundation of Otology, with the purpose of promoting education and research to preserve and restore hearing. In 1970, he rejoined the teaching staff at the State University of Iowa College of Medicine as professor and clinical professor of otolaryngology.

Dr. Kos was certified by the American Board of Examiners for Otolaryngology in 1942 and became a member of the American Academy of Ophthalmology and Otolaryngology in 1943 (when the application fee was \$20). He was an active participant in Academy educational programs and served on several AAOO committees. He was widely respected as an educator, investigator, and innovative developer of microsurgical procedures, and his annual course on fenestration of the eardrum and stapes mobilization sold out in advance for 22 years. Dr. Kos also participated as a member of the Home Study Course faculty for 11 years.

In 1960, Dr. Kos followed Dr. Eugene L. Derlacki as AAOO Secretary for Otolaryngology, and for the next eight years he planned the otolaryngologic scientific program. On November 1, 1968, he succeeded Dr. William L. Benedict as Executive Secretary-Treasurer of the AAOO. Rather than move the AAOO office, Dr. Kos commuted between his private office in Iowa City and Academy headquarters in Rochester (in the summers he eased the commute by moving his

¹ Sources: 1. House HP, Clair Michael Kos, M.D. Otolaryngology-Head and Neck Surgery 1993 (Jul); 109, 1-2.
2. House HP, A Tribute to Clair Michael Kos, M.D., *Am Acad Otol-HNS Bull* 1996 (Mar); 11.
3. Bibliography. *Am Acad Otol-HNS*.

50-foot houseboat to his summer home at Lake City, MN). At the conclusion of his first year in office, much of which was spent reviewing past administrative procedures, Dr. Kos made several suggestions to the Council aimed at expanding, reorganizing and modernizing the headquarters office. He also advised development of a long-range master plan for programs, meetings and activities. In addition, he recommended expansion of continuing education activities, and an increase in annual dues from \$30 to \$100.

During the next few years, five divisions were established within the Academy office, each responsible for oversight of specific areas (administration, membership, continuing education, editorial and advertising, and conventions and exhibits). Mr. David Noonan was hired as administrative assistant in April 1972 to oversee the entire operation. He recalls the strong feeling of support Dr. Kos engendered in Academy staff, and the improvement of management style felt by the Academy Council when agendas and background materials were introduced at its meetings.²

The changes Dr. Kos brought about were not universally popular, and some members felt the administrative growth and expansion of educational programs on an individual specialty basis laid the groundwork for future separation of the AAOO. Sharon Bryan aptly described the precarious position of the Academy in the 1970s: “The Academy’s third Executive Secretary-Treasurer had the unenviable job of what some had previously referred to as presiding over the beginning of the end of the Academy. With a clarity and presence of mind during the most trying time in the Academy’s history, Clair M. Kos and the Academy presidents and members of Council during the 1970s turned the will of the majority—separation of the specialties—into a new beginning. They adopted a positive attitude, and channeled their efforts into making it a worthwhile alternative.”³

In 1978, when the Academy separated into specialty divisions, Dr. Kos became the first Executive Vice-President of the Academy’s Division of Otolaryngology and Dr. Bruce Spivey became Executive Vice-President designate of the Division of Ophthalmology.⁴

In the interview that follows, Dr. Kos modestly discussed his early life and expressed his recollections of his eventful stewardship of Academy affairs.

Dr. Kos died January 22, 1996 in a retirement home in Arlington, Texas. His wife Dorothy Ellen McGinley Kos died in December 1986. He is survived by daughters Susanne and Kathleen [now Mrs. Jeffrey E. Lindenbaum], and a son, Michael.

William H. Spencer, M.D.
August 1997

² See interview in this volume with Mr. David Noonan.

³ See *Pioneering Specialists*, p. 149.

⁴ See interview in this volume with Bruce E. Spivey, MD.

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CLAIR M. KOS, M.D.

[Date of interview: July 12, 1991]

Early Background, Education, and Career

Hughes: Dr. Kos, I thought we should start back with your family. Tell me a little about your parents, and your early education.

Kos: My parents came largely from farm families, and my father, John T. Kos, was a plumber. My mother, Minnie Striegel, was one of nine children of farm parents. I was born on August 6, 1911, in Washington, Iowa. I remember very little of living in Washington, because we moved to Des Moines when I was about four years old.

Hughes: Do you know why your parents moved?

Kos: They moved because my father, being a plumber, decided to go into sales. He became a salesman for the United States Radiator Corporation. His home then was better located in Des Moines. Following that period of about three or four or five years—I've forgotten now—we moved to Atlantic, Iowa, for the same reason: A new territory had developed for his business.

Hughes: How old were you when you moved to Atlantic?

Kos: I was about eight or nine years old. Then following the period in Atlantic, we moved to Des Moines, where I eventually entered high school. From there, just before my senior year, we moved to Lincoln, Nebraska.

Hughes: Did all that moving disrupt your education and your social life?

Kos: Well, it didn't seem to. My mother was quite a disciplinarian—a good disciplinarian—and was also very high on the ethics and requirements of education. I think that's one of the reasons that I wanted to go into medicine.

Hughes: Was that an idea of hers, or was it your idea?

Kos: No, it was not her idea. She didn't plant any specific ideas, but she did plant the importance of education. When I would ask certain questions, she would say,

“Well, now, you can go to the library”—we had a good library in the house—or “go look that up in the library.”

Hughes: How did she get that love of learning?

Kos: I don't know, because she didn't even have a complete high school education. Of her brothers—there were nine of them all together, three or four boys and five girls—the boys were all farmers, and very successful. They were educated too; that's probably why they were successful farmers.

Hughes: They went to college?

Kos: No, none of them went to college, that I remember.

Hughes: Did you have brothers and sisters?

Kos: I have one brother, John. I got named after a professional songstress. My parents named me Clair, but they did give me the masculine spelling for it, which is in French. [laughter]

Hughes: What were you called as you were growing up?

Kos: Clair Michael Kos was my full name, and Michael was the only one that saved my self-esteem. Everybody who didn't know me or see me assumed that I was female. And I still get mail to “Claire,” or “Ms.” I tried to convert my recognition to Michael, but now my son's name is Michael. So all that did was mess things up! [laughter] But anyway, that period is passed, so I don't have to worry about that anymore.

Hughes: How did you do in school?

Kos: Average. I was not an outstanding student. There were maybe one or two subjects in which I excelled, or thought I did. I don't remember details about it, so since I don't remember the details, I would guess that I was just average. I was not impressed with my intelligence.

Hughes: Well, how did you get the idea to go to college and then to medical school?

Kos: Besides the fact that my mother was backing that all the way, I had an English teacher in high school—Lincoln High School in Lincoln, Nebraska—who was also one of those wonderful teachers who stimulates people to do things and to think. That was more or less the gist of her intention as a teacher: to get children to think.

Hughes: *Good for her.*

Kos: I think she introduced me to books, and she also had discussions in class about opportunities for occupations. I remember one class in which she presented a discussion on professions, and one of the professions that was mentioned was medicine, bringing the doctor into the picture.

Shortly after that, I became ill. I can still remember my doctor; he was wonderful. He impressed me so; he was so professional and so kind and so considerate. That feeling has never left me. Even today, inside I seethe when doctors are rough and treat people indifferently. I just can't forgive that kind of attitude in medicine. But it happens too often, I think.

Anyway, I started pre-med in Lincoln, at the university [University of Nebraska at Lincoln], and in those days pre-med students had a choice. You could go four years, or you could go two. The two-year pre-med had a pretty heavy schedule.

If you were successful in getting into medicine, you could use the first two years in medicine to get a bachelor of arts degree. So I got my degrees all right, but I got them in only six years instead of eight.

Hughes: *That was a lot of work, was it not?*

Kos: Oh, I worked my tail off. But, as I say, maybe that was one reason why I wasn't an outstanding scholar, because I . . .

Hughes: *. . . had to do too much too fast.*

Kos: Well, yes. I think that had a lot to do with it, and also I think it had a lot to do with curtailing some of my enthusiasm and my ambition. I got to the point where if I could see I was going to make it, I didn't exert myself anymore.

Hughes: *How were you financing this?*

Kos: I worked; my family was poor. I mowed lawns, shoveled snow, ran errands for grocery stores, and worked behind a soda fountain in drugstores—all odd hours. My mother had to put a stop to some of it, because I was working too much, and she was afraid I'd lose out in school. So I have to smile when I hear about kids working and going to school now. They say it can't be done. It's too much responsibility. And that may be so, I don't know.

Hughes: *Were there outstanding people on the medical school faculty that made a difference in your life?*

Kos: There was one anatomist in Lincoln, and I don't remember his name. And there were two surgeons in medical school who left their imprint on me. I was very fond of them, and I can't even remember their names.

Hughes: *Well, I saw a reference somewhere that you were a student of Dr. [William] Wherry, who was of course the Executive Vice President of the Academy before Dr. [William] Benedict. Do you remember him?*

Kos: Yes, I do. I also remember his son.

Hughes: *Was he a doctor?*

Kos: Yes, he did become a doctor—Walt Wherry. Dr. William Wherry was in practice in Omaha, Nebraska, in ophthalmology, and his son Walt was a student. We both belonged to the same medical fraternity.

Hughes: *Was he a classmate?*

Kos: I think he was a classmate. He may have been a year ahead or a year behind me, I'm not sure; but we did belong to the same medical fraternity, so we had contact there.

Hughes: *Was Dr. Wherry, Sr., chairman of the Department of Otolaryngology?*

Kos: He was at one time, at the University of Nebraska. Both he and Walt are gone.

Hughes: *Did you know at the time of Dr. Wherry's connection with the Academy?*

Kos: No, I didn't, because I was too young when he was most active with the Academy. I was many years away from my connection to the Academy.

Specialization in Otolaryngology

Hughes: *When did you decide on otolaryngology as a specialty, and why?*

Kos: When I was in medical school. I can't remember exactly how I became especially enamored with otolaryngology, except that I became fascinated with the use of small instruments that would do small, minute things. I toyed with the idea of becoming a urologist, because of the instruments that were used. When I had a brief internship in medical school, I was exposed to many different specialties,

and I remember I was impressed with urology, because I liked the instrumentation that was involved.

Then when I got to otolaryngology, I became fascinated, number one with the professor, and number two, with the things he gave me to do.

Hughes: He recognized your interest.

Kos: Yes.

Hughes: What did this professor give you to do?

Kos: He gave me patients to look at—he'd already seen them—and I got to use the instruments.

There was one very sad result that came out of that too, I remember. He was going to do an operation on a patient's nose, and in those days they used cocaine a lot. It happened this patient was hypersensitive to cocaine, and when he injected her, she died. She went into convulsions before they could get into her veins to save her.

Hughes: The cocaine was used as an anesthetic?

Kos: Oh, yes. Topical anesthetic. Until I came to the University of Iowa, they were still using cocaine. That was the 1940s. They were still using it as late as 1960.

The thing that cemented my interest in otolaryngology was that I got an appointment under Dr. [Harris] Mosher at Harvard. That's why I went to Boston for my postgraduate work, after I graduated from medical school. I had an internship at the University of Nebraska Medical College Hospital, and at Bishop Clarkson Memorial Hospital. It's not the University of Nebraska Medical College Hospital. I think it may still be called Clarkson, but it wasn't the medical college hospital at that time. It was just Clarkson hospital.

Hughes: Was that a rotating internship?

Kos: That was a good internship. There again, I was lucky to have men who gave me things to do.

Hughes: They must have seen something in you.

Kos: I never gave that a thought, but I think maybe in retrospect that may have had something to do with it.

Hughes: *Did you do any otolaryngology during the internship?*

Kos: I learned to take out tonsils.

Hughes: *Was that commonly done in those days? More so than now?*

Kos: Yes.

In those days, the instrumentation was very fascinating to me, especially when it came to lancing eardrums. Damn few men ever mastered the skill, the technique, to look through a real small speculum with a bright enough light to see where they were putting that instrument, the little knife.

Hughes: *And you were good at that.*

Kos: I happened to be good at that. I was dexterous. I still am known to be dexterous. I've got a shop out there with all the little tools and the big tools in the country. And I love to work in my shop, because that's compensation for what I had to give up when I retired.

Hughes: *Had you ever been on the East Coast before?*

Kos: No. My wife came from Omaha, Nebraska, too, the last place I went to school. Neither one of us had been east of the Mississippi.

It was through a doctor in Omaha, Nebraska that I got that appointment. And I was flattered. When he told me he was going to recommend me, I didn't think I would get the appointment. Dottie and I were married my last year in medical school. I told Dottie, "I might as well give that idea up," and I started thinking about going out to western Nebraska to practice. I was the most surprised guy in the country when I got this notice that Dr. Mosher had accepted my application.

So here we were. We took a lot of baggage, because we didn't want to have to buy new clothes and everything. And, we had to have a car. My dad had an old Chevrolet Coach that had reached its last legs. It needed a couple of tires. We should have had four new tires, but Dad said, "If you drive carefully, and don't race it, don't be rough with it, it will get you to Boston." And it did. We took our time, and we got to Boston.

I reported to Dr. Mosher. He was a real tough, rough, gruff guy, but with a heart of gold. "Heart of gold" is a mild term compared to what it should be. Anyway, he said, "How did you get here?" We told him how we had come, and I told him I was going to have to sell the car. He said, "What?" "We can't afford to keep the

car.” He said, “What kind of a car do you have?” I told him the circumstances of why we had it.

He said, “Well, now, don’t you be hasty about that. You just keep that car until I tell you you can sell it.” Well, he never told me I could sell it. Two or three times, I suggested it to him, and he said, “What’s the matter? Aren’t you happy with your car?” And I said, “Oh, yeah, sure, it works.” He said, “Well, stay happy with it.” And that’s the way he handled it.

So we kept that car until I finished my residency. He finally came to the point where he just said, “I don’t want you to sell it. I want you and Dorothy to travel around New England. I’ll pay for the gas.”

Hughes: What a sweetheart!

Kos: Because we residents didn’t get any money, like they do today. We didn’t get a cent. I got board, but I had to pay for Dottie, if I took her to the hospital dining room. Boy, I’ll tell you, money was hard to come by. Now, somebody told me that the interns get \$125 a month. Good God, that would have been a fortune for us!

Well, Dr. Mosher said, “No, you keep the car.” I said, “Well, what will I do if I need a tire or have to have any repairs?” He said, “You come and see me first.” We didn’t have to have any, thank God, and we saw New England. He sent us to certain resort areas up there, apparently people he knew or had some interest in. These trips were paid for. Oh, yes. I was treated royally in my internship and residency.

Hughes: What was Mosher particularly known for in otolaryngology?

Kos: He was known for his study of anatomy and preparation for surgery. He had developed several surgical approaches through his interest in anatomy and his work on cadavers. That’s why he was so popular for teaching. Lots of people went to him to get their training.

Hughes: How many residents were there when you were there?

Kos: There were twelve, I think.

Hughes: And were you allowed to do a lot?

Kos: We were allowed to do quite a bit. For example, we had services. We had an ear service, a plastic surgery service, a rhinology service—they were all divided into special services, depending upon the specialties of the teachers.

Hughes: Did you rotate through all those services?

Kos: Yes. The teachers were all what are now called part-time, or clinical professors.

Hughes: Meaning they had a practice as well.

Kos: Yes, outside the hospital. And some of them brought patients to the hospital, but the private patients came to the Massachusetts General Hospital.

Dr. Mosher had many students from Europe. In those days the rush to Europe to get training for specialties was declining. People were beginning to stay in the United States, and then the Europeans began to come here. So it was at that cleavage point that the reputation of Boston began to take on the aura of the Athens of the United States.

Hughes: Was the [Massachusetts Eye and Ear] Infirmary at the pinnacle of American otolaryngology at the time?

Kos: Yes, it was one of the best. There was another top infirmary in Philadelphia, and another one in Detroit, but Massachusetts Eye and Ear seemed to have captured the aura of superiority. At least, that was my impression; but I think it was the impression of a lot of people, because I wouldn't have gotten that impression had I not heard it often enough.

Hughes: How were you doing as a Midwesterner? Did you find that your background was good?

Kos: My background as a Midwesterner did cause me to have some adjustment problems in the east. People's accents were with broad A's, more like the British, and attitudes were somewhat that way, too. They tried to remain sophisticated and reserved and distant. They weren't; they couldn't be. But that was what they wanted to put forth. And when you saw through that, it didn't bother you much.

Hughes: Medically, were you accepted right away, or were they prejudiced against training from the Midwest?

Kos: No. Medically, I was accepted right away. We had residents from North Carolina, Georgia. I think it was rather unusual that I was there from Nebraska. I don't think they had had a lot of residents from the Midwest. When I came back

to the Midwest to practice, they were still using techniques that were obsolete when I was in training, and I had already spent five years in the air force.

Hughes: *My heavens! So Nebraska was behind the times.*

Kos: Oh, yes. And so was I.

Hughes: *Now, were you pursuing your interest in small instruments while you were at Harvard?*

Kos: Oh, yes. I developed an aspirator that became very popular. It was manufactured by an instrument company under my name. It was called the Kos aspirator.

Hughes: *Was that while you were a resident?*

Kos: I developed it when I was a resident, but it didn't get any recognition until I began to practice.

Hughes: *Was it unusual for a resident to develop an instrument?*

Kos: Yes.

Hughes: *Did you publish?*

Kos: Yes, I published it. It was just a right angle tube, that's the aspirator, and it was attached to a rubber tube that suctioned.

Hughes: *How was that an improvement over what already existed?*

Kos: They didn't use the aspirator very much. Ear work was done so crudely that they used mops like cotton and stuff like that. They had bigger aspirators for the nose, and for sucking up blood off of an appendectomy operation or something like that. So I really didn't invent the idea, but I invented the application of it for the ear.

It was taken up almost immediately. It was sold as the Kos aspirator by instrument houses. Then it appeared under somebody else's name.

Hughes: *So someone took the same idea, and it was your idea?*

Kos: Yes. It began to be sold under his name.

Hughes: *Did you do anything about that?*

Kos: I hadn't applied for a patent.

Hughes: Is there anything else you want to say about the Boston experience?

Kos: I met some very interesting physicians in the profession. Many of them are gone now; some of them are still there, but most of them are retired. When I look at the roster of who's on the staff of Massachusetts Eye and Ear Infirmary today, I don't recognize anyone. There are different names and different people than I knew.

I am very happy and perfectly satisfied to live with my memories of the Massachusetts Infirmary. The last time I was there it was not so impressive, mainly because it had been changed physically, "improved." I wasn't familiar with it, and I wasn't familiar with the people. So it didn't leave me with the same kind of adoration I had for my own experience. It's probably really more impressive now than it was then, by quite a bit. But for me, I'm satisfied with what I had.

Military Experience

Hughes: Well, then you spent a year at the Army Air Force School of Aviation Medicine. How did that come about?

Kos: Well, I had belonged to the reserves. I joined the reserves when I was in medical school. I had three months between the time I graduated from medical school and the time I was to report in Boston for my residency. So I was sent up to a camp in Minnesota. That's when the ROTC had been established to keep young men off the streets and give them jobs. So I was sent up there for the three months that I had between graduating and going to Boston.

I enjoyed that, because it gave me some more clinical experience, taking care of the boys. If I had any problems that I couldn't handle, there was always the doctor in town. I had the protection of the fact that there were no lawyers lurking around to see how many doctors they could snare.

Hughes: That wasn't the thing to do in those days, was it?

Kos: That's right. It wasn't in the picture. I don't mean that there wasn't probably some reason for having legal protection, but today it's getting to be a farce, just a downright crooked farce. I shouldn't talk like this, but I do once in a while. I never had a threat of a suit in all my years of practice. Not one threat.

Hughes: *That's remarkable.*

Kos: That is remarkable. I made it a personal rule, first to treat people like they should be treated, and secondly, to explain everything. No coverup. The worst thing that doctors do today is to tell the patient that his chances are fifty percent, or his chances are ninety percent. That leaves ten percent failure. If you happen to be one of those ten percent, what good is the figure? That's a stupid way of presenting a problem.

I always spent a lot of time explaining to patients what their responsibility was, what the possibilities were of failure, and why. In other words, I talked to them. I have heard many doctors say to patients, "Oh, don't pay any attention to that. You wouldn't understand it if I told you."

Hughes: *Where did you learn how to relate to a patient in this manner?*

Kos: I don't know, unless it was because the people who raised me and trained me insisted that you must be square, be honest, and be forthright, and tell people that this is not a joyride. I've had failures. Thank God, not many. When I did, the patient knew that failure was a possibility. There was no question about it. People say, "Well, but you must have lost a lot of patients." I don't think so, because at the university [of Iowa] I had bookings for surgery a whole year in advance. And at Mercy Hospital too. The records are there; I don't have to brag about them.

Hughes: *How did you get from the ROTC to the Army Air Force School of Aviation Medicine?*

Kos: Well, I was in a residency. Of course ROTC kept track of wherever you were and why, and I'm sure they knew where I was at all times. When I had about three months to go to finish my residency, I got a notice that I was being called to active duty. I told Dr. Mosher about it, and he said, "Well, let me handle that for you." I said, "Fine, but I've got to report at a certain date."

Well, before that date, I got another letter from the Surgeon General of the United States. There wasn't a surgeon general of the air force at that time. The air force was a subsidiary of the general army. I got a letter from the Surgeon General saying that I was being sent to Randolph Field, Texas, to the School of Aviation Medicine to take their course to become a flight surgeon. In other words, I was being transferred to the air force.

Hughes: *What did you think of that?*

Kos: Oh, it tickled me to death. I don't know whether I had requested it or not. I really don't remember that detail, except that I know that Dr. Mosher got the appointment for me.

So I went down there, and at that time the length of the school was, I think, three months. Sort of a crash course. We went to class at seven in the morning and stayed until five o'clock at night, and sometimes the weekends too.

When I graduated, I was expected to go overseas. Dottie expected to as well; she was with me. We had an apartment on the edge of Randolph Field. After I graduated from the air force medical school, we were given assignments to live in quarters on the base. They were very nice. Instead of driving a car from some little shack out on the edge of the base, we had our lovely little home right there just across the street from the school where I was working.

Since I had the right credentials, they made me a professor of aviation medicine. I was assigned as a teacher in the School of Aviation Medicine to teach my specialty, because they didn't have anybody to fill that slot. I was at the right place at the right time.

Hughes: You were unusually young, were you not, for that kind of a position?

Kos: Yes, I was. Most of my confreres on the staff of the School of Aviation Medicine were quite a bit older. I remained there on the staff of the School of Aviation Medicine and taught doctors of all sizes, ilks, and breeds and everything else—gynecologists, dermatologists, general surgeons, plastic surgeons. All these doctors were my students of my specialty, otolaryngology in aviation medicine.

Among the students that came through those courses, there were some regular army people who were my students. Among that group, there were two future surgeon generals of the air force. So, who became consultant to the surgeon generals of the air force? I did. [laughs] And this was years later that I got those appointments. So I traveled all over the world to give lectures, and consult with the doctors of air bases, whoever they were, on the problems in otolaryngology.

Hughes: All this was being geared to flying conditions?

Kos: Yes.

Hughes: I know you had a good background in otolaryngology, but you hadn't particularly emphasized flight before that.

Kos: No, that's right, I had not. But when I took the course, one of the requirements was that I had to learn to fly. That was later abandoned, because they considered it a waste of time, and I think it was, under the circumstances of the war going on, and the expense involved. But I was taught to fly. I was never given a license to fly independently, but I have the certificate that I have been taught to fly.

Then, when I got out of the service and came to Iowa, there were several doctors—a urologist, a surgeon, and a dermatologist—who had bought an airplane. So I bought into the airplane, and I continued my flying. That didn't last too long, because I had been taught to fly basic military trainers, which were powerful planes. The plane that I had bought into was one of those putt-putters.

One of the owners was co-pilot, and I was piloting. When I landed, I bounced a few times. I wasn't worried, and neither was the co-pilot with me, but he had to tell everybody about it. And my wife heard it. So one night in the privacy of our room, she said, "You've got to make up your mind. You've got to either be a pilot or a doctor." So I quit flying.

Hughes: What particular problems arose in otolaryngology in aviation?

Kos: The problems: number one was equilibrium. Because in combat, these pilots are subjected to tremendous flight maneuvers and acrobatics, to avoid the enemy or to get on his tail. If you don't have a stable balance system, you can make mistakes. The other is that we have eight cavities in our head, and they're filled with air. If any of those exchange passageways—orifices we call them—is blocked, the air that's in there will change according to the altitude of your body. So you can go up in the air and have your sinuses filled with air, and have to suddenly dive, and if any one of your sinuses is blocked, you experience terrific pain, or in the case of the ear, a loss of hearing as well as dizziness.

Hughes: Not what you wanted in a pilot.

Kos: Yes, if you had to dive. When you're going up, you can be relieved of all that. So the examination had to take into account how clear was your nasal airway, how clear were your sinuses, how good is your balance.

So having had that personal experience, I was frankly a little better off than lots of flight surgeons later who came along and didn't have that experience.

Hughes: Did you develop the screening program?

Kos: No. That was developed probably by some military doctors.

Hughes: Was it pretty good?

Kos: Yes, it was excellent.

Hughes: So it was successful in picking out the people that were good candidates for flying?

Kos: Yes. Every pilot that went through that training had to do these aerobatics. He had to be examined first to see if there was potential for any kind of trouble. And that's where the flight surgeon came in. He had to understand that somebody with a marked deviation of the septum or a polyp in the nose, [which] could bang up against the opening of the maxillary sinus or the frontal sinus and block it off, [could experience balance difficulties and other impediments to flying]. That had to be known before they could get a license.

Duke University

Hughes: Well, then from 1946 to 1947 you were an associate in surgery in otolaryngology at Duke.

Kos: Yes. I was there for a year. The reason for that appointment was Dr. Samuel Crow, who was at that time professor of Johns Hopkins' Department of Otolaryngology. He was also a civilian consultant to the air force, and that's how I happened to meet him. Dr. Sam Crow, because of his position as a civilian consultant to the air force, came to Randolph Field on several occasions. In the five years I was in the air force, I had a good deal of contact with Dr. Crow. And there were occasions when I would go to Baltimore, to Johns Hopkins to visit with him about military problems.

He told me that he was going to retire, and that he would recommend me for a professorship at Johns Hopkins. I was thrilled, but I didn't pin any hopes on that, because first I had to be accepted by the staff at Hopkins. It was nice of him to recommend me, but I wasn't overwhelmed. I was proud that I was selected.

But before that came to pass, he was reappointed as professor, instead of retiring as he expected to do. So he felt rather bad, and he probably thought that I had put more hopes in it than I really had. He felt that he owed me something. So he got me the appointment at Duke University.

Hughes: Did there just happen to be a vacancy there?

Kos: There happened to be a vacancy. Up until my appointment, as far as I remember, the appointments at Duke had combined ophthalmology and otolaryngology. I think I was the first one to be appointed to be a member of the Department of Otolaryngology and Ophthalmology who did nothing but otolaryngology, and, preferably, otology.

My request when I went to Duke was for equipment so I could practice otology. That meant that I needed an audiometer, and I needed surgical instruments to practice otology. They had some, but they were very crude. There was nobody especially interested in otology to bring together the necessary instruments. That was the problem.

Hughes: Was it unusual in that day to want to practice just otology?

Kos: It might have been unusual at Duke, because Duke had never been in the forefront of otology.

Hughes: Did that worry you when you went there?

Kos: It did, but Dr. Crow assured me that I could practice the entire field of otolaryngology, which at that time included otology. So I didn't intend to do only otology, but I wanted to include it in otolaryngology. And I wanted the instruments to do it with.

Hughes: And they got those for you?

Kos: No, they did not. That's why I left Duke. After one year, I resigned from Duke. There was an interval there of several months.

Lempert Institute, New York

Kos: I went back to New York to study again under Dr. [Julius] Lempert, who introduced the fenestration operation to this country.

Hughes: Now, what is that?

Kos: The fenestration operation is the operation on the ear that makes people hear who have sclerosis of the ear bones.

Hughes: That's why you wanted to go there?

Kos: Oh, yes. I had been there before. When I was a resident, Dr. [Phil] Meltzer was my teacher of otology at Massachusetts Eye and Ear infirmary. He was in close contact with Dr. Lempert in New York. And then during my senior year, when I got on Dr. Meltzer's service, he took me with him every Friday afternoon to New York to the Lempert Institute.

Hughes: Was that institute associated with a university?

Kos: No. Dr. Lempert was just a lone man who had developed this technique. He had picked up some of his knowledge from a famous doctor in Stockholm, Sweden, and from another one in England, who was famous for his knowledge of otology. They had been trying to develop the fenestration operation, and had had so-so success. Lempert came along and sharpened up everything. Sharpened up the corners that were round in surgery and made the operation a one-stage procedure, where it had been introduced as a two-stage one in Europe. There was also a Frenchman involved in the attempt to do this surgery.

Lempert pulled it all together and perfected the technique to one stage. Then he expanded his office and called it the Lempert Institute in New York. Doctors from all over the United States went there and took courses. Not all of them practiced the surgery, because after they tried it once or twice, they gave up. They didn't have either the ambition, sufficient knowledge, or interest in the surgery to continue.

Hughes: Did it take great dexterity?

Kos: Oh, yes. A clumsy person, a guy that was all thumbs, couldn't do the operation.

Hughes: The course taught you how to do this operation?

Kos: Yes.

Hughes: How long was the course?

Kos: I took a fellowship with him. I was with him about nine months.

Hughes: Did you mainly observe him operating?

Kos: Mostly it was what they called assistance, which was nothing more than looking through a microscope with two oculars and objectives, to see what he was doing.

Hughes: Was it unusual to do microsurgery in that era?

Kos: Oh, yes. In fact, it was Dr. Lempert's influence that created the first surgical microscope.

Hughes: Was otology the first specialty to use a microscope in surgery?

Kos: It was. At least in Iowa it was, because when I came here, the neurosurgeons, the ophthalmologists, still were not using amplification other than magnifying loupes that magnified the vision about two times, which wasn't enough to do this operation.

Hughes: Gloves, until at least after the war, were very thick and cumbersome. Was that a problem when you were doing such fine surgery?

Kos: That didn't seem to be a problem because the instrument did the work, not your fingers. Your fingers held the instrument and guided it, but it did the fine work.

Hughes: Had Lempert developed the instruments as well?

Kos: Yes. He had developed a whole set of instruments, as did others who went to observe him, such as Dr. [Howard] House, who's now internationally known for his surgery of the ear. You see, not all of the brains involved in this came together at one time. They didn't come with the same result either. Different people had different ideas and applied those ideas to the basic knowledge of what Dr. Lempert could teach them, and what he got from the European doctors.

Hughes: What was Dr. Lempert like as a personality?

Kos: If I could show you his picture, you would get some idea. He was a short man, a little bit hunchbacked, long hair—not the hippie type.

Hughes: Was he American?

Kos: Yes. He was American; he was a German Jew. His parents were German Jews who came to this country. And like many Jews, very well educated. Smart as a whip. He had been to England . . .

Hughes: . . . where he came across the man who had contributed to this operation?

Kos: Yes. I'm not sure when I say that he had come to the United States as a young man, maybe a boy. He had taken advantage of all of the education he could get, and he decided he wanted to be a doctor, and he did become one.

Then I think he went back to Europe, when he became interested in the ear. He went back to Europe and visited these doctors that I mentioned earlier—in Sweden, England, and France. From that, he brought back the principle of what they were attempting to perfect. He could understand it, and he knew that it was possible. They were doing the operations in two stages, and sometimes even three stages, which meant three different operations. He combined it all into one operation, which took the novices hours to do—two or three hours sometimes. He could do it in half an hour. And I got so I could do it in half an hour.

When I got out of the service and went to the University of Iowa, they were still doing mastoids with a mallet and chisel—making an incision behind the ear, and then pushing tissue back and retracting it with retractors. Then using a mallet and a chisel and chiseling off the bone until they got into the mastoid. The mastoid itself is full of air pockets, cells of air. Then it was easier for them to use the mallet to get it done faster with a mallet and chisel. It was slower to get the cortex off, the tough part of the bone.

When Dr. Lempert got down to the semicircular canals and exposed them, he had to have an instrument to make a little window in the semicircular canal. He had to have an instrument for that, so he developed and used little scrapers. He very quickly developed use of a cutting burr, or a polishing burr. There was a whole set of burrs, actually.

Hughes: *Electrically driven?*

Kos: Electrically turned, you see. With a stem, with a burr in the end. He very gently, under the microscope—and this is why the microscope was essential—would polish that down to a very thin layer, and then with a very delicate pick could lift off the cap. He made a ring first, where he could get in underneath it and then lift off the cap. He made a skin flap from the canal that he could turn around and lay over that to protect the inner ear from infection and any further trauma. And that was the fenestration operation.

All through this, not only was he developing instruments, but he was developing treatment techniques and dressings for the ear to make it as comfortable for the patient as possible, with very little postoperative pain. Having cut behind the ear made a difference.

Hughes: *Where did the cut use to be?*

Kos: It used to be from behind the ear into the mastoid. Then later he developed the endaural technique, where you make an incision in the canal. And that put him

in the same position as the incision behind, and left virtually no scar to show afterwards, whereas an incision behind showed forever.

Hughes: And it wasn't any more difficult to operate from that location?

Kos: Well, it was a little more difficult. It required a little bit more skill, but not too much. Anyone with any experience at all could get the exposure they needed for that purpose. And actually, the approach was from a point that was more directly over the area where he had to make this little hole, instead of coming in from behind and pushing the ear forward.

American Academy of Ophthalmology and Otolaryngology

University of Iowa, Appointment to the Academy

Hughes: Then you went to the University of Iowa. You had said before that that was an appointment that was arranged by Mosher.

Kos: That was arranged by Mosher, who was very familiar with Dr. [Dean M.] Lierle, who was the head of the Department of Otolaryngology at the time. And through contact with both Dr. Mosher and Dr. Lierle, I was appointed to the staff of the Academy in Continuing Education.

Hughes: Dr. Lierle had a position with the Academy, didn't he?

Kos: Yes, he did. He had several jobs with the Academy at different times, but the main one was in Continuing Education. I've forgotten now some of the more professional positions he held with the Academy, but he was a very popular and influential person with the Academy.

Home Study Courses

Hughes: The Home Study Courses had been started before the war by [Dr.] Harry Gradle. Did you know him?

Kos: Yes. Those Home Study Courses were a real fine contribution. Too many of the candidates were having trouble passing the boards.

Hughes: *In both specialties?*

Kos: Oh, yes, both. The result of that led to favoritism on the part of some of the examiners, if they had their own residents coming up for examination. They had to change that so that the person with whom they trained couldn't be an examiner. And yet there were circumstances under which it was impossible to avoid that. He was too damn busy and had to do it within a certain length of time.

Hughes: *The applicant was?*

Kos: Yes. Also, the examiners had to keep a schedule; they had so many people they had to examine.

So Continuing Education came into the picture to prepare these people who had not had adequate training in the professional field.

Hughes: *Now, Dr. Gradle originally started the course in the basic sciences, and then during the war—in 1942—he added a course in clinical ophthalmology. Were those two taught as separate entities, or did they eventually combine into one Home Study Course?*

Kos: They were taught as separate entities in the continuing education courses. You could take special courses in certain aspects of either basic sciences or clinical sciences, or both. So the result was that the Academy had to take over the responsibility, which was either overlooked or neglected by the training institutions. If the universities didn't do a good enough job, the examination showed them up.

Hughes: *Was there any resentment that the Academy was stepping into an area that the universities before had taken care of?*

Kos: No, because many of the Academy officials and participants were the same professors that were teaching in the schools.

Hughes: *Did some of the academic departments take on the administration of the Home Study Course, or was it left entirely up to the individual student?*

Kos: Most department professors encouraged taking the Home Study Courses. But there were a few that didn't. I remember hearing one professor say it was not necessary, that the training that his department had given them was adequate. And that's a very poor attitude to take. It's better to leave a group of people to make those decisions. That's where the Academy filled a void of educational jurisdiction.

Hughes: [Did] the faculty on the Home Study Course [comprise] the top people in the different subspecialties of otolaryngology?

Kos: Most of them were, yes, in their respective fields.

Hughes: So in a way, it was like studying with a whole series of experts in your area of interest.

Kos: Yes, that's right. And after all, you must not neglect investment of the student. If the student applies himself, he'll get more out of it than if he doesn't give a damn. The attitude on the part of the student is very important. You can have the most brilliant professor in the world and the cleverest professor in the world with words: He can't teach a dummy who won't accept it.

Hughes: Could students keep motivated? They were sitting at home taking these courses. They didn't have the stimulus of personal interchange.

Kos: That's right. And the so-called question and answer periods that went along with it, there's usually some time set aside for that, at the end of a course. Now, not all of them do, but some of them had done that.

Hughes: You mean that was face to face?

Kos: Yes, face to face.

Hughes: So you're saying that there actually were home study sessions of some kind at the Annual Meetings.

Kos: Yes.

Hughes: What happened to them?

Kos: There still are, I think.

Printed booklets were developed because attendance at meetings was not always possible. Being face to face with an instructor isn't always possible in a busy practice. So they had to develop this other means of education. Doctors in a group practice could take turns going to the Annual Meetings and getting this face-to-face treatment. Those who were practicing singularly had to either take the time off and close the office, or refer patients to a competitor.

Hughes: That's what they feared. How was the faculty chosen?

Kos: The faculty was chosen primarily by the older doctors or members who had had the experience, by recommendation and by nomination. As I remember, a Home Study Course committee was consulted as to the worthiness of people that were recommended.

Hughes: How long did they serve?

Kos: Some of them served practically for a lifetime. And some of them gave it up sooner. Some of them were not invited a second time.

Hughes: Were the Home Study Courses successful at keeping up with the very rapid changes that were occurring in both specialties?

Kos: Yes, but there were voids that developed when a new operation was developed, for example, the fenestration operation. I don't recall any obvious instances where there was disagreement, but I'm sure there may have been some variation in opinion as to what should be done or how a certain instrument should be used.

So I think the best one can do is to take the courses, and not always take the same teacher every time. Get advice from different people.

Hughes: Was it ever a problem when a resident was taking a Home Study Course that presented a procedure in a certain way that did not agree with the way he was being taught in the department?

Kos: Yes, there were occasions of that.

Hughes: You said that you were brought into that Home Study Course. Was it right away when you appeared at the University of Iowa?

Kos: Not right away, but it was within a year or two.

Hughes: What were you doing in the Home Study Course?

Kos: I prepared a course for vocal presentation, trying to perfect it and make it as broad in coverage as possible. I didn't get in on correcting written answers. I'm glad I didn't; I didn't care for doing that.

Hughes: That was very time-consuming, I understand.

Kos: Yes.

Fenestration Operation

Hughes: Was the course you were presenting on the fenestration operation?

Kos: Only on the fenestration.

Hughes: How many years did you teach it?

Kos: Oh, Lord, I don't know. You see, there were different stages of development in the fenestration operation. The first part of it that was developed and taught was stapes mobilization, where we did not remove the stapes, but forced it to be mobile with a pick. That worked in some cases quite well, and lasted quite well; in other cases it hardly lasted at all because it refixed again.

The big successes came when we removed the stapes and replaced it with an object, either a wire or a plastic tube. Placing it on the skin flap was not long tolerated because skin sheds, and you've got to contend with that. But then fascia was used. That worked much better because it had no desquamation. In other words, it didn't throw off any tissue. Veins were also used, as was gel foam.

Hughes: What is gel foam?

Kos: Gel foam is that spongy stuff that doctors use to soak up blood.

Hughes: That was used to replace the stapes?

Kos: To cover the oval window. And then wire was crimped and hung on the incus so it wouldn't fall into the inner ear.

Hughes: Why do you talk of the stapes rather than the other two bones? If I remember correctly, there are two other bones in the middle ear.

Kos: The incus and the malleus very rarely become fixed. They're still mobile. The stapes is the one that most commonly becomes fixed. Now, the others can become fixed in certain types of infection of the ear. That usually introduces other problems which rule out taking out the stapes. You can hang wires, for example, from the handle of the malleus, and you can hang them from the incus, which is done in the stapedectomy if you take the stapes out.

Mobilization was used first; that was the cautious, most conservative way to get some hearing back. The only trouble of it was that it often did not last very long.

Hughes: And you couldn't predict how long it would last.

Kos: You couldn't predict ahead of time. This is what I call the trial and error period, and imagine that it's still going on.

Hughes: When would you say it started?

Kos: The trial and error period? From the very beginning, after fenestration.

Hughes: And fenestration came in before the war?

Kos: Fenestration came in before World War II, before the mobilization.

Hughes: When did mobilization come in?

Kos: That came in as a result of searching for a simpler way of doing it, for an easier way for the patient to take the surgery. All these things had bearing on whether there was safety to the ear—by that, I mean the inner ear, the nerve—safety to the patient, from a standpoint of postoperative infections, and also from the standpoint of duration of result. Mobilization didn't always work. If it did, it didn't always stay there.

Some of these stapedectomy techniques didn't always work, because there was some stapes footplate left in the oval window, which became the nidus or the focus of regrowth. That was due to incomplete removal of the footplate. But even in cases where the footplate was removed, there was some regrowth of bone from the margins. Those were very rare, but they happened. And then of course the whole thing depended on the health of the hearing nerve. If the hearing nerve was susceptible to deterioration for any number of causes, then the stapedectomy wasn't worth a damn either.

Hughes: Could you predict that?

Kos: No. You can't always predict that. You can predict that in some cases of otosclerosis, where the inner ear is involved, where the hearing test shows a loss of hearing. Or you might be able to predict it in cases where the audiogram shows a nerve loss along with the mechanical loss. Nerve loss might be due to exposure to noise or due to exposure to intoxicants, such as certain antibiotics.

Predictability is often very difficult, and that's what sometimes makes it difficult to explain to a patient what his chances of success are. Anyone who uses a percentage, especially someone else's percentage, is cheating the patient, because he doesn't have enough experience to know what his own percentage is.

Hughes: What did you say to a patient?

Kos: I would say, "Your chances are good," "fair," or "not good."

Hughes: Your answer was determined by how much of the problem was connected with the nerve and the nervous system?

Kos: Yes, and the whole hearing system.

Hughes: That was the unknown, wasn't it?

Kos: That was the unknown. But when I saw young doctors who had maybe done, oh, half a dozen of these operations, quote some percentages, what's he going to tell the patient if he'd only say he'd done six operations?

Hughes: Meaningless.

Kos: What's he going to tell the seventh one? Will he wait a year or two to find out what his percentages are? No. He's going to pick somebody else's percentage. So to say that you've got an 80 percent chance, or only a one percent chance of failure—if you're that one percent, that's 100 percent! To use figures like that is very deceiving to a patient, and when they get smart, you know who catches it—the doctor, and the public too.

Hughes: When you were giving these courses year after year, was it with the hope that a person who had taken your course could then do the operation?

Kos: I never accepted anybody unless I knew something about his background. I needed to know about the training he had had. If he came down to observe, the supposition was that he came down to see what this operation was like and what could be done with it. I didn't expect him to go back home and operate on people. Those who did had patients who came to me later with dead ears. That's how I learned what these people were doing.

Hughes: Did that worry you, that people would listen to your course and then try to do it?

Kos: Yes. That would worry the hell out of me, and it happened. For example, a doctor up in the north part of the country came down and watched me twice, then went back and did the operation. Now, he couldn't have had much training, because he didn't study with me; he didn't have my supervision. But he saw it done, and he went and did it. Then he was sued.

Hughes: What did you hope to achieve by giving these instruction courses?

Kos: I hoped to point out some of the things I'm talking about right now. In my own university I used to chastise the neurosurgeons and the ophthalmologists for not using a microscope. Now they are. And their work is a lot more accurate, more refined, than it was when they tried to do it with loupes that would magnify only two or two-and-a-half times. Or with no loupes at all, with just glasses, if they wear glasses.

Hughes: Now, I know one of the things you did when you were Executive Vice President of the Academy was to revamp the continuing education courses. What did you think was the problem with what existed?

Kos: Well, I couldn't do it by myself. I had to have the approval of the entire Board of Directors to do anything, and I never tried to do anything without their approval.

Hughes: Were you usually successful in getting what you wanted?

Kos: Usually. In the first place, if there were proposals that had opponents and proponents, I tried to understand both sides. I think any administrator ought to train himself to do that. You may not necessarily agree with both sides, but if you study the evidence, that very often brings you to the conclusion that you should have. Some people do what they do for convenience, to get rid of the problem. Others do it to do a favor. All of those things can get you in hot water.

Secretary for Otolaryngology

Hughes: What did you do as Secretary?

Kos: I think a large part of my job was to solicit material for presentation, papers.

Hughes: So you had to know who was the expert in different subspecialties of otolaryngology?

Kos: Yes. I was supposed to know that.

Hughes: And do you remember what it was like lining up appropriate presenters?

Kos: You have to know a little bit about the proposed presenter: his personality, his ability to speak. Nothing ruins a speech worse than "uh, uh, ah, um, uh." And you have to know something about the quality of the subject. Is it a good subject to talk about? Or is this just an advertisement on the part of the would-be speaker? There's a lot of that going on.

Hughes: Did you usually just know that off the top of your head, or did you have to do some exploring?

Kos: Usually I did, but not always. Sometimes I had to seek advice about this person or that person. And then after you're in it for a while, you learn to recognize a certain group of speakers whom you can trust.

Hughes: Were you looking for speakers who were on the cutting edge of otolaryngology, the people who were innovative and moving the field forward?

Kos: Yes, I favored those, but there weren't a lot of them. I favored those, and there were some that I was forced to take because of their popularity with the members.

Hughes: So you did listen to the members.

Kos: Yes. It depended on who—politics is a very difficult activity to be involved in.

Hughes: You're saying that there was quite a bit of politics involved with selecting these speakers for the instructional courses.

Kos: There needn't be, and I don't feel that I was overwhelmed by that angle of it. Especially as I became more and more ensconced in that job, and more and more comfortable with how I was doing. I had to be careful, because I didn't want to alienate one person who would indirectly cause several of his friends to be alienated. I didn't want to do that, because my personal friends were not necessarily his, and his were not necessarily mine.

Hughes: Were there ever occasions when you were reluctant to ask an individual to participate because a procedure or whatever it might be that he was espousing wasn't properly tested, or hadn't served the test of time, was too new to know whether it was a good thing to pass on?

Kos: No. Those kind of requests come from relatively naïve people, many of them younger men, younger either in age or experience. Those didn't bother me very much because I didn't hesitate just to turn them over to the committee.

Hughes: Was the Council in general a pretty conservative organization?

Kos: Yes. A good council can make it very easy. All a council needs is somebody to execute their will.

Hughes: And that was you.

Kos: That was me.

Executive Secretary-Treasurer

Hughes: Now, you're skipping to when you were Executive Secretary-Treasurer, not Secretary of Otolaryngology.

Kos: Yes. When I was Executive Secretary-Treasurer, it was probably a little easier, except for the infighting that went on between the two [specialties].

At one time, the ophthalmologists were about two-thirds of the population of the Academy, and the other third was the otolaryngologists. So unless a matter came up that involved the welfare of both specialties equally, or even if it were a little more lopsided the opposite way, then I had a hard time dealing with certain questions I had to get solved.

Hughes: You mean because the ophthalmologists weren't interested in problems that were exclusively for the otolaryngologists?

Separation into Two Academies

Kos: Yes. For example, sometimes that kind of a problem would come up that was related to what to do about the dues. We were only paying one-third of the total dues, and ophthalmologists were paying two-thirds of the total dues. And that sometimes created a problem.

Hughes: You mean whether the otolaryngologists had equal say about how that money was to be spent?

Kos: They did. But you see, that wasn't fair. That's one reason I think I was a little more popular with the ophthalmologists than I might have been, because I was for the ophthalmologists on those things. Same way when it came to separation. Otolaryngologists didn't want separation, none of them.

Hughes: Why?

Kos: Oh, because after all, they'd been riding on the gravy train for years and years when it came to the function of the Academy as a whole. And look what happened to ophthalmology when they got loose. The biggest meetings they

ever had are being held now, since their separation. As I'm told, the best meetings they've ever had, they are having now.

Now, being tied to otolaryngology and the smaller group had some inhibiting effects on what ophthalmology did. And you'd think that by mere numbers of votes, ophthalmology could do what they wanted to, but it worked out both ways. There were lots of ophthalmologists that were otolaryngologists, too.

When there are two principal groups, you run into problems. In the Academy, many ophthalmologists felt that the otolaryngologists were having too much to say about what was done with the dues. And the otolaryngologists were benefitting on some issues, because they weren't paying for all of it. Ophthalmologists were paying for most of it.

The lopsided balance of the two specialties was the main reason I was for the split. I knew that they would go to town after separation. Dr. [William] Benedict didn't want to give up otolaryngology because that made his influence a little smaller. He wanted the whole pie. Benedict was very fair about it, but you see, there may have been exceptions which I wasn't aware of, because I never knew much about the political side of the problem until I got through with all of it.

Hughes: Did you know Benedict?

Kos: I knew him real well.

Hughes: What sort of a man was he?

Kos: A very affable person, very nice guy. His wife was a lovely person. He was definitely not a tyrant, but influential.

Hughes: How did he run the Academy?

Kos: Well, it depends on who you talk to, but I'd say that from what I observed going on, he ran it with an iron hand.

Hughes: No dialogue?

Kos: Very little dialogue. Oh, he was known to talk a lot, but when he made decisions, he didn't elaborate a great deal.

Hughes: Was there unrest in the Academy because of his manner?

Kos: No, there really wasn't. I was not aware of any unrest. Oh, there would be a comment now and then, but in a large group of people like that, mostly men, you're bound to have some unrest, some dissatisfaction with what's been done or what hasn't been done. That's going to be true in any organization.

Hughes: But you weren't aware of talk amongst the otolaryngologists that, "We'd better do something to get rid of this ophthalmologist who's had his finger in the pie for too long"?

Kos: No. I think the ophthalmologists felt that because Benedict had had the position for so long that an otolaryngologist should have that privilege.

Hughes: Well, that was the tradition, wasn't it, that it was supposed to alternate?

Kos: That's right.

Hughes: Why were you appointed Executive Secretary-Treasurer? You served from 1969 to 1978.

Kos: Why me? Damned if I know, because it certainly didn't do me any favor. I really suffered both financially and otherwise. But I had been with the Academy for so long, and Secretary of Home Study Courses, and had been a member of the committee on conservation of hearing, and also a member of the subcommittee on noise. I had been involved that way.

Hughes: And of course, you had been Secretary for Otolaryngology for eleven years. You had a busy practice.

Kos: I did have a busy practice. I know I cut my practice down, because I slowly turned it over to Dr. [Roger] Simpson and Dr. [Terry] McFarlane. Then I thought, I can afford the time to take that secretaryship.

Hughes: Who wanted you to be Executive Secretary-Treasurer?

Kos: I don't know, unless it was Lierle. Could have been Lierle, could have been [Dr. Eugene L.] Derlacki. Among the otolaryngologists, probably all of them.

Hughes: And maybe [Dr. Frederick C.] Blodi among the ophthalmologists?

Kos: Blodi was certainly not against me, I know that.

Hughes: Well, he knew it had to be an otolaryngologist, if the tradition were going to be continued.

Kos: Yes. The other reason why I think I was acceptable is the fact that at least Blodi and a few of the other ophthalmologists knew that I felt that ophthalmology should have what it wished to have.

Hughes: So you stepped into the position cold, except for what you had observed over the years as an Academy member and committee member?

Kos: Yes. Because Dr. Benedict was sick when I took over.

Hughes: That's why he stepped down.

Kos: Yes. I don't remember getting any help, or giving any help.

Hughes: What condition was the Academy in when you took over?

Kos: As far as I know, the Academy was in good shape. It was operating smoothly enough. I knew that there was this friction between the two specialties, but no different than it had been since my membership in the Academy.

Hughes: And yet one of the first things that you did was to do a study and make a report on the condition of the Academy with suggestions for some changes that should be made.¹

Kos: I don't remember too much about that now.

Hughes: I also read that you reorganized the Academy's headquarters and that under your tenure, five divisions were created: membership, continuing education, finance, editorial and advertising, [and] convention and exhibits.²

Kos: Oh, yes. I think all of those jobs were held by Benedict appointees. In order to spread the personal influence around, I thought that those who were dealing with otolaryngology should be otolaryngologists, and those who were dealing with ophthalmology should be ophthalmologists. Where there was a predominance of ophthalmology, I leaned toward ophthalmology on almost everything, I think. I certainly didn't want it the other way around.

Hughes: Just because of the sheer numbers?

Kos: Yes.

¹ Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982, p. 148.

² *Pioneering Specialists*, p. 149.

Hughes: Now, why was it that the ophthalmologists always had outnumbered the otolaryngologists in the Academy?

Kos: In the earlier days, the Academy was made up almost 100 percent of doctors who practiced the combined specialty. And then, as the medical specialties became more and more sophisticated, the work had to be spread out, divided. Some chose to do only ophthalmology, and others chose to do only otolaryngology. One of the main reasons for the split of the specialties that way was that most of those who became ophthalmologists did not want to do the kind of surgery that otolaryngologists had to do. They didn't want to "jerk tonsils"—I've heard that phrase. And they didn't want to do sinus work. All they wanted to do was the "clean job of ophthalmology." I'm sure some of them didn't realize that ophthalmology isn't always clean either.

Many of these men were certified in both specialties. There were others who were not and could not be certified in both. And so it happened that ophthalmology was the most popular for some of those reasons that I've mentioned. It was really a cleaner specialty to work with. Also, ophthalmology had the advantage of the spectacles market.

Hughes: Of course, the otolaryngologists had the hearing aid.

Kos: Yes. But otolaryngology never got involved that way. They should have. My daughter, Susanne, is an audiologist, and she is quite successful selling hearing aids. She's a certified audiologist, and she can test hearing as authoritatively as any doctor—more authoritatively than some of them. The doctors don't want to bother with that side of the specialty.

Hughes: As I understand it, for the ophthalmologist, the Academy was the place to go. That's where he learned what he needed to be a good practitioner of ophthalmology. In otolaryngology, I know there was the Triological Society [American Laryngological, Rhinological, and Otological Society]. Was the Academy only one of several places that an otolaryngologist could go to get the information he needed, and so it wasn't as necessary for him to be a member?

Kos: Well, yes. You see, the split between ophthalmology and otolaryngology was delayed too long. The Triological Society was started in order to have a society exclusively of otolaryngologists.

Hughes: Was it less important for the otolaryngologist to belong to the Academy than perhaps it was for the ophthalmologist, simply because there were many other organizations which an otolaryngologist could belong to? Does that explain why the membership of otolaryngology was lower?

Kos: Otolaryngology [membership in the Academy] was lower because it was split up into more specialties than was ophthalmology. Originally, it was eye, ear, nose, and throat. That was the specialty that doctors entered into. Then along came the natural division of interests and skills. Ophthalmology felt that it was getting nothing out of otolaryngology and otolaryngology felt the same way about ophthalmology.

So that caused that split between ear, nose, throat, and eye. Now, ear, nose, and throat is facing the same thing among themselves, and the government is telling them that there is no official specialty of otology.

Hughes: How can they say that?

Kos: If you're an otolaryngologist, you're also an otologist. That's the government's argument.

Hughes: What is their point?

Kos: All of this is based on finances, fees. Otologists in recent years have commanded higher fees than the rhinologists or the doctors who perform nothing but tonsillectomies. So the government's stepping in through the avenue of Medicare to tell the doctors that, "You ain't gonna be paid these fees that you're asking."

Hughes: I see. So by defining somebody as an otolaryngologist rather than an otologist, the government can lower the fees.

Kos: Yes.

Hughes: Well, one of the things that you did when you became Executive Secretary-Treasurer was to raise the dues, which I read were thirty dollars and you raised them to a hundred.³

Kos: Did I get credit for that?

Hughes: Sharon Bryan gave you credit for that.

Kos: Oh, God. I didn't know Sharon disliked me that much.

Hughes: [laughs] Do you remember doing that, and do you remember why?

³ *Pioneering Specialists*, p. 148.

Kos: I remember that being done, but I didn't know that I was getting credit for it, because I didn't do it.

Hughes: Who did?

Kos: I couldn't have done it without the Board of Directors. That's the point. I was sitting on that throne. I didn't have anything to do with raising the dues, but I got the credit for it.

Hughes: Do you remember why it was thought to be necessary to raise the dues?

Meeting Sites

Kos: I don't remember all of the reasons for that, but I know some of them. One of the reasons was that the cost of having our Annual Meeting was going up very rapidly. We used to have all our meetings in Chicago, and when you have a fixed place to have meetings, your fees are well controlled. They don't get raised. Palmer House [Hotel] lost a hell of a lot of money when the Academy left Chicago.

But then when [the meetings] start travelling around, [the convention sites] compete with one another to get your business. First they'll raise their fees, and then they'll give you incentives to choose them by lowering them five percent, or two percent, or whatever it is. Anything to get you. That jockeying goes back and forth for a while until the meeting places are established.

Hughes: And yet the Academy was stuck with only a few possibilities wasn't it?

Kos: Yes. They couldn't grow at the Palmer House. There wasn't enough room. That was one of the reasons for that subject coming up.

Hughes: Well, somebody told me that when the Academy did outgrow the Palmer House, there were really only two cities that could accommodate them—Las Vegas and Dallas.

Kos: That's correct. And lots of people didn't like Las Vegas. I remember when I was one of the secretaries. I think it was the first year we met in Las Vegas. We got basketfuls of letters condemning the Academy for choosing Las Vegas. Quite a tirade raised by the membership.

Hughes: What was their argument for not liking Las Vegas?

- Kos: The “den of iniquity.” That’s where all the sinful activity went on. People couldn’t be decent and go out there. [laughter] As it turned out, it was one of the best places the Academy ever met, and Las Vegas leaned over backwards by designing its facility to suit our needs. They built a special addition to accommodate our continuing education courses—so we could have meetings all in one place instead of scattered all over the hotel.
- Hughes: Now, I heard you had something to do with the design of that convention center.*
- Kos: I did have something to do with it, but not very much. Dr. [Howard] House had a lot to do with it.
- Hughes: Tell me what you did.*
- Kos: Well, first we wanted a complex that was adequate for the continuing education courses, so that people would not have to go from floor to floor, from one end of the building to the other, to get to their courses. Also, the Academy wanted to settle on one place from year to year, so that we could avoid the expense of moving equipment around. We wanted to find a place where we could store some of that equipment and not have to haul it around, and risk having it damaged. People don’t think about those things, but that was a very important consideration. We thought if we could find a place that the people would accept, and have it reasonably located—well, a lot of the Easterners said that Las Vegas was *not* reasonable, that it was too damn far. But we did get a big break financially. And also the accommodations were far better in Las Vegas than in Chicago.
- Hughes: Did they give you a break with the idea that the Academy would come back year after year?*
- Kos: Yes, that’s the reason they built the accommodations for our Home Study Courses.
- Hughes: But the Academy didn’t come back year after year.*
- Kos: That’s right, we didn’t. But you see, by that time, the Las Vegas convention center could use the addition as a selling point to other organizations.
- Hughes: Yet ophthalmology presently does move from year to year.*
- Kos: I know they do.
- Hughes: Does otolaryngology stay in one spot for its meetings?*

Kos: No. Otolaryngology moves, but it can go to smaller places than the ophthalmologists can—places such as Kansas City, for example. I've forgotten where they have had their recent meetings. I haven't been going to the Academy meetings since I retired.

Reflections

Hughes: How would you describe your administrative style?

Kos: Administrative style? [laughs] I guess I'd describe it as a policy of living as comfortably as possible and letting live as comfortably as possible.

Hughes: [laughs] And yet you obviously made decisions, because a lot happened while you were Executive Secretary-Treasurer.

Kos: Well, fortunately I don't recall all of the bitter experiences that I may have had. Actually, I really didn't have any bitter experiences. I'm very grateful to the kindness which ophthalmology has extended to me.

Hughes: How have they done that?

Kos: They've invited me to some of their meetings. Just recently I got an invitation. I've forgotten the nature of it, because I don't travel anymore.

Hughes: And you got an award from the ophthalmologists, I read.

Kos: Yes, I did.

Hughes: Mr. [David] Noonan gives you credit for revitalizing both divisions of the Academy before the split. Can you explain how you did that?⁴

Kos: Well, I think the mere fact that I supported the division of the two specialties was quite a boost for each of them. I have always had the feeling that ophthalmology, since the specialties have separated, is much better off than it was before. It's had opportunities to utilize the rewards of its high level of membership, and in reading the newspaper, *Argus*, I get the impression—well, it's fact, actually, not only an impression—that it is doing things that it was not able to do when the two were combined. I think that's great that ophthalmology has that freedom now, unencumbered by a group of people that have no interest in ophthalmology.

⁴ Interview with David Noonan, July 3, 1991.

Now, there are still some otolaryngologists who have an interest in ophthalmology, and there are still some ophthalmologists who have some interest in otolaryngology, but not very many of them.

Hughes: *How has otolaryngology benefited after the split? Or has it?*

Kos: Otolaryngology has benefited after the split by being forced into clarifying its purpose for living, so to speak.

Hughes: *You mean, not riding along after the ophthalmologists?*

Kos: Yes. In some respects, not all. Its educational program is good, top-notch. It always was.

Hughes: *So the otolaryngologists didn't need the ophthalmologists to keep them on their toes in continuing education.*

Kos: No, they didn't. The advantage to the otolaryngologist was the two-thirds of the Academy dues that the ophthalmologist paid.

Hughes: *You said, in 1969, and I quote: "[The Annual Meeting was] being suffocated by concurrent and in many instances nonessential activities. We cannot afford to disown them. We must find better methods of accommodating them."⁵ Did you find a better method for the groups that wanted to meet at the same time as the Annual Meeting?*

Kos: Well, that's still going on, I notice in some of the literature, the announcements of meetings, and so on. One of the things that is very difficult to follow is people pollution. The larger organizations become, the more people-polluted they are. We're witnessing that in the world now. We have more problems of all kinds—community problems, city problems, political problems—what are you going to do about it?

Hughes: *What are you going to do about it?*

Kos: Stop breeding!

Hughes: *How did people pollution affect the Academy?*

Kos: Well, we've just reviewed some of the ways. It couldn't meet every place it wanted to go. It was becoming more and more expensive. The dues had to be

⁵ *Pioneering Specialists*, p. 163.

raised; both academies had to raise them. The more people you have to cater to, the more money has to be raised. Inflation has a lot to do with it.

Hughes: Did you find any way of accommodating these satellite groups?

Kos: Well, I don't know whether we have or not. See, I've been away from the picture over ten years now, so I can't be sure what's going on.

Hughes: But nothing changed while you were in office.

Kos: No.

Hughes: The worry was that the satellite groups were going to take attention away from the Academy's business?

Kos: If they become more popular, yes, they would. One thing no organization can afford to do is become stagnant, in ideas or activity or any purpose for which it exists.

Hughes: Well, another thing that Mr. Noonan said was that he felt that you could have impeded the separation of the joint Academy by bringing up arcane legal aspects, which he said you refused to do. He even said that some of the otolaryngologists wanted you to do that.⁶

Kos: Yes, I know they did. I think there was probably a legal avenue which could have been taken, but I couldn't have taken it alone.

Hughes: Did you want to?

Kos: I didn't want to. Although it wasn't a particularly good favor for the otolaryngologists, I'm perfectly happy that ophthalmology had a chance to expand and ruffle up its feathers, to do what it wanted to do. And it is doing that. I read that the Academy has doubled its membership.

Hughes: Well, I know the Annual Meeting last year had something like 22,000 attendees. Now, I don't think all those were ophthalmologists.

Kos: Probably the ancillary groups around ophthalmology, the optometrists, and some of those people. But you see, that's the way it should be. Otolaryngology has failed to include the audiologists, for example; they're crazy for not having done that, because audiology has its own organization, and will remain separate. There

⁶ Interview with David Noonan, July 3, 1991.

have been attempts to combine some of these meetings by attracting one another. I don't know what success is being had. I'm not up to date on a lot of the political things that are going on in any field now.

Subcommittee on Noise

Hughes: Well, we mentioned in passing that you were a member of the Academic Subcommittee on Noise. Do you remember what you did on that committee?

Kos: Well, let's see. I remember stirring up some publicity about noise, which was primarily instigated by my interest in the defects of hearing. I have a sensory neural hearing loss myself due to exposure to noise. Nanette Fabray also has been interested in trying to convince the TV people to cut out the background noise when people are speaking on TV. The listener who has a sensory neural hearing loss can't filter out that background noise.

Hughes: Does she have a sensory neural hearing loss?

Kos: She has a hearing loss. Dr. House operated on her. She had a different type of hearing loss than I have. Mine was due to exposure to noise. But the same effect occurs in a little different way. When you're listening to something and there's noise in the background or music in the background, it's impossible to hear the words. Also they flash their scenes on and off so fast that by the time you think you've heard what you've heard, the scene is gone and you don't have a chance to coordinate them. If I were an advertiser, I wouldn't advertise one cent on TV.

Hughes: Was that one of the concerns of this [Sub]committee on Noise?

Kos: It wasn't especially a concern then. I think the main concern was to get information about the effect of extraneous noise on hearing. I don't know how far that's ever been carried.

Hughes: Did the committee itself do that research, or did it delegate it?

Kos: I don't remember that.

Executive Secretary-Treasurer (continued)

Hughes: Well, on a different subject, why didn't you have the Academy move to Iowa City when you became Executive Secretary-Treasurer?

Kos: Because it was not my intention to occupy that position very long. I would have had to upset my system here in Iowa City; I would have had to find a building to put [the Academy headquarters] in, and I had no intention of keeping the job longer than until somebody could be selected that would accept it for a substantial period of time.

Hughes: Well, it turned out that you remained Executive Secretary-Treasurer or the counterpart thereof—the title has changed—from 1969 to 1980. Was that longer than you expected initially?

Kos: Yes.

Hughes: Why did you stay on?

Kos: The thought of separation was smoldering. I thought that's what would eventually solve the Academy's problems. But there wasn't any move to change. There wasn't any move to separate at that time. So I didn't know how much longer it was going to be. I was about ready to offer my resignation when things did begin to move and change. I could see then that by staying on, I could help both specialties if they wanted it. Apparently, ophthalmology wanted or needed more help than otolaryngology did.

Hughes: The Academy historically had not been an overtly political organization. I know Dr. Benedict, and I believe Dr. Wherry, had a similar line. They believed that education was the main task of the Academy.

Kos: That's correct; it was. But it's pretty hard to eliminate politics from any organizational endeavor.

Hughes: Are you saying that the Academy in fact had more political clout than was ever admitted?

Kos: Oh, no question about it. It did have.

Hughes: When you were in office, did you try to affect legislation at the federal level?

Kos: No. I think everybody agreed not to try to get into that.

Hughes: Were there areas where the Academy began to move when you were in office, where it hadn't operated before?

Kos: No, I don't recall anything like that. I don't recall any move to get involved in political matters. There might have been some move to get involved locally, but it wouldn't have been very effective.

Hughes: There was a Secretary for Public Relations. What did that office encompass?

Kos: Well, the idea was to try to govern propaganda that was being promulgated by the Academy, to avoid any exaggerations or misrepresentations by the press.

Hughes: How did it go about controlling the press?

Kos: Well, the press always had representatives at the meetings. I remember there was one article that a small group of members just raised hell about. The press misquoted a statement on a problem of surgery, and misquoted it badly. So the idea was to have an organization that would review that material before it was released to the press, and that the press people were not allowed to use that material unless it was censored.

Hughes: The press didn't have access to the meeting itself, did it?

Kos: No.

Hughes: So what it had access to was releases put out by the Academy.

Kos: Well, that's the way it should have been.

Hughes: Dr. [Stanley] Truhlsen has described, and I quote him, "an old boys' club at the top of the AAOO hierarchy, which passed secretariats and officer posts around to each other."⁷

Kos: I've not been aware of that. When I was involved I was surprised by the diversity of selection of personnel for offices. I've wondered about it on occasion, how could they be so diverse and not get involved in the old boys' club business? If that problem existed, I didn't know about it.

Hughes: Well, it may have been before your time, too.

⁷ Stanley M. Truhlsen. "The History of the Ophthalmology Secretariats of the American Academy of Ophthalmology." (Undated transcript, p. 11.)

Kos: Could be. Dr. Truhlsen is a very observant person.

Separation (continued)

Hughes: Is there any more you want to say about separation?

Kos: Well, I don't think I can offer anything constructive or destructive either way about separation. I think it was for the good of both specialties. Better, I think, for ophthalmology than otolaryngology, because otolaryngology is split up a number of ways anyway.

Hughes: One of the steps, as I understand it, towards the Academy becoming two organizations was its incorporation in 1978. Do you remember the issues around incorporation?

Kos: No, I don't remember that as a topic of discussion.

Hughes: The Academy actually became a corporation in 1978. Incorporation was looked upon as leading to a possible split. Do you remember anything about that?

Kos: No, I don't remember the reason for it. There must have been some legal reason for it, which apparently wasn't objected to or wasn't turned down.

Hughes: But you don't remember too much controversy over incorporation?

Kos: No, I don't. I think the Academy has behaved quite well. I wasn't in it long enough to become deeply involved in the internal political aspect of it. I knew, of course, there were certain people that had persuasive ways. Benedict was one of them, and Lierle was another, and some of the older people—Blodi was one—that had the ear of anyone he wanted to talk to. And as far as the officers were concerned, he certainly had mine. I regarded Blodi very highly, and I trusted him, and I have no reason to ever regret that. Same way with many of the other ophthalmologists. The fact that there were opposite specialists never entered my conception.

So I'm happy that ophthalmology has done as well as it has, and I'm also happy that my dear friend Dave Noonan is working with ophthalmology. I think if he had stayed with otolaryngology, he would be a very unhappy guy today, and he might not still be a part of otolaryngology.

Hughes: Why do you think he would be unhappy?

Kos: Because I don't think they would keep him. I can't tell you why except that I think the people in ophthalmology were more impressed with what he did, as I was impressed with what he did.

Hughes: Was it ever a consideration that he stay with otolaryngology?

Kos: Yes, it was.

Ethics

Hughes: Did the Academy have control over the ethics of individual members?

Kos: I don't think the Academy exerted itself very much on that score. The Academy shied away from getting involved in ethical problems of the membership, because that invited too much penetration by the legal system.

Hughes: Were you ever aware of somebody applying for membership in the Academy and being turned down because he wasn't thought to be ethical?

Kos: If he was, it was for a substantially good reason, like insufficient training or failure to find anybody to recommend him.

Hughes: Recommendation was necessary for membership?

Kos: You had to be recommended.

Hughes: By how many people?

Kos: At least two.

Hughes: What other credentials did you have to have?

Kos: Well, for full membership, you had to be a certified otolaryngologist or ophthalmologist.

Hughes: You mean having passed your boards?

Kos: Yes, certified. One person who was already a member of the Academy they couldn't get rid of because of his ethical shenanigans. He was even sent to prison.

Hughes: Why?

Kos: Oh, I've forgotten now what it was for, but he had done something crooked.

Communication with the Membership

Hughes: How good was the Academy at keeping in touch with the rank-and-file member?

Kos: How does any organization keep in touch with the rank-and-file members except by its bulletin that's put out regularly, its communications concerning the process of operating the Academy? I guess the only other avenue would be by personal communications.

Hughes: Did you get the impression when you were in office that the people in power in the Academy were trying to find out what the membership thought?

Kos: I don't think I was conscious of that. There may have been some individual effort. I know that from time to time we got criticisms from members individually, but there was no evidence of general agreement as to what to do.

Hughes: So were they more or less ignored?

Kos: Well, most of them were personal gripes. Some of them, if they were frequent enough, were announced to the Academy directors, or referred to some appropriate committee.

Hughes: How important has the Academy been in your professional life?

Kos: Oh, I'm trying to look at it from the standpoint of, could I have gotten along without it? I think I could have. A person enjoys joining groups of people. It's not necessary, but very nice to have that contact and those acquaintances. And also there's a certain amount of pride involved—what's the other guy doing? If you have pride in belonging to the organizations that many of your friends belong to, it's kind of a slap in the face if you're turned down, or if you're not asked.

Hughes: Your association with the Academy was far more intense than most people's is and was.

Kos: Yes, far more. Subconsciously I have imagined that if I were in lone practice, and not a member of the Academy, I would feel left out of the mainstream.

Hughes: Do you mean socially or medically?

Kos: Well, socially more than medically. If you weren't acceptable medically, you might not be accepted socially. You could be accepted medically without being accepted socially. That happens a lot, I'm sure. I think it depends on whether you want to be a member of the group, a member of the crowd, and doing what the next guy's doing, the majority is doing.

I can't practice today, because I don't have a license anymore. I'm retired. There's no point in maintaining it, and I didn't want to keep spending money on continuing education. And besides that, I wanted to do lots of things that I've been putting off all these years. And I've enjoyed doing it. I've enjoyed my family a great deal more.

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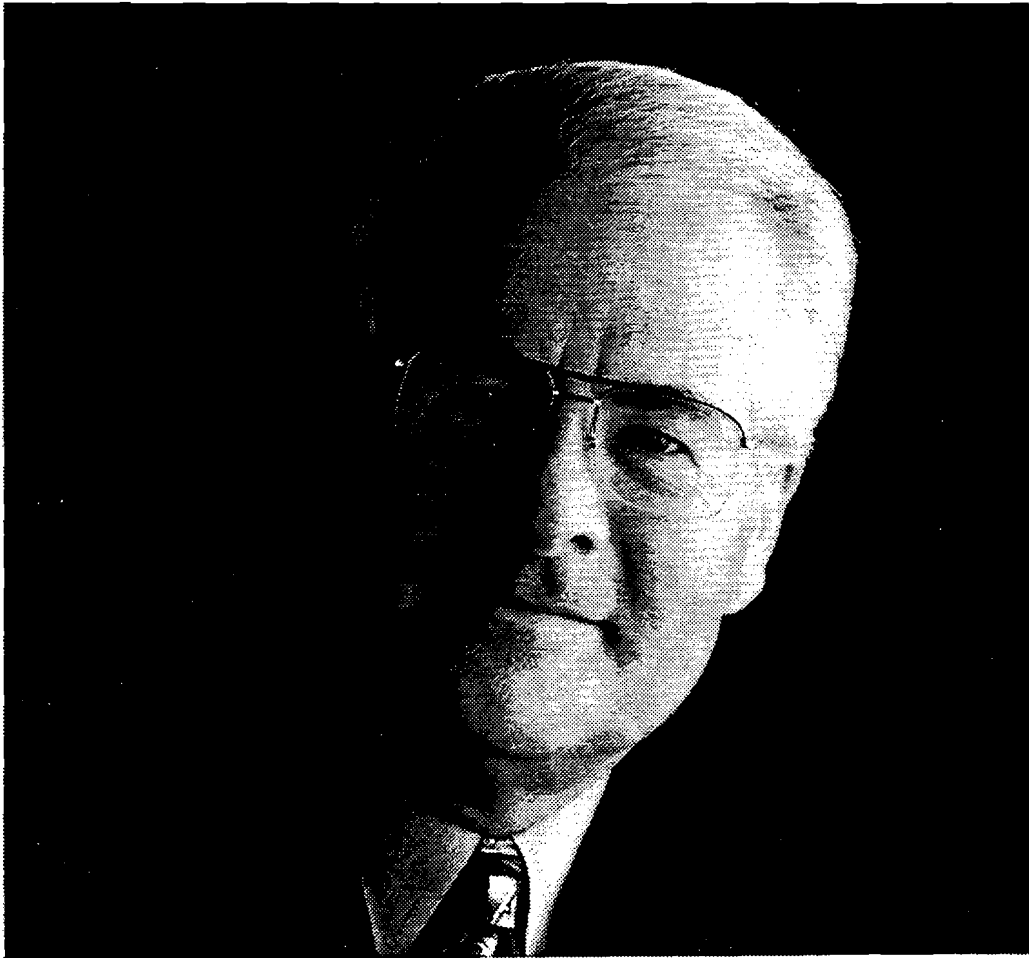
**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

David J. Noonan

Conducted by
Sally Smith Hughes, Ph.D.
July 22, 1991, American Academy of Ophthalmology,
San Francisco, California

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David J. Noonan

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DAVID J. NOONAN

[Date of Interview: July 22, 1991, American
Academy of Ophthalmology, San Francisco]

The Academy at Noonan's Arrival in 1972

Noonan: My first contact with the Academy was a meeting of the Committee of Secretaries in April of 1972. Dr. [Clair M.] Kos brought to that meeting the first agenda that group had ever seen. From experience later on, I learned that it was a habit of Dr. [William] Benedict to come into a board meeting with a single sheet of paper placed in front of himself. He conducted the board meeting, [with] no one else having even a copy of the agenda or any reference materials.

Now, that may be one of those stories that got caught up into the history of the Academy from some of the old-time leaders. I have never been able to document that with anyone. Except that at the first Committee of Secretaries meeting that I attended in '72, there was a lot of comment made about the massive improvement Dr. Kos had brought to the organization by allowing people to have an agenda and background support material, like copies of correspondence. That first agenda, as I recall, was very thin—thirty, forty pages.

Comments were made about how supportive Mike was being in getting people involved in the organizational change. So Mike began with that standpoint.

Hughes: Do you think he came to the position of Executive Secretary-Treasurer with that in mind?

Noonan: Well, my recollection is that Mike came to the organization in 1969, a time when Dr. Benedict was not well. Mike attended a couple of meetings, and then Dr. Benedict got progressively worse, and they asked Mike to take on the job. Then Mike took over. As I recall (this happened prior to my coming on board by a couple of years), Mike wanted to expand the educational programs of the Academy.

There were several people who later became very important to both academies, but principally Dr. [Bradley R.] Straatsma, who was the new Secretary for Public Relations at the time. He was a very progressive, very aggressive—in the proper sense—promoter of a new education program for ophthalmology. This spawned a

similar response in otolaryngology, and both specialties began to revitalize their educational program.

Mike set out to really change the educational program, to make sure that happened. It was under his leadership that the Board finally gave some money to the two specialties to develop an educational program. It was the first time they had put seed money aside to develop an educational program, and out of that came the complete revitalization of what became known as the Basic and Clinical Science Course in specialties.

Hughes: Which was built on the Home Study Courses?

Noonan: It was built on the tradition of the Home Study Courses.

Hughes: But with quite a different format?

Noonan: It was an entirely different format.

Clair Michael Kos, M.D.,
Executive Secretary-Treasurer, 1968–1978

Hughes: Why was Dr. Kos appointed in the first place?

Noonan: Dr. Benedict's illness.

Hughes: But it could have been others; why Kos?

Noonan: I don't know, because I was not a party to the process; it was prior to my coming to the Academy. I suspect Mike was picked for two or three reasons. Otolaryngology as a specialty was very much on the ascent, and he was one of the leading otologists. And in '69, when he took on the job, he was considered a major shaker in the otology field.

Mike was willing to commit himself to traveling back and forth to Rochester. The first couple of years that Mike took that job, '69 to '72, he would leave the office in Iowa City on Wednesday nights, go to Rochester, and in Rochester he would find three stacks of mail on his desk. There was absolute must-handle mail, the mail that needed to be looked at, and the mail that you could just peruse at your leisure. His secretary at the time, a woman by the name of Ruth Enquist, would sort out the mail for him.

Mike would start on Wednesday night, and he would work through Saturday morning. He would go back to Iowa City on Saturday morning and begin to see his Monday pre-op[eration] patients on Sunday afternoon and evening. He was willing to commit that kind of time. So I suspect that some of the reasons that Mike was selected were because he was widely recognized in otology and because he was willing to make that kind of commitment.

Hughes: As far as I know, that was the first time the chief officer of the Academy and the Academy headquarters were in two different locations. Did that cause any problem? What happened to the Academy between Sunday afternoon and Wednesday evening, when Kos was in Iowa City?

Noonan: The telephone was widely used. In later years, before the fax as we know it today became an important part of business, we had one of the first Xerox copy machines tied to a telephone, a Xerox 720. We eventually had three or four of those machines that traveled with the President and the President-Elect. We had one in the Academy office, and Mike had one in his office. In '72 to '75, you weren't even talking about Federal Express or any of those kinds of quick mail systems. You got Mike on the phone, and you told him what was going on. He was always accessible by phone.

Hughes: So location wasn't a problem?

Noonan: It certainly wasn't an operational problem.

Hughes: It must have been a problem to Kos!

Noonan: Well, it was a problem with his family. It was a problem with scheduling, because he always had to be available, and he was never far from a phone. He had a boat on the Mississippi that we all had the radio call signs for. There were times when Mike would be on the boat, and you'd call him by radio. I still have in my Rolodex the code number for his radio. You'd call for Cruiser WZM5291, and you'd get Mike on the phone.

Hughes: So the poor guy was never off the hook, was he?

Noonan: He was never away.

Hughes: Did he thrive on this kind of schedule?

Noonan: A highly energetic man. He liked it; he liked having the diversity. Yes, I think he thrived on it, very much so.

Hughes: *Why didn't he move to Rochester?*

Noonan: He had a very successful practice in Iowa City, and his wife and family were there. They had a lovely home. He had come from the University of Iowa faculty. He was on the staff of Mercy Hospital in Iowa City, which is where I first met him. He and Dorothy were well established in Iowa City.

The houseboat was anchored during the summer months at Lake Peppin in Minnesota, which was about forty-five minutes from the Rochester office. So during the summertime Mike would live on the boat. He and Dorothy would have the boat on this mid-channel lake in the Mississippi. Mike would live on the boat, commute back and forth, and fly down to Iowa City and manage the practice.

Career Prior to the Academy

Hughes: *You were appointed assistant to the Executive Secretary-Treasurer in 1972. How did you come to have that position?*

Noonan: I was the assistant administrator of Mercy Hospital in Iowa City, Iowa. In 1969, after having completed a fund drive and a construction project for that hospital, I decided that if I were ever going to be able to affect the way American medicine was delivered, I had to get at the basic root of the principal component of that system, the education of the physician.

At the same time, the federal government had come out with a program that was called the Regional Medical Program, which was a system envisioned by Dr. [Michael] DeBakey and others to bring to the bedside of the patient, as quickly as possible, the latest scientific information in cancer, heart, and stroke. President Johnson supported the Regional Medical Program. The idea was, you took from the medical center into the local community the very latest known about cancer, heart, and stroke.

Hughes: *Through seminars?*

Noonan: Through teaching programs, through establishment of facilities. For example, the Regional Medical Program for the Intermountain West, which was a five-state consortium, built thirty-five coronary care units in community hospitals. They built stroke units in regional hospitals. They tried through teaching to bring the very latest concepts to the local practitioner. That included cardiologists, family practitioners, pediatricians, and every other type of specialist.

When I made that decision in 1969, Dr. Kos, who had been on the staff of the hospital and whom I knew, walked into my office and slammed the door. He said, "Noonan, you dumb &@%%\$! Why didn't you tell me you were looking for another job?" And I said, "Well, I really wasn't looking for another job; I decided this was something I'd rather do."

He said, "Well, I've just taken this job at the American Academy of Ophthalmology and Otolaryngology, and if I had somebody up there who was running that office for me, then I wouldn't have to worry about it, and I wouldn't have to commute back and forth so much."

I said, "Well, Mike, I've already taken this job; I'm committed to it." So then I went out to Salt Lake City for two years with the Regional Medical Program, and I joined the faculty of the Department of Community and Family Medicine at the University of Utah. One of the persons we tried to recruit for the Department of Family Medicine at Utah eventually took the job at Iowa. He asked me to come back to Iowa for the Iowa Regional Medical Program, which was a single-state program, to help him establish the family practice department.

I returned to Iowa, and I was miserable for almost a year and a half. I was working with a group of people who were just outliers. There wasn't a meeting that I could come away from [where] I wasn't just shaking my head, because I didn't understand their motivation; I didn't understand the kind of people they were. What I did to turn that group off, I have no idea, but I turned them off. I just didn't fit.

Appointment as Assistant to Dr. Kos, 1972

Noonan: My wife was walking down the street, and she ran into Dr. Kos. Mike said to her, "Hey, how are you?" And she said, "Fine." He said, "What are you doing in town—vacation?" She said, "No, we've been back here for a year and a half." He said, "Well, you tell David that if he's interested in that job, I've still got it for him up at Rochester."

Well, it took me about one nanosecond to get on the phone to Mike. Because I was miserable! I had never felt in my life as much a round peg in a square hole as I did in that job. In February of '72, Mike brought me up to Rochester and showed me the job.

Hughes: *Now, what did he see in you?*

Noonan: I don't know what he saw in me. I was the assistant administrator in Mercy Hospital; Mike served there as an otologist and was often asked to serve in the emergency room. He didn't feel comfortable or competent with dealing in general emergencies and things of that nature. And there was always a conflict on the staff as to who would "take the duty," any one week. Even if an individual physician hadn't seen an emergency case in twenty years, the rules were that if you were going to be on the staff, you had to serve in the emergency room. In those days you didn't have emergency room specialists per se; there was no board certification in emergency medicine at that time. It was always tough for these specialists, like the pathologists, etc., to do emergency medicine.

So I negotiated with the Board to find relief for these specialists, really for the benefit of the patients, because some of the specialists were the wrong people to be doing emergency medicine. That worked out very well. So I think Mike saw me working to good end, and maybe that had some appeal. I have no idea. Mike had been very active, along with [Dr.] Bruce Spivey, with the Comprehensive Health Planning Act, which from 1960 to 1969 was a parallel act to the Regional Medical Program. The Comprehensive Health Care Systems was an idea to bring hospitals together in some sort of centralized plan. That's where I first met Bruce, as a matter of fact.

Hughes: You said you decided in 1969 that you wanted to affect medicine. Now, do you mean in the ways that you described, making breakthroughs immediately transmissible?

Noonan: As a hospital administrator, I found that I got swamped with the business of medicine, hospital business. I got swamped with the percentages of occupancy, with making sure that the hospital ran properly. The appeal to me originally was to try and do something so that the patients got better care, and it quickly became obvious to me that the only way you did that was to get at the base root of the heart of the system, which was the physician. If you could affect the physician through education, then you eventually had a much greater impact.

Hughes: I can see how the job in Rochester would have appealed to you, particularly with a man like Kos, who put education at the forefront.

Noonan: First, yes. In both university positions I have had a faculty appointment as an instructor—which is the lowest you can get, mind you. I was on the staff in both medical schools, which was fine.

Hughes: Why did you accept a position at the Academy once it separated from otolaryngology?

Noonan: This is not a bad place to live. I had no problem in moving to San Francisco. I perceived that ophthalmology at that time was very progressive and was moving very rapidly.

Hughes: Did you have an offer from otolaryngology?

Noonan: Yes, and an offer from ophthalmology. I made my decision based on a conversation at Brennan's Restaurant in Dallas, Texas. At the time of the division there was a Dallas meeting. I had been interviewed by both ophthalmology and otolaryngology. I sat down for breakfast with Bruce [Spivey] and Mike [Kos] in Brennan's Restaurant, of the Brennan family chain in New Orleans. It was an elegant place.

There were two gentlemen sitting behind us, and in the course of their conversation, about every fourth word was an expletive of some sort. It was an embarrassment to all of us in the restaurant, particularly to the women patrons. Bruce took it only so long. Then he approached the gentlemen and suggested they amend their behavior, or he would be forced to act. They did amend their behavior, and I made my decision to join his decisive leadership.

Education for the Position

Hughes: Describe for me how you and Dr. Kos worked. Who did what?

Noonan: First of all, it was a long learning process for me to understand the issues in medicine, the issues in specialties, the issues of ophthalmology versus otolaryngology.

Hughes: How did you educate yourself?

Noonan: Mike was a good tutor. He would sit down, and we'd go through all of that mail, which was now on my desk, not on his desk. I had to formulate the answers so that when he arrived on Wednesday night, all of that was available for him. It was all done, and he signed off on it or made changes. So that served as a very good learning position for me, and he taught me a great deal about specialty interests in medicine and specialty interests in ophthalmology and otolaryngology.

Hughes: Nobody had had that position prior to you?

Noonan: There was a woman who was the office business manager, Gladys Thompson, now deceased. She worked for the American Academy of Ophthalmology and Otolaryngology for twenty-four years, a wonderful woman. She didn't have experience with office systems or personnel administration or operational policies. She was the secretary to Dr. Benedict for years and had just kind of grown up in the job. Just a straight shooter with a tremendous resource of knowledge; she had a memory that was encyclopedic.

Hughes: Was she an initiator?

Noonan: No, not really. She didn't have that responsibility. She was a very good implementor.

Hughes: So Benedict made the decisions, and she helped carry them out?

Noonan: Yes.

More on Dr. Kos

Noonan: When I came on, Mike was the initiator, and Mike was the final decision maker and final arbiter. As time went on, he turned operational activities over to me more and more. But he was still very active in the policy decisions affecting the whole Academy and in all the Board interactions and those kinds of things. We would work parallel to each other often. We would take on various sides of a task and work together. Very collegial guy, good teacher, very patient.

He had a good sense of fun. He had a ukelele in the office. He'd be wrestling with a problem, and he'd pick up the ukelele and strum it. Or he would tinker around with model trains and things like that. He made work fun.

Hughes: How had he gotten these administrative skills? As far as I know, he hadn't had a prior administrative position.¹

Noonan: And no classical training. Of course, you must recognize that he ran a very successful office practice with two partners. So he was not ignorant of the dynamics that it takes to run an organization.

Hughes: Did he grow on the job?

¹ See the oral history in this volume with Dr. Kos.

Noonan: Oh, I'm sure he would agree that he did. Challenges came along the way.

Separation into Two Academies, 1979

Hughes: He made what I thought was an interesting comment on the phone when we were setting up the interview: If he had foreseen that the separation into two academies would come during his tenure, he wouldn't have taken the position.

Noonan: Yes, that's true. And yet at the time of the divorce of the two organizations, there were people in otolaryngology who wanted Mike to use every legal tactic he could to stonewall and delay the actual separation, once the separation was decided on. No one knows how easy it would have been for Mike to say, "Yes, I'll do that." There were two or three legalities which he could have used. The Academy was an unincorporated association in the State of Minnesota; if people wanted to leave that association, the assets of the association stayed with those who wanted to stay. Now, at the time of the split of the organization, someone might well have made a legal claim in the courts of Minnesota that those people who wanted to split the Academy would in essence abandon their rights and their assets. There were those people who urged Mike to adopt that tactic, and he just wouldn't play that way. He said, "Look, we've got a referendum of our members; our members want this separation, and my job is going to be to expedite that separation as much as possible."

He could have retarded that, quite legally and quite within his rights as the Secretary-Treasurer, and he just wouldn't play ball that way.

Hughes: I think there had been several junctures where separation had been brought up, but if my understanding is correct, the first really serious move was in 1962, when the Triological Society [American Laryngological, Rhinological, and Otological Society] moved to propose separation.²

Noonan: Yes, a group of otolaryngologists suggested that separation would benefit otology. But the effect was supported by only a few members and failed to gain any support within the Board of Councillors (the name of the Board of Trustees at that time).

² Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982, p. 231.

Hughes: *[Dr. J. Vernal] Cassady was an otolaryngologist. Were you at the Academy meeting in 1973 when Drs. Cassady and [J. Lawton] Smith filed motions to divide the Academy?*

Noonan: Yes.

Hughes: *What was the reaction?*

Noonan: The motion was made in 1973 in Dallas, Texas, as I recall. There was a lot of strong, strong emotion.

Hughes: *Cassady apparently was the first to stand up, and he wanted a survey of the membership. Smith upped the ante by asking for a mail ballot, which I guess took it out of the hands of the Board.³ Is that the significance there?*

Noonan: It was the Cassady-Smith motion that got the issue on the agenda and before the membership, and there was a poll of the membership. That began the separation.

Hughes: *The ballot results were overwhelmingly for the split?*

Noonan: Sixty percent in favor of the split, forty percent against. The only reason that I remember the sixty-forty is that it happened also to be the population base, ophthalmologists to otolaryngologists. Now, certainly there were lots of otolaryngologists who voted for the split. I'm not suggesting the vote was along specialty lines entirely.

Hughes: *My unfounded suspicion is that the people in power in the Academy were less in favor of separation than the rank membership. Is that true?*

Noonan: Not true. There were active supporters of the split on the Board from both specialties.

Hughes: *One of the reasons that some of the otolaryngologists were more hesitant to separate into two academies was that they had a monetary advantage.*

Noonan: Some otolaryngologists feared that in a separated configuration they would be deprived of the revenue of a 60/40 split in Annual Meeting revenues. This proved to be unfounded.

³ *Pioneering Specialists*, p. 238.

Bruce Spivey, M.D., Executive Vice President, 1978–1992

Hughes: *Why was Dr. Spivey chosen as Executive Vice President? Did he have any competitors?*

Noonan: There were others who expressed some interest. I don't think there was ever anybody else seriously considered. Bruce, in addition to being a physician, has a master's degree in education. The Academy is the only job he ever really wanted, and he has said so.⁴ He campaigned for the job; he wanted it. He has a winner personality, and he's capable of bringing lots of people to bear on an issue. He does it very well. He was very up front with people, and they knew that he was interested in the position.

Hughes: *Could you say something about his administrative style?*

Noonan: A very participative, consensus style, [as] opposed to leadership cult style. He is uncomfortable with honors; he is uncomfortable with recognition, genuinely embarrassed by it.

The Academy's Early Years in San Francisco

Noonan: We moved the office to San Francisco on May 15, 1979. We moved 198,000 pounds of materials from the Rochester office by truck and put them down in a warehouse at 10th and Howard until the new building could be ready at 1833 Fillmore. Bruce had an office in the Presbyterian Medical Center Annex, which is not much bigger than twice the size of this room, or about 22 x 18. We put fifteen people in there in the first couple of months until the top floor of the building on Fillmore would be finished. Then we moved everybody to the top floor as the remainder of the building was completely remodeled underneath us. It was a mess to go to work—saws, hammers, all that kind of stuff going on.

Hughes: *You had a staffing problem, too. Only four people from the Rochester staff moved to San Francisco.*

Noonan: Yes, one of the transferees did find a job out here, way down in the South Bay beyond San Jose, but agreed that she would come on for nine months. The idea was that she was definitely going to leave after that time. The other two were

⁴ See the oral history in this volume with Dr. Spivey.

intending to stay full time. One of them did not stay—just sociologically couldn't make the change to California. A Midwest woman, she got out here with the people with the spiked haircuts and nose rings, and I think she decided Rochester suited her style better. [laughter]

The fourth person, who was our Director of Meetings, was here for about a year, and she didn't fit with the newer type of leadership style that Bruce brought to the organization.

Hughes: How many people were at the Fillmore Street address?

Noonan: Twenty-seven people originally, and before we moved to our current address we were close to seventy-five people in that same building.

Hughes: What were the costs to move to San Francisco?

Noonan: Moving from Rochester to San Francisco was not the real expense; hardware or relocation costs for people are easy to budget. The real expense was the two and a half years of training to instill the corporate ethic, the work ethic, the knowledge base in enough staff that you could rely on them to carry on from year to year. That was the real expense, and that was the gastric mucosa slough; every night at five o'clock you had to put a new lining in your stomach, because it was very, very difficult to translate and transfer to a new group some thirty-five years of Academy culture.

Hughes: Did you do that by example?

Noonan: [laughs] No, by trial and error. We began the formulation of what became our management group. We got together with department directors. Initially we hired people who were content-skilled, not management experts. That we had to develop. We had meetings of this management group where people would be in tears. It was very, very difficult—the clash of wills between the four Rochester people and the new San Francisco people. Bruce's image of what he wanted the Academy to be when it finally grew up—that dynamic was going on. We knew we had to publish a journal, we knew we had to produce an Annual Meeting, we knew we had some educational programs; but then we had to begin to grow. Bruce began some very creative team building, and it worked out very, very well.

Hughes: What was his image, if it hadn't changed that much, of what the Academy should be?

Noonan: Up until the reorganization, I don't think it changed very much. Bruce's image of what the Academy was to be was primarily as an educational institution which

supported the continuing education of ophthalmologists in the United States and worldwide. It was to be seen as a place where you could get the very best education. Bruce was definitely committed to that.

He was also committed to the need to keep ophthalmologists current in their field as it related to how to practice sufficiently and how to understand what was going on in Washington as it affected people's practice. He was very committed to leading ophthalmologists, educating ophthalmologists, being an advocate for them, and making sure that they provided the very best care.

The Academy's Changing Political Role

Hughes: What about the political role that the Academy has increasingly taken on?

Noonan: It's growing. We continue to look at the organization as to the best way to do that. I think it's a fairly well-known truism in association management that you can throw a lot of money at Washington or at the state capital—Sacramento or wherever you want to send it—but it's really not going to pay off. You have to be very, very precise in your approach.

There are Academy members who think that everything could be solved with the Academy providing more money. That adds a certain dynamic to the organization, because there will be people who say, "Well, if that's the case, then you ought to raise dues, and Academy people ought to spend a lot more if you want that to be the mission of the Academy." Others will say, "No, we ought to use more of the income we have for the Academy's educational program."

Hughes: As you well know, in the good old days, the Academy at least ostensibly eschewed any political role.

Noonan: When I first joined the staff, I had a directive from Dr. Kos: "Anything political or socioeconomic, you send right to the American Association of Ophthalmology or to the Council of Otolaryngology." The Academy was purely educational. That was our mission. "Send the political, socioeconomic things to those guys. We don't want anything to do with those issues."

I can tell you that any piece of mail that crossed my desk that had anything to do with politics or socioeconomic issues got sent right out of Rochester.

Hughes: What changed?

Noonan: In ophthalmology I think two things changed. Lots of things began to affect the way funding was made available for education. There began to be some real concerns about dollars that were available for education, either at the level of the university or at the continuing education level or funding or payments for services for ophthalmologists through Medicare or Medicaid. And a lot of those kinds of things began to affect the average ophthalmologist.

We needed to be much more knowledgeable about what was going on in Washington, so we established a little two-person office in there to be a listening post. And while the successes were not great, it was *perceived* that the successes of the Academy's office were equal to the successes of the much bigger office of the Association. The members began to say, "Well, wait a minute. We've got the Academy there now with an office, the Association is there with an office. Why am I paying dues to both? Shouldn't we put our minds together?" That began the drive for the Association and the Academy to merge.

Hughes: You're referring to the Office of Governmental Relations, which was founded in 1977?

Noonan: Yes.

Hughes: Who was there?

Noonan: A secretary and a director.

Hughes: Were they considered lobbyists?

Noonan: Not in that sense. They were considered information gatherers. They really didn't do direct lobbying.

Hughes: But the Association at that time was?

Noonan: Oh, yes.

Hughes: Then in 1980 the first Secretary for Governmental Relations was appointed, [Dr.] Robert Reinecke. What did he symbolize?

Noonan: It symbolized that the Academy was making a major committee appointment and a major economic commitment to a federal economic affairs office and that we were really going to get serious about these issues. We had had this little listening-post office with some direction from Bruce and some of the other ophthalmologists, but there was not a committed program. Dr. Reinecke had

been a White House or Kennedy Fellow. He knew how a bill got passed into law, and there were not a lot of ophthalmologists who knew how that happened.

So Bob Reinecke was retained as the Secretary for Governmental Relations, and he began to design and organize a program of how we would begin to interface with Washington. We tried to do lots of things in parallel with the Association, but it became increasingly obvious that a merger of those two organizations would be appropriate.

Hughes: And at that point were the lobbyists and staff hired?

Noonan: Yes.

Hughes: And it became a much more direct effort to influence legislation?

Noonan: Yes.

Hughes: Was there any one event on the political front that prompted the formation of a really concerted effort?

Noonan: There was the growing encroachment by optometrists into the field of ophthalmology by legislative fiat rather than by educational achievement. That is still the major bone of contention between ophthalmologists and optometrists. I don't think many ophthalmologists would have problems with working with an optometrist on a daily basis within the scope of their training and license. It's when they try to do more than they're trained for that it really irks ophthalmologists.

Politicians make this a pocketbook issue, and it's not a pocketbook issue. The optometrists say that patients are not getting the care they deserve, or they're paying an awful lot for it. That bothers me. I have in twenty years' time heard maybe a minute for every year a discussion at Board meetings about the economic achievement of optometry. But I have heard hours and hours and hours of the concern about what's happening to the patient, because they're getting less than a fully trained practitioner. That really bothers me. It's a gut issue of who delivers quality care.

Hughes: Would you say that's the main political concern of the Academy?

Noonan: The relationship with optometry is a major concern. Ophthalmologists want the very best for the patient, and they see themselves as providing the best.

Hughes: *In 1984, a Secretariat for Public and Professional Information was created. I'm not too clear what that actually is.*

Noonan: We began to recognize the fact that the Academy needed to speak to a whole other population base beyond the members. Therefore we needed to inform people about a whole range of public issues: the danger of bottle rockets and fireworks, that BB guns are not toys, the difference between an ophthalmologist and an optometrist—that their ophthalmologist was a physician. So the Secretariat was created to deal with the public interface of ophthalmologists and the Academy.

The American Association of Ophthalmology

Hughes: *Why did the Academy and the Association merge?*

Noonan: The Academy's move into Washington was seen as a major move by the Academy, and the average member said, "If I really value the Academy and what the Academy has done, why don't I stick with the Academy? Why am I paying dues to the Association?" The major benefits of the merger with the Association were [in] bringing all of the forces of organized ophthalmology together, [in] not having separate groups. Each side has helped the other. Knowledge about what's going on in Washington has helped the Academy, and the Academy has certainly brought to bear a lot of brain power on what's going on in Washington. So that merger was very beneficial.

A key benefit to the Academy was that we acquired the services of Larry Zupan for a few years and Mary McCambridge's to this day.

Hughes: *There was a problem of what to do with Association members who were not board certified.*

Noonan: We were originally a fellowship organization that required a member to be board certified. As a board-certified member of the organization, you became a fellow. So we had to create another class of membership that was just called member. To this day, your badge at the Annual Meeting depicts whether you are board certified or not by virtue of your fellow status or membership status.

Hughes: *Was there any resistance to including in the Academy ophthalmologists without their boards?*

Noonan: Yes. People said we shouldn't let these noncertified ophthalmologists join because they represented less quality. Then there was the realization that they represented a certain era, and that in the modern era you couldn't practice ophthalmology appropriately without being board certified. You could, but it would be very difficult.

**The Foundation of the American Academy of Ophthalmology:
The Museum**

Hughes: Another important part of the Academy is the Foundation of the American Academy of Ophthalmology. Can you tell me whose idea it was to have a foundation and how it was founded?

Noonan: I'm unsure whose idea it was. I know that Drs. Spivey, Blodi, Shoch, and I discussed that it would be a good idea if the Academy in its new location in San Francisco began to collect some artifacts. Thus the idea for a museum began. That clearly was something that would have to be supported with philanthropic dollars; the Academy's dues couldn't be used to support that kind of an activity. Bruce Spivey, Fred Blodi, David Shoch, and I supported the concept.

When we moved to San Francisco, I was concerned that the American Academy of Ophthalmology preserve some objects which were part of its history, starting with the traditional gavels and those kinds of things. I was very concerned that they not disappear.

The first donation to the foundation was some books and two trephines from Dr. Thomas Duane. Tom also years later saw to it that the Academy got the gavel that's been used by the AMA Section Council on Ophthalmology since the 1800s.

Hughes: Didn't the glass eye collection come from Dr. Duane?

Noonan: Yes, the first pieces. But the majority of the collection of spectacles has been donated by Dr. William Rosenthal.

Tom [Duane] really wanted the foundation museum to grow. It was Fibber McGee's closet for a while, until we got an acquisition policy and some members who were interested in serving on the museum committee. After struggling with staff for two years, we hired Susan Cronenwett, and then the museum just took off.

Eye Care for the American People

Hughes: *Would you tell me about Eye Care for the American People?*

Noonan: There was a perception that the focus of Academy activities should tie to an overall plan. The idea was that if you had the optimum plan in place in the United States to care for people with vision problems, this is what the Academy would recommend. So a committee of about nine individuals began to write major chapters of what would be the major building blocks of that plan.

The leadership of that project fell to a scholar, Brad Straatsma. Everybody would send their input to Brad, and it would come back in a different form entirely—your words, but worked over by Brad. He was a genius for many things, scholarship being one of them, and he took ideas and built in achievable steps. And now in the era of health care reform, this plan ought to be the major signpost of eye care for the American people. We can pull up that document [*Eye Care for the American People*] today, and interestingly enough, it's very current.

Unfortunately, individual members and organized ophthalmology didn't make the plan a part of their lives. As we continue with our strategic plans, as we look at what the Academy is going to do in the year 2000, that document becomes more and more relevant over time. Refined and honed by Brad, the ideas play out very, very well. He is separated from it now, but he and the committee were wonderful prognosticators, in that we were able to say that these ideas are the kinds of things you ought to have as building blocks, and they're coming to bear.

Eye Care for the American People really sets out the tenet that the American people deserve the very best eye care, provided by a team of professionals, led by an ophthalmologist, at the appropriate cost level. You don't use your most expensive, most invasive treatment first. You do it on an appropriate level. The basic tenet of that program is that you look at affordability and accessibility, availability of high-quality people, to bring eye care to patients at the various levels they need. And you inform the public that it has access to affordable eye care if it shops carefully. You urge people to do that.

Hughes: *How do you get the message across?*

Noonan: First of all, you have to educate the ophthalmologist that this makes sense. Then you have to educate other professionals in the health care field, the non-ophthalmology physicians. Then you have to begin to educate the public, and it's a long, long, repetitive process.

Hughes: How long has this been going on?

Noonan: Since 1985.

Hughes: And you're making inroads?

Noonan: It will go on in 1995, it will go on in the year 2005. But it has aspects of a vital document.

The Office of Academy President

Hughes: Is there anything to be said about the changing functions of the key Academy offices from the time you arrived in 1972 to now?

Noonan: Yes. The President has a far bigger job than he had even in 1979. As a function of his personality, and as a function of what's going on in the Academy, I'm on the phone to our President four times a week. I used to be on the phone to our President maybe once a month in '72, '73.

Hughes: What does he deal with?

Noonan: He deals with bylaw issues, membership complaints, the Federal Trade Commission, the Veterans Administration hospitals, testimony that he has to give on behalf of the Academy, plans for the Annual Meeting. He writes letters to the Academy staff saying thanks for your support. The interaction between the Academy leadership and the Academy staff is multidimensional. People don't have to call the EVP [Executive Vice President] to get permission to talk with somebody in the controller's office; you call the controller's office. The controller knows what his responsibilities are, what information he releases or doesn't release, and he releases it or doesn't release it. You don't have a huge bureaucracy to get information.

The President now sees as one of his responsibilities the motivation and support of the Academy staff. Recent presidents take the job very, very seriously, and they really want to make a commitment. They say to their families and to their partners, "This next two years I am really making a major commitment of time to the Academy." The time is growing more and more and more.

Hughes: They have to cut back on their practices?

Noonan: Yes. And I think their families must be darned glad when the presidency is over.

Hughes: What are the unspoken steps that need to be taken to become President?

Noonan: Presidents of the Academy are individuals who have knowledge of patient care, they know the daily practice of ophthalmology, they're involved in it. They're involved in it in an academic setting or in a group practice or private office practice, but their first concern is patient care.

Hughes: Is that because the Academy wants the world to see an ophthalmologist in—well, am I right in this?—the most visible position to John Q. Public?

Noonan: That is a factor, yes, but generally the nominating committee has suggested an individual who has planted the grapes in a small committee, kept the vines with handwork, cross-pollinated with two or three other committee chairmanships. He became a secretary or served ophthalmology even outside of the Academy with a major commitment to some other organization. The nominating committee looks at a broad range of attributes. It seeks somebody who has a reputation within the Academy for doing homework, being prepared, looking ahead, those kinds of things. I'm not privy to the nominating committee meetings. The EVP sits in as an advisor, but he doesn't have a vote. Those are the kinds of things that I know the nominating committee looks at.

Directors at Large

Hughes: Has this system ever been criticized? What I'm getting from your description is that you have to earn your Brownie points by actual service in the Academy before you are nominated for an Academy office. One could argue that it might be healthier—fresh blood and all that—if there were at least one channel directly to the outside so that a man who hadn't had a long history with the Academy could become President.

Noonan: We have directors-at-large who represent a broad range of interests and who may not have had as much direct experience in Academy activities. The Academy does try to bring those kinds of individuals in. The concern has been that you have an inbred, old boys' club—and I use the term advisedly, because there have only been two women on the Board of Directors in its history. That is probably a result of the number of women in ophthalmology historically and will not be true in the near future; close to fifty percent of the residents in ophthalmology are now women.

- Hughes: Has a director-at-large ever become President?*
- Noonan: Yes. Dr. George Garcia, [Dr.] Tom [Thomas P.] Kearns, Dr. Tom [B. Thomas] Hutchinson, [Dr.] Froncie [A.] Gutman, to name a few.
- Hughes: Do you remember when the directors-at-large were added to the Board?*
- Noonan: By title, in the early eighties, and yet trustees-at-large and [the] "Councillor" title extend back to the fifties. These titles generally fit individuals who represented diverse interests.
- Hughes: How are they appointed or elected?*
- Noonan: They fill a designated position, to advise the Board of Directors and to represent that group of people who may not have a lot of Academy experience.
- Hughes: The offices have a limitation on the number of years that can be served?*
- Noonan: You bet.
- Hughes: Is there a relationship between that rule and the fact that Dr. Benedict was in office for so many years?*
- Noonan: [laughs] There was a relationship definitely between the concern and early history. Kenneth Roper spent forty-two years in one committee structure or another within the hierarchy of leadership of the Academy.
- Hughes: But one could still have successive appointments, and there would be nothing to stop you?*
- Noonan: I suppose so, but I doubt it would happen now.

Business Meeting Minutes

- Hughes: You told me off tape that the minutes of the Council meetings were taken down by a court reporter.*
- Noonan: Not the Council as we know it now but the early title for the Board of Trustees.

Hughes: [laughing] *The minutes didn't appear in exactly that form in the Transactions, did they?*

Noonan: If you look at the *Transactions* up until 1973 or '74, you will see a lot of extraneous material. If we were discussing an issue, and you took one point of view and I another, that would all be in the minutes—which adds a great deal of color but doesn't shed an awful lot of light on the final decision, and it allowed people to make an awful lot of grandstand plays. They were not unlike the *Federal Register*. Somebody hands a piece of paper to the reporter for the *Federal Register*; it gets put in; nobody ever reads it; nobody ever heard it; nobody ever saw it; it just gets added to that bulk of paper that comes out every day. The old Council minutes have a lot of that.

Mike Kos asked what minutes legally are. How are they supposed to be constituted? What do you put in? Now you put in the subject matter and the decision. You don't put in all that extraneous commentary, and that cut the minutes down considerably.

*Transactions of the American Academy of
Ophthalmology and Otolaryngology*

Hughes: *That leads in to the change in the Transactions that occurred during your tenure.*

Noonan: The *Transactions*, which published paper-by-paper the presentations at the Annual Meeting, was published out of Omaha. It was revised in 1970 by the editor, Dr. [Stanley M.] Truhlsen, who proposed that there be some changes made in the material accepted. The changes were later enhanced by a subsequent editor, Dr. [Paul] Henkind. He didn't include every paper from the Annual Meeting, which provided an opportunity for publishing invited papers.

Hughes: *It became a peer-reviewed journal?*

Noonan: Much more. And its readership went up considerably. Very few people would read through the *Transactions* paper by paper by paper. Now, because of the organization of material by topic and by interest, it's a much better journal.

Hughes: *Are there guidelines for advertising in the Transactions? Actually, it's called Ophthalmology now.*

Noonan: Oh, yes. The guidelines for advertisers are published in the journal itself. There have been editorial policy changes over time. We didn't allow advertising to be interspersed or placed in "wells." We now have well advertising in the journal. So we've tried to keep the journal more appealing to advertisers as time [has gone] on.

Hughes: Because you need their support?

Noonan: We need their support. In my tenure we've been blessed by some forthright editors. [Drs.] Howard Morrison, Stan Truhlsen, Paul Henkind, and Paul Lichter haven't placed the organization in trouble by how they have managed the journal. There are other organizations where that is a constant problem.

Hughes: In what way?

Noonan: How they manage the manuscripts, the manuscripts that get published, how they handle the advertisers, how they handle the printer, what they insist on in terms of their deadlines. Our editor, Paul Lichter, manages the manuscripts in a very, very efficient manner. He developed a computerized program for managing the manuscripts. If your name gets affiliated with a manuscript, there is a whole program logic in the computer as to when you get reminders, when you get complimentary letters, when you get copied, when you get Xerox copied. He's got it so slick, it's wonderful. The management problems that lots of other journals have visited upon their organizations are legion, but we have been singularly blessed. The journals have been very well managed.

Academy Relations with Other Organizations

Hughes: Do you have anything to say about the Academy's relationships with other organizations? I think of the Armed Forces Institute of Pathology, the AMA, the AOS, and the American Board of Ophthalmology.

Noonan: Our leadership has been committed to developing good longstanding relationships with those societies. We've been very active with the Council of Medical Specialties Societies, active in communicating with the American Board, and in communicating with the AUPO [Association of University Professors of Ophthalmology].

Hughes: Are there representatives of these organizations at the Academy?

Noonan: Oh, yes, official representatives and outside ones as well. This morning, for example, I got a call from [Dr.] Jerry Goldstein in otolaryngology. We share each other's information all the time. So there's a good, open communication between the Academy's headquarters office and lots of other societies in medicine. Dr. Spivey and I made a commitment to international ophthalmology to make sure that there's a good, open feeling between ophthalmologists outside of this country and the Academy.

Hughes: Has this not always been so?

Noonan: It didn't exist prior to about 1978. Bruce began in 1978 to open the doors to the Academy to the International Council of Ophthalmology. As we put on the international meeting here in 1982, we opened a lot of doors. We have maintained those open doors over time. This is the *American Academy*, after all, but we have an appropriate international role as well. We can't use a lot of resources on international relations, but international ophthalmology knows that the Academy is a major resource.

The Academy and the Rank-and-File Member

Hughes: How important is it to the Academy to keep in touch with the rank-and-file members?

Noonan: I think we have a major responsibility to them. Those people pay over \$500 a year to belong to this organization. They better feel that they're getting their money's worth. We better know that our educational programs are meeting their needs. We better be available to them. We ought to listen to them; we must answer them. When those letters come in, they are answered. It's vital that we keep an open door and an open ear to what's going on.

Hughes: How successful are you in doing just that?

Noonan: I would say the average member of the Academy feels that the Academy has done an excellent job in education. It's available and open to their concerns. The average member of the Academy would wish that we had been more successful in Washington in attempts by the federal government to curtail his income. They wish that we would put more money into socioeconomic affairs. We're listening to that; we are spending more and more time on that. That's going to change the Academy.

Hughes: Do you ever see socioeconomic concerns taking over as the number one priority?

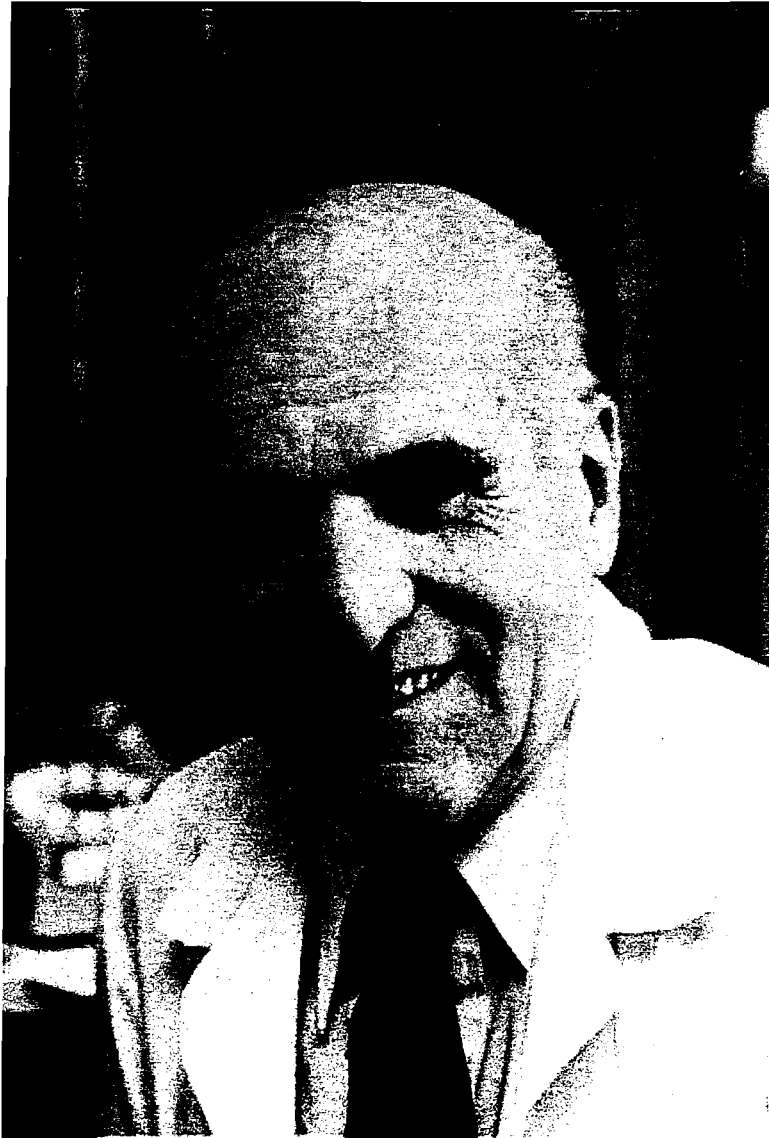
Noonan: No, I don't. I think education has to be. I think if push comes to shove, the average member of the Academy would not give up the educational focus of the Academy. Socioeconomics seems to occupy more of our time these days because we are so successful in the educational side of things. It's there, it's going, it's humming along very nicely. I know I can get the newest, I know the Annual Meeting will be there, I know I'll get the latest papers—those kinds of things. So the average member is very happy with that. They'd like to have us spend much more time on socioeconomic affairs, because things aren't going as well there.

Hughes: What or who makes the Academy work?

Noonan: I think it's a "who." The "who" that makes the Academy work could be generalized as a 47-year-old individual who has been in practice twelve to fourteen years, who begins to investigate his proficiency, sees the Academy as the institution that can help him maintain a level of expertise within his area of interest. He is willing to be a student, participate as faculty, and is willing to give a lot of time to improve the organization. That's the individual who drives the American Academy of Ophthalmology. He's driven by his need to maintain proficiency, by his need to make sure he's enhancing his life in terms of his professional interests and his personal interests.

So I think it's a "who"; I don't think it's a "what." Fortunately, there are about sixteen thousand of those "who's." Without that need to be highly professional and maintain that professional standard, the Academy wouldn't exist.

Hughes: Thank you.



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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Frederick C. Blodi, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
October 30, 1990, Annual Meeting of the
American Academy of Ophthalmology,
Atlanta, Georgia

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Frederick C. Blodi, M.D.**Introduction¹**

Frederick Christopher Blodi was born January 11, 1917, during the first World War, and raised in Mödling, a village on the outskirts of Vienna, Austria. He graduated from the University of Vienna Medical School at the outbreak of the second World War. Drafted by the German army, he was transferred into the medical corps, where he undertook postgraduate training in general pathology and surgery before entering ophthalmology residency training at the First Ophthalmologic Clinic of the University of Vienna. Shortly before the end of the war, he was imprisoned by the Germans for medically assisting desperate soldiers to escape a return to combat. He was liberated by American troops and subsequently served as an instructor and consultant in ophthalmology to the US Army 110th General Hospital in Vienna. There he was reunited with his childhood sweetheart, Otilie Schmakal, who had moved to the United States at the outbreak of the war and was stationed in Europe as a member of the Women's Army Corps. They married in Vienna in 1946 under the War Brides Act and emigrated to the United States in 1947. Dr. Blodi became an American citizen in April 1950.

Dr. Blodi was a World Health Organization-sponsored research fellow with Dr. Algernon Reese at the Institute of Ophthalmology in New York City (1947–1952), where he performed histologic studies of eyes with retinopathy of prematurity and also studied the causes of leukocoria. He was certified by the American Board of Ophthalmology in 1950, and in 1952 was asked by Dr. Alson Braley to join the faculty of the Department of Ophthalmology at the State University of Iowa. For the next 38 years, he devoted himself in a remarkably productive fashion to the department, the university, and national as well as international ophthalmology. From 1967 to 1984 he served as Professor and Head of the Iowa Department of Ophthalmology. His chairmanship was marked by his impressive administrative skills, by faculty recruitment of several internationally renowned basic scientists and clinicians, by a nurturing attitude toward students and trainees, and by a spirit of cooperation with Iowa ophthalmological and community organizations. Upon his retirement as Chairman, grateful students, colleagues, and friends endowed a university chair in his name as a lasting tribute to his departmental stewardship and his avid interest in ocular pathology. Dr. Blodi regarded his time in Iowa City as the most fruitful and satisfying period in his life.

Between 1985 and 1987, he divided his time between Iowa City and Riyadh, Saudi Arabia, where he was Director of Education and Medical Director at the King Khaled Eye Specialist Hospital. He also served as Clinical Professor of Ophthalmology at the King Saud University School of Medicine. He remained active in the department of ophthalmology in Iowa City as Professor Emeritus until 1994, when illness forced him to retire.

¹ Spencer WH, Frederick Christopher Blodi, M.D., *Trans Am Ophthalmol Soc* 1997; XCV: In press.

A true citizen of the world, Dr. Blodi served as America's unofficial ophthalmic ambassador and personified American ophthalmology's European heritage. He spoke several languages fluently, and was invited to deliver 39 named lectures in this country and abroad. Many of the latter were delivered in the language of the host country. All were presented in a succinct, clearly understandable, orderly fashion, enhanced by his charismatic personality, gentle wit, and Viennese intonation.

Honors were bestowed upon Dr. Blodi by universities and ophthalmological associations of many countries, including Austria, Australia, Brazil, Canada, Colombia, France, Germany, Italy, the Philippines, Saudi Arabia, Syria, and Venezuela. He was President of *Academia Ophthalmologica Internationalis* from 1984 to 1987 and a member of the International Council of Ophthalmology from 1986 to 1988. Dr. Blodi never spoke of his many international awards, but he must have been especially pleased in 1984 to have received the Cross of Honor for Science & Art, First Class, from the Federal Republic of Austria. At home, his contributions were recognized by election to membership in Sigma Xi and Alpha Omega Alpha, and awards from the university faculty senate, the University of Iowa Alumni Association, and the Iowa State Medical Society.

Dr. Blodi did not seek high office, but his extraordinary participation in all aspects of American ophthalmology, and his effective leadership skills, culminated in his election to positions of authority in several national ophthalmological organizations. He was a member of the Council of the American Ophthalmological Society (AOS) from 1984 to 1987, received the Howe Medal in 1980, delivered a brilliant Verhoeff lecture at the AOS 125th anniversary meeting, was elected AOS president in 1991, and in 1995 became only the third AOS member (after Arnold Knapp in 1953, and Frederick Verhoeff in 1958) to also be awarded honorary membership. His service on numerous committees of the American Academy of Ophthalmology and Otolaryngology was capped by his election to its presidency during its two-year transition to the American Academy of Ophthalmology (1980 and 1981).

Dr. Blodi was also an influential director of the American Board of Ophthalmology. He became its first foreign-born chairman in 1975, and was a consultant to the Board from 1977 to 1981. He also guided the affairs of the Association of University Professors of Ophthalmology, serving as a trustee from 1975 to 1980, and as president in 1982. In addition, he advised committees of the National Eye Institute, National Library of Medicine, American Medical Association Section on Ophthalmology, American College of Surgeons, Food and Drug Administration, and National Society for the Prevention of Blindness and the Seeing Eye.

His editorial expertise was widely recognized, and he was asked to serve as editor-in-chief, editorial advisory board member, or consulting editor for over 30 eye journals, including the *A.M.A. Archives of Ophthalmology*, *American Journal of Ophthalmology*, *Graefe's Archiv für Ophthalmologie*, *Documenta Ophthalmologica*, *Klinischer Monatsblätter für Augenheilkunde*, *German Journal of Ophthalmology*, *Survey of Ophthalmology*, and the *Canadian Journal of Ophthalmology*.

Dr. Blodi's many contributions to the ophthalmic literature reflected his interest in ophthalmic pathology and orbital and intraocular tumors. He was a stalwart member of the ophthalmic pathology community and a valued contributor to the Verhoeff Society. His linguistic acumen and consuming interest in the history of ophthalmology motivated him to translate into English Julius Hirschberg's monumental multivolume text *The History of Ophthalmology*. The effort required meticulous attention to detail, and the enormously difficult task of double checking all references, and correcting many that were incompletely or wrongly cited in the original German text. A delightful separate volume containing text and photographs of postage stamps about the eye, vision, and ophthalmology was appended to the Hirschberg series. As a hobby, Dr. Blodi had collected the stamps over many years. He also authored or co-authored over 200 publications, including 14 other books translated from German, French, and Italian.

An avid tennis player, he loved the outdoors and thoroughly enjoyed skiing and hiking in the mountains around his vacation home in Estes Park, Colorado. Those privileged to have been his students and friends will remember him for his warm, upbeat personality, keen sense of humor, superlative teaching skills, and graceful Viennese charm.

Dr. Blodi died at a rest home in Iowa City on October 30, 1996. In addition to his wife of 50 years, he is survived by his brother Charles, two children who are ophthalmologists—Drs. Christopher F. Blodi of West Des Moines, Iowa and Barbara Blodi Gottlieb of Madison, Wisconsin—and by grandsons Ryan and Frederick Blodi, and Jeremy Gottlieb.

William H. Spencer, M.D.
August 1997

FREDERICK C. BLODI, M.D.

[Date of Interview: October 30, 1990, Annual Meeting,
American Academy of Ophthalmology, Atlanta, Georgia]

Early Memories of the Academy

Hughes: What are your first memories of the Academy?

Blodi: That goes back a long time. The first Academy I attended in '48. I was still at Columbia University in New York, and my guardian angel, sponsor, and protector was Dr. Algernon Reese. At that time he was the Secretary for the Annual Meeting. It was a very influential position at that time. A lot of decisions were made by one person and not by a committee. He may have consulted them. So he really controlled the program of the Annual Meeting. That was a powerful position, and he did it for quite a few years. Later he became also the President of the Academy.

I attended the first meeting at the Palmer House in Chicago. Of course, for me it was overwhelming, coming out of war-stricken Europe to this fantastic meeting. A lot of activity. But it was still small. It was a nice group. We had otolaryngologists with us, and we would flip-flop. They would have the morning scientific session and in the afternoon the instruction courses; in ophthalmology it would be the other way around. There was at that time still a common banquet, for instance on Tuesday, where everybody who wanted to would go and hear speeches. So it was a small group; it was coherent and very enjoyable.

Hughes: Was there a lot of social and intellectual interaction between the two specialties?

Blodi: Not too much, actually, not that I could see. There was, of course, a common Council, but there was not too much interaction between the two specialties except for the first meeting on Monday morning. There was a combined meeting, and that was on something that interested both specialties. For instance, anesthesia and head and neck surgery, or the corticosteroids and the treatment of inflammatory diseases of the eye and the ear. But from then on we parted. There was no connection whatsoever.

Hughes: How many people do you suppose were involved in that first meeting you attended?

- Blodi: I don't know. I'm sure they have it on record, but it wasn't that many. The Palmer House was full, of course, very active. The section courses were on the seventh floor. The seventh floor was all instruction courses.
- Hughes: How did they compare to those given today?*
- Blodi: They were less sophisticated, but they were sincere and very popular.
- Hughes: Do you know how the instructors were selected?*
- Blodi: Again, there was a Secretary for instruction courses. For a long time this was Dr. [Glen G.] Gibson from Philadelphia. Oh, and Dr. [Albert D.] Ruedemann [Sr.] from Detroit was along for the instruction courses. [laughs] He had a bell, and he would go along personally, himself, during the instruction course, with this bell and collect all the tickets that everybody had paid.
- Hughes: [laughs] Circulate around the table?*
- Blodi: Yes.
- Hughes: Did the instructors tend to be the big names in the field they were lecturing on?*
- Blodi: Right.
- Hughes: It wasn't necessarily a guarantee that a course would be given year after year?*
- Blodi: No, there was a limit on how many rooms were available, and you had to apply for it, I think usually to the Secretary himself. Maybe there'd be a consultant; there'd be others who would decide whether there would be a course on a given topic.
- Hughes: Was there an attempt to pick the courses according to what the hot subjects of the year were?*
- Blodi: Right. Hot subjects, who was a good speaker, which courses performed well the preceding years.
- Hughes: Do you remember how much they cost in 1948?*
- Blodi: My recollection is two dollars an hour, but I'm not sure that was the cost when I began.
- Hughes: Was there opportunity for questions and answers?*

Blodi: Oh, yes, there was a question-and-answer period. It was usually very well done. We had hands-on sessions. We had a big course in ocular pathology with twenty microscopes. It was under Dr. [Georgiana D.] Theobald, a lady from Chicago.

Hughes: *Practical courses have always been a part of this program?*

Blodi: Yes. Not as much as now. I don't think there were any practical courses in surgery, for instance, as they do it now, like hands-on courses. But they did a few, like microscopy and refraction, where they had actual practical exercises.

Hughes: *What are your memories of some of the early names in the Academy? One of them is Harry Gradle.*

Blodi: That was before my time.

Hughes: *And [Dr.] William Wherry also?*

Blodi: Before my time.

William L. Benedict

Hughes: *How about [Dr.] Bill Benedict?*

Blodi: Oh, I knew Bill Benedict. When I first attended, he was the dominant figure. He was the Executive Secretary-Treasurer at that time, and he played an important role. He was a permanent figure. You see, all the others would change every year—the President, Vice President, and so on. He was the permanent figure.

Hughes: *I read in *Pioneering Specialists*¹ that he was the first full-time Secretary-Treasurer.*

Blodi: Is that true?

Hughes: *Yes, but only after he retired from the Mayo. Would you say something about him as a personality?*

¹ Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, 1982, p. 144.

Blodi: Well, I didn't know him that well. I was, of course, much younger, but he was a powerful personality. His will was usually listened to and obeyed. He was running the Academy pretty much by himself and doing very well. A very well-organized man, very intelligent.

Hughes: The thrust of the Academy, I understand, in those days was almost exclusively educational.

Blodi: Only educational.

Hughes: Were you aware of any effort by elements of the membership to move into the political or economic realm?

Blodi: Not at that time. We only talked about education and how to improve it—the Home Study Courses, the instruction courses, movies, things like that. Nothing else.

Hughes: When did that begin to change?

Blodi: Only after we separated into two organizations.

Hughes: That late?

Blodi: I don't think there was anything to speak of before that.

Separation into Two Academies, 1979

Hughes: Was the widening of the Academy's concerns a reflection of what was going on in American medicine as a whole?

Blodi: Yes, I think so. There were a number of reasons. The idea of separating into two academies started at one business meeting, and I'm sure if you read about it you can recall it better. There was a motion by [Dr. J.V.] Cassady from South Bend and [Dr.] J. Lawton Smith from Miami. They wanted the Academy to explore the possibilities to separate into different academies. Before that, people talked about it but were always told, "Impossible, impractical."

Now, why impossible? Number one—this came out later, but it turned out to be a stumbling block—we were not incorporated. There's no way you can divide an unincorporated association like that without having a legal basis. Number two,

they said, “We have this trust fund of a million dollars. How are you going to divide this?”

Then they said, “If you divide this Academy and go to a convention center, you just have some other people [from another organization] having a convention at the same time. You’ll just be meeting with plumbers instead of otolaryngologists, because you’ll fill the lecture room half a day and the instruction courses the other half a day. The hotels of the congress will not leave it empty the other half day, so you are defeating your purpose.” And so on. There was always a current against separation.

Well, anyhow, these two guys made this motion [in 1973], and I think at that time [Dr. Clair M.] Kos was the Executive Secretary-Treasurer. Cassady and Smith said they should find out by a poll of the membership whether the two groups should separate, and they did it. By a majority the people said, “Yes, we should.” Not by an overwhelming majority. Two committees were formed, and they met together. The otolaryngologists and the ophthalmologists started slowly to begin the motion of separating into two academies.

Hughes: Was the rationale for separating more than simply that the two specialties really had no rational relation?

Blodi: That was one of the main reasons. The second reason was that ophthalmology was growing to such an extent that the otolaryngologists didn’t think it would be possible to meet with us and compete for space.

Hughes: How were the financial questions settled?

Blodi: It wasn’t easy. The question was always whether the money should be divided fifty-fifty or according to membership, which was about sixty-forty in favor of the ophthalmologists. I think the latter solution was then finally agreed upon, though [Dr.] Bruce Spivey would know more about that detail.²

Hughes: Was this arrangement reached amicably?

Blodi: Finally, yes. At the beginning there were some acrimonious words. The first problem was that we had to be incorporated as the American Academy of Ophthalmology and Otolaryngology. This was done.

Hughes: Why hadn’t the combined Academy been incorporated?

² See the oral history in this volume with Dr. Spivey.

Blodi: For eighty years or so this existed as an organization without any official constitution or bylaws.

Hughes: Is that characteristic of similar organizations?

Blodi: In the past. Now they all incorporate, because there's the legal threat of suits. But in the past they just formed a little organization and didn't think about incorporating. Why should they think of that? It costs money, so they didn't do it. So, you see, our work was first to draw up a constitution and bylaws for the combined Academy, have them approved by a lawyer, then incorporate it in Minneapolis. Once we had it done, there was then a legal clause on how to dissolve the Academy, and we could follow that.

It caused a lot of meetings. It required a lot of time. We would meet three, four times a year, usually, at O'Hare [Airport] and hash it out slowly, step by step. Painful.

The American Association of Ophthalmology

Hughes: Would you say something about the effort to merge the American Association of Ophthalmology with the Academy?

Blodi: I was not directly involved in that, but it seemed to us clear after a while that these two organizations were overlapping to such an extent that it would be a benefit, both from political and financial aspects, to combine them, though for a while they were really opposed to each other like dog and cat. The people who really straightened it out were [Dr.] Brad Straatsma and [Dr. Theodore] Steinberg in California. They were personal friends, and they smoothed it out and kind of quieted all the hotheads and made [the] merger possible.

Hughes: Can you date the political efforts of the present-day Academy to that particular event?

Blodi: It certainly was a great impetus.

Hughes: So it meant more than just taking in an organization? It meant quite a different . . .

Blodi: . . . a change in direction. But that had occurred already a little bit. Of course, this was a turning point. It became clear in the preceding years that government

was taking such an interest in the practice of medicine that just by defense you had to answer them and [that the Academy] could not just be concerned with education and research alone.

Hughes: So the membership was ready for a move in a political direction?

Blodi: Yes, they were ready for it. Most people agreed with it.

Hughes: And the Secretariat for Governmental Relations . . .

Blodi: . . . was established, yes.

Hughes: . . . in 1980. What about government representatives? Did [Dr.] Whitney Sampson have some sort of a role in Washington? Is that where he was?

Blodi: That I don't know. We have an office that is concerned with government relations, but I'm not sure that Whitney Sampson was there.

Hughes: I don't know that he was physically there, but I thought he somehow represented the Academy's interests at the national level.

Blodi: I don't know. He represented the Academy at the AMA.

Hughes: Well, maybe that's what I'm mixing up. From what period was there a lobbyist in Washington?

Blodi: That was at that time established.

Hughes: That was a paid person?

Blodi: Yes, they had a whole office.

Hughes: Did that office predate the separation?

Blodi: No, that was after this merger with the American Association of Ophthalmology.

Hughes: So it really did all begin with that merger?

Blodi: Oh, yes. No question. There were a number of problems that had to be solved in that merger. For instance, the Association had members who were not diplomates of the American Board of Ophthalmology, whereas it was an Academy prerequisite to have it for membership. In order to bridge this gap, they created two types of members, the fellows and the members. The member

is the one who does not have [certification from] the American or Canadian Board of Ophthalmology, but who still can participate in functions. I think they can even vote but cannot hold office. A fellow has full rights.

Hughes: And that was a concession to the Association?

Blodi: Yes, because about a third of the membership of the Association was not board certified.

Hughes: Were there any other concessions?

Blodi: I don't recall them. Mr. [Lawrence] Zupan was taken over for a while, just because he had done so much for the Association.³ He was put on the staff of the Academy as a public relations man or lobbyist.

Key Academy Positions

Hughes: Let's go back to how some of these key offices have evolved through time. How was it when you first joined the Academy?

Blodi: There were only three secretaries at that time. One was for the program of the Annual Meeting, another one was for instruction courses, and the third one was for Home Study Courses and other educational activities. These were the three. This was the Board of Secretaries.

Hughes: What about the relationship between the Council and the various other offices? Would you say that the relationship was similar to [what they have] nowadays?

Blodi: I think so. They were a consulted body. They had a meeting once a year.

Hughes: And the President's office was similar as well?

Blodi: Wherever the President had his residence. Most of the work was done by the Executive Secretary. The President was a figurehead.

Hughes: Is that not quite so true nowadays?

³ See the oral history in this volume with Mr. Zupan.

Blodi: Maybe the President has a little more influence, but still the main direction of the ship is determined by the Executive Vice President.

Hughes: *Is that somewhat by virtue of his continuity? I mean, the President only has a year in office.*

Blodi: Yes, that's the point. He's the President-Elect for the previous year, but he still has so many other obligations, frequently in active practice, that you just can't expect him to be as knowledgeable in every aspect of the Academy as the Executive Vice President.

Hughes: *When was the idea of having a President-Elect instituted?*

Blodi: There was always a President-Elect. There were three Vice Presidents in the old days, but the Vice President didn't become President hardly ever. It was just an honorary position. Usually it would flip-flop again. There would be either two otolaryngologists and one ophthalmologist, or two ophthalmologists and one otolaryngologist.

Hughes: *Why is an individual chosen to be President?*

Blodi: I don't know. It's usually that he or she has worked for a considerable time in the framework of the Academy, has done a good job, and has proven to be reasonably compatible with the others. Doesn't get too abrasive or too controversial. If that's the case, the individual keeps on working and, step by step, comes up to the presidency, usually via Secretary, member of the Council, and is selected for the presidency.

Hughes: *So there is a chain of offices leading to the presidency?*

Blodi: Oh, yes. It's not going to be somebody brand-new.

Hughes: *Dr. Truhlsen described in his article on the secretariats, "an old boys' club" at the top of the AAOO hierarchy which "passed secretariats and officer posts around to each other..."⁴ Is that the way you remember it when you first became associated with the Academy?*

Blodi: The program Secretary, which I was, was always in the position at least for five years, sometimes seven and eight years, so he got pretty much entrenched and

⁴ Stanley M. Truhlsen. "The History of the Ophthalmology Secretariats of the American Academy of Ophthalmology." Typescript, April 1989, p. 11.

maybe fell into a certain routine. My predecessor was [Dr.] Kenneth Roper of Chicago, and his predecessor was [Dr.] Al Reese. When the time came that I became the Secretary, Ken Roper invited me to Chicago, took me out to a splendid dinner, and had a whole folder of documents, memos, and instructions that we went through very carefully, with all the minutiae. He handed it over to me and said, "Fred, from now on you are to carry this." He was really introducing me to his job in a very thorough and pleasant way. I'm not sure everybody else would have, but he was extremely conscientious about it, there's no question.

Hughes: That is an unwritten part of the transfer of power. It's really left up to the individual.

Blodi: He did it extremely well. I was most grateful to him.

Hughes: This is a quote from Pioneering Specialists: "As the Academy grew in stature, the Council"—which I guess is the present board of directors?

Blodi: Right.

Hughes: —"received many requests for Academy support, intervention, or decision on everything from local physician disputes to national politics. These were answered with a statement that such matters were outside the jurisdiction and purpose of the Academy."⁵ Could you comment on why the Academy divorced itself from non-educational affairs?

Blodi: They did not want to touch anything that had not to do with education. They were afraid to get involved in little struggles and disputes at a local level, and so on. They would not consider those.

The Academy as Arbiter of Ethics and Research

Hughes: What happened in questions of ethics?

Blodi: I'm not sure that it ever came up. The only part of ethics that could come up was when somebody would apply for membership and his ethics were questioned or challenged. But they probably wouldn't have accepted the membership of that person. It could be done in the past. I'm not sure they ever did anything against them. I'm not aware of any procedure.

⁵ *Pioneering Specialists*, p. 15.

Hughes: *Would the Academy officially enter into a scientific or medical debate, such as the validity of a procedure or the correctness of a scientific approach?*

Blodi: It has [been] done in the past. A number of new procedures were introduced. Let's say phacoemulsification. It was a sensation, and a few people thought this was a cure-all. Others thought this was a frivolous method, a dangerous procedure. The Academy instituted an experiment, a controlled series, which was done under supervision, and then the results of the treated group were compared with the control group.

Or the intraocular lenses. There was a *tremendous* discussion. You know, the early intraocular lenses all had to be taken out again, with great damage to the eye. So the conservative leaders of the Academy said, "Voila! You're not going to do it. This is damaging the eye more than doing good." Well, of course, then better models came, better material. People tried to do it, and then again the Academy would say, "Yes, we'll start a controlled series on a prospective study and see whether it really comes out all right, and then we'll give the green light."

Hughes: *The Academy was the institutor in these studies?*

Blodi: Right. And the arbiter.

Papers Presented at the Academy

Hughes: *Did you feel there was complete freedom to discuss any aspect of a paper presented at the Academy?*

Blodi: Yes, I don't think there was any restraint of discussion. There was only a time limit, you see. At the most there can be one discussor, and there's hardly ever time for a response. So when I, for instance, was the Secretary, I abolished discussions altogether, because I felt this was not enough: Either you have complete, free discussion where people can talk back and forth—but for that you don't have the time—or if there's only one discussion, then usually it's very complimentary and says, "Very nice, very well, good." Well, that we don't really need; that doesn't add anything to the discussion. So I said, "We won't have any discussion."

Now they have discussions again, but on a limited basis. They have, as you can see from the program, one discussion for two papers. Some don't have discussion, which is fine. It puts another light on the topic, but on the other hand

I personally feel it would be fair to then give the author a chance for a rebuttal. But that takes so much time that they can't do that.

Hughes: Do the discussions nowadays tend to take a critical standpoint, or are they laudatory?

Blodi: Occasionally they are critical. It depends upon the discussors. Some point out certain weaknesses, certain strengths, what else should be done to make the paper more valuable. That's reasonable, but I would like to hear what the author has to say in rebuttal.

Hughes: Have you noticed any change in tenor of the discussions? Do we have Freddy Verhoeffs any more?

Blodi: No. Nobody would be like that. That was, first of all, extremely abrasive and, secondly, frequently *ad personam* and not to the topic. I think that's practically eliminated.

Hughes: But people are frank if they disagree?

Blodi: Oh, yes. Some discussions will be very frank. Some are nearly brutal, but not many. I think in general there's a gentle ribbing, a gentle reminder that this [research] is incomplete, it could be better done, maybe it needs more patients to prove the point, and things like that.

The Instruction Courses

Hughes: The postgraduate courses were first instituted in 1921. The format was a bit different from what they eventually became. Namely, there was a theme under which all the courses were integrated.⁶

Blodi: Yes. In the beginning that's how it started, and then it branched out more and more. The instruction courses became extremely important. There's no question about it.

Hughes: The effort is to encompass all aspects of everyday, practical ophthalmology?

⁶ *Pioneering Specialists*, pp. 78-80.

Blodi: Yes, and any advance that has occurred lately. Well, I was involved in the instruction courses for a long time. As you know, [Dr.] Harry Gradle introduced them, and they soon became extremely popular. Slowly, of course, they have changed and become modernized and more efficient. They have more pictures, whole booklets. It was kind of primitive in the beginning, but it did its work.

Hughes: Did you take them in the beginning?

Blodi: Oh, yes. Everybody took them. They were especially valuable for residents who came from a small program where there were not extensive didactic opportunities. A lot of people took them. And also people from abroad.

Hughes: Were you ever involved in correcting papers for the instruction courses? I understand there was a actually a committee that corrected the papers.

Blodi: Right. For two years I had to do that also. It was a lot of work at that time.

Hughes: Were there criteria?

Blodi: It was either right or wrong, and we gave a certain rating for approval.

Hughes: It was personal opinion?

Blodi: Yes.

Hughes: How is it done nowadays?

Blodi: I'm not sure how they examine. They examine on a multiple-choice basis, and it's computer graded.

Hughes: I guess this is before your time, but I understand that Wherry was not at all enthusiastic about Harry Gradle's idea of the Home Study Course.⁷

Blodi: That was before my time.

⁷ *Pioneering Specialists*, p. 147.

The Ethics Committee

Hughes: Well, let's get back to ethics. The Ethics Committee was formed in 1980, and I understand that the Academy is quite unusual in having a written code of ethics.

Blodi: That's right. It's very unusual to have it.

Hughes: Why is that?

Blodi: Ethics is extremely difficult to formalize and verbalize. It's not like the Ten Commandments. You can't just say that this is right and that is wrong. There are so many conditions that would influence the judgment. People are reluctant to take a stand on a difficult question.

Hughes: How does it work nowadays?

Blodi: You'd better ask this to somebody on the committee. They send [offenders] a reprimand and so on. How far they actually have gone, whether they actually have ever thrown anybody out, I'm not aware. Maybe they did.

Hughes: Another unusual aspect was submitting the code to the Federal Trade Commission for approval.

Blodi: And they approved it. That was a tremendous plus.

Academy Relations with Other Medical Organizations

Hughes: Do you have anything to say about the relationship of the Academy to other medical ophthalmological institutions? The obvious one, of course, is the AMA.

Blodi: Yes, there's a representative of each specialty organization in the House of Deputies. Dr. Whitney Sampson has been for a long time the representative of the Academy of Ophthalmology. He defends the ophthalmologic interests in the House of Deputies.

Hughes: And the same is true, is it not, of the American Ophthalmological Society?

Blodi: You know that on the Board of Councillors there are representatives of various ophthalmic organizations. The American Ophthalmological Society is one of them. Many other specialty organizations are represented.

Hughes: Is it a means of exchanging information between the organizations?

Blodi: Right. It's an attempt to keep the Academy as a central organization for all ophthalmologists.

Hughes: And has that been true in the past?

Blodi: Yes. In general it's been true, much more than in any other specialty. If you look at otolaryngology, they're split in three or four organizations that have very little in common; [they] don't meet together. Whereas in ophthalmology we've been fortunate enough to keep all these subspecialty organizations—the retina group, the Castroviejo Society, and so on—under the umbrella of the Academy.

Hughes: The Section on Ophthalmology of the AMA is defunct, but in the days when it wasn't, was there rivalry between it and the Academy?

Blodi: No, there was no rivalry. I was an officer of the Section, too. There was no coordination, but there was no rivalry, either. You could say, "There's a Section on Ophthalmology also in the College of Surgeons," but it is small.

Hughes: How would you differentiate the purposes of the Section and the purposes of the Academy?

Blodi: Well, the Section of the College of Surgeons is subservient to the College of Surgeons. They have to follow their rules and regulations. They would like to make general surgeons of all of them first and then ophthalmologists. That doesn't go over very well.

Hughes: So the Academy really has been the leading institution for ophthalmology?

Blodi: Oh, there's no comparison. You go to the Section meeting of the College of Surgeons, and there will hardly ever be more than two hundred in attendance.

More on the Separation

Hughes: Is there anything else you want to say?

Blodi: No, except the establishing of an independent Academy. The separation of the two academies was a long, long, painful process over the years.

Hughes: What do you think would have happened if the old pattern hadn't been broken?

Blodi: If we hadn't separated, it would have been a terrible, terrible place. There was a group of us who championed the separation very early. About the earliest one was [Dr.] David Shoch. David Shoch was like a Seneca the Elder in the Roman senate who ended each speech with, "We should separate. We should separate."

Hughes: What was his reasoning?

Blodi: Because we had nothing in common with otolaryngology. There was nothing we could do together. We were tangentially involved at other meetings with neurologists and neurosurgeons. David Shoch was at that time the Secretary of the instruction courses when I was the Secretary of the scientific program, but he was very outspoken on separation and persistent. He never let loose.

Hughes: What we haven't talked about is your presidency.

Blodi: It was '80 and '81. It was a funny situation, too. You see, when I became for the first time President—I'm talking about the first time, because I was President twice, the only President who served twice. I was President of the Section of Ophthalmology of the American Academy of Ophthalmology and Otolaryngology. Before there was a clear split, they had two sections [ophthalmology and otolaryngology] established. They would meet independently, but they still had a common Council. But there was already an independent meeting of each section; everything was independent. And each section had a President. I was the President of the Section of Ophthalmology. The otolaryngologist at that time, because this position was also flip-flopped, was not only the President of the Section of Otolaryngology but also President of the combined Academy. That year they split, and they said, "Okay, the last President of the Section of Ophthalmology of the combined Academy will become the new President of the new independent Academy of Ophthalmology." It was I, so I happened to be President twice.

Hughes: Oh, I see.

Blodi: If you don't learn the job right away, you have to repeat it. [laughter]

Hughes: Well, thank you for the interview.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Stanley M. Truhlsen, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
October 29, 1990, Annual Meeting of the
American Academy of Ophthalmology,
Atlanta, Georgia

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Areas of expertise _____

Other interests or activities SPORTS, READING, HISTORY

Organizations in which you are active Foundation Am Acad ophth

Am Ophthalmological Society - STATE & LOCAL MED SOCIETIES

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STANLEY M. TRUHLSSEN, M.D.

[Date of Interviews: October 29, 1990, Annual Meeting,
American Academy of Ophthalmology, Atlanta, Georgia]

The Palmer House

Hughes: How far back do your memories of the Academy go?

Truhlsen: During my residency, which was in Saint Louis at Barnes Hospital, they offered the opportunity for some residents to go to the Annual Meeting of the American Academy of Ophthalmology and Otolaryngology [AAOO] in Chicago. In those days it was at the Palmer House. The resident ahead of me for one reason or another elected not to go, and I jumped at the opportunity. That was in 1949, and I haven't missed one since.

Another resident from St. Louis and I stayed in the residents' quarters at Northwestern University, and we went to the Palmer House and saw this great meeting. What was particularly wonderful about it [for] a resident in ophthalmology was to see and put a face on the people who had been writing the books and articles that we were studying and reading while we were in training. And of course the exhibits. Now, the exhibit area in the Palmer House would probably fit in the area of the Academy Resource Center here. [laughter] But it was for the companies that sold to both otolaryngologists and ophthalmologists. In addition, I remember they gave away free Camel cigarettes, free Coca-Cola, and things like that.

You've probably picked this up before, but in those days the Academy, being really kind of two joint specialties, used the ballroom for one specialty in the morning, after which they went to the seventh floor for the instruction courses in the afternoon. The otolaryngologists did the reverse. So it was all well organized, as it is today, and quite an experience.

Hughes: As a resident, how free did you feel to approach some of these big names in ophthalmology?

Truhlsen: We didn't approach. You just looked at the lapel badge and said, "Oh, that's—," unless one of your senior staff members would introduce you to one of them: "This is my old friend So-and-So"—[Dr.] Connie Berens, [Dr.] Derrick Vail, Jr., or others.

One of the big names in ophthalmology for many, many years was Sir Stewart Duke-Elder from England, who wrote two different series of textbooks of ophthalmology. When we were in training we had a six-volume series. The plates for one volume were destroyed when a ship sank during the war, but this was the definitive knowledge of ophthalmology at that time. He was a marvelous writer and had an excellent command of words. He was a guest of the Academy that year. In those days they seated everyone in a ballroom and had a banquet. He was the speaker in 1949 at the annual banquet of the Academy.

Hughes: That impressed you?

Truhlsen: Yes, because we were literally studying his textbook daily with quizzes like you had in high school. We would be assigned fifty or so pages daily in the second volume or in the third volume. So seeing him in person made you a little starry-eyed.

The Instruction Courses

Hughes: How about the instruction courses in terms of being able to ask the instructor questions? Was there always a discussion period after lectures?

Truhlsen: The instruction courses, which by the way cost \$2 an hour, were of course available to the fellows of the Academy and guests. When we found out we were going, we had to have somebody on the teaching staff order tickets so that we could get into the courses. We listened to the instruction courses and the scientific papers. We didn't enter into the discussions of these presentations, but rather listened to our elders.

Hughes: Is that still true today?

Truhlsen: I presume. I imagine if you go to an instruction course here [at the Academy Annual Meeting], there's not a great deal of questioning and answering anyway. It's a pretty definitive lecture. Likewise, at the larger scientific sessions there are papers on various subjects, and there are probably two or three thousand people present. Usually there will be no questions until it's all over, and then they may have a panel and questions from the floor. But I don't imagine there are very many residents who do that.

Hughes: Was there any censorship in any form?

Truhlsen: Not that I could ever recall. People got up and gave the results of their research or their findings or, in the instruction courses, in many cases gave a course that they'd given for several years on a given subject—[for example], cataract or retina or motility. They pulled out their slides and updated them and gave the same course year after year.

The man who was Secretary for Instruction in those days was Dr. [Albert D.] Ruedemann [Sr.], and he'd come around and go into each course and collect the tickets. He could get an idea whether you had a full house or whether you had a half a roomful of people. Those that weren't drawing well would not be asked again, and new people would be brought in to keep up a viable and interesting set of instruction courses.

Hughes: Was a poor draw because a man or a woman might not be a particularly apt instructor, or was it more that the subject he or she chose to discuss wasn't popular?

Truhlsen: I think to a certain extent the draw was the name of the instructor, but the subject was important, too. People are famous in ophthalmology like they are in other fields. Today, if leaders in ophthalmology give a talk or a course, usually it's in a subspecialty, and people flock to hear them, particularly if they are interested in that subspecialty. The same applied then: The people who were leaders or at the cutting edge of a subject could command a full room. Now, if they used the same slides or talked year after year until everybody had seen or heard them, then a fall-off would occur. Later on, the Academy developed a system of grading and asked people who attended courses to grade them on whether they were good, bad, or indifferent, and to comment.

Hughes: Are the lectures strictly a volunteer activity?

Truhlsen: Oh, yes. I believe most people consider it an honor to some degree to be asked to give a course. Likewise a paper in the scientific sessions. They submit papers or abstracts. They submit, I think, far more papers than are selected. The courses and the papers are judged by a committee as to quality, and those that meet certain standards are then included in the program. It's a feather in your cap to be involved in the teaching process in something as wonderful and prestigious as the American Academy.

The Academy Journals

- Hughes:* *Is acceptance of a scientific paper a guarantee of eventual publication in Ophthalmology?*
- Truhlsen:* When I was editor for ophthalmology [1976–1980] of the *Transactions [of the American Academy of Ophthalmology and Otololaryngology]*, it was. Because that was the name and function of the bimonthly *Transactions*. Then, along about '77, we decided that we would allow people to submit papers which were not presented at the Annual Meeting. We developed an editorial board and accepted what we called “free papers” and started publishing them. We had the editorial board review them, or “referee” them, as they call it, to judge if they were worthy of publication. We did that until I finished as editor of the *Transactions*, and they continue refereeing papers now in *Ophthalmology*.
- We changed the name on the cover to *Ophthalmology* in '75, although it was still legally the *Transactions*. Then when [Dr.] Paul Henkind became editor, he did a marvelous job of developing the journal *Ophthalmology* into a world-class periodical, publishing many papers that are presented here at the Annual Meeting [and] also many papers that are submitted to it. I'm not sure what the percentage is now. Paul Lichter is editor now, of course.
- Hughes:* *Why was the decision made to broaden the scope of papers considered for publication?*
- Truhlsen:* There were two reasons. One, a paper that was given at the Academy might not quite live up to expectations and maybe not warrant publication. Second, there was such a deluge of papers that were of high quality that there weren't enough journals to print them all. The *Archives of Ophthalmology*, which is part of the AMA publication group, and the *American Journal of Ophthalmology* were the two major eye journals, and the *Transactions* was primarily an Academy publication, printing all the eye and ear, nose, and throat papers. In 1973 we split the *Transactions* into two volumes, one for ear, nose, and throat, and one for ophthalmology. But prior to that, the papers had been one after the other in one volume—one eye paper followed by one on ear, nose, and throat.
- Hughes:* *Were there any stylistic or other differences among Ophthalmology and Archives and the AJO?*
- Truhlsen:* Well, I think *Ophthalmology* made an attempt to be primarily a journal that presented clinically oriented papers. In other words, [they were] papers that could be utilized in practice, in contradistinction to the official journal for the American

Association for Vision and Research Ophthalmology, where most of the papers which are presented at their annual meeting are related to basic research—chemistry, physiology, and things like that. So I think there was an attempt to publish articles that could be utilized immediately in practice. And I believe the *American Journal of Ophthalmology* also attempted to do that, as well as did the *Archives*.

Hughes: *But the expansion of the Academy journal was mainly in response to the flood of papers coming in?*

Truhlsen: I think more and more papers were available, more and more papers were submitted, and the *Transactions*, which was limited heretofore, attempted to relieve this overflow, so to speak. Then other journals came along. *Ophthalmic Surgery* was edited by [Dr.] George Weinstein originally and now by [Dr.] George Spaeth. Then there is *Survey of Ophthalmology*. There are a lot of different ophthalmology journals published now.

Hughes: *There really is a market for all these different journals in the same specialties?*

Truhlsen: Some of them are free journals, and some of them are refereed journals. Papers in refereed journals have to pass rather demanding levels of review by the editorial boards or selected experts in order to be accepted. Papers are sometimes sent back and revised and sometimes rejected. I have an idea that some of those that are not accepted in refereed journals may show up in some of the journals that aren't refereed.

Hughes: *What was the process for changing the Transactions to Ophthalmology? How is that kind of a decision made?*

Truhlsen: Let's go back a little bit. Years ago, Dr. [William P.] Wherry, who was the Secretary-Treasurer of the American Academy of Ophthalmology and Otolaryngology, was also the editor of the *Transactions*. After he died, Dr. [William L.] Benedict became editor of the *Transactions*. Dr. [W. Howard] Morrison became an associate editor for ophthalmology in the 1930s, and there was an associate editor for otolaryngology. They were the editorial board of the *Transactions*.

Along about 1967, Dr. Benedict became ill, and Dr. Morrison took over more of the functions of the editorship and became editor-in-chief in 1969. To go back a little bit before that, I joined Dr. Morrison in 1951 in practice. He had been an associate of Dr. Wherry, so this office goes way back in Academy history. Dr. Wherry had made Dr. Morrison an associate editor, which didn't require a great deal of editing as far as judging whether or not a paper should be published,

because they were all part of the official transactions. But it meant proofreading and attending to the editorial details. The ear, nose, and throat associate editor edited and performed the same functions for otolaryngology.

When Dr. Morrison traveled, oftentimes page proofs would come to the office, and if there were some urgency, why, I'd proofread the papers while Dr. Morrison was out of town. That, over a period of time, led to my becoming an associate editor when Dr. Morrison took over as editor after Dr. Benedict had to retire for health reasons. But the editorial board—I'm now answering your question—along in 1973 took the journal, the *Transactions* of the Academy, and split it into two sections, one for otolaryngology and one for ophthalmology.

Then about the middle seventies, along about the time Dr. Morrison retired as editor and I became editor, we were in the process of changing into two separate journals, even though both were legally the *Transactions*. In 1975 we put "Ophthalmology" across the top of one and put it in a yellow cover, and we put "Otolaryngology" across the top of the other one and put it in a blue cover. We continued in that way for the duration of the joint existence of the two specialties in one society. But by that time each editor did his own specialty, and we didn't have much interface during those years when they were in the process of separating the Academy into two separate entities.

The Council

Hughes: *Would the Board of Directors of the Academy have anything to say about a position like the editorship?*

Truhlsen: Yes, they appointed the editor. In those days the governing body was called the Council. The Academy, almost from its inception—at least going back for seventy or eighty years—was run by a Council which was made up almost equally of members from ophthalmology and otolaryngology. In alternate years the President was an ophthalmologist or an otolaryngologist. If you go clear back to the time of the conception and the formation of the Academy, many of those people practiced eye, ear, nose, and throat. But even then there were some who did more ophthalmology and others who did otology or otolaryngology. So the Council then had equal representation of each specialty in councillors and officers. They would have a President and a first, second, and third Vice President, and they alternated between the two specialties. Then they had councillors, what we now call directors at large, who represented the rank and file. All major policy decisions were made by the Council, just like everything

today is with the Board of Directors. The editorial committee would say, "This is what we want to do," and it would be duly taken to the Council for an okay, and the committee would do it. This included naming the editor and the composition of the editorial advisory committee.

Hughes: *It sounds to me as though the Council action on editorial matters was pretty much a rubber stamp.*

Truhlsen: Yes. For many years the Executive Secretary-Treasurer, now called the Executive Vice President, also served as editor. In the old days it was an autocratic position. Pretty much everything in the Academy in Dr. Wherry's and Dr. Benedict's time was done the way they wanted it, without anybody objecting too strenuously.

Hughes: *Was it you who told me that Dr. Benedict used to run meetings with an agenda that he didn't distribute to the rest of the group?*

Truhlsen: I don't know whether that's exactly right or not, but I was given to understand that the minutes, when they were completed after the meeting, were tailored, and he okayed them or changed them or altered them as he felt they should represent what happened. So whether or not he controlled the agenda from the beginning, he controlled what came out in the end.

Those minutes of the Council meeting were published in the *Transactions*—that Dr. So-and-So said thus and so, and Dr. So-and-So made a motion. I have the volumes of the *Transactions* back to 1908 at home. I wrote a history of the instruction courses, using those old minutes, which is going to be part of the Centennial celebration (to be published later). It traces the history of this type of postgraduate instruction, which began about 1921. It's an interesting story because the Academy, I believe, can take credit for the instruction-course type of postgraduate medical education.

[Harry] Gradle was largely responsible for developing it and was the first Secretary for Instruction. For many years they had a Secretary for Ophthalmology and a Secretary for Otolaryngology, and in 1926 they put in a Secretary for Instruction to supervise the instruction courses. Dr. Gradle was in charge of them up until he was President of the Academy in 1938.

The Home Study Courses

Truhlsen: Dr. Gradle was an innovator, and soon after completing his presidency he started what were called the Home Study Courses, which are now the Basic [and] Clinical Science Courses. This was, of course, very useful during the war, because it was a type of correspondence course, primarily for residents. On a given subject each month, they'd send out maybe ten or twelve questions, and then you could go to the library or use your Duke-Elder or whatever reference book you might have to answer those questions. They were written out or typed and mailed in. There was a separate faculty for each month and each subject. I served on it years ago, and we would have to read and grade each paper.

Well, Dr. Gradle started the Home Study Courses after his presidency, about 1940, and in 1943 became the first Secretary for Home Study Courses. First there were two secretaries in addition to the Secretary-Treasurer, then they added the Secretary of Instruction, and now we have about seven secretaries, each in charge of a specific area of Academy activities.

Hughes: The emphasis of the Home Study Courses was on the basic sciences?

Truhlsen: No, not originally. It's now called the Basic and Clinical Science Course. I took the course following the war. I was located at Scott Field in Illinois right after the war, serving as a lab officer because I'd had a year of pathology. I could spend most of my days studying ophthalmology and writing answers for these courses. But the emphasis was both basic and clinical. Part of it was on optics, which is pretty basic, and another part might be on the clinical subjects. I believe it was a ten-month course.

Hughes: Was it considered a substitute for the Lancaster Course, or were they complementary?

Truhlsen: A little bit. It was not as intensive as the Lancaster Course. It was a means of introduction to ophthalmology, primarily for residents, when it was started. It developed, I think, that many physicians took it for refresher purposes. Many of the residencies around the country required that you do this as part of your residency training. It broadened and directed your reading into areas that you might not be getting instruction in.

This grew over a period of years, until now the Basic and Clinical Science Course has, I believe, eleven or twelve books on different subjects—neuro-ophthalmology and anatomy and all these different subjects. Each book was

written by a committee, and they're used as a text for study, again primarily for educational purposes of residents. It's been a wonderful educational thing.

Hughes: Do you remember how far back having a booklet on a subspecialty goes?

Truhlsen: I can't tell you when they developed. They had this Home Study Course for many years, which was just an assignment-type thing, and of course used books like Duke-Elder. Duke-Elder's second set had fifteen volumes in it, in which there was a breakdown of different topics. The Academy also published manuals on different subjects. [Dr.] Bradley Straatsma became Secretary for Continuing Education back in the early seventies,¹ and he had such people as [Drs.] Bruce Spivey, Bob Reinecke, and Mel Rubin on his committee. They developed the present program. It may be that those books were an outgrowth of that, but you'd have to ask them. I don't remember exactly.

Hughes: As I understand it, the educational mission of the Academy was their preeminent goal in the early days.

Truhlsen: I'd go almost so far as to say it was the only goal. If somebody brought up politics or a socioeconomic problem, it was not pursued. These areas were not to be dealt with by the Academy.

Hughes: Why was there that policy?

Truhlsen: The Academy had always been developed for educational purposes, and I suppose politics was kind of a dirty word. "We'll practice medicine, and the government will take care of its side of the fence." There wasn't any reason why we should have any interface with government, long before Medicaid and long before all the other governmental intrusions in medicine came about.

The American Association of Ophthalmology

Hughes: Could you tell me something about the origins of the American Association of Ophthalmology?

Truhlsen: It was probably about '67 when a man by the name of [Dr.] Ralph Rychener, with Dr. Benedict's blessing, got up during a break in the scientific program at the Palmer House. Maybe it was '57; I'm not sure. He proposed forming a new

¹ Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982, p. 189.

group called the American Association of Ophthalmology [AAO]. They did, and it grew, and we had many members who were also members of the Academy. This was the “political arm” of ophthalmology. [Dr.] Whitney Sampson was very much involved. [Dr.] George Garcia was President at one time, and [Drs.] Tom Hutchinson, Byron Demorest, and Ted Steinberg were involved in it. They were all Academy members, but they were more heavily involved in the Association activities up until the time of the merger. So with that organization functioning, the Academy said, “We’re educational in nature; we’ll continue to be educational. We will not get involved in lobbying or supporting candidates or trying to guide or direct legislative activities, and we’ll just stick to our activities in teaching.”

I don’t think the Academy had any participation in what the Association did. The Association kind of developed under the umbrella of the Academy to start with, but it went off in its own direction and had its headquarters in Washington, D.C. Larry Zupan was their Executive Secretary.² He was a lay person who held a position in the Association analogous to David Noonan’s in the AAO. The Association was in Washington, D.C., and it was involved in fighting optometry and in governmental political activities. The Academy rode the high road and said, “We are involved in educational pursuits; we’ll give papers, and we’ll give courses.”

Hughes: *But secretly pleased that somebody was tending to the political problems?*

Truhlsen: People wore different hats. A man, I suppose, could be involved fairly deeply in some Association activities, but he didn’t bring those up in any Academy meetings. He walked across the hall, put on his other hat, and spoke his piece at the Association regarding what was happening.

Also, for a long time there was another arm, you might say, and that was the Section of Ophthalmology of the American Medical Association [AMA]. The sections for many, many years had a scientific program, but each section representing the different specialties in the AMA was involved in some of the activities that the AMA was involved in, and the AMA certainly has been involved in lobbying and other political activities. So there was some ophthalmological input to politics through the AMA House of Delegates and through the activities of the AMA.

² See the oral history in this volume with Mr. Zupan.

Separation into Two Academies

Hughes: *What happened in 1979, at the time of the split into two separate academies?*

Truhlsen: They prefer not to call it a split. They call it a termination or separation. [laughs]

The separation of the specialties probably had its genesis about the middle seventies. People who were involved in that were on the Council—[Drs.] Ed Maumenee, Bradley Straatsma, Frank Newell, Bruce Spivey, and various other people who were active in the superstructure of the Academy. I was not involved, although I was involved in the editorial aspects of it. I didn't sit on the Council in those days. But there were proposals—well, you can read this in the *Decade of Decision*.² There was a proposal brought up in the late sixties to split, which never got anywhere.

Then at the business meeting in 1973 it was brought up again, when it was requested that the Academy take a poll regarding separation, which was subsequently done. It wasn't an overwhelming decision. There was some concern and some heels dug in, I think, in both specialties. The Academy had been a long, ongoing cooperative venture. Ear, nose, and throat weren't as strong in number as they were later to become. We were about 60–40, ophthalmologists to otolaryngologists, in favor of separation. But the rank and file directed that we go in that direction.

It was over a period of about three or four years that this evolved. For instance, the Academy was not a corporation. It was an association under Minnesota law, and in order to effect a separation you would have to have unanimous decisions. Well, that was thought to be unlikely, if not impossible. So it took a couple of years of going through the mechanics of changing the Academy from an association to a Minnesota corporation. Then, when that was accomplished, we could split into an ear, nose, and throat division and an eye division, still under corporate structure of the Academy. And then action was taken in 1978 in Kansas City to separate the two divisions. Each one in turn became incorporated. We became the American Academy of Ophthalmology. Bradley Straatsma was the President of the AAOO during those years. Fred Blodi was the first President of the new American Academy of Ophthalmology.

There was some rather strong language exchanged in the process of separation.

² Felch, M.D., William C., *Decade of Decision: The American Academy of Ophthalmology 1979–1989*. Stanley M. Truhlsen, editor-in-chief. Foundation of the American Academy of Ophthalmology, 1989.

Hughes: Between the two specialty groups?

Truhlsen: Yes, between the members of the Council and the two specialty groups. The rank and file didn't enter into it too much except to vote on it. But the talk around the table in what was then the governing body of the Council was not always pleasant, I'm told.

Hughes: Did it revolve around money?

Truhlsen: No, I think not. I think it was philosophy. People sometimes resent change. "If it ain't broke, don't fix it" type of thing.

There was money involved. The Academy had an educational trust fund, even back then. There were several hundred thousand dollars in it. We split it, I think, with a very liberal settlement for ear, nose, and throat, even though there were more fellows who were ophthalmologists. I'm going over this rapidly from memory, and you can go back and pick up the details at some later time with those who were more intimately involved.

American Association of Ophthalmology Merger with the Academy

Truhlsen: After the American Academy of Ophthalmology was incorporated in 1978, there was a liaison committee formed. Bradley Straatsma was chairman of the Academy committee. [Drs.] David Shoch, Marshall Parks, and Tom Duane served on Association committees. Ted Steinberg was chairman of the committee for the American Association, which consisted of [Drs.] Alfonse Cinalte, Burton Krimer, George Santos, and Lawrence Winograd. Everyone on both committees belonged to the Academy, and all of them belonged, with the exception of Dave Shoch, to the Association. These two liaison committees met several times to see if we could effect a merger of the Academy and the Association.

That proved a little difficult. We met numerous times. You see, the Association had a house of delegates modeled after the AMA, and they had members who didn't have their board certificates. The Academy had a rule that you had to pass the American Board of Ophthalmology to be eligible for fellowship. Well, what are you going to do with the Association members who have not passed their boards? This involved changing AAO bylaws, since all who belonged to the Academy were called fellows, and having a "member" classification for those

who were not certified. Subsequently they formed a category of members who were in training, and so forth. There were a lot of ticklish little problems.

Through the diplomacy and the cooperation of two old friends, Bradley Straatsma and Ted Steinberg, the meetings continued. We would separate, and we'd come back and talk. Those two deserve the credit for finally bringing about an agreement that would be acceptable to both entities and finally accepted by both by a vote to merge the Association into the Academy. That didn't happen until 1981.

Hughes: I know there's much more to say on that subject.

Truhlsen: Yes, and there are other individuals who can give you more details.

Hughes: Let's go back to some of the early Academy people—Harry Gradle, William Wherry, and Bill Benedict.

William P. Wherry

*Truhlsen: Wherry was a vivacious, outgoing, rather large man who was professor of otolaryngology at the University of Nebraska. He was involved deeply with the Academy, and when Secretary-Treasurer really ran it out of his hip pocket. Our former office in the Medical Arts Building in Omaha was for many years the Academy headquarters, and I think there were only one or two people on the staff back in the twenties and thirties. Benedict was one of the Academy secretaries. After Dr. Wherry died suddenly of a heart attack in 1942, there was a good deal of material in the *Transactions* by his contemporaries and peers eulogizing him. I think he was orphaned. He liked to play poker, he had a stamp collection, he had many friends—all these things that make up the man.*

William L. Benedict

*Truhlsen: I was in medical school when Dr. Wherry died, so I never knew him. But I did know Dr. Benedict, who succeeded Wherry, when I became assistant editor of the *Transactions*. We had frequent meetings with him. The *Transactions* was printed in Omaha because Dr. Wherry knew the local printer. We used to go to Academy headquarters when it was in Rochester, Minnesota, and meet with Dr. Benedict.*

He was physically a large man, a rather domineering type of person who ran things just the way he wanted to. He was formerly the head of the section of ophthalmology at Mayo Clinic and did the Academy work as a labor of love. When he reached the age for mandatory retirement, he suddenly was hired by the Academy as a full-time Secretary-Treasurer. He was Secretary-Treasurer from 1942 until about 1967, when he became ill. That was when Dr. [Wendell L.] Hughes was President.³ Dr. Hughes would travel to Rochester when Benedict was in his hospital bed and try to get things straightened out.

Dr. Benedict, even though sick, was still trying to control things and run the Academy. Dr. Hughes was President; [Dr.] Ed Maumenee was involved. I can remember that Dr. Hughes went to Rochester at that time. It was a difficult time for the Academy, because Benedict was going to try and get well, by golly, and he was going to stay in control. Members of the Council were saying, "He's not well enough to run things. We've got to run things." And that's where Dr. Hughes came in.

Hughes: *Dr. Benedict retired from Mayo in 1950, and he died in 1969, so that's almost twenty years that he was full-time Secretary-Treasurer.*

Truhlsen: Yes, and he was majordomo until about 1967, I believe, which is when he became ill. [Dr.] Mike Kos was elected Secretary-Treasurer in 1969. He was Benedict's successor. He was an otolaryngologist.

Harry S. Gradle

Hughes: *The other name that stands out in Academy history is that of Harry Gradle. Do you have any personal memories of him?*

Truhlsen: No, he died before I became involved; but Dr. Morrison trained under him. In the July, 1990, I wrote a historical vignette for *Argus* about Harry Gradle, who was the father of the instruction courses.⁴ He was one of the founders of the Pan-American Association of Ophthalmology, which is meeting jointly with the Academy next year at Anaheim. I think he addressed in Spanish the opening ceremonies of the first meeting of the Pan-American Association of Ophthalmology.

³ Interview with Wendell H. Hughes, October 28, 1990, Atlanta, Georgia.

⁴ Truhlsen, MD, Stanley M., "Harry S. Gradle: The Father of the Academy Instruction Courses." *Argus*, July 1990.

He was a very interesting man who devoted much time, many hours, and many years, to the Academy. He was a professor in Chicago and also had a large private practice in Chicago, and he was very important in Academy history.

Hughes: Is there anybody else of those early people whom I should pay attention to?

Truhlsen: Dr. Howard Morrison is one, because of his memory and his association with Dr. Wherry. Dr. Daniel Snyder in Chicago was an associate of Dr. Gradle. He was also a Secretary for the Home Study Course, I believe, back in the fifties. So he would have recollections of associations and people like Dr. Kenneth Roper, Dr. Al Ruedemann, Sr., and the secretaries who were, in effect, running the Academy.

Hughes: I gathered, from your article.⁵

Truhlsen: Each one of them has their own area of control, as directed by the Board of Directors.

Hughes: How does the Executive Vice President fit into that scheme?

Truhlsen: [Dr.] Bruce Spivey is the top of the pyramid. He's the administrative officer. For instance, two or three times a year they have a meeting of the Board of Secretaries, in which they all discuss their respective activities and decide how to budget their programs. Bruce is the fellow sitting at the head of the table, and oftentimes he has to make final decisions as to what the Academy can or can't afford and whether they're going to cut back here or can afford to carry on activities.

The Academy has just grown exponentially. The budget was \$3 million in 1980, and it's over \$20 million now. When I was President in '83, it was \$6 million. Many say, "What's the Academy doing for me?" But if they stop and look at all the available services and programs, they will realize the advantages to AAO membership. I don't know what percent right now of the budget is spent on educational activities and what is spent on socioeconomic and political efforts. The Academy has a PAC [political action committee], which is a separate entity. There is a Washington office which is active in socioeconomic and political efforts. I don't know how that's broken down in our budget.

⁵ Truhlsen, MD, Stanley H., "The History of the Ophthalmology Secretariats of the American Academy of Ophthalmology." Typescript, revised April 1987, 32 pp.

Political Actions

Hughes: We talked about the educational emphasis, if not preoccupation, in the early days of the Academy. Now there definitely is a political-economic thrust as well.

Truhlsen: We have a Secretary for Governmental Affairs, yes.

Hughes: Does that lead to tensions between the educational aspect of the Academy and the political?

Truhlsen: No, I don't think so. I think there's been such a tremendous intrusion into the practice of medicine by government, insurance companies, third-party carriers, and industry that everyone in ophthalmology realizes [that] they are things we have to contend with; we have to try to influence them to the extent that we can. We have to talk to our representatives; we've got to try to control or direct our profession to some degree. We can't just sit and let somebody else control our professional lives. So I don't think there's any ivory tower professor saying, "Let's not pay any attention to what's going on," because it affects everything—medical schools, residencies, private practice, pocketbooks, the whole works.

Hughes: When did the Academy begin to have representation at the national level?

Truhlsen: When we had a division of ophthalmology under the old Academy, we had a man in Washington, a lawyer, who was a liaison or intermediary with whom Bruce [Spivey] dealt. He helped us keep track of political activities as they pertained to ophthalmology. When the incorporation of the present Academy took place, a Secretary for Governmental Affairs was instituted. We had a Secretary for Instruction, for Program, for Continuing Education, a new one for Governmental Affairs, and later we developed one for Public Education. [Dr.] Robert Reinecke, who was Secretary for Program, became the first Secretary for Governmental affairs. He did a tremendous job, running back and forth between Philadelphia and Washington.

Hughes: So he was actually acting as a lobbyist?

Truhlsen: Yes, that's right, but more than that. We had a person in Washington who was, you might say, *the* lobbyist, who worked in conjunction with Bob and under his direction as the Secretary, like Cynthia Root Moran does now. She's the one who goes up on the Hill and talks to the staff of the various senators and so forth and keeps up-to-date. [Dr.] Hunter Stokes is the Secretary for Governmental Relations, and he has five subdivisions under him—associate secretary for state

affairs, associate secretary for this and that, and this and that. Those are all under the direction of one Secretary, whose position has evolved over the years.

Hughes: *How effective do you think the Academy is in having its voice heard?*

Truhlsen: In their lobbying and Washington presence? Well, I don't know. I wouldn't categorize the Academy as alone in this. I think medicine is just getting beaten down. The government is concerned, and I guess rightly so, with this ever-increasing cost of medical and health care, and I'd like to subdivide those a little bit. Medicine gets blamed for health care, when it really ought to be only blamed for medical care. We talk about premature deaths, infant mortality, and similar things, and they're not all medical problems; they are social problems which our country hasn't dealt with. But then they say, "Well, infant mortality statistics in America aren't as good as they are in Spain," or some other country. That's because you can't persuade some people in some poor areas or ghettos to go to a doctor. You can't drag the single, teen-aged mother, pregnant, to a doctor. Her nutrition is bad, or she's not getting prenatal care. So doctors and medicine are painted with that broad brush.

I don't know how effective we are. We sometimes score a little here and lose a little there, and it seems like at the same time we're losing ground. When Medicare came in twenty-five years ago, the Academy didn't have anything to do with it. But organized medicine, the AMA, said that Medicare would continue to expand and would be more costly, and the doctors would lose control of medicine and how they take care of their patients. The proponents of Medicare promised that there would be no intrusion between the doctor and the patient.

Well, it's all come about. We're in many respects almost being told now how to practice medicine. We're given relative fee schedules and told how much we're going to be paid for our services. If you don't accept Medicare, the patient gets a letter saying, "Your doctor does not accept Medicare, and if you'd like to know who does, we'll supply you with some names." That's intimidation, and it's not fair. But as the thing goes on, more and more physicians are taking assignments from Medicare. It used to be 37 percent; I think it's up around 50 percent now who are taking assignments from Medicare, and the government just keeps pushing, pushing, pushing. It's the way many things happen. It doesn't happen suddenly. Every time Medicare makes a move, for instance DRGs [diagnostic related groups] or something like that, pretty soon here comes Blue Cross or Aetna or the other health care insurers, the third-party carriers. They're going to do the same thing if they can.

Hughes: Does the Academy have an overall policy that attempts to reconcile the need to reduce the cost of health care in this country and at the same time maintain the autonomy of the physician?

Truhlsen: Yes, but I don't know how much we've done, what inroads have been made. Long-range planning continues to say, "This is what we want to do, and we want to control this," but in effect how much we really have changed things, it's kind of hard to judge.

The Ethics Committee

Hughes: The Academy formed an Ethics Committee in 1980, but am I right in thinking that the Academy did interest itself in medical ethics prior to that?

Truhlsen: I think the Academy always stood for high ethical standards, but I don't recall that they ever had much in black and white. In 1980, as you say, ethics was brought before the Board of Directors, and [Dr.] Jerry Bettman was assigned chairman of a committee to initiate a code of ethics.

Hughes: Was it his idea to initiate the committee?

Truhlsen: No, I don't think it was. I can't tell you whose idea it was. It had been talked about for years. It was something that was needed, something that was a guideline. I don't know that there's any one person who did this. Now, there may be, and I would stand corrected.

Hughes: Why was there the feeling that there should be a committee on ethics at that point?

Truhlsen: There was the thought that medical ethics is a very important part of the practice of medicine. There were some physicians who were kind of frowned upon, I guess you might say, for the way they practiced medicine. We wanted an ethical code that would set standards for practice in ophthalmology.

The committee began its meetings and had many of them. It slowly developed a code of ethics, which I believe would really have greater impact if it could be accepted or endorsed by the Federal Trade Commission [FTC]. Because of a Supreme Court ruling that allowed advertising by the professions, and in effect made us a trade instead of a profession, we had problems with people who did in fact do unethical advertising. The Academy was involved in a lawsuit, about

which you may have heard. A man was doing what the Academy thought was clearly false and misleading advertising on television. It went to a lawsuit, brought about by a local ophthalmological society. The Academy entered as a friend of the court, so to speak, and all of a sudden we were spending lots and lots of money, and we did not win.

Hughes: On a restraint of trade basis?

Truhlsen: Not on restraint of trade. We were beaten on legalisms. The offender was advertising that he had developed a new operation. He had done this, he had done that, and he was flying across the country to do surgery. It just looked like an out-and-out, blatant deception to us as ophthalmologists. When the Academy finished with all the lawyers and legal maneuvers, we literally had to retreat. It cost us some money, and we didn't accomplish what we wanted. That was important, I think, in this whole ethical thing.

The committee continued to work and went to Washington, D.C., and presented its code to the FTC. I believe we made presentations several times. I remember I went with Bruce Spivey one time, when we were having a Board meeting in Washington, to discuss the code with the chairman of the FTC, Mr. Miller. We wanted their okay or their assurance that we were doing something that was proper and acceptable to them. This culminated in 1983. The year I was President, 1983, the code was finally adopted at the Annual Meeting and has been, with minor changes, in effect since then, and I think it has been an important guideline.

We have videotapes explaining the Code of Ethics that we show our residents. The Ethics Committee has little, if any, legal authority. We can expel someone from the Academy in the extreme case. However, the implication or knowledge that the Academy is looking at one's ethics straightens out many people, so maybe it's been helpful to some. Anybody who makes an accusation regarding ethics has to testify to it, so that whoever is accused can meet his accuser. That is legal, and that's proper. If people get an inquiry, sometimes that's all it takes, and very seldom does it come to an actual confrontation. I think it's a wonderful thing. The Academy's Code of Ethics is the only one, I believe, that has the FTC stamp of approval, so to speak.

Hughes: How common is it among medical associations to have a written code of ethics?

Truhlsen: I think at the time we were going through this there was one other one. I'm not sure, but I believe it was the psychiatrists. It was the only one that we knew about at the time, and I'm not aware of any other ones being developed. But I haven't

been on the Board for four years, so there are things that are happening that I'm not aware of.

Hughes: *At least it sounds as though you were among the first few.*

Truhlsen: I think we were a landmark in getting the acquiescence or approval of the FTC. We felt, and rightly so, that to go to the government and have something like this accepted was a real feather in our cap. It showed that, "Look, we're trying to do the right thing. We want to be ethically guided and sound in this area."

Hughes: *Did the FTC look at the code carefully?*

Truhlsen: You bet. We had to go back and make some adjustments that made it acceptable to them. Then once they give their approval, we can't just arbitrarily change the code. We have to live by what we developed and they accepted, or ask for the adjudication of changes that we might want to make. So it was a kind of long and labored birth over a period of time, and Jerry Bettman and the original committee did yeoman work.

Now, I believe Jerry's no longer chairman. I can't remember who the current chairman is, but like all committees in the Academy, you are supposed to have limited tenure, with limited numbers on the committees. There are about fifty-five different Academy committees, and usually the membership is limited to nine. Some of the committees aren't full. Committee members can only serve for a certain length of time, which is good, because it brings in new blood.

Hughes: *Is the time limit a long-term policy?*

Truhlsen: Yes, it was in effect, I think, even before the incorporation of the Academy. There are certain exceptions. For instance, the editor of *Ophthalmology* is an exception. He can serve for longer than the usual five years. At one time, committee members served for seven years. Back in the olden days I think probably Dr. Roper was Secretary for Program for maybe eighteen or twenty years, and Ruedemann likewise, who was Secretary for Instruction for many years. That was kind of a self-perpetuating group on that Council—Dr. Benedict, Dr. Roper, Dr. Ruedemann [Sr.]. They were all friends and buddies and good old boys, so to speak, and they kind of ran the show.

The Old Boys' Club

Hughes: You mentioned in your paper on the secretariats⁶ what you called an "old boys' club" at the top of the Academy.

Truhlsen: They ran it. They were all friends and buddies and played golf together. They used to take trips after the Academy [Annual Meeting] to Bermuda and other places.

Hughes: Did anybody protest?

Truhlsen: No, the Academy, going back fifty or sixty years, only had about a thousand members. Back in the twenties, they had maybe five hundred members, a thousand in the thirties, and then the Depression decreased the numbers. That's in that paper, too. But as long as they had a good meeting every year, there were few complaints. They had the Annual Business Meeting in the Palmer House through all those years, and they would do well if they had thirty or forty people attending.

So a few people would wander in and see what was going on, and the Council would get up and renominate their members and their secretaries and vote on them. Dr. Benedict would run the show, and that was it for another year. There wasn't any insurrection. There wasn't anything like that until 1974, when Dr. [Whitney G.] Sampson was nominated by petition for a Council seat and won over the Council's nominee.

The Foundation of the American Academy of Ophthalmology

Truhlsen: As was mentioned in the meeting about the educational trust fund, over 90 percent of the members probably don't even know we have a foundation. Now, the foundation hasn't been very active. It was formed at the time of the Academy incorporation and was initially composed of past presidents, and it didn't have well-developed goals. It was a vehicle that perhaps could be used but wasn't utilized much. In the last few years it's been restructured. It has named a board of trustees and five vice chairmen who have very definite functions. I think it's going to be a more vital and important entity than it has been in the past.

⁶ Truhlsen, MD, Stanley H., op. cit.

Hughes: Is there a reason why it came about at the time of the separation?

Truhlsen: Well, yes. There wasn't any similar AAOO body. The old Academy had an educational trust fund which was mostly just a little-used bank account. When we became an incorporated Academy, we became a 501(c)(6) organization under the Internal Revenue Code, which allowed us to enter into the political arena. But that removed us from the 501(c)(3) classification, which allows you to deduct for charitable or educational purposes. We needed that type of entity, so the foundation was developed with the idea of using it for educational pursuits, perhaps for research, perhaps for the benefit of residents, and for maintaining our ophthalmic heritage. It was indefinite or undetermined. We had discussed a good many times what the function of the foundation was to be. Now I think that bringing in Bradley Straatsma as chairman of the trustees, and [Drs.] Ed Norton and Fred Blodi and others as vice chairmen who are past presidents or have served the Academy in various capacities and have executive skills and ability, portends a bright future for the foundation.

The Insurance Program

Truhlsen: I might say just a little about the Academy insurance program. Back in the fifties, Dr. [Kenneth] Roper, with Dr. Benedict's okay, developed some insurance programs. The Academy had health and accident, disability, and I think at one time even liability insurance programs. They were developed through the Dennis Company in Chicago. This made available to the Fellows of the Academy these various types of insurance coverage.

Along about the late sixties or early seventies, I started serving on the insurance committee with Dr. Roper. There were only three of us on it: an ear, nose, and throat man, [Dr.] Eugene Derlacki; Dr. Roper, who was an ophthalmologist; and I. We later worked with another insurance agency in Chicago to try to enlarge and develop the insurance program. We had ten or twelve different types of policies available. The Fellow could purchase it for himself and, in some policies, for his spouse.

I went off that committee in the middle or late seventies, about the time we separated. The committee has continued to grow and provide coverage. However, I no longer have much contact with it. They developed a medical liability insurance program during the last few years, which is not large, and I'm not even sure how successful; but nevertheless we do have it as one of the programs provided by the Academy insurance committee. The College of

Surgeons has this type of program, as well as do the College of Physicians and the AMA.

Hughes: Is there a dollar advantage in insuring through an organization?

Truhlsen: In some areas. For instance, you can write any kind of insurance you want, and your premium depends on what your coverage is. It was thought for a long time that medical or professional liability insurance probably shouldn't run as high for ophthalmologists as it would for orthopods or neurosurgeons or obstetricians. This was the idea for having a policy only for ophthalmologists.

Now, various states have different laws covering malpractice and caps on awards. The medical malpractice program is not the same in every state. Three states that I know of have caps. In other words, the jury can only award up to a million dollars in Nebraska and, I believe, Indiana and North Carolina. Well, I don't know if the Academy could be too competitive in those states, because their premiums are already lower than almost every state around them. But I think the Academy did offer a premium savings that was meaningful to people in some states.

Hughes: Do you have anything that you'd like to say in conclusion?

Truhlsen: No, except that I have a great deal of admiration for this organization, as you've probably gathered, and I've been interested for these past forty years in its activities, its progress, its development, and its personnel; and I admire the people who run it. Professionally and objectively I just think they do a great job. The group [The American Society of Association Executives] that judged the mechanics of running the Academy also graded it highly. I guess there are a lot of people who pay their dues and come to an Annual Meeting, get their journal and accept it as such, and don't pay much more attention. Probably a majority.

Hughes: Anything else, Dr. Truhlsen?

Truhlsen: No, I don't think so.

Hughes: Thank you.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

Lawrence (Larry) A. Zupan

Conducted by
Sally Smith Hughes, Ph.D.
October 29, 1990, Annual Meeting of the
American Academy of Ophthalmology,
Atlanta, Georgia

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BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

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Areas of expertise State legislative activity concerning optometric
and medical practice

Other interests or activities None

Organizations in which you are active None

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LAWRENCE (LARRY) ZUPAN

[Date of Interview: October 29, 1990, Annual Meeting,
American Academy of Ophthalmology, Atlanta, Georgia]

**Founding of the American Association of Ophthalmology
and the National Medical Foundation for Eye Care (NMFEC)**

Hughes: Please tell me why and how the American Association of Ophthalmology was founded.

Zupan: The original group was identified as the National Medical Foundation for Eye Care [NMFEC]. It had its origin after a general session of the Academy which took place in 1956 in Chicago at the Palmer House Hotel. At that time, the Academy being composed of otolaryngology and ophthalmology, both groups were strictly concerned with the scientific aspects of their specialty. The American Medical Association at that time did have a Section on Ophthalmology, but the grassroots ophthalmologists felt that the AMA, even though it had a lobby-type structure, was not concerned with those areas of socioeconomic and legislative affairs, primarily that of optometry, which were appearing on the horizon and affected ophthalmology.

Furthermore, the NMFEC was organized to replace the original Committee on Public Relations of the AMA Section on Ophthalmology. A decision of the Board of Trustees of the AMA and confirmatory action of the House of Delegates had ruled that the various sections of the parent organization were scientific bodies only and therefore had no autonomous function in the realm of nonscientific matters.

So there was an organizational meeting of ophthalmologists who were interested. I heard that there were six hundred members at that meeting. It was an open session, led by Dr. Ralph Rychener, who more or less became the patron saint of the organization. They held a preliminary discussion of the issues and then asked those present if they were interested in setting up and joining a new organization. Approximately ninety percent of them said yes and became charter members. So they asked for their names and addresses, and from what I recall in learning from Dr. Charles E. Jaeckle, who was very active in the early organization, interested members wrote their names and addresses on the back of match covers, on slips of paper, or on prescription blanks. These were then collected. That basic list became the nucleus of the foundation.

In October of 1956, the formal organizational papers were drawn up. It was an organization established in the state of New Jersey.

Hughes: *Was there any particular reason for that?*

Zupan: I think the reason for that was that Dr. Jaeckle, the founding secretary, was a New Jersey resident, and Reed B. Dawson, the attorney who developed the organizational papers—the certificate of incorporation—was probably a resident of the state.

The first group didn't have many resources. They could not afford, because of that limitation, to establish a staff; so they retained the firm of James Bryan and Randall Norris to serve as administrators. Bryan & Norris was an association management firm in New York City. They handled the initial administrative activity of the National Medical Foundation for Eye Care in close contact with Dr. Jaeckle. Their professional technique in building that membership, writing the original newsletter, and developing legislative testimony and position statements is what got the foundation off the ground. After one year of operation, the membership grew to 1,700 members from a potential membership of 9,000.

The foundation carried on from '56 until '63, at which time the Board of Trustees felt that when Bryan & Norris were called upon, they were not in a position to give priority to the ophthalmological issues at times, because they had multiple association accounts. So the Board decided perhaps it was advisable to establish its own staff. They asked me to set up the Washington office in 1963. They terminated a contract with Bryan & Norris, so I opened up the Washington office at 17th and L Street N.W. with a limited staff of three—Mary M. McCambridge, secretary; Lois O. Ryder, bookkeeper; and one clerical assistant, Margaret V. Smith—all former co-workers and employees of the Medical Society of [Washington] D.C., who followed me to the NMFEC in 1963.

Hughes: *Now, why had they come to you?*

Zupan: Well, I had seven years' service (1941–48) as a layman in the Army Medical Department and in the Medical Service Corps. Then I served thirteen years as the assistant secretary of the Medical Society of D.C. (1948–62) and one year as administrator of the Washington Clinic, a group practice.

Hughes: *So you knew medical affairs.*

Zupan: I was medically oriented in administrative and association affairs. My military service and subsequent association employment were comparable to an intern and

resident training program. Then I had continuous service with ophthalmology from '63 until I retired in 1984.

The NMFEC initial year's membership rapidly increased from the nucleus of six hundred to a total of three thousand, because the men out there realized that certain issues which were appearing on the horizon—the expansion and definition of optometry, especially in the various state legislatures—were going to threaten practice. And whatever happened on a state level could eventually and subsequently did become an issue on a national level. By 1980, the membership was almost six thousand.

[Mr. Zupan added the following three paragraphs during the editing process.] I wish to point out that prior to the organization of NMFEC at the Academy meeting in Chicago in October, 1956, there was no organization in existence to deal with these vitally important socioeconomic problems, although the need for such a group had existed for a long time.

Another contributing factor which also served as a catalyst leading to the formation of NMFEC was that the American Optometric Association [AOA] at its Seattle, Washington, meeting in 1954 published its official policy statement: "It is the stated policy of the American Optometric Association in convention assembled that the field of visual care is the field of optometry and should be exclusively the field of optometry. Throughout the years, the optometry laws of the several states have granted exemptions to certain groups and classes. Resolved that the individual state associations are recommended to make serious study of the optometric laws prevailing in their states to the end that exemptions be restricted, limited, and ultimately eliminated."

In 1938, the American Optometric Association adopted a resolution which began: "Whereas the physiological eye care known as optometry and the surgical eye care known as ophthalmology are two separate and distinct professions...." The image of the ophthalmologist as a surgeon has always been exploited by optometry. Its goal: to be optometric physicians.

Inroads by Optometry in the 1950s and 1960s

Hughes: Optometry and ophthalmology had always been at loggerheads. Was there anything going on at this particular juncture that made people afraid?

Zupan: You see, optometrists were already well organized in large numbers, and they were a separate entity, whereas ophthalmology was tied in with otolaryngology. So here you had a homogeneous adversary group already with a common objective, and here you had a diversified group with nothing, no representation, no voice in legislative, legal, or sociomedical affairs.

There was an amendment to the Social Security Act which permitted the optometrists to determine legal blindness. That was the first accomplishment they had on a national level.

Hughes: Do you remember that?

Zupan: I believe it was introduced in 1950 and adopted in 1955.

Hughes: Early on, then.

Zupan: Yes, that's right. You see, the National Medical Foundation was not yet organized. However, there were enough independent active ophthalmologists at the time, even though they didn't represent any special group. Some of them did testify as individuals, saying that optometrists weren't qualified to make the determination of blindness or whether it may be alleviated by medical or surgical treatments.

Then another bill that came in right after that concerned the optometrists seeking equal pay as physicians in Veterans' Administration facilities.

Hughes: What was their justification?

Zupan: Refractive work. With the exclusion of surgery and the medical aspect, they performed the same type of service as an ophthalmologist.

The first bill on which the NMFEC provided testimony at the national level, in 1957, and the only testimony provided by any organization on that bill, dealt with the Veterans' Administration and optometrists. The foundation supported the VA's policy of limiting optometric services to within a VA hospital setting. The VA House Committee approved a bill which became law, extending the right of optometrists to provide outpatient VA care.

Hughes: Were they successful?

Zupan: No.

The first issue that I was confronted with was the Health Professionals Educational Act. Senator Lister Hill of Alabama was very active at that time and concerned with health and medical issues. In 1964, HR 8546, extending federal loans to optometric students, was approved by the House Commerce Committee. We had opposed the bill and urged the Committee on Rules not to grant a rule on HR 8546. Despite our argument and reasons, the optometric students were placed in the same category with Aid to Students of Medicine, Dentistry, and Osteopathy. The optometrists wanted to be included with dentistry and medicine for student scholarships, establishment of new optometric schools, and broadening the base of those already in existence.

So we tried to fight that. We were the only opposition group at the time—now, I’m talking about 1963 and ’64—and we were not successful, because we were not strong enough, and they had more clout. The optometrists had established a Washington office in 1961, and their legal advisor in Washington was a very prominent man who had the number-one private license from the Federal Aviation Agency. To boot, he was an arthritic who navigated on crutches, so when he appeared he always made a point to come into the hearing room late. He already had some sympathy by the fact that he was on crutches. But I’ll never forget; his name was William B. MacCracken. “Mr. Mac” was their big wheel in Washington. He was highly respected, honest, capable, and well liked by the members of the Senate and the House. So we lost that.

The Veterans’ Administration had a policy of excluding optometrists from treating veterans outside the VA hospital setting. MacCracken worked through the House VA House Committee by having a law passed extending the right of optometrists to provide outpatient VA care.

The Association’s Relations with the States

Hughes: *What individuals were actually representing the Association?*

Zupan: We tried to establish what we called key contacts in all the states. [interruption] The NMFEC already had a key-man structure from its inception. Those members served as representatives of our affiliate (state) organizations and were active in serving as watchdogs, witnesses, and spokesmen at the state and local level. They also served as a grassroots voice on national issues.

In 1977, the Association restructured the key-man program by setting up a key MD arrangement involving ophthalmologists to cover those congressmen who served on the four Congressional committees dealing with health legislation.

The first key MD program was held in Washington, D.C., in April 1978. The AMA had such a system, but ophthalmology could not rely on their system to get its message told and to meet the inaccuracy in the AOA views and goals. At the time, no other specialty group had a key MD structure. Our program became an annual spring affair.

Actually, in some states there were no ophthalmological societies that were concerned with socioeconomic or legislative matters. Many were strictly formed for a scientific purpose, because most of them were under the domain of their state medical society. There were states that didn't even have a statewide ophthalmological society at that time because of the sparse distribution of ophthalmologist population or the lack of organizational leadership and initiative. One of my initial assignments was to help, through Dr. Jaeckle, who drew up a model constitution and bylaws, to contact those states to encourage the ophthalmologists to organize a representative group. Then too many were dual membership groups composed of otolaryngologists and ophthalmologists, as was the Academy.

Hughes: *Was the AMA helpful in any way?*

Zupan: Not in that regard. They were completely aloof from us on state issues or state organization back then. We had ophthalmologists serve on the Section, which had its own scientific program. We functioned just like any other group—general practice, surgery, or what have you. They had no bearing on or were not concerned with issues of a state matter, because they did not dare to interfere with state medical society affairs. They were primarily concerned with federal and national issues.

But some of those ophthalmology groups that already were in existence reorganized and broadened their scope, which permitted them to become involved in socioeconomic legislative matters. There were some states that even combined the small, county-type ophthalmological bodies into one state organization. We then established what we called a Council of Delegates, which we hoped would bring a representative from each of the states into our annual and special meetings. In those states which had not yet developed an organization, the Board of Trustees would then appoint one man, and we invited him to attend our meeting to represent that state. He was usually a person who our officers knew was concerned or already active as an individual in those activities.

The Association's Relations with the Academy

Zupan: The Council of Delegates in 1962 voted as a body that the NMFEC establish an annual leadership conference at the Annual Meeting to be held in conjunction with the Academy meeting. The first leadership conference was held in New York City, and that was at the Academy meeting in 1963.

Hughes: Was this again with an eye towards the optometrists?

Zupan: That was part of it. But there were other issues.

I'm happy to say that I have a copy of the first program. Even though it is a very simple, plain thing, it was the first activity we got involved with after we established our own staff. I also have copies of other programs which took place in subsequent years.

We had a lot of discussion of issues at those early conferences. I don't know whether I should say this. I hope Dr. Bruce Spivey and the rest of the officers will understand. The attitude of the grassroots at that time was that the leadership of the Academy was not concerned and did not care. We knew they couldn't be because of their constitution and bylaws; they were primarily a postgraduate education organization. But the rank-and-file men, the grassroots, the general ophthalmologists, felt that the Academy leaders were all ivory-tower guys, the professors. They were all secure. They couldn't get involved with fights with optometry, because they were all fearful of jeopardizing the grants that they were getting in their own departments or institutions. So that was the existing feeling.

Hughes: How did the Academy regard the Association?

Zupan: To some members we were the bad boys in the black hats at the time. I think some of the Academy leadership thought this was a bold action on the part of our ophthalmologists. But then again, I think there was another group that felt this organization was necessary to protect the practice of ophthalmology. There were some ophthalmologists in the Academy who looked at our organization as a splinter group. Some felt we were too radical. The others who did not wish to join the Association were apathetic toward political or socioeconomic affairs, even though their future was being threatened.

I think the fact that we were accepted as a public health exhibitor at the Academy meetings from the outset was a token of acceptance. From that time on, and even up to the merger, we were always given an exhibit space at the Academy meeting. We were also provided with hotel facilities, which we paid out of our own funds;

but we were an accepted group for socioeconomic affairs. They gave us assigned times when we could meet with our House of Delegates, our Board of Trustees, and our Executive Committee, so I can't complain about that. In recent years, the Academy would appoint a member to serve as its representative to the Association.

But even as late as the sixties and seventies when I attended the Association's booth at the Academy meetings, the apathy of the rank-and-file doctors toward prevailing issues appalled me. They would walk by, many of them, and say, "There's the anti-optometric group." You know, just pass by as if we were bad boys, not realizing that here we were concerned with the socioeconomic aspect of medicine that in time, with the way things were going, would be the major issue of the future. Fortunately, the men who organized our group were pioneers and had enough foresight to realize that. The Academy has spent millions on what we tried to accomplish on a shoestring budget and small staff.

Coming to the present time, I smile now, because when I read copies of the *Argus*, and I go to meetings of the Academy Council, all the issues that are being discussed or published are socioeconomic or legislative matters. *Argus* is, from page one to the back page. And it's the same thing we [the Association] promulgated years ago.

The Association's Skirmishes with Optometry

Zupan: After the Health Education Assistance Act, we had several skirmishes with optometry involving the military services regarding optometrists' rank and pay, use of drugs, and the definition of optometry as to its scope of practice in the military. We had personal conferences and correspondence with the surgeons general of those groups, trying to make direct contact with them. Even though they were physicians, there was still a matter of politics involved. Some of them would sympathize with us and realize our position, but we never did succeed in accomplishing much with the military because of optometry's influence on Capitol Hill and the Congressional committees on military affairs.

Another issue which arose, and probably the most important one, was Medicare. When the Medicare issue came up in '65, optometry, along with podiatry and all the other nonmedical groups, wanted to be included in Medicare. The optometrists submitted a voluminous history of optometry and its scope, its education, the whole gamut—a very well-done piece—to the so-called Cohen Committee. That was when Wilbur J. Cohen was secretary of Health, Education,

and Welfare [HEW]. Fortunately, his group was made up of enough physicians and other specialties—social workers, et cetera—that in the so-called Cohen Report,¹ which came out after evaluating all submissions, they decided: “It is recommended that present coverage for optometric services not be expanded at this time.” So that was the one battle that we won.

We had input to individual key people at HEW and some of the panel experts. It was not a sub rosa thing per se, but enough of it was under cover so as not to jeopardize the jobs of those people who were physicians. They were physicians who sympathized with us but were definitely fearful of jeopardizing their own jobs, because they were in a position to eliminate one group in supporting their own medical group. And that’s what happened.

Years later, optometry again had bills introduced by Senator Robert J. Dole of Kansas, when they were broadening Medicare. I hate to say it, but I have forgotten what year; I think it was in 1976. A new group was appointed, and that included Dr. Al Lemoine, an ophthalmologist from Kansas. Dr. Robinson D. Harley and James P. Gills were also on the panel as ophthalmologists. The panel of outside consultants recommended amendment to the Social Security Act so as to make reimbursable under Medicare a wide variety of optometric services.²

Dr. Lemoine, who was a very well-meaning ophthalmologist, felt that if optometrists were willing to do anything, he would participate in training them to a limited degree in the recognition of diseases for referral purposes. He became their advocate in a sense. He was appointed to this new group because of his status on MD-OD [physician-optometrist] relations, his teaching of optometrists, and his Kansas residence. Senator Robert Dole of Kansas played a pivotal role in having the amendment adopted by Congress. The other consultants who were brought into the new panel all thought alike. They were pro-optometry. Wherever the word “ophthalmology” appeared, they inserted “or licensed optometrists”—you know, licensed by his state. And they succeeded. The technique they used the second time to win was pretty much the same technique we had used the first time when they were excluded. Many ophthalmologists felt the panel was a “stacked deck” of AOA representatives and pro-optometry public members.

¹ “Independent Practitioners Under Medicare: A Report to the Congress,” Department of Health, Education, and Welfare. Wilbur J. Cohen, Secretary, December 1968.

² “Report to the Congress: Reimbursement Under Part B of Medicare for Certain Services Provided by Optometrists, v.s. Department of Health, Education, and Welfare,” July 1976.

Hughes: How much overlap in membership was there between the Association and the Academy?

Zupan: Quite a bit. I would say that there was a small percentage of the men in our group who were not Fellows of the Academy or who were not board certified. I would say that probably 96 percent of our members wore two hats and paid dual membership dues; however, we never had as many members as the Academy did over the years. In its infancy and up to the mid-sixties, the Association had physician ophthalmologist members, corporate membership, and affiliate and associate lay person membership. Eventually the non-ophthalmologist classes or members were thanked for the early loyal support, and they were dropped from the rolls.

In October 1965, the NMFEC became the American Association of Ophthalmology. The foundation identification gave many individuals and groups the erroneous impression that we had ample funds to disburse upon request, similar to other philanthropic foundations. When I came on board, our dues were \$35 per year. The Board of Trustees had voted a \$10 increase in dues for the 1963 calendar year. We lost some of our members who did not wish to pay \$35 dues. This happened each time dues were raised. Can you believe it? Our dues never exceeded \$150 a year. Compare that with what groups charge today.

Hughes: Did they experience any sort of discrimination or disapproval when they attended Academy affairs?

Zupan: Not by the Academy, because before the second issue on Medicare was enacted to include broadened optometric services, the Academy in 1977 had set up a Washington office.

Hughes: Prior to separation.

Zupan: Yes. The Academy officially separated from otolaryngology on January 1, 1979. This took place during the separation and division procedures from otolaryngology. Their first Washington representative was John Lynn, a capable former Congressional staffperson. In June 1977, John opened the Academy's Office of Governmental Relations at Seventeenth and K Street, N.W., in Washington. He had a small suite of offices and a staff of one secretary. I remember her name, Cindy Carter, from Texas. His legislative assistant and lobbyist was a girl named Cathy Greeley, who subsequently became Cathy Greeley Cohen, an Irish Catholic girl who married a wonderful Jewish guy. Lovely couple. They've got two beautiful daughters.

Hughes: *This isn't the same Cohen you spoke of?*

Zupan: No, that was Wilbur J. Cohen, Ph.D. He was dean of the School of Graduate Education, University of Michigan, and formerly Secretary of Health, Education, and Welfare. Dr. Cohen was the keynote speaker at the first joint session of the Academy and Association, held in Dallas in 1973. He spoke on "Next Step in Medical Care Policies." It was a public affairs program. He was anti-organized medicine but an expert on health matters.

The proposed expansion of optometric services under Medicare was the first issue John was confronted with as an Academy staff man. To tell you the truth, he was more handicapped, I think, than I was, even though I had a limited staff. But we subsequently hired, on demand of our councilor, our House of Delegates, a part-time lobbyist, James Foristel, who became available to us when he retired from the AMA.

Hughes: *Was he effective?*

Zupan: Jim was retired, and he was a very well liked, very accepted man on the Hill. Even though we lost the issue, we felt that we delayed it long enough. But the Academy expected too much from John, to open an office and then go up there and win a battle; it was a major battle, and here you had one man. John had been a legislative aide to Congressman James R. Jones from Oklahoma. He took the job, but I don't see how he could have done it. At least we had enough key MDs and contacts out in the grassroots whom we were using to approach other members of the health committees that were concerned with that legislation.

After John Lynn's tenure ended, the Academy's Washington office was reorganized, and several committees were established to function as the Secretariat for Governmental Relations under the direction of Dr. Robert D. Reinecke, Secretary. Today the Washington office employs a staff of eight and retains a couple of legal firms as additional lobbyists and consultants, quite a contrast to what Lynn had to work with.

I hate to say this, but PEN (Physicians Education Network) was more aggressive than we were. Some of the American Optometric Association staff dubbed PEN "The Poison Pen" because of its censorious theme in all its publications. PEN was originally organized as Ophthalmology Physician Education Network (OPEN) in 1977. Its primary function was as an information service only. It took no action on its own, it distributed no funds, it had no assets. PEN duplicated and disseminated news items to interested parties involving state legislators. The founders of OPEN believed the PEN is mightier than the sword.

To my recollection, the only action PEN initiated was the suit it brought against HEW, challenging the department's 1976 Report to Congress finding that optometrists were qualified to do things they were found not qualified to do in the 1968 "Cohen" Report. The suit also challenged the selection of the panel of consultants and other alleged irregularities. The Report was submitted to the Congress as a consensus of a select committee and several departments and agencies of the Department of Health. PEN filed suit against HEW in U.S. District Court in Washington in the early eighties. The court dismissed the complaint. The U.S. Court of Appeals allowed the Report to stand.

Hughes: *What was PEN's mission?*

Zupan: Anti-optometry from the letter "o" all the way to "y."

Hughes: *These were ophthalmologists, or were they from all the specialties?*

Zupan: Primarily ophthalmologists—Physicians Education Network. They were trying to influence that same legislation. They had fewer members than we did, and we never even came close to the Academy membership; I don't think my membership ever got up beyond more than five thousand people. Our dues were so limited—\$150 a year before the merger.

Hughes: *What were you using for money?*

Zupan: Dues. We were providing leaflets, which we sold a little above cost. The National Society for the Prevention of Blindness and our organization were the only organizations in the United States that provided any health educational leaflets on eye care and eye disease topics.

The Association's Home Study Course for Ophthalmic Assistants

Zupan: In 1964 we took a survey of our membership to determine how many of them would be interested if we were to establish a home study course for ophthalmic assistants. There was a preponderance of the vote in favor of such a thing. So a committee, headed by Dr. Joseph M. Dixon of Birmingham, Alabama, was established to develop the home study course. We got the idea for such a course from the Section on Ophthalmology of the Ontario Medical Association. They already had an ongoing course that [involved] mimeographed materials which were assembled and issued by a man named Dr. Harold A. Stein.

The purpose of our course was to provide a primer for existing or newly hired ophthalmic assistants. The first series consisted of eight lessons. They were individual booklets. The enrollment for each course was merely \$25 per person. It was a home study course, and we included a multiple-choice mimeographed examination with each booklet. Those examinations were returned to us at the individual's own discretion; there was no set deadline. When they came in, they were assembled and sorted according to lesson number one, two, three, four, five, six, seven, eight. I used to take them home and grade the exams.

Hughes: *You were the one?*

Zupan: Well, I had a master sheet. Grading papers was in addition to my other duties. The course was so popular that we established the second series, which we called the advanced series. That also [comprised] eight lessons.

Hughes: *Who set up those lessons?*

Zupan: Dr. Dixon had a committee, and we picked men who were prominent in a given field. We had about twenty-three prominent authors who submitted manuscripts for the sixteen subjects covered. David M. Vess, Ph.D., of Birmingham, Alabama, served as editor. For pediatric ophthalmology, we had men like Marshall M. Parks write the book. I don't have the booklets, but we managed to pick men who were involved with the Academy, or AUPO [Association of University Professors of Ophthalmology], to do these books, so they weren't just haphazard things. They were excellent pieces and in demand at the time. The courses sold themselves and were [welcomed] by ophthalmologists and their staff to fill a void.

Hughes: *Was there any overlap with the Home Study Courses that the Academy had been doing for a long time?*

Zupan: No!

Our courses were organized and somewhat on the pattern of the Academy's Home Study Course in the basic sciences for ophthalmology residents. They were prepared for the ophthalmologists' lay staff in terms that were understandable but still scientific.

Well, the men did a beautiful job. At the successful completion of each series, we then awarded that individual a certificate. It's unbelievable how that caught fire.

The Association Trains Ophthalmic Assistants

Zupan: We subsequently awarded and made available a pin for the physician staff to buy at a very minimal cost. The pin identified the aide as “Medical Assistant—Ophthalmology,” a new term. We hoped that they would wear the pin in the office to identify themselves as members of the team. Just a little thing like that helped the staff morale.

Hughes: *Did the course relate to the controversy with the optometrists?*

Zupan: It didn't. The only threat came when Duffy, a member of your legislature in California whose first name slips my mind, introduced a bill in California that provided for a limited activity of physician assistants and was considered applicable to ophthalmic assistants.

In the seventies, physicians' assistants (PAs) bills were being introduced in the state legislatures, sponsored by state medical associations to meet the health manpower shortage in many areas. This new member of the health care team posed a threat to optometry and other licensed limited practitioners. You see, at that time in all the state legislatures, most of the definitions of optometry were comprehensive in what optometrists were permitted to do. Here they said he was qualified to do this, this, this, this. At the end they would say that anyone functioning in these capacities was violating the practice of optometry, with the exception of a physician. So that meant your ophthalmic assistant was practicing optometry. And that's the way it went. So I think optometrists resented what we were doing because we were training ophthalmic assistants to function as an assistant to the surgeon, and we weren't even willing to teach them in schools of optometry. And here they were, so-called “doctors of optometry.” That part of it they resented.

I was glad to see the course happen, because this was a positive activity of our organization for doctors who weren't even members of our group. Oh, they readily accepted the course and took no time in signing up their staffs—three, four, or five people. Many doctors were paying for the course for the staff and even told the girls, “If you complete it successfully, I'll pay for the whole course and even take you to dinner.” There were all kinds of awards being established, because they felt the more the staff learned about the job, the better employee she would be. As far as we were concerned, even though the course fee was a nominal charge, it increased our funds. But those funds were kept separate from our other income and expenditures.

Hughes: *The course increased your visibility as well.*

Zupan: That's right. A positive aspect.

Hughes: Did you notice an increase in membership when you began the course?

Zupan: Definitely. But most of all, it was the goodwill we created, not only with the Association members but the members of the office staff, because no one else had this course available. They couldn't take out a medical textbook to find the precise chapter on glaucoma or visual aids or nearsightedness or ophthalmic drugs and things like that.

After we merged, the Academy took the course upon themselves, and they restructured the whole thing, making it more technical and scientific. It is still being accepted by the grassroots.

I just learned at this meeting from Dr. Dixon that it's now all in one book. He feels that was a mistake.

Hughes: Why is that?

Zupan: Because he feels it's now too voluminous. He feels that our piecemeal manner was the way to do it; give it to them gradually.

Hughes: How did the Academy, which has always prided itself on being an educationally oriented group, regard these educational endeavors that the Association was engaged in?

Zupan: The Academy never took it upon itself to go into that. As I said, we could never get them interested in the leaflets that we put out. We had some of their own people sit on some of our committees to help draw the leaflets up. But they had nothing [no instruction] except for physicians.

We had one leaflet called "Glaucoma: Thief in the Night," and we were threatened by the NSPB [National Society to Prevent Blindness] that we were stealing the copyrights of a similar leaflet which they put out on the same topic. I think their publication was titled, "Glaucoma, Sneak Thief of Sight."

Hughes: What was the result?

Zupan: No problem arose. We didn't change the name. Mrs. Virginia Boyce and Dr. John Ferree, who was then director of the NSPB, accepted it because they knew we had good intentions. The leaflets were similar in name, but what else can you call glaucoma? Even in daily communication, many of the ophthalmologists refer to it as "the sneak thief of sight."

At one time the Association was prevented from distributing an early version of its leaflet, "What is an Ophthalmologist?" by order of the Attorney General of the State of Florida. We were not allowed to send the leaflet to Florida residents until a reference to optometrists was deleted or modified to comply with the definition of optometry in the state's optometric practice act.

Optometry, Puff Tonometry, and Diagnostic Drugs

Zupan: One other very active role that the Association played was in getting information from the states that optometrists were introducing bills in their state legislatures that would prohibit the functioning of the ophthalmic assistants. They were also introducing bills that were broadening the scope of optometry, for example the introduction of bills which permitted them to use diagnostic drugs.

At one time the optometrists were not permitted to use a Schiötz tonometer, because it was an instrument that touched the eye and required the use of an anesthetic. So subsequently they developed a tonometer—I think one of the first was called the McKay-Marg's tonometer, which many of the optometrists used in testing for glaucoma—which did not need the use of an anesthetic on the eye. I think they call them puff tonometers now; I'm not sure. It would shoot a jet of air and record the same pressure reading.

But with the Schiötz tonometer, the ophthalmologist would put a drug on the patient's eye and then put that instrument on the eye to get a pressure reading. Optometrists weren't allowed to use that. We had asked the Academy to give us a position as to the use of the Schiötz tonometer by optometrists, which they refused, because it was not [their] policy to take a position on such issues at that time. We also asked the American Ophthalmological Society to support us on that, and they refused. So we stood alone on that legislation issue in all states.

But going back to the drug issues: the optometrists were so well organized on the state level that they had even received from their national headquarters a litany of legislative approaches and techniques which was distributed throughout the United States to every optometric society.

The optometrists were joining organizations like the Kiwanis Club, American Public Health Association, the Jaycees, and the Lions [Club]. They found themselves involved in local groups like that, and through them they were identified as purveyors of health concern, because now they were mingling with the business community.

The ophthalmologists were so damned busy with their patient load that we could never get them to join a civic group, because they didn't want to give up the time from their office or their family to become involved in that kind of activity. But these were political moves which supported optometrists in their total legislative effort, because with their drafted bill they could then come into the legislature with support of these clubs as individuals and as organizations. Eventually we lost the first diagnostic drug bill in the state of Rhode Island in 1971.

We never had a fight as such in New Jersey, because they had already had an attorney general opinion which stated that under the definition of optometry they were already permitted the use of diagnostic drugs. So there was no need for optometrists to have enabling legislation submitted in New Jersey, because it was already interpreted to permit them. Despite the efforts that the New Jersey Academy of Ophthalmology and Otolaryngology made to seek another opinion, the situation remains the same. And even with what support we tried to give them in getting a change in that opinion, we never succeeded.

So I would say that the first diagnostic drug permissiveness was in New Jersey. The first act enacted was in Rhode Island. West Virginia was the first state that permitted optometrists diagnostic and therapeutic rights, both in the same session.

Hughes: *Is there an accounting for that?*

Zupan: Yes. If you turn the tape off, I'll tell you. [tape off]

The success of the drug bill in Rhode Island gave optometrists enough impetus and support and, I guess, togetherness so that from that time on, it served as a pattern for other states to follow. One by one they were successful in achieving the use of diagnostic drugs in all the states, despite the opposition of ophthalmology. Now, in most cases, from what I recall, when the ophthalmologist would go to testify, it was always a matter of being on the defense. Here we were, bringing people in to testify against [what was perceived as] a well-meaning group.

Hughes: *Ophthalmologists were in a bad position to start with.*

Zupan: The optometrists had already established an excellent legislative approach to matters where they knew their legislators on a face-to-face, one-on-one basis, not only in their respective legislative halls but even back home as businessmen or whatever relationship they were in, holding that office. They couldn't be "bad guys," so to speak.

Hughes: *What was it that sold the legislature on the optometrists?*

Zupan: We challenged them on their lack of educational ability to do this. It was also pointed out that the application of a diagnostic drug in the eye could even lead to death. When you were asked to submit any data to prove those points, in many instances there wasn't any data available to make that presentation to support those accusations.

Then other approaches were to come in with examples of mismanagement or misdiagnosis of previous optometric activities, and the optometrists just turned around and said that, well, if they had the use of drugs, maybe these things wouldn't have happened.

But I think primarily it was the back-room functioning of the optometrists on a one-on-one basis and that these hearings were more or less a formality; the decisions were already made in advance. Which is probably the same thing that happens today.

Hughes: *Do you think there was a "favoring the underdog" philosophy as well?*

Zupan: I really believe, because of the anti-AMA stance that some people might have had, or anti-physician stance as a group, that the same people might have felt that ophthalmologists want to dominate; they want to usurp optometry, they want to limit these men in what they're going to do. I think that probably had a lot to do with it. But the irony of it is that if you were to ask each of those individuals, they probably had high respect and high regard for their own physicians. Optometric witnesses often identified the ophthalmologist as a surgical specialist, whereas they provided vision care. Many legislators who were hearing the issues had themselves gone to optometrists. So there you were, making an accusation that they were going to the wrong person.

Hughes: *Yes, it was a difficult thing for the ophthalmologists to argue. Also, the argument about why an ophthalmologist is preferable to an optometrist could get very technical. The niceties of diagnosis and prescription might be lost on laymen. It's not an easy argument to make convincingly.*

Zupan: What optometrists brought up, too, was the fact that the ophthalmologist is an eye surgeon. "He's a surgeon, and I'm an optometrist. He performs refractions, which I'm trained to do. I'm not trained to do surgery, but he's doing what I'm trained to do. Therefore, he should only do surgery and not do refractions. I dispense eyeglasses in conjunction with my optometric practice, and so does he, but he's a surgeon." So you're demeaning the ophthalmologist because he's an M.D. who is dispensing and functioning as an optometrist and as an optician. All the arguments came into play.

Hughes: Yes. Very difficult.

Zupan: I can't say that to Bruce Spivey. [laughter]

There were other things that came up in the state legislatures, but once the optometric drug bill succeeded in twenty-five states, then it was just a domino effect right on through.

Hughes: Using one state as an example for another?

Zupan: Oh, yes. Then the optometrists could say, "Mr. Chairman, we now have twenty-six states that permit us to use diagnostic drugs, but I regret to say that the Minnesota group is behind the times."

The Association's Strategy in Legislative Battles

Hughes: Were you orchestrating the overall legislative strategy?

Zupan: We would supply what limited suggested testimony that we felt would support ophthalmology's position. We would develop that in Washington or reproduce it when we received it from other states that might have stalled the bill from one year to another. We acted as a resource center.

We also had leadership conferences where the state representatives would get together, and we would discuss pros and cons on how we did it. These were very informative. We could not send witnesses to those affairs to testify because we didn't have the funds, and again some of our people felt that you have to fight your own battle. Number one, why should an ophthalmologist from Ohio go to New Jersey to testify on a New Jersey bill and give up his practice, when you've got three hundred guys in New Jersey who ought to do it themselves? Number two, when you take a man from Ohio, and he goes before the New Jersey legislature, they'll say, "Doctor, where are you from? I understand you're from Akron, Ohio." "Yes, sir." "Well, this is a New Jersey bill. We think we're capable of making our own decision."

Again, we were the only organization at that time that did this. We even had special meetings at different times of the year in different locales, like New Orleans or Chicago, where we brought the men together to discuss [political] issues. Since its inception, the Association sponsored leadership meetings, legislative conferences, seminars, public affairs workshops, and other means

of apprising ophthalmologists on vital issues. Then at open meetings at the Academy, which we called public affairs workshops, we invited not only the physician but spouses and staff, and we would present talks on national or state issues that were confronting ophthalmology at the time.

Hughes: *Your hope was that they would then become spokesmen for the cause?*

Zupan: That's right. Not only that, but they'd become involved in it by word of mouth so that we would gain momentum, and this thing would snowball to the point where we would then equal our opposition, optometry.

Hughes: *How successful were you?*

Zupan: As we went along, prior to the merger, we became more effective, even though we lost states, just as the Academy did, no matter how many people or how much money was involved. It all goes right back to the individual state organization: the outlook of the state ophthalmological society, the state medical society, the state public health officer—all the medical organizations within that state. These people all had a part in it, and in some cases the optometrists were able to keep them neutral or even get their support.

The optometrists even were able to get the other non-medical groups, such as podiatry, chiropractors, and the practical nurses. All these other people who claim to be part of the medical team who were individually licensed had their own licensure under the state act. They were even able to form coalitions to work together to help each other achieve their legislative objectives. That's something we couldn't do, because we could not get the support of the specialties to fight ophthalmology's battle.

Again, I might say that the reason for that is because there were articles in several issues of *Medical Economics* at the time saying that ophthalmology was a rosy practice. They were publishing statistics on the annual income of the ophthalmologists and all that. Well, hell, G.P.s [general practitioners] and pediatricians read that and said, "These guys want me to go fight their battle? To hell with them; they're making more money than I am."

Hughes: *Were the drug houses involved in any way?*

Zupan: No. They couldn't get involved, because if they did, they knew there probably would be some kind of attempted boycott.

Then we also had issues on so-called "freedom of choice" or "non-discrimination" bills in all the states, and I think optometry succeeded in getting those passed

in every state. You could not discriminate between any health practitioner. Wherever optometry or ophthalmology was mentioned, or any specialty, you had to include optometric services. So there was a freedom of choice in that regard. The same thing applied to prepaid insurance activity within the states. They succeeded in that regard, and they got that in all fifty states.

Hughes: *When was that accomplished?*

Zupan: The freedom of choice bills were all done during the sixties and seventies, I would say, prior to the merger, and prior to the opening of the Academy Washington office.

Hughes: *Were you yourself testifying?*

Zupan: No.

There was another issue that came up on the Hill that just came to my mind, called the Medical Restraint of Trade Act, drawn up by Senator Philip A. Hart of Michigan. Hart was chairman of the Senate Antitrust and Monopoly Subcommittee. The Hart office building in Washington is named after him. He married a wealthy woman in Michigan and had a large family. His wife even rode a motorcycle around Washington, a very strange thing at the time but acceptable.

The original Hart bill, among other restrictions, would have prohibited an ophthalmologist from profiting from dispensing eyeglasses, contact lenses, and drugs in his own office. All physicians would be barred from making money on products they prescribed under that bill.

A second bill, introduced in 1967 by Hart, differed from the original in that it made no reference to "profit," but would make it illegal for any person licensed "in the practice of medicine" to dispense except under certain conditions.

The Association's Refusal to Support Opticians

Zupan: We always suspected the Hart bill as being supported and possibly initiated by the Guild of Prescription Opticians as an effort to relieve any restraint on opticians from developing their stores. Because if they were to get the optician, as an employee, out from under the ophthalmologist and to remove the dispensing of eyeglasses and contact lenses from ophthalmological practice, then all these patients would be forced to go to the optician to obtain spectacles and contact

lenses, even though they would still be on a prescription basis, because the opticians were not licensed to examine or to refract the eye.

Even today—you may not realize it—the opticians are not licensed in every state in the United States. Some of them may function under regulatory regulations, but they're not licensed in all states. We were reluctant to support them for licensure in all states, because we felt that once they would gain that recognition then they, too, could become a monkey on our backs, like optometry. Because once they become strong enough, then they could challenge the ophthalmologists or their staffs as practicing opticians. So we never supported them, and without the support of the physicians, the opticians never achieved success to any great extent comparable to optometry.

I think another reason for the difference between opticianry and optometry is that there were more optometrists than there were ophthalmologists and more optometrists than there were opticians in the guild.

The Hart Bill

Zupan: The Hart bill was a very vital issue, as you can imagine, because even though there was a [difference] in the practice of ophthalmology between those men who were already dispensing and those men who felt, well, "That's unethical, this is verboten; I'll never do it," for the men who were doing it, this was an economic issue, and it was part of their income. These same men may not have been doing as many surgical procedures as the other group, so therefore their refractive and dispensing practice might have been the backbone of the practice and of their income. They were threatened by opticianry if the Hart bill went into effect.

The guild brought in all its big wheels in opticianry to the hearings of the Hart bill. We had testimony by our people. This was the first time in my recollection that the AMA actually took a part in testifying at the same time as we did, because now it not only affected the ophthalmologists but every physician when the bill referred to dispensing drugs and appliances. For example, the orthopedic men dispensed crutches, braces, supports, and so on; so the AMA did testify against that issue.

Hughes: *Was it effective?*

Zupan: This is like a soap opera. [laughter] I was not a lobbyist; I didn't profess to be a lobbyist. I did have contacts on the Hill, and I had contacts through AMA

lobbyists whom I knew and worked with. We were able to get in touch with Senator Everett Dirksen of Illinois, who at that time was secretary of the Senate. He had a very capable attorney on his staff, Peter N. Chumbris, who was handling this particular issue. Mr. Chumbris was Minority Council, Subcommittee on Antitrust and Monopoly of the Senate Committee on Judiciary. He was a participant in the Association's Public Affairs Workshop held in Chicago in 1966. His subject was, "Pros and Cons of S.2568 (Hart Bill)." About three hundred members [of the Association] attended that session.

I went up on the Hill every day during these hearings, and I gathered all the testimony that was being presented on that day. When you testify, you're obligated to present prepared material. I would take that back to my office after the hearings, and Mary [McCambridge] and I would burn stencils. We had a piece of equipment that would scan a piece of material, and it would cut a stencil simultaneously. This was when Xerox was coming out. We couldn't afford a Xerox machine at that time, so we were still mimeographing our materials. We would cut stencils and mimeograph that material until one or two o'clock in the morning and then mail it to all the state organizations. With our limited staff, we were trying to keep them as current and as apprised as we could as to what was going on with this particular issue. We did that all the way through the hearings.

Later we also brought in men from the Illinois Ophthalmological Society who were constituents of Senator Dirksen and who also knew Mr. Chumbris personally. We used their input as key MDs with their representative on the Hill to try to influence him to encourage the defeat of the Hart bill. We brought Mr. Chumbris to a meeting of our leadership conference at the Palmer House Hotel in Chicago, at which time he addressed our key MD state representatives and our Board. He returned to Washington, and subsequently the bill died.

Now, I might say in all fairness that, through the input of individual ophthalmologists who came to Washington to testify, probably the only groups in the United States on a statewide level that were primarily concerned were California and Illinois.

Hughes: *Why?*

Zupan: I suspect the principle of the thing is what concerned the California ophthalmologists: Here the federal government was now dictating to a physician what he could do and what he could not do. California law permitted dispensing. So they formed a separate national organization. I think it was called the National Ophthalmological Society or something of that sort. Dr. Theodore Steinberg could give you the exact name of that group. There are many ophthalmologists who were active in that group. I would say not all the ophthalmologists in the

state belonged to it, but enough of them paid into it. These funds were also used to fight the Hart bill.

Hughes: *Did you look upon that organization as helpful?*

Zupan: We considered them an ally, because they were using the materials that I was sending them and their members in supporting their own testimony against the issue.

The one thing that I don't want to come out of this discussion, which I've already seen happen, is any organization or individual claiming that they defeated the bill on their own. That is not true. I'll challenge anybody who says that, and I'll bring men in to prove my point. I've even talked to men here who were involved with that issue who also agree that they didn't do it alone.

When the hearings on the Hart bills were being held, the Academy did not take a position on that proposal. The Association had its witnesses testify against both bills.

On the matter of supplying and fitting eyeglasses, the Association's position was that the principles of medical ethics of the AMA adequately set forth the right and the responsibility of the physician to his patient in this area as in all other areas of medical service.

The Association did not advocate that all physicians should supply their patients with required visual aids. Instead it defended the principle that it is up to the professional judgment of the individual physician to determine what medical measures are in the best interest of his patient.

From a legislative point of view, there were other issues on a state level, but the defeat of the Hart bill was our biggest victory, I would say, on the Hill.

We were an organization composed of ophthalmologists who did dispense glasses and ophthalmologists who did not dispense glasses in the care of eye patients. We were guided by the AMA principles of medical ethics and therefore were opposed to any legislation which would interfere with the ethical practice of medicine. Ophthalmologists throughout the country had different views on the ethics of dispensing eyeglasses. Some state and local ophthalmological societies supported dispensing, and others considered it unethical. A nationally known ophthalmologist who was being considered as the nominating committee's choice as president of the Association declined the nomination because he felt the organization advocated dispensing. Today I read about the Academy's position on comprehensive ophthalmology: Does that include dispensing?

But there were other issues concerning freedom of choice, participation, and health insurance policies. The optometrists wanted hospital privileges; they wanted any governmental or state funds that involved grants to hospitals that would require them to provide optometric services in hospitals and things of that sort—anything to broaden the scope or to identify with the health team. All these issues came out.

Now I understand, even though I've been away from it, that many of the optometric practice acts refer to use of light or light beams as a part of optometric practice. Mind you, these laws were written years ago, and here we come along with lasers, which are what? Light. Now optometrists want to use lasers.

Hughes: *And there's no legal reason why they shouldn't.*

Zupan: When we started, we never dreamed that the laser would come into being. We even said that optometrists were limited to doing only this and this and this. Usually the definition of a diagnosis was that the optometrist was only licensed "to detect," "to determine," "to recognize," or loose terms of that nature. It never said "diagnose" per se.

The Association's Merger with the Academy

Zupan: Getting back to the merger. There were preliminary meetings of some of our officers with the Academy officials. We were trying to maintain a good rapport with the leadership of the Academy, so from time to time a limited number of our Board members would meet and have dinner with members of the Board of the Academy during an Annual Meeting. This would give us an opportunity to exchange views. I was never permitted to attend, because this was always a doctor-to-doctor, one-on-one meeting. I would say that the seeds of the merger probably were prompted and developed through meetings between Dr. Bruce E. Spivey and Dr. Whitney G. Sampson, Dr. Spivey being the Executive Vice President of the Academy. Whitney was a very active member of our Board of Trustees, Past President, President, and eventually Executive Director. He and Bruce would meet informally to discuss the pros and cons and the potentiality or the need of a merger, or the fact that now here were activities which were possibly going to eventually be duplicated by the Academy that we [the Association] were doing. I think they saw this eye to eye and agreed upon this. Then it was proposed that in due time a liaison committee of our people and theirs meet.

Hughes: *Who was on the committee?*

Zupan: I can't give you an itemized recall on that, but I recall that Dr. Ted Steinberg was one of them. I think Dr. Al Cinotti, Whitney Sampson, and Brad Straatsma were on it. I don't recall the names of the other people because I'd been away, and when you're not involved day to day, it's like going back to a high school reunion and trying to remember names.

Hughes: *Do you have records of all this?*

Zupan: The Academy has.

The joint committee met. They would, I guess, take up each issue, one at a time—what the terms of the merger should be. I think it was agreed that a merger would be a good thing to do, but what would be the conditions of the merger?

The Academy's Secretariat for Governmental Relations

Hughes: *This was quite a shift in philosophy for the Academy, wasn't it?*

Zupan: Well, it was, but you have to remember that here they were, already separated from otolaryngology; here they were, already involved in setting up a Washington office. They had not only set up the Washington office, they had already developed what they called a Secretariat of Governmental Relations, which involved federal legislation, federal regulation, the whole gamut, and also included state affairs and subspecialties. The only thing they hadn't done yet was to put out the Home Study Course. They had not yet created the Council, which is what they have now, and they did not publish *The Ophthalmologist*. But they were already involved in things of a socioeconomic nature by setting up the Washington office. Not only that, they enlarged it by hiring additional people and releasing Mr. Lynn.

Hughes: *Is there a story behind that?*

Zupan: I can't say. It's a personal matter between John and the Academy.

So then they hired another man named Charles B. Sonneborn, who replaced John. He retained Cathy Greeley Cohen. Not only that, he also had employed a woman named Marie Feninger, who succeeded Cindy Carter, I believe. He was still functioning out of the K Street office. An organizational chart was developed for the Secretariat of Governmental Relations, I believe, by Dr. Robert B. Reinecke, which made Charles, the lobbyist, directly responsible to the Secretary,

Dr. Reinecke. John Lynn had been responsible directly to the Board. Also, under that structure there were other divisions within the Governmental Relations Office that were eventually staffed by associate secretaries. Dr. Reinecke was the Secretary for Governmental Relations, which was comparable to Secretary for Continuing Education and all the other secretaries the Academy has.

Dr. Reinecke then established a lower echelon of the subcommittees which were responsible to him. The individual committees functioned independently, but in time they would meet, and then Bob acted as chairman of the committee, which was then [composed] of the chairman of each of the subcommittees. And that's how they functioned. Then Charles was responsible to them as the administrator and lobbyist.

More on the Merger

Zupan: After the two groups kept meeting, and they reached a point where there was more or less unanimous agreement, they decided to go ahead and vote for a merger. They took the matter back to their individual organizations on the condition that the Academy—now, I'm doing this from recall—would make some provision to provide some form of membership within the Academy to those members of our organization who were not board certified. In other words, they had to set up some category of membership for them so that they wouldn't be lost. I think this had to be done.

Hughes: *Was there any opposition from the Academy?*

Zupan: No. They agreed because they thought that this group would increase their membership, and there were so few without their boards that they would be negligible as far as eroding or degrading the Academy status. One of the other things was that they were going to continue to publish *The Ophthalmologist* up to a certain time, and then that was to be reviewed by the Academy Board if it were to be continued after the merger. Another condition of merger was that the Academy was to establish a representative body comparable to our House of Delegates, which became their council of representatives from the state organization.

Hughes: *That was the Association's stipulation?*

Zupan: Yes.

Hughes: What was the idea?

Zupan: This group was to act as an advisory body for the Board of Trustees. This was the function they performed for us [the Association], and to destroy that would mean that the Board of Directors would function irresponsibly to the states. These men represented state organizations, so here you had grassroots representation through the Council and then through the Board. They weren't in a position to make policy, only to make recommendations and be advisory on any matter that might have been referred to them.

At first the Academy didn't do that, from what I recall. If a state came in with a resolution that was adopted by a state ophthalmological society or a group of ophthalmologists in a state, if they submitted a resolution to the Association in advance of our annual meeting at our House of Delegates meeting, we reproduced those things and sent them out so that they got studied and considered. Then we voted on those issues at our meeting. Our Board did send things down to the states for adoption and approval, but we didn't say, "You can't do it from there [the state level] up."

Hughes: The Academy didn't resist the idea of having broader representation?

Zupan: To my knowledge, not having sat in on those meetings, I don't think they did. I think there may have been a fear of the merger among individual members of the committee at that time or even among those who weren't on the joint committee. When a representative body like that is established, it's kind of threatening, because even though you're trying to instill democratic action within the group, sometimes if these things become too vocal or aggressive, then they could overcome the organization and take control of the Board. So I'm sure there must have been some fear of that developing. It is said that the seeds of destruction exist within every group.

But fortunately I think the way the Council started as an advisory group has progressed very readily. Now they not only function in accepting resolutions from the states, they also are doing what Dr. Jaeckle, our founder secretary, had hoped to do years ago. He hoped that we would reach a point in our organization where we were able to have reference committee hearings, comparable to the AMA's, on those issues that were coming in as resolutions. These matters would be referred to a reference committee for open discussion, and the recommendation of the reference committee would then go back to the delegates. Then they would accept or reject or amend those resolutions, and then they would go to the Board.

The Academy is now doing this. I'm very happy to see that, because these were goals and objectives that the Association had set and strived for but was not able

to accomplish. Not only that, the Academy has done it so well, I'm happy to say, that they've even brought in a whole host of new groups—the specialty organizations, the army, the navy, the air force; you name it, they have a voice in the Academy Council. The Association wasn't funded well enough or accepted that well to have been able to do that, because we were still somewhat the guys with the black hats and working in a space age with a horse and buggy budget.

Hughes: A remarkable turn of events.

Zupan: And I say it's ironical to go to these [Academy] meetings and to think that the issues the Association discussed back in the sixties are the same ones they're discussing today. The fact that they're the Academy, they can do it; the membership accepts it. But when we did it, it was a different matter.

The Association Decides Not to Form a PAC
(Political Action Committee)

Zupan: The Association called a special meeting in Washington of a representative body of our Board of Trustees, and we invited some other men who were very active on the legislative level in their respective states. One of those men, who I think is now retired, was from California—Dr. Richard P. Kratz.

We met to consider establishing an ophthalmology PAC, as the AMA had established a PAC. We realized that the optometrists already had their PAC and that even though they were not able to buy votes, at least it gained access to senators and congressmen. So we endorsed that concept and agreed at that meeting, but no formal procedures were established. Then when we were in Chicago, our group met with officials of the AMA at the time, and they begged us not to establish our own PAC. They didn't encourage us to splinter away from the AMA PAC, and I think they were also fearful that other organizations would follow suit and that this eventually would have an effect on the AMA PAC itself. Now, it's interesting again that we had that idea way back in the seventies, and now the Academy has recently established a PAC which has a million-dollar fund.

Hughes: So many of these ideas had origins in the Association. Thank you, Mr. Zupan.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

Bradley R. Straatsma, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
June 19, 1993, Jules Stein Eye Institute,
Los Angeles, California

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(Please write clearly. Use black ink.)

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BRADLEY R. STRAATSMA, M.D.

[Date of Interview: June 19, 1993]

Early Associations with the Academy

Hughes: Dr. Straatsma, I want to start with your memories of the earliest days you were associated with the Academy.

Straatsma: My earliest recollections of the American Academy of Ophthalmology and Otolaryngology date back to the latter 1950s, when I was a resident of ophthalmology and attended the Annual Meeting, giving a paper on one occasion and being responsible for one of the scientific exhibits on another occasion. On both of these occasions my recollection is that I approached the Academy with a sense of awe. I was then a resident at the very beginning of my learning process in this profession, and the Academy represented all of the finest minds, the best science, and the rapidly advancing field of ophthalmology.

Hughes: Do you remember the year?

Straatsma: It was 1957. My association as a resident was particularly with Dr. Algernon Reese, one of the great ophthalmologists of this nation, who was a past president of the American Academy of Ophthalmology and Otolaryngology. Several of the presentations that I was fortunate to deliver were co-authored with Dr. Reese, and he was my mentor in introducing me to the quality that was expected and the traditions for formal presentation at the Academy.

I remember one particularly valuable exchange with him, one that I've used repeatedly in my own association with residents. I was to be beside one of our joint scientific exhibits, with many members coming by and asking questions. I asked Dr. Reese, "How do I respond to a question?" He said immediately, "A very good answer is, 'I don't know.' An even better answer is, 'I don't know, but I've thought about it.' And the best answer is, 'I don't know, but I've thought about it, and I think the answer is—' and then deliver the answer."

In effect, it indicated a very confident ability to approach science as an unknown and not to pretend that we are further along than we really are in our understanding of the diseases we are dealing with.

Hughes: Was that first meeting you attended at the Palmer House?

Straatsma: These meetings were all at the Palmer House in Chicago, and that is a facility that's emblazoned in my memory as the Academy and all that it represented in those early days.

Hughes: Can you give me a feeling for the atmosphere?

Straatsma: Remember, I was quite a young, new member of the ophthalmic fraternity at that point, and I thought it was spectacular. There were crowds of people; there was congestion. Moving up and down in the elevators was really a challenge because of the true congestion, and yet the courtesy and the dignity and the true fraternity among the members of the profession were evident in every exchange, at every meeting.

Hughes: What was the relationship between the otolaryngologists and the ophthalmologists?

Straatsma: At that time, it was a truly unified, single organization, very much dominated by a single personality, Dr. William Benedict, who for more than a quarter century was the Secretary-Treasurer of the organization and the dominant figure.

Hughes: Say something about his personality, please, and also how he ran the Academy.

Straatsma: My true relationship with Dr. Benedict was somewhat limited, but my recollection is that he ran it in a very direct, forthright, and authoritarian manner. The business meeting of the Academy was pro forma, attended by no more than thirty, forty, or fifty of the several thousand people who attended the scientific meeting, and the decisions were generally made well in advance of the business meeting by Dr. Benedict.

Hughes: And who were those forty or fifty who did attend?

Straatsma: I think those were members of the Council, leading members of the academic and professional group of ophthalmology.

The Academy changed rather distinctly when Dr. Benedict passed away. Leadership fell to a very competent and very gregarious otolaryngologist, Dr. Mike [Clair Michael] Kos.

Hughes: Do you know why he was chosen?

Straatsma: I don't know why Mike was chosen.

Secretary for Continuing Education in Ophthalmology

Appointment

Straatsma: I became aware of the structure of the Academy shortly after Dr. Kos was chosen, when I was invited to take on a new position, a position established for the very first time in the history of the Academy, and designated as the Secretary for Continuing Education in Ophthalmology. Officially, according to the bylaws of the organization, I was the Secretary for Public Relations; but in reality I had assumed the functional title of Secretary for Continuing Education in Ophthalmology.

Hughes: Why the disparity in the titles?

Straatsma: The Academy bylaws just didn't change frequently. There was a position on the board of the organization for Secretary for Public Relations, and there was no position for Secretary for Continuing Education in Ophthalmology. Rather than change the bylaws, they just simply said, "You have one title officially, and one title that's functional."

Hughes: What was the path to assuming a position in the Academy, such as Secretary?

Straatsma: I'm not sure what the path was. My first recollection of this sequence was during one of the Annual Meetings in about 1968, when Dr. Edward Maumenee, a towering figure in ophthalmology, one who had great authority, insight, and judgment, spoke with me and discussed the possibility of joining the Academy structure. It was shortly after we had developed the Jules Stein Eye Institute at UCLA [University of California at Los Angeles]. I was at that time involved in several other national organizations and thus looked forward very much to the challenge and opportunity of being part of the structure of the then-combined American Academy of Ophthalmology and Otolaryngology.

Hughes: If I remember correctly, you had spent some time in Dr. Maumenee's department. Is that not true?

Straatsma: Yes, that's a very good recollection on your part. I was a fellow [1958–1959] at the Wilmer [Ophthalmological] Institute of Johns Hopkins [University] prior to coming to California and assuming the position as chief of the ophthalmic enterprise at UCLA.

Hughes: Is that where your friendship and association with Dr. Maumenee began?

Straatsma: Actually, it began before that, because while I was a resident in ophthalmology [1955–1958] at Columbia Presbyterian [Hospital] in New York, my association with Dr. Algernon Reese led me to attend several meetings of the Ophthalmic Pathology Club. This organization was also attended each year by Dr. Maumenee and many other members and leaders of ophthalmology. So I had become quite well acquainted with Dr. Maumenee through these informal meetings before I became a fellow at the Wilmer Institute.

Hughes: *Why to you think he proposed your name or urged you onward?*

Straatsma: I don't know the answer to that question. I would think the best answer would come from Dr. Maumenee at this point.

Hughes: *Had education been an interest of yours all along?*

Straatsma: Education has always been an interest of mine. I think it's an interest of every thinking person. And it's a true theme in everything that I've enjoyed and wanted to both advance and develop in my career.

Hughes: *Do you go back far enough to talk about the instruction courses and the Home Study Courses—the past tradition of the Academy in education?*

Straatsma: I go back far enough to have taken the so-called Home Study Course, and I recall writing carefully the answers to the questions, sending them in, and some months later receiving a review of my responses.

But I think my main function within the Academy structure was to change that, because one of the very first things I did after becoming Secretary for Continuing Education in Ophthalmology was to review and restructure the Home Study Course into what is now known, and became known in 1970, as the Ophthalmology Basic and Clinical Science Course.

The premise for the restructuring was that the fundamental body of knowledge of ophthalmology could be broken into rather arbitrary units, each one of which had a strong component of basic science and applied clinical science. The most effective way to teach that information and make that part of the ongoing lore of the ophthalmologist was to combine these parts into a single program that was both basic and clinical. That was a new concept for the Academy.

Hughes: *Because prior to that, it had had two separate streams?*

Straatsma: It had been a separate stream, and the focus had been primarily on basic science. But clinical ophthalmology was advancing so rapidly and yet had its roots so

firmly embedded in the advances of basic science that this method of combining the learning process was really a very exciting one. I think the fact that it has endured over the last decades since then, with intense modifications and improvements to be sure, but without fundamental change, indicates that the basic concept was sound.

Committee Members

Hughes: *Who was on the committee to do the restructuring of continuing education?*

Straatsma: It was a very fortunate combination of individuals and abilities. The first thing I did after assuming that role was to establish a formal advisory committee for continuing education. One member was the then-chairman of the Home Study Course, about to be restructured into the Ophthalmology Basic and Clinical Science Course, Dr. Robison Harley. Dr. Harley was from Philadelphia.

Dr. [Melvin L.] Rubin¹ was already involved in educational activities through his very intellectually invigorating development of the OKAP, the Ophthalmic Knowledge Assessment Program.

Dr. [Bruce E.] Spivey had just completed his graduate training in medical education at the University of Illinois and was a faculty member at the University of Iowa. He joined Dr. Harley, Dr. Rubin, and me.

There was one other member of the group who added a very invigorating, intellectually exciting element, Dr. Robert Reinecke. That group became the first advisory body. You can recognize that several of those people went on to major leadership roles and a continuing association with the American Academy of Ophthalmology.

Other members who joined that group in the short succeeding years in which I was the Secretary included Dr. David Paton, Dr. Paul Henkind, and Dr. Paul Lichter, again all individuals who went on to major roles of leadership with the American Academy of Ophthalmology.

¹ Dr. Rubin became President of the Academy in 1988. His recollections of the Continuing Education Committee are included in his presidential memoir, *Melvin L. Rubin, MD, American Academy of Ophthalmology President 1988*. The memoir, which is on file at the Academy's Museum of Ophthalmology, is part of a series written by past presidents of the American Academy of Ophthalmology.

Hughes: This was at the outset, at least in most cases, of their association with the Academy?

Straatsma: It was at the outset in any administrative or managerial or leadership role.

Creating the Basic and Clinical Science Course in Ophthalmology

Hughes: How did you go about this? It seems an intimidating task.

Straatsma: Actually, it was great fun. This was an extraordinarily talented group of people, and we all were deeply stimulated by the opportunity to conceive of a broad new program that had national implications and national opportunities. We worked extraordinarily well together. We would meet frequently during the Academy Annual Meeting, generally each morning before the program would begin. Our meetings might begin at 5:30 or 6:00 in the morning in a hotel room, because we had no meeting place. We would meet for breakfast, talk about programs.

And we quickly developed a system of assigning to each member an area of responsibility. So that member became, in effect, not just a member of the parent committee but the director of one or more separate programs of continuing education. That individual in turn developed an advisory body that was in effect a national faculty.

Hughes: Now, you're talking about division into subject areas of instruction?

Straatsma: Yes. It's probably best described if we think of it in specifics. Dr. Harley became first chairman of the Ophthalmic Basic and Clinical Science Course, greatly aided and supported by Dr. Spivey, who had a great deal to do with the organization and structure of that program. Dr. Rubin developed a committee to further enhance the Ophthalmic Knowledge Assessment Program. Dr. Reinecke developed the video education program for the Academy, something we called COVE in those days, Continuing Ophthalmic Video Education. You can see that each member of the group had specific responsibilities.

Hughes: There are eight subject areas. How was the actual course content divided up?

Straatsma: Somewhat arbitrarily. We picked the traditional areas of major importance in ophthalmology and then looked for the leaders of those areas, both in the clinical practice and in the basic science. There was an original faculty for the course that in 1970 had some thirty-four members. It included at least three faculty members who subsequently went on to become presidents of the Academy:

Dr. [Whitney G.] Sampson, Dr. [Frederick C.] Blodi, and Dr. [Marshall M.] Parks. We had a consulting faculty of some seventy-nine other ophthalmologists, at least one of whom, Dr. Froncie Gutman, became President of the Academy later. Perhaps I've omitted one or two others from that original association with the first faculty in 1970 who have been presidents of the Academy.

Hughes: *Was there any opposition to changing the format?*

Straatsma: Change always creates opposition, and the answer to that question is yes. We, as a rather independent-thinking group of individuals, did have a great deal of trouble initially developing a means of working with the rather formal, structured organizational entity of the American Academy of Ophthalmology and Otolaryngology. Change always encounters some resistance; we encountered that.

I believe that can be looked upon as one of the little bumps along the road and not as a major roadblock, because within a year or perhaps two, we had developed enough decentralization to work directly with the staff of the Academy and not have the structure become an obstacle. But initially, yes, there were some obstacles.

Audience

Hughes: *Were these courses aimed at any subgroup of ophthalmologists in particular?*

Straatsma: Yes. We created a tier in these first sections. That is, we had some knowledge that we felt was absolutely essential for the beginning ophthalmology resident, something that should be mastered—notice I didn't say learned, but I said mastered—in the first year by the ophthalmology resident. There was a second level that we felt should be mastered by the senior resident, and that was more detailed. It included everything that should be known by the first-year resident but a great deal more. Then there was a third tier that focused primarily on those applied clinical aspects that should be mastered by the ophthalmologist in practice.

So we put together one comprehensive program for ophthalmic knowledge, and then we developed a tiered approach, which was presented in each of the sections in various color and italic formats so that the reader immediately knew what was expected at each level.

While I'm speaking about it, I think one of the true indications that the overall program was valid is that, to the best of my knowledge, it is used in every single one of the ophthalmology residency training programs in the United States today. It became very quickly a part of the curriculum for education in ophthalmology in this country.

In addition, it's used in many, many other countries around the world. Dr. Spivey and I were responsible for bringing copies of that program into the People's Republic of China some years ago. We also were associated in bringing copies into Brazil, Argentina, Chile, Colombia, Peru, and other countries throughout Latin America. And the program was quickly adopted by teaching units in Great Britain, Canada, Australia, New Zealand, and many, many other parts of the world.

Hughes: Adopted without change?

Straatsma: Obviously used selectively, but not truly changed. Even to this day, when new editions of the Ophthalmology Basic and Clinical Science Course are published, the old editions are either given or sold at marked reduction in price to training programs that have less fortunate economic resources than we do in this country.

Hughes: Let's go back to your use of the term "master" as opposed to "learn." Please clarify how you distinguish between those two.

Straatsma: That is a very nice distinction that I try to make in my discussions with the second-year medical students at UCLA and try to make in my own mind.

Some things it's nice to become acquainted with or to learn or become familiar with. But we should set a more rigorous standard for those of us who are truly engaged in delivering health care. We can't be content just to say we're familiar with, we are acquainted with, we understand. We should truly be able to say we have mastered the body of knowledge that is expected of us by the public and by our patients.

Hughes: Was the course a source of friction in academic units? They could have had the idea that the Academy was moving into territory that up until then had been the purview of academic institutions.

Straatsma: That's an interesting comment. I'm sure there was opposition. As I have truly come to realize, change is always associated with resistance, just as one can honestly say change is constant and continuing. Those statements are axiomatic in dealing with change.

But in reality, I don't remember true opposition. I think the reason is that from the very outset this was not conceived of as a program run by or dominated by or controlled by any one or two individuals. It was truly a national faculty. And if you recall, there were nearly forty people involved in the writing of the material the first time the course appeared, and there were nearly eighty major national figures on the consulting faculty; indeed, there were people from every program who felt they had a buy-in or a part in this activity from the very beginning.

The first sections were very, very rudimentary and limited and didn't pose much of a challenge or threat to anyone. Within a year or two the program truly became much more the benchmark in ophthalmology, but by then people had become accustomed to it.

Hughes: You spoke of the program having national implications. Did you mean within ophthalmology or broader than that?

Straatsma: We planned it to have national implications within ophthalmology. I don't think any of us felt at the very beginning that it would ever go beyond the constituency of the American Academy of Ophthalmology and Otolaryngology. It was only in later years that we began to realize that it was so vastly superior to the educational outlines available in other parts of the world that we began receiving requests for this material from other countries and began taking it with us when we were invited as guests to visit other countries.

You must remember that at that time, the worldwide context at the American Academy of Ophthalmology did not exist. It was a United States activity, with the participation of Canada but with really no other individuals from other countries. Generally there would be one, two, or three international guests at each Annual Meeting, carefully selected, brought in to give major presentations or to take some specific part.

That's quite different from today, when the American Academy of Ophthalmology Annual Meeting attracts literally hundreds of people from all different segments of the world. So our horizons back at the beginning of this program were very much United States horizons.

Hughes: How novel in medicine in general was this concept of integrating basic science with clinical medicine?

Straatsma: I don't know the answer to that. I am quite confident that we did not pattern what we did after anything else, and I'm also quite surprised as you ask your question that I have not looked around to see if others have copied it. I have been quite content to see what it has done within ophthalmology and to concentrate on

watching as many, many talented people over the years added their special knowledge and touch and made a better product with each succeeding year.

Hughes: *Please go back to your residency experience.*

Straatsma: My residency was at Columbia University and the [Edward] Harkness Eye Institute of Columbia Presbyterian.

Hughes: *Which of course is renowned for its basic science in ophthalmology.*

Straatsma: It is a department that has had a great tradition of scholarship and fine ophthalmology and continues that to this day.

I was aware as a resident that it was difficult to bring together all the things that a resident was expected to learn, because there was no single outline; there was no single program. The best framework was the so-called Home Study Course, developed by [Dr.] Harry Gradle as far back as 1939.

Harry Gradle and Jules Stein

Straatsma: I might pause and put in an interesting correlation. Harry Gradle was certainly one of the leading ophthalmologists of his day. Not only did he bring together the concept of the Home Study Course for the Academy, but he is one of the founders of the Pan-American Association of Ophthalmology.

Hughes: *Did you know him?*

Straatsma: He passed away before I [could know] him directly, but he was the ophthalmologist with whom [Dr.] Jules Stein entered ophthalmic practice in Chicago. When Jules finished his training in Vienna and at the institutions of Chicago, he entered the private practice of ophthalmology with Dr. Harry Gradle. It was within the office of Dr. Harry Gradle that Jules Stein began booking bands and arranging entertainment engagements for performers. And actually it was from the office of Dr. Harry Gradle that he took a leave of absence to found what was called the Music Corporation of America and subsequently became MCA, Incorporated. So there are tie-ins of Harry Gradle to the Academy.

Hughes: *How did Dr. Gradle regard Jules Stein's escapades?*

Straatsma: Oh, they remained lifelong friends. Jules is a memory that's very strong and very, very fine in my background. I've always admired the fact that although Dr. Gradle passed away, his widow was someone whom Jules related to for the rest of her life. He managed all of her financial affairs, and when she passed away she was a very wealthy woman. So that friendship went from Dr. Gradle to Mrs. Gradle and lasted during the lifetimes of all the individuals involved.

More on the Course

Hughes: How was faculty for the courses chosen?

Straatsma: Initially faculty appointments were made on the basis of seeking out the most renowned individuals in the various areas. We were cognizant of the need to balance not only the most renowned people in the field but to combine them with people who had distinctive parts of the knowledge, represented different institutions, represented a national constituency. Since then, the process has become much more carefully organized, and individuals are often nominated by their department chairs or by members of the Academy Board.

The other thing that we insisted on was that this be a moving faculty. There was no way in which an individual could remain dominant on this faculty, because a person was appointed for several years, became chairman of that particular section of the course, and after one or at most two years became a past chairman. So there was a constant movement. This enabled, over a period of time, literally dozens of faculty members to participate in the development of each section of the course. It truly did remain a moving, continuing, national faculty.

Hughes: And that was the intent?

Straatsma: That was the absolute intent.

Hughes: Was this effort to keep new blood flowing, unlike in other Academy committees?

Straatsma: It might have been a bit different from most of the Academy committees. From the very outset we set out to develop something that would have movement and opportunity for new members. I felt very strongly about it, and after what I considered a reasonable term as Secretary for Continuing Education in Ophthalmology, I submitted a resignation indicating that I felt it was appropriate to let someone else take that leadership role. I very much hoped that would become a precedent in the organization, and indeed it has become one.

Hughes: I read about the residency and training exam, which was instituted in 1968. What was that?

Straatsma: That was a brilliant product of Dr. Mel Rubin. Mel realized that part of the educational process is the assessment of knowledge. He organized, through AUPO initially—the Association of University Professors of Ophthalmology—an annual examination that would be taken by residents. The same examination is taken by all residents, but they are compared in each of the core areas with residents at their same level of training. So an individual is able to take this exam and gain from it a concept of his or her own knowledge relative to the group as a whole.

Very quickly the Academy was able to combine its educational program with the knowledge assessment component. That was a key unit that became extremely important in making the program of instruction useful to the residents in training, because it indicated the body of knowledge on which they could be expected to be knowledgeable and could expect to be examined.

The Ophthalmic Knowledge Assessment Program (OKAP)
and the American Board of Ophthalmology

Straatsma: We did one other thing a few years later: We combined the Ophthalmic Knowledge Assessment Program with the American Board of Ophthalmology, so that a resident in training could take the examination in each year of training as a practice or self-assessment exam. Then, when prepared for certification, the resident would take the same examination, under more rigorous proctoring and supervision circumstances, for the purpose of completing the written examination requirements for the American Board of Ophthalmology.

That sounds very, very basic, but you must remember that before that coordination, the educational program was managed by the Academy, and the examination process was managed by the American Board of Ophthalmology, and the two had no relationship to one another. So a person could study one curriculum and be examined on an entirely different body of knowledge. That seemed to be totally inappropriate; thus bringing those two together was extremely valuable in educational terms.

Hughes: Was there worry that the American Board would be deflated in prestige because of this cooperative approach?

Straatsma: I don't think that really became a significant issue. The Board still retained a very strong input into the content of the examination and retained its own standard of grading the examination. The Board members set the standard for pass/fail, so that they retained all of the identity and independence required to fulfill their true responsibility. But they gave some indication to the people taking the examination of the body of knowledge that was expected of an ophthalmologist.

Hughes: *According to my notes, the Ophthalmic Knowledge Assessment Program was first given in 1970.*

Straatsma: Yes. Perhaps I would be repeating my recollection of the Ophthalmic Knowledge Assessment Program, but repetition may be appropriate. The really genius idea that started it came from Dr. Mel Rubin, and it's difficult to overly credit Mel for that.

This began as an examination that was given to residents in training under the auspices of AUPO.² But as soon as we developed the [Academy] continuing education program in ophthalmology and Mel became part of that, the responsibility for OKAP changed from the university professors' group to the Academy; it became an Academy program. It has remained an Academy program to the present day.

Basically, the OKAP is an examination taken by all the residents in the United States at one time but in many different locations. It consists of a series of very carefully prepared multiple-choice questions. These questions are in various areas so that the questions correspond to the curriculum of the Ophthalmology Basic and Clinical Science Course. When the grading is done by a national educational testing program, the individual who takes the examination gets an overall score in percentile as well as in absolute numbers, comparing his or her performance with [that of] other residents at the same level. We've used ACT, American College Testing program, one of the leading educational consulting groups in the country, as the professional group working with the Academy on this activity.

The department chairman at each institution, or the residency program director at a location that's not an academically affiliated program, receives the results of the residents in that program. Thus the department leader has an opportunity to assess the performance of residents as a whole, residents as individuals, and the training program in each of the areas of knowledge. It's an extremely useful coordination of the curriculum with an assessment process.

² Melvin Rubin created OKAP in the late 1960s specifically as a means to assess gaps in the knowledge of ophthalmology residents. William C. Felch. *Decade of Decision: The American Academy of Ophthalmology, 1979-1989*, Foundation of the American Academy of Ophthalmology, 1989, p. 53.

The nicest thing about OKAP is that it's designed to be helpful and instructive and not punitive. The results are kept absolutely confidential. The individual receives the results, and the department chairman receives the results; but there is no public announcement. There is no comparison of one individual to another; there is no stigma for doing badly. There's no great praise, except for self-satisfaction, for doing extremely well. There's no attempt to compare one program with another. It is simply an opportunity to evaluate the process of learning and education in a very useful and constructive way.

Test Assessment

Hughes: *How are all these tests and assessment programs and educational programs updated?*

Straatsma: There is a science to the assessment of educational progress. Consulting services such as ACT are extremely useful. The examinations are made up of a mixture of older questions that have been used before and have been rated in terms of their validity, and new questions that have been developed by an examination preparation committee.

Hughes: *Of the Academy?*

Straatsma: Of the Academy, but one group of people working as advisors to the examination, quite separate from the group who are faculty members for the educational [curriculum] program. Each question is evaluated just as carefully as the performance of the individual is evaluated, so that there are statistical tests done on each question of the examination. In effect, how many of the best students got that question correct? How many of the worst students got that question correct? Or did one question seem to have an ambivalence so that the best students were just as likely to miss it as the poorest students? In that case, it was probably a poor question. In effect, were there two answers that seemed to get an equal number of responses, and therefore were those two answers in some way ambiguous or confusing to even the qualified students?

In essence, each question has a variety of statistical parameters, and those determine the validity of that question. If the question is absolutely invalid, there may be a decision on the part of the examination committee to simply delete that question from the final reporting.

Hughes: *This sort of assessment is done every time the test is given?*

Straatsma: This careful assessment goes on for every question, every year. This is what makes it a very professional, high-quality activity.

Hughes: *How long has that been the case?*

Straatsma: That's been the case as far back as I can remember. I remember early visits to ACT in Iowa City, Iowa, where we would meet with the professionals and talk about our plans for the examination, invite their advice on its preparation, and set up the professional process of evaluation—every aspect of it, from the security of the examination to the conduct of the examination, the proctoring, the return of papers, the careful assessment of the quality of each question, and the prompt reporting of the results. It has been done extremely well, and my compliments to Dr. Rubin and many others. Dr. Thomas Pettit in this department [at UCLA] was chairman of that program for many years and developed a high level of expertise in this testing process.

The AAO Council

Hughes: *What was the role of the Council in the old Academy?*

Straatsma: My first participation in the Council of the American Academy of Ophthalmology and Otolaryngology took place in about 1969, when I was first appointed as Secretary for Continuing Education in Ophthalmology. My recollection of the Council meetings is that these were very formal, very rigid, very limited in content, and, frankly, less than I had hoped they would be in terms of their ability to provide new ideas and new plans and forward movement for a major national specialty organization.

For example, an individual on the Council might just simply read a letter that had been received and ask the Council to help him formulate a response. Not a high level of executive behavior for a body of skilled people!

Hughes: *Why was the meeting conducted in that fashion?*

Straatsma: The Council had not begun to recognize its true responsibility for leading an organization. The leadership had been focused for many years in Dr. Benedict, and that same mantle of authoritarian central control had been transferred to Dr. Kos. Individuals expected that the organization would continue to be run very closely by an individual and therefore didn't expect to have a formal process

of raising issues, making decisions, formulating long-range plans. Change had not occurred, and therefore there was no reason to have plans.

It was really near the conclusion of one very fine era, but a different era, and just after the beginning of another era which, in my judgment, was absolutely essential to the future of both ophthalmology and the Academy.

Hughes: *How responsive was the Council to the wishes and concerns of the rank-and-file membership?*

Straatsma: There was a great gulf between the Council and the rank and file—a surprising gulf, because it was really absolute. The only reason a gulf could have existed is that the Academy at that time was focused solely and exclusively on education. It took no position whatsoever on any issue that had social, economic, or societal implications. Education was important and well recognized but not fundamentally controversial. For that reason, the Academy was able to have this very centralized, autocratic leadership that really did not have a relationship to the rank and file.

Separation into Two Academies, 1979

Movement Toward Separation

Hughes: *When did things begin to change, and why?*

Straatsma: During the sixties and seventies there was a steady movement toward a more active program of the American Academy of Ophthalmology and Otolaryngology, and with that more active program, topics of greater, broader dimension began to be considered. That brought about an awareness that those topics were different for ophthalmology and for otolaryngology, and so during the sixties and seventies we first began to have talk of the wisdom of separating the Academy into two separate units. It was during the early seventies that this reached broader discussion. I think you'll recall that it was about 1973 that Dr. [J. Vernal] Cassady and Dr. Lawton Smith brought forth a motion to simply ask the members to consider restructuring the Academy into two components.

But probably the key decision came about when the Council of the Academy, actually stimulated largely by marvelous leaders of that time—Dr. Maumenee, Dr. [Frank W.] Newell, Dr. Blodi, and several others—passed a resolution to restructure the American Academy of Ophthalmology and Otolaryngology. That

became a topic for a member vote in the following year, 1975, and it was passed by the members. That led to the separation process being firmly under way in the Academy.

Hughes: *In 1967 a motion to poll the membership for separation was made, but tabled.³ Do you remember anything about that?*

Straatsma: No, I don't remember it. Stan's [Dr. Stanley M. Truhlsen] recollections and records would be the best source. He was very close to the *Transactions* of the Academy and worked with Dr. Howard Morrison for a number of years.

Hughes: *I thought it was interesting that the motion had occurred that early. In fact, in 1962 a motion calling for a separate Academy of Otolaryngology was passed by the Triological Society.⁴ Do you remember hearing any rumors of this motion?*

Straatsma: I really don't have recollections of that. My memory of the process becomes much more vivid a little later. I agreed with the concept. As momentum for division developed in the Council and in the membership of the Academy, it was the ophthalmology group that was proposing this more strongly than the otolaryngology group. It's important to point out that at that time, not only had I taken the position as Secretary for Continuing Education in Ophthalmology, but David Shoch was Secretary for Instruction, and Fred Blodi was Secretary for Program. Thus we had three people who enjoyed working together, had very similar dynamic concepts about the future, and became very articulate proponents for the separation of ophthalmology and otolaryngology. Again, I'd like to give firm credit to Dr. Maumenee, Dr. Newell, and Dr. Spivey for understanding the need for and value of a separate academy for ophthalmology, way in advance of many others who were working within the organization.

Hughes: *The results of that poll were that only 54 percent were actually in favor of a split.⁵ How that broke down in terms of numbers of ophthalmologists and otolaryngologists, I've never read. I don't know if you know anything about that.*

Straatsma: I'm not sure that it ever was broken down.

³ Truhlsen, MD, Stanley M., "The History of the Ophthalmology Secretariat of the American Academy of Ophthalmology." Typescript, [n.d.], 32 pp, p. 17.

⁴ Bryan, Sharon A. *Pioneering Specialists: History of the American Academy of Ophthalmology and Otolaryngology*, American Academy of Ophthalmology, San Francisco, CA; American Academy of Otolaryngology—Head and Neck Surgery, Rochester, MN, 1982, p. 231.

⁵ *Pioneering Specialists*, p. 238.

Hughes: I believe the membership at that time was roughly 60 percent ophthalmology and 40 percent otolaryngology, but that's not to say that the vote went that way. How do you explain that marginal vote?

Straatsma: I believe it returns to the fundamental issue. The members perceived the Academy as purely an Annual Meeting with an educational activity. Some continuing activities throughout the year were developing rapidly, but still were not as important as the Annual Meeting. They felt that there might be an economy of scale; there might be an economy of keeping a single organization that would be committed to education of the two fields. There were virtually no programs of education that did attempt to combine ophthalmology and otolaryngology, and there were virtually no members who practiced both specialties. It was truly at that point a marriage that had historical background and convenience, not unlike some marriages that we can think of in history.

Hughes: What were the prime reasons that people were behind the separation into two academies?

Straatsma: Probably you would receive a different answer from everyone who attempted to respond to that question. The compelling points to me were the rapidly advancing knowledge and technology of ophthalmology and the concept that they could be further developed in an appropriate way by an organization devoted exclusively to ophthalmology.

A second thread was awareness that we couldn't totally ignore the social, political, and economic aspects of the way in which medical care is delivered. Thus we needed an organization that could truly represent the viewpoints of ophthalmology to the public and to government. It was highly unlikely that this could be accomplished in an organization that was rigidly staying within its educational framework.

Hughes: That, I believe, was a controversial stand. Certainly the tradition of the Academy as expressed through William Benedict was, as you well know, that it was strictly an educational institution. But, of course, times change.

Straatsma: You'd have to put it in the context of legislation in our country. Medicare legislation clearly indicated that health care was a matter of government involvement, not just individual involvement, and ophthalmology had a major part because of its focus on elderly Americans. So it became clear to many of us that we needed a political voice.

And there's another curious tie-in. That political recognition really stemmed largely from Dr. Ralph O. Rychener, who as early as 1956 spoke at a carefully

declared recess in one of the Academy business meetings about the need to form an organization to represent ophthalmology in the economic, social, and political discussions of the day. Curiously, Ralph Rychener and my father were roommates in medical school at the University of Michigan. So I had known Ralph Rychener, while I was growing up, as a frequent guest in our home and thus recall his role in beginning the process that led to the American Association of Ophthalmology some years later.

The Separation Process

Straatsma: I have a rather acute knowledge of how separation was implemented, because it went through a stage as a Division of Ophthalmology and then as an organization. That was an interesting transition time.

Hughes: *I'd like to hear you talk about that, and please include why it was thought a good idea to form two divisions rather than to leap directly from the joint Academy to two separate academies.*

Straatsma: Once the decision was made by both the Council of the Academy and the members to restructure into two separate successor organizations, there was an immediate recognition of the issues of restructuring. One of the important ones was a legal issue. The American Academy of Ophthalmology and Otolaryngology was an unincorporated member organization, and by the rules of Minnesota, the state in which it was functioning legally, any single member could oppose a restructuring.

So the first hurdle was to develop the Academy as an incorporated organization. This incorporation was actually managed by a committee made up of ophthalmologists and otolaryngologists who worked during the period 1976–77. The representatives on that committee were Dr. Frederick Blodi, Dr. Whitney Sampson, Dr. Bruce Spivey, and I [who] served as chairman. There were four equivalent members from otolaryngology, and we solved the legal problems of separation by establishing the combined AAO as an incorporated organization, and then divided the AAO into two successor organizations, the American Academy of Ophthalmology and the American Academy of Otolaryngology. While these steps were taking place, we began to prepare for reformation by establishing a Division of Ophthalmology and a Division of Otolaryngology within the combined AAO.

AAOO President-Elect 1976 and President 1977

Hughes: When did the combined Academy become incorporated?

Straatsma: At the business meeting of the combined Academy in 1977, a motion to adopt the Articles of Incorporation was presented to the members. I recall the moment very well, because I was President of the Academy at that time. We realized that a single dissenting voice could have undone the preparations of the last several years.

Fortunately, there was not a single dissenting voice, and the decision to incorporate the American Academy of Ophthalmology and Otolaryngology was passed unanimously at that 1977 business meeting.

Hughes: Had you done any lobbying or preparation of the membership?

Straatsma: Actually, the *de facto* separation took place a year before the *de jure*. So the two specialties were functioning entirely separately from 1976 onward.

I entered the process in 1975 as the result of a contested election for President of the Academy. That was the only contested election the American Academy of Ophthalmology and Otolaryngology ever had.

Hughes: Contested on what grounds?

Straatsma: There were two candidates! People literally had to vote. But that's one of the reasons I became a candidate for the role. I don't recall volunteering, but I recall being asked if I would run, and I knew at that time that there was another very, very fine gentleman, Dr. Joseph M. Dixon, a very good friend to this day, who was also going to be a candidate for the position as President.

But the election took place, and I am pleased to say that I wasn't even present at the Annual Meeting at which this took place. I was the guest of honor at that exact time at the German Ophthalmological Society meeting in Essen and had accepted that position before I became aware of all the events that were likely to take place in 1975. So I was at the DOG (the Deutsche Ophthalmologische Gesellschaft), actually trying to moderate the German Ophthalmological [meeting] in German while this was going on at the Academy meeting in 1975.

I became the President-Elect of the joint Academy in 1976. But it was during that 1976 year that ophthalmology began to function as a totally separate organization. It had its own budget, it had its own council, and Dr. Bruce Spivey became the Executive Secretary for the Ophthalmology Division that first year. We had our

own secretaries for education, instruction, Annual Meeting, and we began some of the important new committee activities of the Academy by establishing a committee on governmental relations, which became the Secretariat for Governmental Relations, and the current Secretary for Representation.

Hughes: And was that a controversial act?

Straatsma: I think it was. But we felt so strongly that I don't recall any truly significant opposition to the idea.

Hughes: It was certainly blatant evidence that the Academy was no longer strictly an educational institution.

Straatsma: Yes, and if there was a controversial aspect, many people thought we were beginning to intrude upon or to compete with the traditional role of the American Association of Ophthalmology, which had always represented ophthalmology in Washington on the issues of social and governmental activity.

Perhaps the significant point is that it was in 1976 that the Academy for Ophthalmology truly began to function separately, but it was in 1977 that the Academy became incorporated and immediately announced that there would be two successor organizations. They were formally established the following year with a business meeting in 1978, and the separation became official on January 1, 1979.

Hughes: Was the decision to separate first into two divisions in order to work out some of the logistics, the structure that would be needed in the two independent academies?

Straatsma: That's a good comment. I believe the reason for doing it was fundamentally the legal requirement—that we couldn't separate all at once because of the legal requirements. But the reality was that it gave everyone a year to catch their breath and get organized and be infinitely better prepared. There was a great deal of activity during these periods—many, many discussions and meetings. My recollection is that there were decisions that were controversial, but in every instance the decisions were made with the highest degree of attention to principle, integrity, and quality. There was absolutely nothing that I can remember that was narrow or divisive or petty about the process.

Dividing the Funds

Hughes: I understand that the decision about how to divide the kitty, namely the \$750,000, was controversial. Can you speak to that?

Straatsma: Money is always controversial. [laughter] The amount is not important; it could be a nickel or a dime or a million dollars.

Hughes: Could you outline the issues?

Straatsma: The issues were the obvious ones: Should it be divided equally as we separated into two academies? Should it be divided in percentage according to the number of members? Or should there be some complicated process of trying to determine where the money came from originally? The ophthalmologists felt that their instruction courses had contributed an even greater than 60 percent component to the total kitty. I seem to have been very wise in somehow staying far enough away from that discussion so that I know the outcome but not the details of how we got there. Probably Dr. Spivey would have a better idea of the actual negotiations of the fund division.

Hughes: And how was it partitioned in the end?

Straatsma: My recollection is that it was on a 60-40 basis, based on the number of members. That was also done to be sure that we provided otolaryngology with capital resources as they began a new organization. Our structure seemed to be far more established at that point of division than the otolaryngology structure. Thus to provide a firm financial building block for otolaryngology seemed not only appropriate but absolutely necessary.

Hughes: Before the Academy split, were you aware of reluctance on the part of either specialty to deal with matters that pertained to the opposite specialty?

Straatsma: Yes, there was a growing separation. One has to go back to the original Council, which was such a static group that they became related to one another as individuals. Some of them had been members of the Council for nine, ten, twelve years. And thus they had a great vested interest in the status quo.

When the process of change began in 1969 and the early seventies, there then became involved a group of individuals who were committed to change, and change meant that they were more resolved to the issues of the individual specialties. I noticed, as everyone did, that there was a greater tendency for the ophthalmologists to interact closely with the other ophthalmologists; the otolaryngologists did the same. I felt exceptionally comfortable, because several

of the leading otolaryngologists were people from Los Angeles with whom I had a separate set of local relationships. One of the absolutely leading otolaryngologists of the era was Dr. Howard House. Howard House had been one of my mentors and role models in Los Angeles for many years, and we were very, very good friends.

Another subsequent president of the otolaryngology Academy was Dr. Victor Goodhill. Victor was a member of the UCLA faculty during his lifetime. He was a marvelous classic violinist, and we have played together in both classic and jazz ensembles on many occasions.

So with several warm friendships among the otolaryngologists, I didn't sense the separateness of the two specialties as much as many others did who had no such similar additional interactions.

Hughes: *Anything more that should be said about separation?*

Straatsma: Yes. There were some nasty parts, but I'm going to leave them out.

Benefits of Separation

Hughes: *Could you say whether there were immediate, tangible benefits to the rank-and-file ophthalmologist after the division into a separate academy?*

Straatsma: There were many immediate, tangible benefits from the separation. They permeated every part of the Academy activity. The meetings were less congested, accommodations were more readily obtained, whether it be for hotel or dinner, and there was a unity to the meeting that was not possible before. With all facilities available for ophthalmology education, there could be duplicate courses and sessions so that people had a greater range of choices in going to educational activities. More courses could be accommodated.

The communication with ophthalmologists became greatly enhanced, because the single communication for the combined Academy had to present information and news about both specialties, and that was done quite well in something termed the *Perceiver*. But with the new Academy, Dr. Spivey quickly organized the publication that exists in the Academy to this day, the *Argus*. This became a tabloid presentation of key information that went quickly from the world and national press to the ophthalmology office.

Hughes: *Which the Perceiver had not done?*

Straatsma: The *Perceiver* had stayed strictly within the narrow confines of the educational process. *Argus* immediately took on the broader scope of informing the ophthalmologist of issues and problems and concerns that went much beyond the educational process. The *Transactions of the American Academy of Ophthalmology and Otolaryngology* became a separate publication for ophthalmology.

I recall being very much involved in this transition, which led from the *Transactions* to the new journal, which we very simply, very directly—and to some people perhaps somewhat arrogantly—called *Ophthalmology*. Dr. Truhlsen, Dr. Henkind, and now Dr. Paul Lichter are among the people who had an absolutely brilliant impact on that publication, and it is one of the world's leading, most highly respected journals in the profession today.

But I should say a word about the fact that we simply called it *Ophthalmology*. If you look at the more than forty, fifty, sixty, seventy ophthalmology journals—depending on what you're willing to include—in the United States and around the world, many of them are called archives, journals, annals, acta, or many other words. But none had simply picked the word “ophthalmology.” Thus when searching for a new name for the future publication, not only was the name changed in a very simple, direct, declarative way, but the scope of the publication changed; instead of being just a [record of] transactions, it became a truly peer-reviewed scientific journal.

Hughes: *You mean an organ that no longer was a vehicle largely for reporting the activities of the Academy itself but a peer-reviewed publication?*

Straatsma: There's a big difference, and you are correct in sensing that. “Transactions” means fundamentally a record of what took place at the meeting, pure and simple. Nothing else is included, and nothing that took place at the meeting is left out. That is one kind of publication that has generally disappeared from the scientific literature.

It has been replaced by journals that adopt the process of peer review, not a new process. It can be traced back to England and France several centuries ago, but is one that has become increasingly dominant in scientific publications for something that is reviewed by experts in the field for accuracy, completeness, and narrative, and is published on the basis of scientific review.

The American Association of Ophthalmology
Merger with the Academy

Hughes: I think the place to start is with the history of the American Association of Ophthalmology, and then perhaps you could move into why you felt it expedient to join the organization.

Straatsma: I briefly noted that the origin of the American Association of Ophthalmology, as I understand it, goes back at least as far as 1956, with Dr. Ralph Rychener, an ophthalmologist in this country. Dr. Rychener spoke during a recess of one of the Business Meetings of the Academy, and thus with a degree of official sanction, about the need for an organization that would represent ophthalmology in socio-economic and political matters.

From that initial stimulus, shared by Dr. Rychener and a few of his friends and associates, the organization went through several evolutions and name changes and became the American Association of Ophthalmology.⁶ I became a member sometime during the seventies, perhaps even earlier, because I recognized the role that the organization played in representing ophthalmology in a way that could not at that time be done by the Academy.

When the Academy became a separate entity for ophthalmology and developed an office of governmental relations, the activities of the Academy became very similar to the activities of the Association. Initially there was a determined effort on the part of both organizations to work together and support one another so that they truly became complementary.

But gradually it became evident that there was duplication, and individuals were being asked to pay with their dollars and dues for activities that were being done in the same way by two organizations rather than more efficiently by one. There was also an awareness that sooner or later there could easily be conflict and confusion in the way the profession was represented on socioeconomic and political issues. And so, some time in the early seventies, discussions began to take place very informally about the possibility of merging the Academy and the Association.

Those informal discussions took place at several levels. Dr. Spivey, at that time very well established as the Executive Vice President of the American Academy of Ophthalmology, and Dr. Sampson, who had the equivalent permanent

⁶ See the interview in this volume with Larry Zupan.

leadership role for the Association, began to meet and discuss the way in which the organizations could work more closely together or possibly become joined.

There were probably many other levels of informal discussion, but at least one other involved Dr. Ted Steinberg and me here in California. Dr. Steinberg had been a president of the American Association of Ophthalmology, and I was a past president of the Academy. We both were involved in California activities, had worked together on behalf of ophthalmology in this state on more than one occasion, and were very good friends.

Those discussions at several levels took place, and probably the first movement toward a true assessment of merging the two organizations came about when Dr. Sampson proposed a motion at one of the Academy meetings—Dr. Sampson then being a member of the Board—to establish a liaison committee to meet with the equivalent representatives of the Association and consider the possibility of merger.

I recall Dr. Sampson making the motion, because, to my surprise, I was named in his motion as chairman of the liaison committee. There were several other members of that committee whom I enjoyed working with and [who] were part of that process: Dr. Thomas Duane, Dr. Marshall Parks, Dr. David Shoch, and Dr. Stanley Truhlsen. The Association went through the same process, and the member of their delegation to work with us included (not surprisingly) my very good friend, Dr. Ted Steinberg, as chairman of the liaison committee, and Drs. Al Cinetti, Burt Krimmer, George Santos, and Larry Winograd.

I'd like to point out that Ted Steinberg deserves more credit than any other single individual for making this process of liaison and merger actually lead to a successful result. Ted not only is a superb ophthalmologist, but he has training in the legal field as an attorney, so he is used to looking at issues very dispassionately, very fairly, and very judiciously. I recall literally several dozen informal conversations with Ted in addition to the formal meetings in these liaison committees.

The process finally led to a recognition that we would be wise to merge. We had three major issues to resolve. One was a legal issue, another was a membership issue, and the third was a governance issue. The legal issue was related to the fact that the Academy, as a purely educational organization, was established as a 501(c)(3) organization. That's a provision of the Internal Revenue Service tax code in this country. The Association, with a greater commitment to political, socioeconomic lobbying and representation, was a 501(c)(6) organization.

The ultimate resolution of that issue was to change the Academy to a 501(c)(6) organization and concurrently establish a separate foundation of the American Academy of Ophthalmology as a continuing 501(c)(3), or not-for-profit charitable organization.

Hughes: This was deliberately to facilitate amalgamation?

Straatsma: Yes, the merger could not have taken place without resolution of this issue, and it had to go in the direction it did. There was no way for a 501(c)(6) to become a 501(c)(3), and even if that had been possible, it would have greatly limited the Academy in what it could do in the future.

The second issue was one of membership. All of the members of the then American Academy of Ophthalmology were Fellows and had been certified by the American Board of Ophthalmology. The members of the American Association of Ophthalmology were, in some instances, certified by the Board but in other instances not certified by the Board.

Hughes: Do you have any idea what percentages one way or the other?

Straatsma: Half or more of the members of the Association were Fellows of the Academy, so somewhat less than half of the Association members had not been certified by the Board. It was unacceptable, clearly, to all of us that we would suddenly abandon nearly 2,000 members of the Association in merging these organizations. The fundamental solution there was to establish two categories of Academy membership, and those exist to this day. There are Fellows, who are certified by the American Board of Ophthalmology, and there are Members, who are not certified.

And, of course, that was greatly to the advantage of the Academy, because suddenly we gathered thousands of new Members who could support the activities of the Academy, not only ophthalmologists from this country who were not certified by the Board but ophthalmologists from other countries who became the International Members of the Academy. We also gained probably 2,000 ophthalmologists in training.

So the decision to establish different categories of membership came from this need to resolve the merger issue, but the byproduct for the American Academy of Ophthalmology was an enormous strengthening of membership.

The third issue was one of governance. The Academy had by tradition been governed by a small and to some degree self-perpetuating Board of Directors. You might say it had been a top-down organization with a high relationship to

the academic leaders of the profession. The Association, because of its interest in socioeconomic and political activities, had begun as a bottom-up organization, with members selected on the basis of their state representation forming a house of delegates and in effect having the membership be the policy-establishing group.

The compromise there was probably the most difficult, and it led to the concept that the Board of the Academy would continue to be the policy-making board of the organization, but the Academy would establish a Board of Councillors that would be established on the basis of state representation, subspecialty representation, and representation for international organizations, such as the Canadian Ophthalmological and the Pan-American Association of Ophthalmology.

Hughes: I read that the Board of Councillors did not in fact have actual power.⁷ Is that correct?

Straatsma: Yes, that is absolutely correct, and I probably was as much responsible for that as any other individual. I felt that the authority should remain within a Board of Directors and felt that if we blurred that issue, we would have conflict.

It's interesting that we were pleased to establish the Board of Councillors, because the Academy had grown so large and had become involved in so many new issues that the leaders of the Academy recognized that a small board of a dozen or so people directing an organization of more than 10,000 independent physicians was an unworkable circumstance. We needed a body to be more representative and more broadly participatory. The discussion was on what role that body should play.

Hughes: Was the Board of Councillors listened to by the Board of Directors?

Straatsma: Probably less than it should have been. And over a matter of years, some conflict between the Board of the Academy and the Council developed. That seemed to come along after my direct participation in the organization, and there are others who would give you a better understanding of it. But that was a classic confrontation on the principles of governance. It has now been resolved by establishing the Board as a dominant decision-making body of the Academy, but with a greater recognition of the participatory role of the Council.

Hughes: Does the Board of Councillors serve as a conduit for issues that the rank and file might bring up?

⁷ *Decade of Decision*, pp. 31-2.

Straatsma: The Board of Councillors may have been established primarily to facilitate the merger, but it also was established to facilitate the process of communication and deliberation within the organization. Frankly, it's inconceivable in retrospect to think of the Academy functioning without a council or some equivalent body to serve as a receiving organization for the concerns and viewpoints of the state constituency organizations and the subspecialty organizations, to filter those ideas and bring forth recommendations.

I believe that the greatest index of the success of the Council has been the ability to retain ophthalmology as a single homogeneous specialty, because in the Council there is representation of each state society and of each major specialty society. Prior to establishing the Council, none of those organizations had any impact or any voice in the activities of the Academy. They had no place in the program; they had no way of bringing forth ideas, making recommendations, or in any way influencing the Academy.

Though the Council has gone through stages of governance, its fundamental accomplishment was keeping a single voice for ophthalmology. And that has been very important. It's best judged by looking at some other specialties that did not do the same sort of a bring-together. Those specialties have a great deal of dissonance in their representation, of duplicating organizations, of uncoordinated meetings, and of extra expense. The physicians in those specialties are supporting multiple, non-communicating, non-interacting organizations.

Hughes: *How did the Association and the Academy look upon each other before there was talk of a merger?*

Straatsma: [laughs] The two organizations looked upon each other as each going its separate way. There wasn't any real support for the opposite organization.

Hughes: *Wasn't there a status difference? I'm thinking of the Academy as the image of the academic and the Association as the image of the practicing ophthalmologist, the man in the trenches.*

Straatsma: You're absolutely correct. The Academy felt it was the elite organization, and many members of the Academy were very upset that we would associate with people who they didn't feel were as well trained or well qualified. The Association was deeply concerned about coming under the influence of ivory-tower type academicians who didn't really know the real world.

That's where this liaison committee, by developing an interaction between the two entities, began to realize that each part could contribute to the whole.

Hughes: Of course, the merger is another indication of the dual function of the Academy, if you split it broadly into education and politics. The mere fact that the Academy was willing to accept the Association was another validation of its role in the socioeconomic, political arena.

Straatsma: It gave credibility to the Academy in this area, because many of the leaders of the combined organization had had major roles in the American Association of Ophthalmology. Many of the officers of the Association became presidents of the Academy. For example, two are Dr. Whitney Sampson and Dr. George Garcia. And there are others who came to leadership through the Association and then became leaders of the combined organization.

Hughes: How seamless was the merger?

Straatsma: Extremely satisfactory and seamless. I recall that after the liaison committee had presented its report, we had an open forum at one of the business meetings of the American Academy of Ophthalmology. As chairman of the liaison committee, I was prepared for a violent set of questions. My recollection is that there were no questions. The members intuitively accepted this as something that represented the best interests for ophthalmology as a whole; the debate and discussion had taken place long before the formal ideas were presented.

Reasons for Ophthalmology Unity

Hughes: This question is provoked by your observation of the difference between ophthalmology's unified front and the fragmented front that some other specialists present. Can you think of any reason why ophthalmology would be more able to have a cooperative, unified approach than other specialties?

Straatsma: I can think of reasons why ophthalmology would have a less unified front. It's made up of very precise, technically oriented, aggressive, and bright physicians. The competition to enter ophthalmology has been severe. These factors could have led to even more fragmentation than any other field, and your question should really be: Why did this not occur?

I believe it was a matter of timing and serendipitous good fortune that we were able to bring in the representatives of other organizations in a variety of ways so that they felt it was to their advantage to be part of the Academy. In effect, the Academy used its very strong prestige and dominant role to become the central

organization. It did it through the merger, and it also did it through an International Congress of Ophthalmology that was conducted in 1982.

That international meeting, the largest, most successful ophthalmology meeting in the world to date, was carefully organized to not only conduct an International Congress of Ophthalmology in the United States but to combine it with the Annual Meeting of the American Academy of Ophthalmology. As the organizational group for that combined meeting, we invited the participation of all the specialty organizations and gave them a role in this international meeting so that they could immediately see the advantage of working with the Academy to their prestige and to their members.

I believe it was a matter of timing and of willingness to provide for participation of these different organizations that prevented the fragmentation.

You're going to have trouble editing this conversation. It's longer than you expect. [laughter] You must remember that some of us are used to working with residents, and our residents are very articulate. If you think I talk long on a simple question, you should talk to them!

Hughes: I'd much rather have more than less, believe me.

Do you have any concerns about the Academy moving more definitively into the political arena?

Straatsma: Yes. I believe there could be a backlash. The backlash would not stem from anything inadequate or inefficient or inappropriate by the Academy. The backlash could extend from the fact that a professional organization is not going to be the definitive policymaker in health care. People who expect the Academy to have more influence than it reasonably can have may become disenchanted and disappointed with the Academy, as many physicians have become disappointed with the American Medical Association or any other entity that is trying to represent the interests of physicians.

The Academy does need to be very careful to constantly remind its members that it's representing their viewpoint, but that it's not the only viewpoint being presented to the government.

The Foundation of the American Academy of Ophthalmology

Formation

Hughes: You mentioned the formation of the Foundation of the American Academy of Ophthalmology, which was necessary, I gather, for somewhat legalistic reasons. Would you speak to the purpose of the Foundation and also to what your role has been?

Straatsma: The genesis of the Foundation stemmed from the change in the Academy status from a 501(c)(3) to a 501(c)(6). And, as you recall, that took place in the late seventies. At about that same time, the Academy established a Foundation of the American Academy of Ophthalmology as a 501(c)(3) charitable organization.

I looked up the signers of the original incorporation documents for the Foundation. They were Drs. [Francis] Adler, Blodi, Maumenee, Newell, Norton, Spivey, and Straatsma. That was done in about 1980.

But the Academy Foundation remained quite dormant for a number of years. First it took on the role of establishing the Ophthalmic Heritage Unit. That has become a very effective museum and public outreach activity for the Academy, with programs that are going into schools, museums, and places where identification of ophthalmology as a part of medicine is very important.

The National Eye Care Project

Straatsma: Next the Foundation came into prominence through the National Eye Care Project, which was conducted as a charitable program through the Foundation. Many people should be given credit for the National Eye Care Project. I'm sure I'm overlooking some, but I would give credit for the original idea to Dr. David Paton and give enormous credit to Drs. George Garcia and Thomas Hutchinson for being absolutely superb in the way they catalyzed their personal energy and the organization energy to bring about the largest public service activity in American medicine.

Hughes: Is that so?

Straatsma: Literally hundreds of thousands of people have been served by ophthalmologists on a no-cost basis to the patient through this public activity. It has been

recognized at the federal level and at the corporate level as really an extraordinary activity of the American medical profession.

Hughes: *Why don't you outline its services.*

Straatsma: The National Eye Care Project provides eye care services to United States citizens who are sixty-five years of age or older and do not have a regular ophthalmologist. These people are invited to call a telephone number, and they are referred to a member of the Academy who is geographically near to the patient making the request and who has volunteered to participate in this program. The individual can then contact that physician and be given an appointment and an examination at no cost to the individual.

This has brought forth an amazing number of individuals who, for one reason or another, are isolated from the health care delivery process. The statistics are staggering. These public service examinations have led to services not only to people in need of a pair of glasses but to other people who have cataracts, glaucoma, retinal disease, and even malignant tumors of the eye. And this project is ongoing.

I was invited to become the chairman of the Board of the Foundation. At that time, a planning process within the Academy had identified the desirability of a more active role for the Foundation. So I was invited to become chairman at a time when the Academy had said, "We'd like to see more happen." And that was a very opportune moment. I was able to bring together a board, some of whom already were there and some of whom I was able to bring into the organization.

Individual Contributors

Straatsma: Dr. Melvin Rubin was the chairman-elect, and we established four vice chairmen: Edward Norton for resource development, Fred Blodi for heritage, Tom Aaberg for program development, and Steve Ryan for public service.

Any discussion of the Foundation should recognize that Mr. David Noonan has played the role of central organizing figure and leader. David is a brilliant, totally responsible, and fine individual in everything he does. He has taken the role of Executive Vice President for the Foundation, and thus many of the ideas that came forth from the eye care project, to the heritage, to what I'll speak about in a minute as a long-term endowment, reflect David's leadership.

The Endowment Fund: Bruce E. Spivey, M.D., Educational Trust

Straatsma: The endowment aspect of the Foundation is new. It's as good an example as any I know of to indicate that change always meets resistance. In attempting to establish an endowment for the American Academy of Ophthalmology through the Foundation, we encountered a lot of resistance, because people said, "Why do we need it? We've never had it. What's it going to do? Why should I have anything to do with this?"

But the reality is that the Academy is fundamentally an educational organization, yet it has no endowment like the University of California or Harvard or any university that you or I have been associated with. It doesn't have a corpus of money that can be committed in a long-term manner to the development of new activities or to the essential support of core activities. It's entirely dependent on membership dues each year, and there's a greater competition for those dollars each year.

So an endowment for the Academy is strongly needed to provide the core resource so the Academy can develop the new types of programs that are needed to transmit information that's accumulating more rapidly than we can possibly imagine, to develop new programs in instruction, and to maintain the educational flow for ophthalmology. In the last year, this endowment has been designated the Bruce E. Spivey Educational Trust, in recognition of Bruce and his central role in the Academy over the last two decades or even longer. I'm totally in support of that designation. The Academy can't be separated from Bruce's talent and energy and extremely fine personal qualities.

But the concept of an endowment is a new thought. Originating within the Foundation, it will grow slowly. But it is the absolutely essential new element that the Foundation is bringing to the organization for the nineties.

Again, when you look at something and say, "Is it a good idea?" you have to look around and see what's happening around you. After we started this concept for the Foundation, many other specialties within medicine began establishing an endowment—orthopedics, otolaryngology, and many other branches of medicine—not before we did, but within a year or two after we did. So serendipitously or not, we clearly are doing what's correct.

Academy Relations with other Ophthalmological Organizations

Hughes: *Would you care to say something about the Academy's relationship with other ophthalmological organizations?*

Straatsma: I'm not sure anything I say would be very profound. Let me try to make it brief.

The formal structure of the Academy with the Council provides an ongoing interaction and communication with many of the major organizations in ophthalmology, each one of which serves to fulfill a specific purpose in the broad arena of the profession. An exciting and in the future extremely important part of this interaction will reflect the international stature of the American Academy of Ophthalmology, a stature that has been gradually growing over the last fifteen to twenty years.

There was a time when one or two international figures attended the Annual Meeting of the Academy, and that was considered a very good representation of the international influence. Now there are many hundred ophthalmologists who come to the Annual Meeting from a single country such as Japan, Brazil, or Mexico. Many of these people are now International Members of the Academy, and to me, the next step for the Academy is to establish a regular, continuing mechanism to build on this international representation. For example, the Pan-American Association of Ophthalmology has had one very successful meeting with the Academy. It is beneficial to both organizations financially, intellectually, and in terms of simple energy.

Another meeting is planned with the American Academy of Ophthalmology and the Pan-American Association in '95. So this is a six-year interval between joint meetings of these two groups. During these intervening years, it would be desirable for the Academy to have a similar liaison with the Asia-Pacific Academy of Ophthalmology and probably with the European Society of Ophthalmology.

The advantage to the United States would be an opportunity for the leaders of these other parts of the world to become known by our members. The advantage to these other individual organizations would be a union with the Academy and an opportunity for their members to feel significant as they attend a meeting of the Academy.

Who Makes the Academy Work?

Hughes: *Could you say who and/or what makes the Academy work?*

Straatsma: That's an easy question. Who makes the Academy work is everyone, but everyone is not equally represented in the way it works. The absolutely central figure from the very beginning of the American Academy of Ophthalmology has been Bruce Spivey. There has been no substitute for Bruce as a magnificent executive, probably the best medical executive of his generation. And he just happens to be an ophthalmologist. His ability to bring people together and to have a sense of principle and honor and integrity, while also listening to different viewpoints, is absolutely magnificent. The secret weapon that has been behind all of this successful activity is Bruce.

Now, behind a secret weapon you need to have a secret weapon number two, not in any way secondary but to work as a team at an absolutely equal level of importance, and that would be David Noonan. David has that ability to know what's right and to do what's right and somehow to have everyone else think it was their idea. That's done by his extremely judicious support for an idea that he recognizes is valuable and the nondenigration of an idea that may not be valuable, knowing that it will rise or fall on its own merits.

The association that has existed between Bruce and David is extremely important, because that now permits a translation of that excellence to Dr. [Dunbar] Hoskins. Dunbar will be the logical person to develop the same relationship with issues, with members, with organizations. He'll be continuing as Executive Vice President, with many of the same skills and values that Bruce has had, and he will continue to have the support of David Noonan.

Hughes: *My final question is whether the Academy is leaving an imprint on American medicine of the late twentieth century.*

Straatsma: The Academy is leaving an imprint on ophthalmology, and ophthalmology is part of American medicine. But ophthalmology has permitted itself to become a little separate from some of the main thrusts of American medicine, and this needs to be addressed very carefully by our profession. You might ask how we have permitted this to happen.

Ophthalmologists have a tendency to be separate. We build separate institutes, we have separate organizations, and we have not been as [attentive] as we should have been to the education given to medical students in universities around the country and the support to general physicians who need to examine eyes. We

permitted ourselves in a variety of ways to become fairly separate from the mainstream of medicine.

Second, we have a very successful technology that has made the average ophthalmologist during the eighties economically very successful. Much of our economic activity has been performed on an older population under Medicare, so we have been a big factor in the rise of Medicare expenses. We have attracted a certain amount of envy and attention by our own success.

We need to recognize these shortcomings and return to the mainstream of American medicine. The Academy is capable of doing this, but it must be very active in professional education as well as in public education and health care policy. I believe the Academy is addressing these subjects with its new programs.

Hughes: *Thank you, Dr. Straatsma.*

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with
Bruce E. Spivey, M.D.

Conducted by
Sally Smith Hughes, Ph.D.
July 2, 1991, American Academy of Ophthalmology,
San Francisco, California

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Bruce E. Spivey, M.D.

Regional Oral History Office
Room 486 The Bancroft Library

University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name BRUCE E SPIVEY
Date of birth 8/29/34 Birthplace CEDAR RAPIDS IOWA
Father's full name WILLIAM L. SPIVEY
Occupation WELDER / MILKMAN Birthplace LAFAYETTE, GA.
Mother's full name GRACE L. BARBER SPIVEY
Occupation HSW / SCHOOL UNIFORM WORKER Birthplace WYOMING, IA.
Your spouse PATTI AMANDA BIRGE
Occupation LAWYER / GOVT OFFICIAL Birthplace SHERMAN, TEXAS
Your children LISA L. SPIVEY 7/10/58 SPIRIT LAKE, IA
ERIC W. SPIVEY 8/15/60 IOWA CITY, IA
Where did you grow up? CEDAR RAPIDS, IA
Present community CHICAGO.
Education See attached cv (brief).

Occupation(s) Same.

Areas of expertise _____

Other interests or activities _____

Organizations in which you are active multiple - see C.V.

Bruce E. Spivey, M.D.

Introduction¹

When the Academy of Ophthalmology separated from Otolaryngology and Bruce Spivey became its Executive Vice President designate, he wrote a 30-page memorandum to the Academy's Board of Trustees presenting his views regarding the advantages and disadvantages of having the Academy either remain in Rochester or move to Chicago, Washington, D.C., or San Francisco. The board quickly chose San Francisco, where Spivey had maintained an active ophthalmological practice, and had served as Chairman of the Department of Ophthalmology and President of the Pacific Medical Center.

The trustees may have been a bit apprehensive on May 15, 1979, when Spivey took them on a hard-hat tour of a rather unprepossessing gutted building in which he proposed to rent renovated space. The building was located at 1833 Fillmore St. in an area of San Francisco slated to undergo redevelopment, and Noonan recalls trustee approval of their recommendation as "a huge leap of faith." But in a short while, the wisdom in selecting this site became apparent. The remodelled space had an open arrangement that facilitated staff interaction, the redeveloped neighborhood underwent improvement, and the new staff soon felt quite at home.

The combined academies of Ophthalmology and Otolaryngology in Rochester had forty-four employees but only four—along with over 932,000 pounds of records, furniture and equipment—made the move west with the Academy of Ophthalmology. Spivey and Noonan had a \$2.5 million budget to work with, and envisioned no more than twenty-four employees in San Francisco. They could not have foreseen the immense growth spurt that would result in expansion of the Academy's annual budget to almost \$20 million, and of its workforce to 123 people by the time Spivey ended his tenure as EVP in 1992.² By 1985, the Academy had outgrown its rather limited Fillmore Street space and moved to its present 655 Beach Street location, where it acquired a minor equity interest in a portion of the building. (In March 1998, the Academy purchased the building to accommodate its present staff and enable future expansion.)

To a large degree, the Academy owes its steady physical growth and greatly increased stature as a national specialty organization to Spivey's self-deprecating managerial style. At the outset, he admitted to being "an amateur manager learning to be a professional." However, his innate absence of pretense, his intelligence, and his quick wit soon enabled him to win the respect of his medical colleagues and create an ambiance of camaraderie amongst the Academy staff. Spivey

¹ This introductory material has been derived from conversations with David Noonan, from personal observations of the Academy's development and growth in San Francisco since its move to this city, from interactions with Academy staff while the author served as their community ophthalmologist, and on several Academy committees as well as its Board of Trustees, and from a long-standing professional and personal friendship with Bruce Spivey.

² This trend has continued under the stewardship of Dr. Dunbar Hoskins; there are currently 153 employees and the 1998 annual budget has risen to \$32 million.

recruited and assembled a truly professional and effective staff who came to expect and receive attentive consideration of their efforts, as well as straight answers to questions that they might not have felt free to ask elsewhere. Spivey established a collaborative decision-making process and, although he was fond of saying "I decide who decides," most important decisions were guided by his common-sense approach.

In the interview that follows, Spivey is quick to acknowledge others who were involved in furthering Academy goals during his tenure, while modestly admitting his own contributions. Most certainly he deserves credit for being the guiding light in completely renovating the Basic and Clinical Science Course, for broadening the structure and scope of the Annual Meeting, for establishing a more rigid rotational structure within the Academy's governance (e.g., maximum terms of office), and for facilitating the evolution of women in ophthalmology.

In addition, he oversaw the creation of the Washington office, the merger with the American Association of Ophthalmology, and the development of an appropriate balance between the authority of the Board and its responsibilities *vis-à-vis* the newly formed Council. Spivey also initiated *Argus* as a means of communication with Academy members, and shepherded the formation of the Academy Foundation, as well as the movement of the *Transactions of the American Academy of Ophthalmology* to a true journal (*Ophthalmology*). He was also a prime mover in encouraging the growth of international membership as well as the development of non-clinical education (practice management), Preferred Practice Patterns (PPPs), and the National Eye Care Project (NECP), and the establishment of the Ophthalmic Mutual Insurance Company (OMIC).

William H. Spencer, M.D.
February 1998

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BRUCE E. SPIVEY, M.D.

[Date of interview: July 2, 1991]

Family Background and Education

Hughes: *Let's start with your family background and early education.*

Spivey: My father [William L. Spivey] is about to be eighty-eight and he works four days a week as the head handyman of a retirement home. My father finished all eleven grades that there were in Jessup High School in Georgia. He hated Georgia, hated the cotton and the tobacco and farming in general, and got out as fast as he could.

Hughes: *At a very young age?*

Spivey: After high school—1926 or something like that. He ended up in Iowa, and worked as a milkman, delivering milk from '26 to '41. He met my mother [Grace Barber Spivey] who was born in Iowa. They got married after a brief courtship and are now sixty-three years married. I was born a couple of years later [1934]. No one in my family had ever gone to college.

My paternal grandfather [Marion Spivey] could not read or write. None of his generation could. He was born in the hills of northern Georgia.

Hughes: *Do you have brothers and sisters?*

Spivey: A twelve-year-younger brother [Daryl Spivey]. He has his own company in management consulting.

I was the first one to go to college. When the war started, my father was a little bit older. He started working as a welder in a factory. This was considered a "defense" job. He retired at age sixty-five as a welder. So there has not been a great deal of educational background in my family in the formal sense.

Hughes: *Were they encouraging of you?*

Spivey: Oh, yes. I grew up in a warm, close, and supportive family. They expected more from me than opportunities that were presented to them provided. School was quite easy for me, and I went to medical school because my buddies were going

to medical school. There were four of us in high school that palled around together; we all went to the same college [Coe College, Cedar Rapids, Iowa].

I had a full scholarship at the University of Iowa—that is, tuition and books—but I couldn't afford to go there, because the scholarship didn't have board associated with it, so I stayed at home and went to Coe College.

The other three friends were dead set to go to medical school. It seemed like a good thing to do. So I went, too.

Hughes: Were there any more reasons than that?

Spivey: No. They asked me in my medical school interview—I cringe at the thought of it today—“What would you do if you don't get into medical school?” And my honest answer was, I would go into the clothing business, because I was working in college at a clothing store. I thought I could sell, and always liked clothes, so that seemed like a very reasonable alternative to medical school to me at that time. I started working each summer at age twelve. Actually I started working every summer for my uncle on the farm when I was seven.

Fortunately, 1954 did not involve the stress of medical school admissions today. I applied to two colleges; I applied to one medical school; I applied to one residency. I applied to three internships because they said you should, but they were all in California. My first choice was Highland Hospital [Alameda County], and that's where I went. My second was Santa Clara County Hospital, and the third was San Francisco General Hospital.

Hughes: Why California?

Spivey: It seemed like a long ways away from Iowa. [laughter] It seemed distant and exotic. And these were all interns' hospitals, where you could do a lot. There was excellent didactic education at Iowa, but you didn't have great clinical responsibility.

Hughes: You knew in advance that these were places where you could do things, gain clinical experience?

Spivey: Yes, for sure.

I never learned how to study until I was out of medical school. Really, it was in residency when I think I began to learn to apply myself. Oh, I studied; I'm not meaning to imply that I didn't study. I just didn't really commit myself very much.

Introduction to Ophthalmology, University of Iowa

Hughes: Now, when did ophthalmology come into the picture?

Spivey: Well, I worked as a railroad section hand for the last four or five summers at the end of high school and through college. It was the best paying job, and outside.

Hughes: What is a railroad section hand?

Spivey: It was working on railroad track bed, repairing ties, laying new and replacing old rail, and tamping ties and repairing the rail bed. This is done basically by machinery now. It was a job occupied heavily by minorities.

The year before I started medical school, I was almost killed in an accident. The same events of the accident if repeated would have resulted in my death a hundred times to one. They were laying new track, and I was up in a gondola car full of gravel. They didn't holler, and I went right down with the gravel when it started to go. I went down out through a very small chute and an opening even smaller, and was spread on the track with the gravel as the car being pulled by a locomotive moved on slowly.

I broke my back and scapula, ripped my knee, and injured my eye. It was about the middle of June, so I was able to recuperate and begin medical school. I had a big body brace. That was before air conditioning, and it was a very poignant summer. It was a warm summer in Iowa, as I remember it.

Hughes: *[laughing]* I don't even want to think about it!

Spivey: The EENT [eye, ear, nose, and throat] doctor in Cedar Rapids, where I grew up, didn't know what was wrong with my eye. When I started medical school [University of Iowa College of Medicine, Iowa City], I went to a fellow by the name of Phil Ellis, who's now chief of ophthalmology at Colorado. He was a junior faculty member at that point, and he looked at my eye. I have a pericentral scotoma, and I still don't know today the cause of that; it's in my right eye. He said, "I don't know what the hell is wrong with your eye, but do you want a job?" There was a guy across the hall who was looking for a medical student to work for him. I knew I was going to be getting married that spring, or sometime soon, and yes, I always needed a job. So I said yes.

He took me across the hall, and there was [Dr.] Hermann Burian. So I started working with Hermann Burian at Christmas time of my freshman year in medical school in 1955. I worked there each summer and on vacations in electro-

Introduction to Ophthalmology, University of Iowa

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Hughes: Your master of science degree [1964] came as a result of the research?

Spivey: Yes.

Hughes: And was this more research with Burian?

Spivey: Yes, this was my own research in electrophysiology, but it began while I was working in Burian's lab.

Lee Allen

Hughes: Helen Dell [Dr. Spivey's secretary] mentioned that you had done some interesting research with Lee Allen.

Spivey: Well, I have done a lot of things with Lee Allen. I helped him a little when I was in medical school with his ophthalmic photography. But Lee and I were particularly involved with studies related to enucleation and the various implants that were used. Lee along with Jimmy Allen developed the Allen implant, and with Ed Ferguson the Iowa implant. Lee also during that time was looking at the development of the chamber angle. He was really an original thinker.

Hughes: He was a photographer and an artist?

Spivey: Yes, as well as an ophthalmologist. During his time in the WPA [Works Progress Administration] he studied under an artist by the name of Grant Wood. In my office, I have an original oil of Lee's which is symbolically "American Gothic" revisited. It shows the site pictured in "American Gothic" thirty years later.

Military Service, 1964–1966

Spivey: I had a great residency. I stayed on six months and did a lot of surgery, including cataract surgery in one-eyed patients. I was really the first junior faculty they ever had. Then I went into the army for a distinguished military career: Fort Polk, Louisiana; Fort Dix, New Jersey; and Qui Nhon, South Vietnam. I thought I was going to avoid being drafted though I had been deferred by the Berry Plan, because I joined the reserve. I needed the money, so I joined the reserve. But they got me. I raised hell and got moved from Fort Polk where they had never had an ophthalmologist and really didn't need one, to Fort Dix. Then when they

decided they needed an ophthalmologist in Vietnam, my name was at the top of the list because I had raised so much hell.

Hughes: That will teach you!

Spivey: Well, it was a big improvement over Fort Polk, and it was at least as good as Fort Dix.

Hughes: I bet you had some good medical experiences.

Spivey: Yes. I learned more about myself in Vietnam than I learned anywhere else. I became a triage officer, which caused the army to rewrite their war manual, and a few other things.

Hughes: Were you allowed to do much ophthalmology?

Spivey: I did ophthalmology except when we got a lot of injuries. We were supposed to have the most senior surgeon become the triage officer, to decide who gets operated in which order, and who do we put under the tree to let die, and that sort of stuff. It became clear to me that the chief of surgery was inept in that regard. Well, I had had a wonderful internship where I saw gunshot wounds; the knife-and-gun club met every Friday and Saturday night in Oakland. I could make decisions. So I finally said to the chief of surgery, "Go operate." He was easily led anyway. I helped out a little in surgery, but basically I was the triage officer for a year.

I was the first ophthalmologist in Vietnam with the army. Also I was the first ophthalmologist to go to a Vietnamese leprosy hospital of eleven hundred lepers. We had very little anesthesia, but the lepers didn't need it because everything was numb anyway. You could just sew things together and they never felt it. And I taught a nun to do cataract surgery at the Holy Family Hospital in Qui Nhon.

Ophthalmology Faculty, University of Iowa, 1966–1971

Hughes: And then you came back to Iowa?

Spivey: I came back to Iowa on the faculty, not being sure that I wanted academic medicine, but being absolutely convinced that if I didn't try academic medicine, I would never go back into it.

Hughes: The alternative was going into private practice?

Spivey: Yes. I had a number of good offers, in Iowa City, Cincinnati, New York City, and lots of other places. When I came back, I did the ophthalmic plastics, most of the corneal transplants, the strabismus operations, and a lot of cataract surgery. Maybe Bob Watske was doing as many hours in the O.R. [operating room], but I was doing more cases, because he did a lot of retinas [which take longer].

There were a few things in ophthalmology that I didn't want to do; I didn't want to do external disease, and I didn't want to do pathology, and I didn't want to do neuro-ophthalmology. I wasn't too hot for retina, and I didn't really want to do strabismus full time, but I liked it. There wasn't at that point a cataract surgery specialty.

Master's Degree in Medical Education, 1969

Spivey: What interested me was education, and I was observing all these people on the faculty of medicine who didn't much care for education, didn't know how to educate.

Hughes: Had you been doing some teaching?

Spivey: Well, as a faculty member, you teach residents and medical students. I had heard about this program in medical education at the University of Illinois, and so I got Fred [Blodi] to support me. I had an RO1 grant in the genetics of strabismus by that time. I went to summer school at Champaign-Urbana, and then spent the rest of the year in Chicago. I worked from Monday morning until Thursday noon in Chicago, and then I would drive back to Iowa City Thursday, and then I would do my grant and see a few patients on Friday, Saturday, and Sunday. I'd go to bed about six o'clock Sunday night and I would get up at midnight and drive to Chicago so I could begin classes Monday morning.

Hughes: All I can say is you're consistent. [laughter]

Spivey: I received a master's degree in education in 1969.

Hughes: Was the program exciting?

Spivey: It was wonderful, and difficult, quite unlike any of my prior formal education.

Hughes: And you had learned to study.

Spivey: I had learned to apply myself in my residency; “study” may not be the right word.

Hughes: *What was the purpose of the program?*

Spivey: It was a master’s degree in medical education that was a natural for people who wished to become deans or directors of medical education or associate deans for medical education, and so forth.

Hughes: *Was your idea to combine medical education with the practice of medicine?*

Spivey: Yes, but I really didn’t know what I wanted to do. I then came back to Iowa, and I became chairman of the curriculum committee of the College of Medicine. We totally revised the curriculum. I was a young assistant professor; usually the more senior heads do this sort of thing, but I had this course and was involved.

After several years it became clear to me that despite the idyllic world in Iowa City, I needed “other world” experiences. I had a number of offers, including a chance to be associate dean at a new medical school in Lubbock, Texas, Texas Tech; to go to Milwaukee as co-chief there; and to go to three or four other places.

**Positions at California Pacific Medical Center,
San Francisco, 1971–1992**

Spivey: I had been recruited by [Dr.] Art Jampolsky, mainly at [Dr.] Paul Boeder’s suggestion, to replace Art as chief of ophthalmology at Pacific [Presbyterian] Medical Center, now California Pacific Medical Center. That was 1971. I also became dean [1971] of a barely existent School of Medical Sciences. I had several jobs; I was chief of ophthalmology, dean of the School of Medical Sciences at the University of the Pacific, and in charge of the educational programs at Pacific Medical Center. There wasn’t really much staff when I became chairman of the department, because there was no one there other than [Dr.] Henry Metz, I think, one-eighth time. So I was really the first full-time person they had ever had, although there was a long, rich tradition of ophthalmology at the center.¹

¹ See *Dohrmann Kaspar Pischel, M.D.* Ophthalmology Oral History Series, A Link With Our Past. Interview conducted in 1988 by Sally Smith Hughes. The Foundation of the American Academy of Ophthalmology, San Francisco, and the Regional Oral History Office, University of California at Berkeley, 1988.

So then I recruited [Dr.] Bob Stamper and a bunch of other people, and we started to make the program in ophthalmology very competitive nationally.

Hughes: Is that what Pacific Presbyterian expected you to do?

Spivey: No, they had no idea what I would do. Then I also got a grant to look at new forms of medical education with the idea that there might be a medical school there, since Stanford [Medical School] had moved to Palo Alto in '59. This was '71, the idea was still warm, and the University of the Pacific was very interested.

When I decided to go there, Dr. Robert Burns was the President of the University of the Pacific. I never met the man. He died before I arrived. He enticed the dental school and was very interested in a medical school. His successor was frightened to death about the idea of a medical school. And the funding for medical education began to get more difficult. So we never did really pursue a medical school.

I had made a big study with a lot of people that I had met at the University of Illinois about alternative medical education, called the School of Health Professions, where there would be one school for anybody from nurses to dentists to physicians. It was an interesting concept.

Hughes: The idea of closer integration of the professions.

Spivey: Yes. But it was an idea whose time still hasn't come; it may never.

Hughes: Was that a disappointment to you?

Spivey: Sure. That was, I would say, my first big failure. I didn't do very well at putting that concept in front of the world. I was also disappointed at not being able to start a medical school. In retrospect it was the proper thing, but it didn't feel like it at the time. I recognized I didn't have University of the Pacific backing; I didn't have the financial backing. We had a lot of problems with the hospital at that time, and we were going broke, and in '76, I became President and CEO of Pacific Medical Center in San Francisco, the head of the entire medical center.

Hughes: How did this happen?

Spivey: Well, the medical center went broke. We were technically in bankruptcy. I was very worried, and the Board was about to fire the CEO—who was one of the key people who recruited me. I was very worried for the residency program. They were ready to fire the CEO, but they didn't have anybody in place, and the docs were unhappy. They thought maybe a doctor running the place would make it

better, so I was asked would I become President and Chairman of the Board. I had never been to a Board meeting; I didn't know the difference between a President and a Chairman; didn't know anything about finances. But I said yes, for really two reasons: one, I didn't want the hospital to go belly-up, and if it did we would lose the ophthalmology residency program; and two, I knew that it would take a year or so to recruit anybody, and by that time we really would be broke. We needed somebody right away, so I took the job for eighteen months, which stretched to over fifteen years.

I also became CEO of a hospital holding company, California Healthcare System—over three (and now four) hospital organizations including Pacific Presbyterian Medical Center, which is what we finally call PMC.

So that's more about me than you really need to know.

First Associations with the Academy

Hughes: Well, let's plunge into the Academy. What were your first associations with the Academy?

Spivey: The Palmer House in Chicago, Illinois, 1960. As residents at Iowa, we were encouraged to go to the Academy meetings, even as first-year residents. So we would all pile in someone's car and just raise hell. I couldn't afford to stay at the Palmer House, but we stayed in hotels, flea-bags around there. We generally took our spouses and sort of went to the Academy.

Hughes: Sort of?

Spivey: Well, we weren't compelled to feel we were going to get a test right away, so the nights were as important as the days. Those were years that the meeting was totally contained in the Palmer House. I have missed one Academy meeting since 1960, and that was when I was in Vietnam. It was a little hard to make it then.

Hughes: Well, can you describe the atmosphere of the Palmer House meetings?

Spivey: Well, the meeting was very small. Mornings were ophthalmology plenary sessions, afternoon instruction courses, and otolaryngology the reverse, and it flipped year to year. Small, intimate feeling, by and large. Sort of the old-time school; Bill Benedict I saw and was introduced to. I met a number of the other senior functionaries of the time. You really bumped into all the big names in the

elevators or the restrooms. Then while still in my residency, the Annual Meeting went to Las Vegas. Several of us would get into a car without spouses and drive nonstop. The further along in ophthalmology I went, the more attention I paid to the meeting.

Hughes: The reason the 1962 meeting was held in Las Vegas was because the Palmer House had been outgrown?

Spivey: I don't know why it was moved there.

Hughes: Did that cause a ruckus?

Spivey: Oh, yes. Las Vegas, sin city, and all that.

Hughes: Why that choice?

Spivey: I have no idea.

Hughes: What about the tenor of the scientific meetings?

Spivey: Well, the Academy was entirely scientific. If you said socioeconomic, you had to wash your mouth out with soap within three minutes or you self-destructed. It was perceived, and probably was, [as] a pretty stodgy group—probably just as people perceive it today—stodgy, controlled by a few people, and whatever. I believe it is not true today but I'm sure that's the perception.

It was a pretty relaxed meeting. I remember it fondly. The elevators were a mess and a crunch. I gave courses even as a resident, so I was very much involved.

Hughes: That was unusual for a resident, wasn't it?

Spivey: Yes. Because I got involved in color vision, I gave a course on this. I had helped as a resident with the Home Study Course, that's what it was; but I gave courses—must have been a junior faculty—no, I think I was a resident when I gave the course in '63, '64.

Hughes: Because you were an expert in that particular area?

Spivey: Such as experts went at that point, I presume.

Hughes: Did you volunteer?

Spivey: Oh, you apply to teach a course. You either get accepted or not accepted.

Hughes: And what about papers? Was it a similar system?

Spivey: You always submit your own abstract, which is reviewed and again selected or rejected. Now there are some symposia that you are invited to go on, but if you want to give a free paper on the program, you have to submit your own.

The Academy as a Focal Point in Ophthalmology

Hughes: Was it considered an honor to give a paper at the Academy?

Spivey: Oh, yes.

Hughes: So it was a place where top ophthalmology was presented.

Spivey: Oh, without a doubt. In otolaryngology, there were a number of other outlets. The Triological Society meets in the spring, and that consists of three ENT organizations. It is a serious contender with the Academy [of Otolaryngology—Head and Neck Surgery] for otolaryngology papers. There were not the plethora of subspecialties that exist today. Consequently, the Annual Meeting of the Academy was *the* place to present new material that was primarily clinical. There was a fledgling ARO [Association for Research in Ophthalmology] which later became the Association for Research in Vision and Ophthalmology (ARVO).

There was the American Ophthalmological Society [AOS], which still exists, but even in the early sixties [was] not relevant for most ophthalmologists. Having just been chairman [1991] of the Council of the American Ophthalmological Society, I looked up the relative numbers, and the AOS was about 20 percent of all ophthalmologists near the turn of the century, and now it's less than 1 percent—225 people.

So the Academy was then and is now the premier national exposure in ophthalmology, and people try very much to have an instruction course or give a paper at the meeting.

Hughes: What about the Section of Ophthalmology of the American Medical Association?

Spivey: When I arrived on the scene, it was on the way down, as was the AMA's commitment to education and science, although the ophthalmology section lasted longer than most. The last leaders were [Drs.] Brad Straatsma and Tom Duane. [Dr.] George Weinstein I think was the last Secretary of the section.

George has been the President of the Academy. So it was an important segment in American ophthalmology in its time, but it waned as the AMA has waned as an educational forum.

Hughes: *Because the AMA took on more political interests?*

Spivey: Yes. And as the specialty societies proliferated, the AMA was not able to capture the interest, and that's the concern I have about the Academy. It could happen again. The AMA became so damn political, and they just got out of the educational scientific business—in large measure because the specialties became stronger.

Hughes: *From the beginning, education was the thing that the Academy stood for.*

Spivey: No question.

The Academy Assumes a Political Role

Hughes: *When would you say—let's put it diplomatically—that the Academy entered into external affairs?*

Spivey: Or less diplomatically—socioeconomics or money or the legislative arena. Nineteen eighty-one, but it really started before that.

American Association of Ophthalmology

Spivey: When we separated from otolaryngology, I was the Executive Vice President designate of the Academy. I thought we needed a Washington [political] activity. The American Association of Ophthalmology was started because the Academy wouldn't deal with socioeconomics. It consisted of a group of people, never really the front-runner academics, relatively few of the major names in ophthalmology, but people who were very good and committed and dedicated to fighting optometry and advocating for ophthalmology basically at the state level. It had headquarters in Washington.

Larry Zupan ran the Association, but he never had the financial and consistent ophthalmologic leadership. The Association's fight was with optometry in the states. It was clear ophthalmology didn't have any real national presence. I

started the Washington office [Office of Governmental Relations, 1977]. The fellow whom I recruited turned out to be an alcoholic and not very functional. [Dr.] Whitney Sampson was the Executive Vice President of the Association at that time, and it was just clear to me that it was a matter of time for ophthalmology to beat itself up internally. I went to Houston and talked to Whitney, and I suggested we merge. And with intense discussions and negotiations beginning in late 1979, '80, and then finally July of '81, the Association merged into the Academy.

At that point, and as a response to Association pressure, the Academy then created a Board of Councillors, which became the Council, and that started the internal politics. Over the years, the Council contributed a great deal to the Academy, but it also wanted to control the Board of Directors—much as occurs in the AMA, which I think has a fatally flawed organizational structure. There's been a lot of struggle about who should be leading what.

The Council and the membership want the Academy to hold the line, i.e., keep things as they are or even used to be. None of medicine is holding the line. There is this inexorable pressure against the present status of medicine in our case, particularly with optometry. It has become a legislatively oriented process. That's sadly where the game is played. And legislative processes are acts of compromise. And acts of compromise are only to the detriment of medicine, and in our case ophthalmology, because compromises only take away what we have. We have what we want. We can only lose. So it's really a murderous position.

If you ask where the Academy's political activity really began, it started with my feeling we needed a national legislative arena, and starting a Washington office with federal intent, and then moving from there to the merger with the Association, and then just the external pressures that have come up, at the state and particularly at the federal level.

Office of Governmental Relations [OGR] and the Secretariat for Governmental Relations

Hughes: *Could you look upon the Office of Governmental Relations, which was founded in 1977, as the concrete form of the Academy's new political orientation?*

Spivey: Well, the Council was really the internal political activity. The OGR is the external staff-board identification of it. Then we decided we needed stronger direct ophthalmologic day-to-day leadership, so we started the Secretariat for Governmental Relations in '80.

Hughes: Before that, you didn't have lobbyists at either the state or the national level?

Spivey: The Academy had nothing political before '78. This American Association of Ophthalmology really didn't have lobbyists; it was an association of ophthalmologists who fought the battles by themselves.

Hughes: Now, how did that compare with other medical associations?

Spivey: Not dissimilar to specialty societies.

Hughes: All were nonpolitical?

Spivey: Well, most were apolitical, but ophthalmology became more political because it had a direct antagonist/competitor called optometry. The analogies are psychiatry and psychology, and obstetrics and midwifery, and orthopedics and chiropractory. We had the Association that was very active legislatively, but the Academy was not.

Hughes: Did you pay attention to what the membership was saying?

Spivey: In part, yes, but there are often countervailing messages. There were a lot of things happening in Medicare and at the state level, and we just needed to be more involved. If we had two organizations doing it, they were going to be fighting for resources, and they were going to try to outdo one another in their own dues and loyalty developments. I made a decision to become politically active, then only time will tell.

Hughes: We agreed that the Academy before the separation was primarily an educational organization.

Spivey: Only.

Hughes: What is it now?

Spivey: Well, I still say it's primarily educational. If you look at the budget, it's primarily educational. The vast majority of income and expense is for education. Now, my detractors and a few of those on the Board will say that we're not spending enough for socioeconomic. I think that's probably true. The realities of the political scene and the way that non-physician providers are going to the legislatures, both at the state level and at the federal level, are such that in order to protect your position, some segment of your specialty has to be very political. That isn't my joy, that isn't my delight, it's painful in some ways, and, in fact, can fragment the society. The only way we will "win" in the long run is by a

commitment to education. I have had to spend a lot of time in Washington. I enjoy the strategic games, but I don't enjoy the slugging it out and telling bigger and better, more attractive, prevarications than the competition.

If you look at medical specialties, if you look at all economic segments of society—not just the health care industry, but the petroleum industry, the manufacturers—everybody's spending more time in Washington because the government is playing a greater and greater part in our lives through the regulatory process. The legislative thrust to redefine everything from the physicians to who can do what when means we have to stay and play.

Hughes: *I'm unclear what the various vice presidents do.*

Spivey: David [Noonan] and I are the only vice presidents today. The present analogy to a Vice President is a Secretary. In years past, those elected ophthalmologists who were vice presidents weren't likely to be President, so they were given, in the old Academy, first, second, and third vice president positions. If you ever got that, you were damned. That was an honorary position. The AAO had vice presidents for a while, people again unlikely to move up, and then one did, and then we said, Why do we have vice presidents? Let's have a President-Elect.

Reorganization of the Academy, 1969–1970

Spivey: Briefly, my involvement in the management and the committee structure of the Academy started with Brad Straatsma in 1970. Brad knew [Dr.] Mel Rubin; Mel Rubin knew me and knew that I had just received an educational masters degree. The reorganization of the whole Academy occurred in '69-'70, and Brad became a Secretary for Education. His secretariat started up with Reinecke, Rubin, Harley, and Spivey. Prior to this time, the secretaries had been long entrenched, and they would serve ten, fifteen years—[Dr.] Al Ruedemann [Sr.] from Detroit, and there were one or two others that served a long, long time, including [Dr.] Ken Roper from Chicago. That was about the time that [Dr. A. Edward] Maumenee and others moved to reorganize the Academy.²

Hughes: *Reorganization meant revitalization?*

² See *A. Edward Maumenee, M.D.* Ophthalmology Oral History Series, A Link With Our Past. Interview conducted in 1990 by Sally Smith Hughes. The Foundation of the American Academy of Ophthalmology, San Francisco, and the Regional Oral History Office, University of California at Berkeley, 1994.

Spivey: Yes. [Dr. William] Benedict had died. Yet the existing power structure continued with very little turnover and very few changes. The status quo reigned. The educational programs needed to be changed, the instruction courses needed to be changed. Brad took over as Secretary for Continuing Education [1969–1974]. Initially there were no statutes or bylaws for the reorganization, and they were made later.

Hughes: Was Dr. Straatsma the impetus?

Spivey: He was a younger leader and was brought in along with [Dr. Frederick] Blodi and [Dr. David] Shoch. The major forces for change were Ed Maumenee and others who were on the Academy Council, which was the Board of Directors of the Academy of Ophthalmology and Otolaryngology at that time. Three people were recruited as new secretaries: it was Blodi for Program, Shoch for Instruction courses, and Straatsma for Continuing Education (the non-Annual Meeting education). At the inception, the only educational activity not associated with the Annual Meeting was the Home Study Course. [Dr.] Rob Harley started with the revision of the course and soon I was given responsibility for the change and I became the Associate Secretary for Basic and Clinical Science Courses, which we started as the successor to the old Home Study Course. It was a lot of fun.

Hughes: Why?

Spivey: Well, it was a chance to really develop a new educational curricular format, with fresh thinking, and new programs. I can remember Brad saying, “Someday we’ll have a \$300,000 budget for education.” We all said, “Oh, no way.” Well, you know, the budget for the educational secretariat alone is now close to \$6 million.

Hughes: Was this revitalization an updating?

Spivey: It was a *complete* reorganization. At the same time, we rather significantly changed the papers at the Annual Meeting, and instruction courses began to turn over. We changed the Home Study Course to the BCSC [Basic and Clinical Science Course] and developed a whole new set of programs. Then Brad got into a presidential race, and I took over the secretariat for him. Since then I’ve been involved in a lot of other things.

In the early seventies, the presidential role was primarily ceremonial, and as committee members or secretaries we had little involvement with the Academy President. The Board meetings were really preparation for the Annual Meeting with intense review of papers, symposia, and instruction courses. This never gets to the Board level these days. It was very much an educational organization; the educational activities were run by the secretariats.

Slowly, now, the entire Academy enterprise has gotten far more active as well as political. We've got conference calls and special meetings, and the President has to go here, there, and everywhere, and is much more visible at the national level, giving speeches and attending state society meetings. So the pace of commitment and the time and political knowledge required has dramatically increased.

Hughes: All that goes into the selection of the President?

Spivey: Well, I hope and believe it does.

Hughes: I would think with that changed environment, the reasons you would choose an individual would also be different.

Spivey: We will, by necessity, begin to change. We'll see fewer and fewer pure educational leaders, and more sort of educational/socioeconomic leaders. This has already occurred. You can no longer be a single directional leader and evolve to the Academy presidency—or, better stated, this is highly unlikely. We've already done that with a number. And a number of the past presidents of the Association became presidents of the Academy. It's gotten so that the Academy is more political, has far more committees, far more involvement, far more staff, lots of complex programs in education, and public and professional communications.

We've developed many alternative means of funding the Academy; the dues are just a third of it. We've done an awful lot in the last fifteen years relating to new sources of revenue, new approaches, new interests. We've gotten a committee on international ophthalmology in the last couple of years. The original stimulus came from George Garcia's presidency. This was at a time when we developed an international membership category, catered to international members, especially in education. Other examples of change include a Secretariat for Ophthalmic Practice [1988], a Secretariat for Governmental Relations [1980], a Secretariat for Public and Professional Information [1984], and an Ethics Committee [1980]. An awful lot of new thrusts and new programs, and there will be a reorganization into three major areas: education, ophthalmic practice, and advocacy.

Hughes: On what basis are these secretaries chosen?

Spivey: By a search committee of the existing secretaries, who recommend [their selections] to the nominating committee of the Board. They're chosen on the basis of their past performance in Academy programs and activities as well as their stature and overall performance in ophthalmology.

Hughes: But not necessarily in the field in which they are to serve?

Spivey: Well, they generally have played some role as a committee member or something. For example, George Weinstein was the first Secretary for Public and Professional Information [1984]. He followed [Dr.] Byron Demorest, who got it started as a committee. Neither [was an] expert in public information, but [they were] quick learners who brought a wide perspective and capacity to any arena.

[Dr.] Tom Hutchinson, the first Secretary for Ophthalmic Practice [1988], is in private practice [in ophthalmology], was past chairman of the Council, and [was] very much involved in practice development activities. He is very educationally committed and capable, but also has a bigger picture as it relates to ophthalmic practice.

Hughes: How likely is it for an ophthalmologist who has not been terribly active in the Academy to hold an Academy position?

Spivey: Very unlikely. You have to really get involved, probably at the state level or in some specialty society. Individuals can get involved further if they're very capable as a committee member, and then if they really perform as committee chairman or special project leader, then they can get nominated for higher office.

Hughes: Is that because of the feeling that one should pay one's dues?

Spivey: Well, partly, and also I would say [it's part of] a desirable management philosophy that says, you like to see people perform before you give them major responsibility.

Hughes: But performance outside the Academy doesn't . . .

Spivey: Doesn't quite translate. There are many people who are wonderful people and performers but have not been very much involved in the Academy, and won't be because there are so many people that are involved in the Academy, that pay their dues, it's hard to elbow your way in. But there is an opportunity for every ophthalmologist who wishes to be involved—it's just hard to come in at the top!

Women and the Academy

Hughes: *Why aren't there more women in Academy positions?*

Spivey: Well, now you're speaking to a dues-paying member of the Women in Ophthalmology.

Hughes: *I'm glad to know that!*

Spivey: Well, first of all, there is a growing number of women members, substantially more. My request in recent years has been that I wanted to see a woman on every committee, then that I wanted to see women chairmen, and there are. There's a woman Board member. Previously, [Dr.] Alice McPherson was a Vice President, and more recently, [Dr.] Marilyn Miller is a director-at-large, and now [Dr.] Eve Higginbotham. I think that women by and large had less interest and less commitment to organized medicine historically, and maybe less opportunity. I don't know which came first. It takes a lot of time and a lot of travel. About a third of the Academy will be women in fifteen, twenty years. I know the tremendous pressures of practice, family, children, et cetera, which often make it more difficult for women to be as available for meetings as men, especially at a younger age when children take precedence. We are working very hard to include women and minorities in Academy committees and programs.

Forty-three or more percent of the residents in [obstetrics and gynecology] are women, and twenty-some percent of the ophthalmologist residents are women, and that's just going to grow, grow, grow, grow. Ophthalmology is a particularly attractive specialty to women. And that isn't quite as sexist as it sounds: It is more schedulable, controllable, it's not urology, and it's also much more precise, surgical. I've always said that it's the most attractive specialty, the "queen of specialties." We'll see how the modern woman does medicine. It's yet to be determined. Obviously, there have been many women who are leaders in medicine, but less proportionately than there are women in medicine. A good deal of that has been their dual, triple existence—mother, head of the household, and then health care provider, and that just takes its toll. If you have children, you can't drop them on the weekend and fly to a meeting in Atlanta.

I also observe how people commit themselves. Probably that's one reason my first marriage failed. I was *very* dedicated to my career, and *very* interested in doing well and performing, and I spent a lot of time traveling. I probably spent forty weekends or more on the road last year. Now, that's a lot. Fortunately, I have a wife who understands and who likes to travel.

It's a hell of a lot easier as the husband-father to duck out of town that it is for the wife-mother. If you have to be home during your childbearing and -rearing years, it cuts you out of an early advance into organized medicine.

I feel very committed to making women a more important part of Academy governance—this is my personal feeling, and also that of a very capable professional spouse who educates me—but it is also self-preservation of the Academy. If you've got a third of your potential members in one pack, whatever that pack is, you better show them a real opportunity to play.

Hughes: What is your observation about women's competency as ophthalmologists?

Spivey: First-rate. Women are every bit as capable and competent as men. I probably ought to stop right there. The struggle doesn't have anything to do with competency. I think there is still a struggle for women to be taken as equals, and men to know how to do that.

Recently, I have noted that women seem far less willing to pay their dues than men. They want to start at the middle or at the top—not all of them, clearly. This is a sweeping generalization. They are much less willing to toil in the vineyards for a while until they're the winemaker. Some want to start as assistant winemaker for a little while, and then be the winemaker. Maybe it is because in some cases women are behind in terms of years of service. There are a lot of factors to it. But I think there's a lot of understandable resentment on the part of women—in medicine, at least—to not having been given the same opportunity.

Executive Secretary-Treasurer and Executive Vice President
1978–1992

Hughes: What is the background to the Executive Vice Presidency [EVP], which you assumed in 1978?

Spivey: I was originally called the Executive Secretary-Treasurer, which was what Wherry was, which is what Bill Benedict was, which is what Mike Kos was. The position flip-flopped back and forth between an ophthalmologist and an otolaryngologist. I don't know what Wherry was; was he an ophthalmologist?

Hughes: He was both.

Spivey: EENT.

Hughes: Yes, but his emphasis was on otolaryngology.

Spivey: So it was natural that when he left it, they picked an ophthalmologist, Benedict, who held the position for a long time. When Benedict died [1969], they picked an otolaryngologist, Mike Kos from Iowa, whom I know very well. Mike never moved to Rochester, and I think lost interest after a while. David Noonan was really running the day-to-day business, and continues to do an excellent job and actually let it be known I was interested. In every other job others have recruited me. The EVP of the Academy was the *only* job I ever really wanted.

Hughes: How did you get it?

Spivey: Well, at the time the Academy separated, I was Secretary for Education and on the Board, and I think Brad [Straatsma] established a search committee. I don't know who was on the search committee, but I let it be known that I was interested, because I was. That was before I took over as—it started sort of in '76—I don't know—1977—that I was interested in that, with the idea that there was a separation, this was the process that was going. In '78, I became the Executive Vice President designate, and I think technically '79 is when I became Executive Vice President, because January 1, 1979, was the first year of the [new] Academy. I don't know how many candidates the search committee looked at; I don't know how many other people wanted the job.

Hughes: Do you know why you got it?

Spivey: Not for sure. I would like to think it's more than the fact that my buddies thought I was capable. I'm sure that had something to do with it. I think I had performed.

Separation into Two Academies, 1979

Hughes: Presumably you agree that separation into two academies from the original AAOO was necessary.

Spivey: Well, yes, I think so. There was little or no mutual scientific content exchanged, we were paying a disproportionate percentage of expenses, and our interests and needs were quite different. The reasons we gave were also somewhat spurious, such as, we could go into more cities if we went without otolaryngology. I kiddingly said to the otolaryngologists, "You know, the reason that we're with otolaryngology is that we need the ears and the nose to hold up the glasses." Which they didn't care much for. [laughter]

The feeling was that there was little politically, little educationally, that held the two specialties together. I don't know what the real pressure was, but I think the idea was: we'll have our own President every year; we'll be dealing with our own issues.

Hughes: *I also read in the minutes that there was a complaint in 1976 that every other time, ophthalmology had considerably less voice on the Council, because of the way these positions alternated. What difference has it made to the ophthalmologist in the street, so to speak, to have a separate Academy?*

Spivey: Well, we've gotten so large that the Annual Meeting certainly can't be held in any more cities. Even our first separate meeting in Kansas City in 1978, where the Academy was founded, was far larger than we expected.

Hughes: *But aside from that.*

Spivey: I think that it is a more focused organization that relates to the interests and the needs of ophthalmology. You don't have to consider how otolaryngology feels or what the Hearing Aid Society feels or whatever. I think it allows more involvement in leadership. It is clearly more focused educationally, and there are fewer Annual Meeting accommodations that have to be made. I think it is just truly focused on ophthalmology and the broad range of concerns of ophthalmologists, and the rest of the arenas and accommodations don't have to be made, whether it's space or time on a program or whatever.

The Academy Moves to San Francisco

Hughes: *Was there ever any question that the headquarters would move to San Francisco?*

Spivey: Oh, yes. I was Executive Vice President before that decision had been made. I remember I worked to get it made. I think it was in a meeting in June 1977, in Chicago. David Noonan wrote a thirty-page justification document that was presented to the Board. Their deliberation took less than an hour. I got the Board to move to San Francisco. I don't think anybody understood what that meant at the time. I'm sure I didn't.

Hughes: *What did it mean?*

Spivey: Well, it meant that we had to start from scratch. There were forty-four staff members of the American Academy of Ophthalmology and Otolaryngology; four came out.

Hughes: David Noonan being one.

Spivey: Yes, and three others, none of whom stayed. So we really started an organization from scratch.

Hughes: It was not on Beach Street [the present location of the Academy].

Spivey: First it was at Pacific Presbyterian, on the sixth floor, people stuck here, there, and everywhere.

Hughes: How many?

Spivey: Oh, probably we had ten, fifteen by the time we moved. I hired somebody as my assistant, and through her next-door neighbor, we found a place on Fillmore that needed to be rebuilt, and he said, "I'll do it," a design-build concept. He lost his shirt as it turns out, because it was a very expensive remodel, but we didn't have to pay for it. So we constructed space there, and moved into it.

Hughes: Do you remember when that was?

Spivey: The move date was April 15, 1979. I must have gotten the notice of my position in 1977.

Hughes: Well, officially it was '78.

Spivey: The American Academy of Ophthalmology didn't start until '79. So I was really technically a designate at that point.

Hughes: But the separation was almost a sure thing?

Spivey: It was functional for about a year and a half, so we had taken votes, and then we operated as two separate organizations within one. We had separate meetings beginning in Kansas City in '78. That's when I almost got lynched by the membership as the American Board of Ophthalmology proposed recertification. But that's another issue.

Hughes: Now, did you come to the job with ideas about what you wanted to do?

Spivey: I had the clear idea that we needed to do more in education than just the Annual Meeting, that we needed to become somewhat more political, that we really needed to be a much more complete and dynamic organization than we had been.

I don't know if I had any more ideas than that. In fact, I think I probably had relatively few big expectations at the time. I mean, I can remember saying, "Well, we'll get this building, and it will last for some time." I remember telling Dave Noonan when we went to Japan to plan for the '82 international meeting, "The most we'll ever have is twenty-four employees."

Hughes: [laughs] And how many do you have now?

Spivey: About a hundred and fifty.

Hughes: How long did you stay in the Fillmore building?

Spivey: We moved in October '85.

Hughes: Why?

Spivey: We just outgrew the building. We developed more and more programs and people and began to rent space outside—really beginning in 1982 at the time of the International Congress of Ophthalmology.

The Foundation of the American Academy of Ophthalmology

Hughes: You're also a Board member of the Foundation of the Academy.

Spivey: Well, when the American Association of Ophthalmology joined the Academy, we had to move from a 501(c)(3) to a 501(c)(6) organization. We changed from a not-for-profit to a trade association. I felt that we needed to make sure that we had an appropriate 501(c)(3) vehicle to be a repository for contributions and serve as a not-for-profit foundation. I led the establishment of the Foundation of the American Academy of Ophthalmology in 1980.

It was more in a defensive position in order to receive funds and donations and credit them as tax deductible. Now we're trying to get offensive about raising money for an educational trust, because the pressures are going to be inexorable toward taking more and more of the Academy's dues and funds from other activities for socioeconomics. I want to protect education. Because the thing

that got us to where we are, the thing that's going to keep the Academy a pre-eminent organization in the minds of people, is its educational thrust. It's always controversial when you're in politics. The Republicans fight amongst themselves, and the Democrats kill each other. Education is much less contentious. We all have a stake in it, and it benefits the standards of our profession without question.

Hughes: On the other hand, ophthalmologists will have increasingly less in their pockets. Do you think they're going to go along with the idea of a bigger proportion of their dues going into education rather than fighting political battles?

Spivey: That's my point: They will not accept more and more money going to education. See, I can make a case right now saying that essentially none of their dues goes to education. It all goes to noneducational activities. It's not quite true, but it's mainly true, because their dues dollars will pay for part of the overhead and the Board and the Council and all the socioeconomic activities. If you count education as the Annual Meeting and our other educational sales, it's a \$2 million profit to the Academy. So in fact, education more than pays for itself. But that isn't how the members perceive it, and that's a problem. We've got to do a better job in explaining that.

Not unlike what's going on right now in some ways. It's no wonder that there's a lot of hassle internally within the Academy right now. You look at Eastern Europe; everybody talks about democracy. What does it really mean? It's chaos if everyone has a different perception of what it means. A lot of people are trying to make the Academy look like the AMA, which I consider to be the worst of all possible outcomes.

Hughes: Because it's so exclusively political?

Spivey: Yes, exclusively political. There's all sorts of electioneering that goes on, all sorts of energies that are spent in what I consider nonproductive activities. It's a politicized organization that reaches the lowest common denominator in many ways. And [only] half or less of the physicians belong. That's a telling number right there.

Medical Ethics and the Academy

- Hughes:* *What role over time has the Academy played in ethics in ophthalmology?*
- Spivey:* Well, I was the one who really stimulated it. I tried to get an ethics committee in the American Board of Ophthalmology; wasn't very successful. After talking with [Dr.] Jerry Bettman, I encouraged the formation of the Ad-Hoc Committee on Ethics and continued to stimulate both the committee and the Board as it at first reluctantly embraced the idea. So I played a major role in that.
- Hughes:* *Why do you think it was necessary?*
- Spivey:* Well, because I saw a lot of aberrant behaviors out there that embarrassed me. I was of the naive opinion that we could probably make quite a difference as it related to regulation of ethics. I advocated getting an approval from the Federal Trade Commission. I can show you a document that gives our experience on that.³ We accomplished far less than what the membership expected and desired in our ability to rein in these crazy, inappropriate practitioners with their lack of surgical indications and their advertising and whatever.
- Hughes:* *Is that because of the legal ramifications?*
- Spivey:* It's because of the FTC. They approved our Code of Ethics, and in approving it, they tied our hands a fair bit. At the same time, we have the only legally approved FTC code of ethics in medicine and can really drum people out of the organization without fear of suit to the same degree as if we didn't have it.
- Hughes:* *Is the FTC always an arbiter?*
- Spivey:* In ours, because they've approved it.
- Hughes:* *Was it the Academy's initiative to submit the code to the FTC?*
- Spivey:* Yes, because the AMA was trying to declare the FTC as inappropriate to have anything to say about the professions. It's a nice idea, but . . .
- Hughes:* *It wasn't reality.*
- Spivey:* It didn't turn out to be reality. And I never thought it was.

³ Bruce E. Spivey, "Ethics and the American Academy of Ophthalmology." Unpublished draft of speech, Academia Ophthalmologica Internationalis, Paris, May 1991.

Hughes: How does the FTC claim to have jurisdiction?

Spivey: Well, it's restraint of trade issues, uncompetitive practices, or that sort of thing. A lot of people want the Academy to shoot the bad guys, or to make them walk the gangplank and skewer them just before they fall in. You can't do that. That's been a frustration, and so much has changed in medicine—situational ethics, the capacity of doctors to advertise—I believe the FTC rulings are a bad deal and they have, in my opinion, worked against medicine and the best interests of patients and the public.

Hughes: Well, has the Code of Ethics accomplished anything?

Spivey: Well, I think it has retarded some of those people who have a conscience. I don't think it has seriously affected those who don't, and who don't wish to be constrained to what most of us would consider to be appropriate activity.

Hughes: What about expulsion of members?

Spivey: We've done some. If they're expelled or even resign, then they're out of the world; they're even more bizarre then. No one has to have the approval of the Academy to practice. So it's a loss if we can't somehow modify their behavior, because they're still viewed as ophthalmologists.

Hughes: So you do your best not to expel?

Spivey: Yes, we do our best to get them to change their behavior, but a lot are just impossible.

Hughes: Is there a formal procedure?

Spivey: Oh, yes. If you read the bylaws, they outline a complaint and hearing process.

Hughes: When were the bylaws written?

Spivey: That was '83, '84, and they have recently been further revised.

Hughes: The old Council minutes record instances in which censure or expulsion of an Academy member was discussed.

Spivey: Really? As litigious activities have gotten more and more frequent, it's really hard to drum somebody out unless he's or she's done something quite egregious; his [or her] rights are protected. We remove membership from people now if they lose their license to practice.

- Hughes:* *The individual has a right to represent himself?*
- Spivey:* Oh, yes, with a lawyer. That always chills the event a little.
- Hughes:* *What can the Academy do, other than dismiss a fellow?*
- Spivey:* We can't take away their license; we can't economically sanction them. Nothing. Only moral persuasion.

The Present and Future Academy

- Hughes:* *How responsive is the Academy to the rank and file membership?*
- Spivey:* I believe the Academy Board during my tenure has always acted in the best interests of the private practitioner of ophthalmology. Yet I don't think we've done a particularly good job of communicating this to the membership. We've got a real hassle going on now. We've created a Council which now wants to run the Academy, and there's a struggle between the Council—particularly its executive committee—and a few people on the Board. A lot of bad feelings exist. People want to portray the Academy leadership as eggheads and academics and out of touch. We have not done as good a job as we should in communicating the reality of Board dedication to the membership. A few people want to improve the Board, so that makes the perception worse.
- This is a very difficult time and it will only get worse. If you look at the environment now, and the hits that ophthalmology's taking from RBRVS—Resource Based Relative Value Scale—the inroads of optometry, the overall perception of medicine by the public, and managed care—nobody's going to be happy, because it isn't 1970. It isn't even 1990. Maybe I'm rationalizing too much, but I do know that doctors are understandably unhappy, and they can't take it out on the government. They can't really take it out on their congressmen. They can't quite take it out on their state medical association, but they sure as hell can take it out on the Academy. So they're coming at me in every direction, and I understand that. I try not to take it personally, although some days it feels a little bit more personal than I truly believe it to be. In some ways I have come to personify the Academy and, therefore, attacks are naturally directed to me. I understand this and it is simply a part of the job.
- Hughes:* *Does part of you thrive on it?*

Spivey: I don't thrive on that part of it. I like a good, legitimate, up-front, fair, intellectual or even emotional exchange, but there are some things that are going on that are intellectually dishonest, patent obfuscations or lies or misrepresentations. I don't like to deal with people whom I either don't respect or don't trust or both. Some of those have oozed to the surface recently, so I have to deal with them. But I don't find any joy in that. I'm saddened by what some ophthalmologists have done. I'm still proud of what ophthalmology is able to do for people, but I'm not proud of the way some ophthalmologists are doing it to and against people.

I don't want to overstay my place here in the Academy, but on the other hand, I know the motives of some people, and I'll probably stay longer than is comfortable for me, and I'm concerned that it may be too long for the organization's best interests. I want to protect what I think is the essence of what ophthalmology and the Academy ought to be, which is primarily educational, not primarily socioeconomic and secondarily educational. I have often said a person in a leadership position for seven years will institutionalize his or her errors. I have been the EVP for fourteen. I hope I have squared my mistakes. I do not feel as if I have!

Hughes: Does it worry you that your successors may not hold education so dear?

Spivey: I don't think they can hold it any more dear than I do, anyway. Most everybody looks at their successor in some askance, but does it worry me? It worries me for the Academy; it doesn't worry me for me. I will have done the best job I can do. But I will feel sad if somebody doesn't carry the torch for education, that's for sure.

Hughes: Is there anything in particular to be said about the Academy's relationships with other ophthalmological organizations?

Spivey: There's a lot, and we have to do an even better job with the subspecialty societies. Most of them are happy to be left alone, by the way. Less than half of ophthalmologists across the country belong to state organizations. So we've got representatives from state organizations who are elected or appointed by less than half of the members of the academy in their state, and they're telling us what to do. We have to do a better job with the state societies as well as with the subspecialty societies. Also we need to make sure that we are viewed as the creator of educational materials for recertification for the American Board of Ophthalmology. We need to make sure that we're supporting in every reasonable way the best of education in conjunction with the AUPO, and, while less directly, continue to be supportive of ARVO and the funding of ophthalmic research. There are lots of things we need to do. By and large, we have enough overlapping

members so that we're not too much at cross purposes, but we have to put increasing thought and action in the activity, not just passive activity.

Hughes: Is there any final statement that you'd like to make?

Spivey: No, thank you. There are different thrusts, different tacks, different cul-de-sacs we could run down. But that's a first cut. I'm proud of what I've been able to do with and for the Academy, and what the Academy's been able to do. Good staff, loyal staff. It's going to be a tough decade, the rest of the nineties, for medicine and medical specialty societies. A lot of turmoil.

Hughes: How do you see the face of ophthalmology changing?

Spivey: Well, I'm concerned about this cataract PPO, for example, that could disrupt the way the average practitioner can get the opportunity to do cataract surgery. Surgery, especially cataract surgery, is a wonderful part of ophthalmology. I think that eventually the solo practice of ophthalmology is dead; the solo practitioner of medicine is dead. It's just too complex; there's too much managed care. So physicians are going to have to be in groups, they're going to have to cover all the subspecialties in those groups. Managed care, HMOs, salaried physicians, a whole change is in the process of beginning to occur. How fast that comes, I don't know. And what form it will take is not clear to me as yet, but it is becoming clearer. As physicians, we will not like the changes. The future will be less collegial, more competitive, more "business-like." After a lot of state experimentation, there's going to be much more regimentation of medicine. Then the question is, how many people really want to belong to the Academy, or will be able to if they are salaried, as in large groups? How many members will be able to attend the Annual Meeting of the Academy? There are lots of changes and difficult decisions on the horizon.

The golden era in medicine is gone. Too much of that golden era related to actual 24-karat gold or money in your pocket, and that's what got us into a lot of trouble. But another part of the golden era was the opportunity to take time with your patients, and not feel as though you were pushed because of some regulation. A lot of individualistic practices, most of which were quite good, some of which were quite bad. So there's good and bad in everything.

Hughes: Well, in this era, doctors, for probably the first time in history, have been able to do something tangible for their patients, rather than just psychological.

Spivey: Absolutely. Well, yes, in the recent past several decades, we have been increasingly able to do definitive care for the first time. We can do more and more, as you implied. Imagine what our successors will be able to do ten, twenty,

thirty, forty, and fifty years from now. I suspect we will be able to prevent cataracts, understand and prevent glaucoma, make most people free from glasses or contact lenses, and many more wonderful, positive interventions for our patients. Early in this century patients were worse off seeing a doctor than not seeing a doctor, because of iatrogenic disease. This is a wonderful time, but the future will be even better for the average person—as it always has been.

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**THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
ORAL HISTORY RECOLLECTIONS OF PAST AND PRESENT LEADERS**

An Interview with

H. Dunbar Hoskins Jr., M.D.

Conducted by
Sally Smith Hughes, Ph.D.
September 15, 1997, American Academy of Ophthalmology,
San Francisco, California

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H. Dunbar Hoskins Jr. M.D.

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

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Occupation Housewife Birthplace NY, NY
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Areas of expertise Ophthalmology

Other interests or activities skiing, Golf, Tennis,
Reading, Advocacy, Teaching, Research.

Organizations in which you are active AAO, AMA, ACS

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H. DUNBAR HOSKINS JR., M.D.[Date of interview: September 17, 1997]¹**Background and Education**

Hughes: *Let us start with your education and career up to the time you became head of the Academy.*

Hoskins: Well, I was born in Lynchburg, Virginia, September 5th, 1939. I think Hitler invaded Poland almost on that very day, and the world has been different ever since. More because of Hitler than because of me. [laughs] In any event, I went to public high school in Lynchburg, went to Virginia Military Institute for college, and to the Medical College of Virginia for medical school, internship, and residency program in ophthalmology. I graduated from my residency in 1968.

My full intent was to stay in Richmond, Virginia, practicing in a relatively provincial southern town, and be a humble, small-town country doctor. But it wasn't clear what subspecialty training I should take. Pediatrics was taken—[Dr.] Keith McNeer had come back from taking [Dr.] Art Jampolsky's course. There were some other subspecialty slots that were filled, but glaucoma was missing. So [Dr.] Dupont Guerry [Chairman of the Department of Ophthalmology at the Medical College of Virginia] suggested I go meet this fellow by the name of [Dr.] Bob Shaffer here in San Francisco and take a fellowship in glaucoma so I could come back and serve the community, because there was nobody subspecializing in glaucoma. So I did that and then came back to Virginia. Bob [Shaffer] then called me and suggested I return to San Francisco and join his practice, and I've been here ever since. That's from 1972 on.

I got involved in the Academy, probably about 1980, with the Media Committee. During my fellowship, I had done a couple of COVE [Committee On Visual Education] tapes and worked on the BCSC [Basic and Clinical Science Course] Committee shortly thereafter. I became Chairman of the Media Committee sometime around 1978–1980. I was very much interested in the Annual Meeting program, and got on the program committee with Bob Reinecke when he became Secretary for the Annual Meeting, or for the program I guess it was at that time. Ultimately, I became Secretary for Instruction in 1986, and replaced [Dr.] Mel Rubin in that position. Then, in 1988 or 1989, it was decided to combine

¹ The interview was conducted in Dr. Hoskins' corner office at Academy headquarters in San Francisco with the periodic sound of cable car bells in the background. The bulk of the queries were posed by Dr. Hughes; Dr. William Spencer also asked a few questions.

instruction and program into a single Annual Meeting secretariat, and I headed that until I became EVP in 1993.

Selection as Academy Executive Vice President

Hughes: Do you want to say something about the process through which you became EVP?

Hoskins: Well, I do remember [Dr.] Bruce Spivey announcing at the June Board meeting in Cleveland in 1992—Froncie Gutman was President and the retreat was in Cleveland—that he was going to step down as EVP and move to Chicago to take his position with the Northwestern HealthCare Network. Bruce and I had had an opportunity to talk a little about what was happening in medicine; he knew I was a little disenchanted by two things—the corporatism of medicine, and the criminalization of physicians. Both of these bothered me—an awful lot of Big Brother looking over your shoulder. I had been a lot involved in the Academy and happened to be local San Francisco, so they wouldn't have to pay any moving charges [laughs]. The Board put a search committee together led by [Dr.] Tom Hutchinson. I don't remember all the members. I know [Dr.] Froncie [Gutman] was on it and Bruce [Spivey] was a consultant to it. I believe [Dr.] Ron Smith was on it also, although I'm not certain of that. And I think in a quick matter of about three months, I was selected and took an office part-time here in the Academy in September of 1992, and became the EVP officially January 1, 1993.

Hughes: Did you come to the position with some personal goals for where you wanted the Academy to go?

Hoskins: Well, I did; I think we all do. Some you can realize, some you can't. I came to it with a little trepidation, actually, because the Academy's a big business—150 employees. I had never run anything like that. I had been chairman of the board of St. Mary's hospital here in San Francisco for a period of time, and we had done a fairly dramatic economic turnaround during the two years that I was there. I had been involved in some other small companies, a computer company and things like that, but I'd never run anything the size of the Academy. But the good news was that it was well organized; we had a terrific staff. David Noonan was a terrific number two and responsible for the internal workings of the Academy. So my job, as I saw it, was to help move the Academy into the future of whatever this new healthcare was going to be. I think all of us had pretty clear ideas in '92-'93. We thought everything was going to go to fully integrated managed care and everybody was going to look like Kaiser. And, of course, that hasn't played out, and now we don't know where it's going. [laughter]

Hughes: Do you think that those who appointed you felt you were the person who could move the Academy in the direction it needed to go to respond to the changes in healthcare?

Hoskins: I think I brought some useful characteristics. I was a private practitioner, basically. I had a clinical appointment at the university [the University of California at San Francisco], not in the university system; I was not paid by the university. So I think there was a sense, maybe, that we needed to relate more directly to the private practitioner; that may have played part of the role. I was reasonably well known in the academic centers—I had published and been on the lecture circuit. So I thought I could bridge the gap between academia and the clinical world, the private world. I think those things may have helped in my selection.

The Academy and Socioeconomics

Hughes: Because the Academy, in the past at least, has had education as a primary goal, do you think that the practitioner regarded it as an academically oriented organization that did not necessarily speak to his needs?

Hoskins: That was becoming increasingly obvious to the Council starting probably in '88 right up to '90-'93 when the reorganization took place. I think there was a feeling that the Academy wasn't necessarily responsive to the socioeconomic areas as much as it needed to be. Because of that, societies, such as the American Society of Cataract and Refractive Surgery, evolved. There was a tendency to be very careful about what the Academy said scientifically, which I think was good. On the other hand, it could be overly restrictive so debate could not occur on new ideas. I think, maybe, some of that happened with intraocular lenses and phacoemulsification. The forum for the debate should have been the Academy, and somehow we missed that. So I think there was a whole revolution in that time from 1976 to 1986.

The Council and the Merger with the American Association of Ophthalmology

Spencer: A moment ago you mentioned the Council. Other interviewees haven't talked about its origins. Could you speak a little about how the Council came to be, how it functioned in the past, and how it functions today?

Hoskins: Let me go back to the origins of the Council. I'd have to go back to get the date, but it was probably about 1980², I believe, that the merger between the American Association of Ophthalmology and the Academy took place.

The merger created the Council. The Association was the political arm and the Academy was the scientific and educational arm. I think the leaders at that time were very wise in recognizing we would be stronger together than we would be separately, as long as one side didn't eat up the other. So the Council came into existence and its role was initially advisory. But there were those who felt that the AMA [American Medical Association] was the appropriate model, in which a house of delegates, which corresponds to our Council, would set the policy for the organization. There were others who felt we were in a rapidly changing environment and having a body as large as the Council, which met no more than once a year, making policy decisions in a rapidly changing period, probably wouldn't work. That debate raged and came to a peak about 1991.

We recognized that there was great conflict developing between the Council and its executive committee on one side and the Board of Directors on the other. So one of the great things that Dr. Spivey did was recognize that if the organization was going to go forward under any leadership, be it new or otherwise, the conflict had to be resolved. That led to the development of the Ad-Hoc Committee on Organizational Design, chaired by George Weinstein.³ He was very instrumental in leading us through a reorganizational process. We went on for a whole year trying to think what would be the best way to reorganize the Academy. The vote for that reorganization occurred at the November meeting in 1992. Quite frankly, if that vote had failed I would not have taken this job, because I think it would have been untenable. The conflict would have continued between those who wished the Council to assume authority and those who wished the Board to listen to the Council—to hear the grassroots—but ultimately to have a smaller group make the decisions. I think that would have been chaotic.

² The merger occurred between the American Academy of Ophthalmology and the American Association of Ophthalmology on July 1, 1981.

³ The Ad-Hoc Committee on Organizational Design issued its report in June 1992. See Memorandum dated June 10, 1992 (appendices) for the introductory statement of this report.

The Ad-Hoc Committee on Organizational Design

Origins

Hughes: Perhaps you could address the origins of this report. Why was reorganization felt to be necessary in the first place?

Hoskins: I think we were beginning to see other organizations arise, such as ASCRS [American Society of Cataract and Refractive Surgeons]—a whole plethora of subspecialty organizations that were beginning to develop and split off from the Academy. I think that was one signal that maybe we needed to do something differently. Secondly, we were having a lot of conflict between the Council and the Board, so that wasn't working well. Thirdly, the organization was set up internally so that there were two executive vice presidents—Bruce Spivey and David Noonan, who was Deputy Executive Vice President—and fourteen managers of various departments reporting to them, mainly through David to Bruce. It was felt that that wasn't necessarily the best organization, so we needed to provide a new structure for the Academy so it could grow more efficiently. It just wasn't a small group, anymore, where everybody could talk to everybody else and make decisions together. We had an advocacy group over here that was doing things that education didn't know anything about—probably didn't need to know very much about. Therefore, to combine those two groups in discussions didn't make much sense; it would just slow things down. So we set up the four divisions; they were advocacy, education, ophthalmic practice and services, and then something we called organizational services.

Hughes: What is that?

Hoskins: That is the underpinnings of Academy activities; like print production, financial services, information services, mail, telephones; sort of the things that make the Academy work on a day-in-day-out basis. We initially folded the Annual Meeting into organizational services because we felt that the Annual Meeting cut across all aspects of the Academy. It was a place where every division had some input. So that was put in there originally, too. And we created vice presidents [VPs] for those positions. VPs for Advocacy, Education, Ophthalmic Practice and Services (which included ethics and quality of care), and Organizational Services.

Staff and Secretariat Reorganization and Subsequent Modifications

Spencer: These VPs were staff?

Hoskins: That's right, these were staff vice presidents. And then we modeled the physician structure after that; we created senior secretaries for each of those areas, and beneath them, secretaries who ran the committees that did the actual work in each division. That worked very well for a while, and probably could have worked for a long time. But we recognized that some areas were getting stressed a little bit and other areas less so. So we divided it up and peeled Annual Meeting out, I think a year ago, as a separate division. Since it makes up a third of our budget, we thought it deserved that kind of recognition and attention. [laughter]

Spencer: Was that in 1996?

Hoskins: I believe we established that in '96. We had added a Vice President for Membership in '95. The membership became interesting. We had never had anybody in the Academy whose one hundred percent job was to focus on the membership and its needs, and our communication process, too. And we realized, well gosh, we live and die on our membership, and we needed someone responsible for this area. That's when Ron Mattocks joined us.

Spencer: What is his title?

Hoskins: He's Vice President for Membership Services. And that now includes *Argus*, which is going to evolve into something called *EyeNet* this coming month, as our main communication magazine and vehicle to our membership; it includes a website.

International Members

Hoskins: Membership services includes all of our dues management, the awards committee and awards processes. It is also responsible for helping us manage the growth of international membership. International membership has grown from next to zero in 1985 to 5,000 international members. Next year we'll have 6,000.

Hughes: Why are they prompted to join what is essentially an American organization?

Hoskins: They tell us the reason they join is that they like the journal as a membership benefit. They like the Annual Meeting and membership does let them get into the Annual Meeting at a slightly reduced cost. And we are told by some of our advisors that it is the cachet of America that is appealing also. I think there is no question that the Annual Meeting is a terrific opportunity to see people that you

haven't seen before, for old friends to gather and meet new friends, and an opportunity to see and hear directly from leading physicians in the field.

Academy Reorganization and the Decision-Making Process

Hughes: You describe the reorganization as essentially responding to Academy needs, but I'm wondering if there was not an eye also cast on what was happening in the healthcare field. Was there any thought, for example, of streamlining the Academy so it could move more quickly in the political realm?

Hoskins: No question about that. The way we did that most effectively was by cementing the Board as the policy, and decision-making group. The vote at the Annual Meeting was 2,500 to 6 in favor of this redesign document, which said clearly that the Board would make these decisions.

Hughes: As opposed to the Council?

Hoskins: As opposed to the Council. The Council had been vying for that option.

Hughes: And that was the basis of the tension between the two entities?

Hoskins: Yes. The Council Executive Committee asked the Academy for veto power of the Board decisions. It got pretty sticky for a while. [laughs] But it all resolved. You know the wonderful thing about ophthalmology, and the wonderful thing about all those debates, is that personalities weren't driving it. It was ideology that was driving it. People believed in what they said. And I think that was good. It was a great debate. The debate was useful, and it led to what I think was a successful conclusion for the Academy.

Hughes: What were the two ideological camps?

Hoskins: One was total democracy to run the organization; the other was more of—I'm not sure what the right word would be, it's probably a republic—where you actually get input, but a small group makes the decisions. Probably it's an oligarchy, I guess. But, since it is a volunteer organization, and since we do work hard to make sure that people who care about the profession are involved in the leadership—and the membership gets to vote on that—then the representation really is clearly focused on what is best for the membership and the public. So the decision-making process is guided by that.

Public Members on the Board of Trustees

Spencer: One thing that seems to be new, at least to my observation, are public members on the Board of Trustees. Could you comment on that?

Hoskins: That was part of the organization redesign. It came up as an idea, I'm not sure from whom, and it's one of the best things we've done. We've invited lay people to sit on our Board and they can participate in every decision except those affecting the governance of the Academy. We have two wonderful public trustees right now, Humphrey Taylor, who is President and Chairman of Louis Harris polls, and Jim Cooper, who is an ex-congressman from Tennessee. He is one of the most knowledgeable political people about healthcare. These people have been terrific in helping us realize when we aren't looking outward enough. When we are looking inward too much and not making decisions on the right basis—not thinking about the big picture.

Spencer: Could you comment on how they are selected and the length of their term of office?

Hoskins: They have three-year terms, renewable once, so they have a six-year potential. They are selected, first by the nominating committee, and then by the Board. We have an option for three [public members]. We have not filled the third slot yet, because there is a desire to make sure we have the right person. They have to be interested enough to contribute, because we bore them to death talking about minutiae in the Board meetings sometimes. They also have to have a big picture that is not driven by any agenda. Nobody else has jumped off the page as a candidate as yet. Plus, we're so happy with the two we have; I'm not sure we want to disturb the mix right now.

The Academy's Advocacy Role

Hughes: One of the overall goals of the 1992 report was to have the Academy provide greater leadership in the field of ophthalmology. You have, by implication, mentioned some ways that that was to be done. Would you like to elaborate? I'm particularly interested in the advocacy role which, if I'm right, was not clearly emphasized in the Academy up to that time.

The Washington Office and the State Societies

Hoskins: Well, [Dr.] Bob Reinecke had started in the Washington office back in the '80s.⁴ The Washington office worked diligently on behalf of ophthalmology with the regulatory agencies on the legislative side. The State effort has been mostly driven by the State societies; it has mostly been concerned with scope-of-practice expansion issues.

Hughes: How did the State societies interact with the Academy?

Hoskins: Through the Council. This is not a federation, so they have input through the Council. One of the things we've done in terms of leadership is expanded our goals. Now setting goals is important, and achieving them is also important. But sometimes it's harder to achieve them than it is to set them. We think that the Academy really ought to become a credible source of information for the public about eye care. We waffle about some things. Right now I've got a problem dealing with a new untested and untried glaucoma treatment that is being advertised in a town. What should the Academy do about that? How do we respond to that? It's a ticklish problem because it's fraught with restraint of trade issues and things like that. Somehow, we think it's only fair that the public know what has been proven, if we can define that, as opposed to that which remains unproven.

The Academy Website and Communication with the Public

Hughes: In the past, my perception has been that the Academy's effect on the public's knowledge of ophthalmology has mostly been through the practitioner. Not a direct line. When did this new approach come in and why?

Hoskins: It changed with the website.

Hughes: That recently?

Hoskins: Yes. The website is open to the public. We've had over a million hits on the website since January, most of those being public.

Spencer: Didn't it start before that with Public Education Committee activities and the National Eye Care Project?

⁴ Bruce Spivey first initiated a Washington office, which later came under the supervision of Robert Reinecke when he became Secretary for Governmental Relations in 1980.

Hoskins: Right. The Media Committee actually started it. It's an outgrowth of the whole attitude that the public is going to be needing appropriate information about eye care, and the Academy should provide it. The website has made it very easy and inexpensive to do it. Also the members buy patient-oriented brochures and distribute them to their patients. We also get a significant number of requests from the media to respond to issues about eye care. And we want to increase that.

The Relationship Between Ophthalmology and Optometry

Hughes: Where does optometry fit into this approach to the public? Is there an element of counteracting what optometry is doing?

Hoskins: The relationship between ophthalmology and optometry has varied over the years. When I was in the navy, two optometrists were right next door. They did the optometric refractive work and I did the clinical pathology work. We had no problems working together. They even gave me a little plaque when I left saying what a wonderful time we had. It was great.

Then the optometry movement toward scope-of-practice expansion occurred. And it became clear that the goal of the leadership of optometry is to create thirty thousand more ophthalmologist-equivalents. The world doesn't need that and the world won't benefit from that. The people who go through the effort won't benefit from it because there aren't nearly enough patients to go around today. So increasing the manpower that way is not going to have any benefit for anybody. It'll just add cost to the system. Unfortunately, a lot of the people trained to do that won't be able to earn a living down the road. So that's a fundamental issue.

The optometrists' method of going about expanding their scope of practice has been through legislative activities. The Academy has opposed that, along with the state societies. Recently, the optometric board in Idaho decided that optometrists should do laser surgery. We took that to court and won the battle there. We took the optometrists in Oklahoma to court and won a similar battle there. The courts have said that without surgical training and experience you shouldn't be doing surgery. We kind of agree with that. If you're going to do surgery you ought to be a surgeon. That, maybe, is a little bit more aggressive than we might have been in the past. We believe in this as a fundamental protection of the public.

The Academy Vision Plan—PrimeSight

Hughes: I understand that the optometrists have long had a vision plan. And I notice in some of the literature I was given as background for this interview that there is talk about instituting a vision plan. Or is it already off the ground?

Hoskins: I signed a contract last week for forty million patients.

Hughes: Forty million!

Hoskins: Yes, forty million!

Spencer: Is that PrimeSight?

Hoskins: Yes.

Hughes: Do you want to describe that?

Hoskins: This arose from the Council, actually. About 1992, the Council began to talk about how they were being cut out of taking care of vision care patients and refractive patients because of managed vision care plans. What could we do about that? And like most organizations we debated it. [laughs] We debated it for a couple of years, and within the Council, the voices became more strident about doing something about this.

The first thing we did was recognize that the Academy was not big enough to go head-to-head with major business competitors whose gross revenues were in the hundreds of millions of dollars, and we're nowhere near that. We realized we'd need a partner if we were going to do that. So we thought about who might be a good partner. LensCrafters came to mind because they are big, they have good marketing, and they are not liked by the optometrists. So they could benefit from a partnership with ophthalmology in this arena. We had that all negotiated right down to signing the papers and they got bought by Luxotica and we didn't pursue it. It came apart.

The Council still wanted something to help them get into the vision care market on a national basis. So we took a bold step. It will take us ten years to know whether it was the right step or not. We created an organization called PrimeSight, raised five million dollars from the membership, and hired a staff. It's not driven by shareholder desires. It's a very tough marketplace and it's in its infancy, but this first contract certainly makes us a very valid player.

Hughes: That seems to me to be a very clear example of responding to changes in the healthcare field.

Spencer: When was PrimeSight formed?

Hoskins: Officially, we hired a CEO [Chief Executive Officer] in September of last year. We raised the money. We had a deadline of May first '96 and we met that deadline. We had set a minimum of five million dollars, and didn't go much over it. And so the company has been formed. We've spent the first year getting organized, getting the infrastructure in place, and signing this first contract.

Academy Planning Mechanisms

Hughes: What amount of the new activities of the Academy, would you say, are proactive rather than reactive? You talked just now of having a debate for several years apropos membership satisfaction. Do you see the Academy anticipating problems and acting before they actually happen? Or is it inevitable for a relatively large organization to be reactive rather than proactive?

Hoskins: I think there are a number of theories about how you react or act. One is proactive, one is reactive, and one is resiliency planning. Long-term strategic planning has fallen out of favor because nobody can look out more than about a year and a half to two years and know what is going to happen. Things are changing so fast that the ability to plan far ahead is difficult. That doesn't mean we shouldn't set long-term goals and continue to work toward them, but they need to be broad goals. I'll give you a copy of the Strategic Plan that the Board approved. It'll show you our goals. It's one side of one piece of paper; a fairly concise strategic plan with broad goals.⁵

Reactive Planning and the Surgical Care Specialty Coalition (S²C²)

Reactive planning is exemplified by HCFA [Health Care Financing Administration] putting out a notice early last January that cataract fees, among others, were going to be reduced by anywhere from 30 to 60 percent. We reacted to that. We created a consortium of specialty groups beyond ophthalmology. We talked to each other, and when that happened we were prepared to go together to fight the battle with HCFA. Now we have cut those reductions dramatically. And we're still working on it. Where the outcome will be we don't really know yet.

Spencer: Does that group have a name?

⁵ See appendices for the AAO Strategic Plan.

Hoskins: It's the Surgical Specialty Care Coalition. We call it "S squared, C squared" [S²C²]. I got together with the EVP from Orthopedics, who came in about a year after I took my job. The EVP from ENT [Ear, Nose, and Throat] came in about the same time that he did. The three of us decided that we didn't know what we were doing, so we'd share things with each other and see if we could help each other through the process. From that, we've expanded to include Neurosurgery, Thoracic Surgery and Plastic Surgery. Dermatology got in there because they had attended one meeting and kind of liked what we were doing, so they thought they'd stay around. And then cardiology and gastroenterology joined us. We probably represent more than half of the specialists in the country.

Spencer: The procedurally oriented specialists?

Hoskins: Yes. The procedurally oriented specialists.

Hughes: Is this a first for the Academy—to work closely with other specialties?

Hoskins: Well, we are a member of the Council of Medical Specialty Societies, and over the years the CMSS has tried to speak for the specialties. But, because it has all the specialties as members, it can't be focused. Therefore, it's not effective in any kind of an advocacy role. I think it's good because it supports the ACGME [Accreditation Council for Graduate Medical Education] and the ACCME [Accreditation Council for Continuing Medical Education]. These educationally oriented organizations need that support. But in terms of trying to protect the specialist, in this day of primary care orientation, from incursions by Congress and health plans, S²C² is the closest it comes. It's very loose; people can come or not come, it doesn't matter. But that organization in one day raised eight hundred thousand dollars, and ultimately, went to about a million four, to deal with the practice expense issue in Washington.

Spencer: Are the funds used for purposes of lobbying health groups?

Hoskins: Partly lobbying, partly working with HCFA on regulatory issues and doing a lot of the analytical work. It's very expensive to crank out all the data that has to be done in dealing with these rather arcane formulas that are used by the Health Care Financing Administration. But they govern the reimbursement. It is clear that what we're seeing in healthcare is a reduction in reimbursement for specialty care, and that, effectively, is a form of rationing. I know members who have stopped operating because they can do just about as well in the office financially where it doesn't begin to involve the degree of stress that surgical care does. I'm afraid that if we continue in that direction, access to high quality specialty care is going to be diminished. I personally think that specialty medicine is the best medicine. If you're sick, you usually want to see a specialist.

The Academy as an Umbrella Organization

Spencer: How has the Academy managed to quell disunity within ophthalmology with respect to working with some of the subspecialty groups with healthcare agendas that might be different from those of the Academy? How do you get ophthalmology to speak with one voice to Congress or to HMOs [health maintenance organizations]?

Hoskins: We try to act like an umbrella organization. We've invited representatives of those groups to meet with us in Washington to talk about issues together. As we do that, we find we have fewer differences than we thought we might have. In this instance, the cataract group joined the effort. They contributed funds to the practice expense coalition and helped it go. In other areas, there was another proposed rule by HCFA that was coming out, and we invited all the other groups to come in and look at it and bring their analysts to see how it impacted them. What were the flaws in HCFA's data? That sort of thing. So we're beginning to do much more of that. We're trying to truly be an umbrella organization and involve everybody.

Right now we are seeing a big dispute between primary care and specialty care in Congress over this practice expense issue. We ought to be able to resolve that in our own house of medicine, rather than have to go fight Congress over it. And we hope that the Academy can provide that opportunity for ophthalmology to resolve its own problems internally, rather than having to fight each other on the streets.

Spencer: Is there a group opposed to the specialists?

Hoskins: This particular effort has been led by the American Society of Internal Medicine and the American Academy of Family Practice, mainly the American Society of Internal Medicine. We'll have to go talk to them.

Communicating with Members

The Mid-Year Forum

Spencer: I'd like to come back to Academy history by raising the subject of communicating with members. How did the Mid-Year Forum come about and what is its purpose?

Hoskins: I think it came about partly as a recognition that we were a bit isolated from the membership. We needed an opportunity to have more time than simply a four-to-six-hour session at the Annual Meeting called the Council meeting.

The Mid-Year Forum provides an opportunity to bring the state leaders, the Council, the academic committee chairs, and those sorts of people all together to talk about issues important to ophthalmology. We have plenary sessions with speakers talking about an issue, such as healthcare reform or managed care. This year, for instance, we talked about the pros and cons of PPMCs [Physician Practice Management Companies], and people asked questions from the floor. We also have smaller sessions that split off and talk in greater detail with more interchange. One of them is a “tell-us-what-you-think session,” where the President, the President-Elect, and the EVP sit at the table and the members ask them anything they want.

Spencer: Who attends this meeting?

Hoskins: The ones who hold office in some fashion are invited by the Academy. We found that inviting people beyond that doesn't result in a huge attendance. We end up with about three hundred people that way. If you think of an organization of 15,000, that's probably most of the opinion leaders in the organization. We're perfectly happy to have others attend if they want to, but we can't afford to pay everybody's way.

Communicating with Young Members

Spencer: How about young members? How would a young person just finishing residency training learn about the Academy and gain from an association with the Academy?

Hoskins: Their first introduction to the Academy is when they join as members-in-training. Most of them do. The second is the website, which provides a lot of information about what's going on in the Academy. And then the Annual Meeting. Many residents have been to an Annual Meeting by the time they finish their training. Those three ways sort of give them a big overview of the Academy.

There is a committee on young ophthalmologists that creates a program at the Annual Meeting focused on young ophthalmologists; there are opportunities to participate in that way. “Professional Choices” is a job match program for young ophthalmologists where practicing ophthalmologists looking for someone to join them can put up an available position on the Academy website. The resident can click on it and send an e-mail response, or do whatever is needed to make contact and see if there is a match. So those are the major ways.

Getting into the hierarchy of the Academy itself is one of the things we continually talk about—how to improve that process. We accept and keep letters from people who tell us what they want to do in the Academy. We

have a stack of those, and they get circulated periodically so the committees can know who is interested. But there are a finite number of committees in the Academy. I can't remember the full number, but I think there are about five hundred physicians, or thereabouts, who actively participate in Academy activities in some way or other during the year. That doesn't include speaking at the Annual Meeting. If you include that, it's much more. [Not everybody wants] to participate, and not everybody can. Oftentimes, it's a matter of recognizing who has the talent and willingness to be involved.

Women Members and the Academy's Hierarchy

Spencer: *Could you comment on women membership and their participation in the Academy hierarchy?*

Hoskins: Increasing—no question about it. We currently have a woman on the Board. It's a hard thing to do, sometimes, to get women elected to the Board, because our existing membership is still majority male. Before the organizational redesign, the Board could nominate a person for a position. Now we have to nominate at least two people for a contested election for a position of trustee-at-large. We've debated how to go about dealing with that in order to make sure we have the diversity on the Board that we want. It's a bit of a challenge. [Dr.] Monica Monica is now on the Board. [Dr.] Marilyn Miller was on the Board up to a couple of years ago. We're going to see women Board membership increasing, I'm sure. Women are playing a more active role in the structure of committees, which is natural as they increase their percentage of membership.

Hughes: *What about women's participation in ophthalmology as a whole?*

Hoskins: I don't have the data on that, but I heard that residencies a few years ago were about 40 percent women, so there is no question their participation is going to continue to increase.

Status of AAO's Traditional Education Activities

Spencer: *Could you comment on the current status of the Academy's continuing education activities?*

Hoskins: Well, you had a lot to do with planting the seeds, and the flowers are growing. [laughs] Twenty percent of our educational materials are now purchased by our

international membership, or offshore in some way. One of the things that has become more obvious is that incomes are going to get squeezed and, as incomes get squeezed, physicians are going to buy fewer educational materials. Our challenge in the Academy is to make sure the members can get what they need at very reasonable prices, so we subsidize the educational efforts of the Academy.

The BCSC [Basic Clinical and Science Course] continues to be the flagship of ophthalmology products. It's going to broaden this year, or next year, to include a lot about the international aspects of clinical ophthalmology.⁶ We've also recognized that the electronic age is upon us, and we have a project under way called "EyeCon: Information on Demand."⁷ You can imagine sitting in your office and a patient with some arcane disease will come by that you know you've heard of but you can't remember it completely. You'll call it up on your computer and, bango, up will come something like the summary of that disease in the BCSC. It will have links that will allow you to dig deeper into the pathology of it, the current therapeutics of it, the side effects of the drugs related to it, the other possible diagnoses you want to consider, the tests you need to do to rule them out, and so on and so forth—all done through the website. It may take us a few years.

Outcome Studies, Cost Effectiveness, and Quality of Care

Spencer: *Has the ProVision program been successful?*

Hoskins: Very successful. It started out in print and has gone through an electronic edition. It'll continue to evolve on CD-ROM.

We recognize that, in the future, we are going to have to be more accountable, financially, and will have to be sure that we provide things that help the physician have the value he wants. If there is anything healthcare reform is doing, it's demanding value and accountability. So, what we're trying to do is understand how disease management creates an outcome, and whether altering that management changes the outcome—then cycling that information back through the educational process. Ultimately, education has the goal of changing behavior, hopefully, for the better. In order to do that, we'll need to know what better behavior really would be, and try to measure it. So we have a cycle of repeatedly

⁶ *The Basic and Clinical Science Course* text series expects to have an added volume on selected topics in global ophthalmology in two to three years.

⁷ EyeCon: Clinical Information on Demand is a long-term research and development effort of the AAO. The current AAO website (9/11/97) carries the first pilot effort using the information on diabetic retinopathy.

trying to measure the results, educate, change behavior—measure results, educate, change behavior.

Spencer: That would all be done by the educational secretariat?

Hoskins: It's mixed with NEON, the National EyeCare Outcomes Network, which is quality of care. This effort was started, probably 1995, with the cataract module for NEON. The idea is to begin to understand clinical outcomes. It's fairly easy to get patient satisfaction outcomes, but I think those of us who are clinicians know we can drive those in a certain direction; it's more difficult to drive clinical functional outcomes. We need those to balance the satisfaction outcomes, and NEON is designed to do that. The problem, of course, is it's horrendously expensive, and right now nobody is quite willing to demand it because they're afraid they'll have to pay for it. [laughs] But it'll evolve over time.

Hughes: I noticed that one of the goals of the Ophthalmic Practice secretariat is cost effectiveness. Is this a new goal for the Academy?

Hoskins: It's not brand new. It's something we've been working on for quite a while. Even before I got involved, practice management existed. It came from a recognition that people would stop paying so much for services. The only way one could survive long term would be to become more efficient. Cost-effective care is demanded in today's market. You have to do that.

Hughes: In my mind, I link it with the demise of fee-for-service practice, where cost-effectiveness is not a primary goal.

Hoskins: It wasn't a driving force. Fee-for-service said do everything for the patient, and capitation says do nothing for the patient. So we have two very conflicting financial arrangements. Personally, I'd rather be treated under one where they do everything for me, but I don't know that I could afford it. I'm very concerned about a capitation concept that says everybody providing the treatment does better financially if they don't do anything for me. That bothers me, and I think it bothers the public. I think intuitively, they understand that that's wrong.

Hughes: There is a tremendous demand by society for cost-effectiveness, yet one of the things the Academy has always stood for is quality of care. How do you reconcile those two aims?

Hoskins: The big problem we've had in past years is defining quality, and nobody's been able to do it. The purchasers of healthcare for their employees have similar problems. One representative of big business who purchased the healthcare coverage for a consortium of 17 companies that were in the Fortune 100 group chose his own definition: "Do it right the first time every time." And, of course, that means just what it says. "Do it right. Don't make mistakes. Do it right and

don't have us pay for having to do it twice." It also says: "If you don't know what you're doing, send it to someone who does." I think those kinds of attitudes are evolving as we move into managed care. We've squeezed about all the dollars out of healthcare that we're going to. I think it was Bob Waller, who is an ophthalmologist and President of the Mayo Clinic, who said: "The public wants universal care, high quality, and low cost. We can give you any two, but can't give you all three." Ultimately, our society is going to have to make the decision about what's important for them, financially. We'll see.

Promoting the Value of Specialty Care

Hughes: Are those issues very much in the mind of your outreach both to the public and to the government?

Hoskins: Certainly, to the government. We don't get into the public debate too much on that, because it's a broad medicine issue. It's really something the AMA should address.

Hughes: Should and is? How effective is the AMA?

Hoskins: Maybe I should ask you that. [laughter]

More on the Surgical Specialty Care Coalition

Hughes: If you think of the world out there being in a process of consolidation in practically every field you can think of, it's not irrelevant to think of the Academy in conjunction with what the AMA might be doing. You're both in this together. You and all the other specialty organizations in medicine are either going to sink or swim, to a certain degree, by how you approach the general problem.

Hoskins: One of the things I think is important is to begin to promote the value of specialty care. I think it's more likely to come through this S²C² surgical specialty care group than it is through the AMA. We've not done that, and the public intuitively believes in it. Unfortunately, what we've heard is that primary care cuts cost. Nobody's ever proven that argument, it's just that somebody said it. I think that debate is going to begin to be entered more actively.

Hughes: And will the Academy, or this surgical specialty coalition, be trying to get data that supports that?

Hoskins: Oh, sure. I hope so. Our Board this week voted some money towards that effort. We're the first one to do that. I'll be able to go to the meeting with this group next week and, at least, say that we've done that and we hope the rest of them will come along and kick in because we think it's important. [Dr.] Jim Todd, who died recently and was the Executive Vice President of the AMA, was an articulate speaker, and I liked him very much. He said, "Getting doctors to work together is like herding cats." And somebody made the comment that getting specialty societies to work together is like trying to get eagles to fly. [laughs] There's a great deal of independence and different sizes, and different goals.

Spencer: How often do you meet and communicate?

Hoskins: Four times a year. We communicate a lot. That's where I was just before this interview started—on a conference call with that group about the practice expense issue. Right now, we have a leadership position in the group, and probably will continue to have that for a while. We need to have the specialty societies learn to work together better. We can be more cost-effective in terms of the programs we offer. Practice management for the specialist is very little different from an ophthalmologist, to an orthopedist, to a plastic surgeon, to a—you name it. So there is really no reason for each of us to have a full-time staff developing product to deal with that effort. We can do that together and save money. We could also have an infrastructure that would save us money on outcome studies. Certainly, if we don't do advocacy and lobbying together we don't have an impact at all.

Hughes: Is outcomes research in ophthalmology far enough along that that, itself, is going to provide quite a database?

Hoskins: No. [laughter] You know, I think the real question on outcomes is, Is anybody willing to pay for the data? Are they really willing to do it? Do they really want it? I wrote an editorial ten years ago about truth as an elusive ideal. Number one, how hard it is to prove anything in medicine. Number two, by the time you've proved it, it's already obsolete. The big fundamental issue is doctors being required to work more and more and more, and see more patients for less income. They don't have time for the data collection process. And they resist it. If you had to hire somebody just to collect data, and multiply that by all the doctors out there doing it, you can imagine the cost. And that wouldn't include the costs of the data management processing.

Hughes: So what's the solution?

Hoskins: Long term, it'll come off the computerized patient record. Once that's in place, you'll be able to siphon the data off directly. But you'll still have a problem with the data you'll get. It has to be entered properly. Is it valid? How do you deal with that? Some people are saying there is going to be a whole new industry evolving that does nothing but audit data. That adds another cost factor that goes

on top of good patient care. So, often you finally get down to making your healthcare decision not so much on data, as on the judgment reached between the physician, who has had experience in disease management, and the individual patient. The data can help, but does it really serve a purpose?

The Role of the Academy President

Spencer: *I'd like to come back to the governance of the Academy. You've not talked about the role of the President of the Academy.*

Hoskins: The President is, obviously, very important. I report to the President. We ask each President to begin thinking, at the time of their election as President-Elect, about what they want to focus on during their presidential year. [Dr.] Steve Obstbaum chose international ophthalmology and [Dr.] Elliot Finkelstein has chosen the eye care of children. [Dr.] Paul Lichter had the centennial during his year, which was a huge and wonderful event.

The President also runs the Executive Committee. Since the institution of the reorganization plan, the Executive Committee meets every month by phone call. This keeps them up to speed and helps supply them with information for whatever decisions need to be made, so we can keep things moving. We tried to streamline the whole governance and implementation process. One of the things within the staff that we tried to do is to make the lowest possible accountable person aware of every decision. We don't like mistakes, but we understand that risk is necessary in today's world. You have to take a few chances if you want to move things ahead. We're reasonably risk tolerant. So far, everything seems to be going well. I think the relationship with the Council is much better. We've gone to a consensus approach instead of an adversarial approach. We no longer have votes where if it carries 51 to 49, that means that's what we're going to do. Instead, we tell the Council we're looking for consensus. If we don't have consensus, the Board's probably not interested in acting until there is better consensus. So, let's debate it some more. And that seems to work. I think people feel involved and feel their input has effect.

The Academy Board Changes its Modus Operandi

Hughes: *I understand that Board minutes have become perfunctory, largely for legal reasons. If that, indeed, is the case, not just in that instance, but in all Academy-*

related minutes, what is the Academy's memory? How do you proceed when a decision is made for which there is only a skeleton on paper?

Hoskins: The Board shifted, in 1993, from being an operational board to a contingent board. It was a major goal of the organization. We recognized that it's inappropriate to ask any 20 people to come together quarterly and decide on the implementation of programs. So, what we said was that the Board would set broad goals and determine budgets, but it wouldn't get into how we'd accomplish things. And we stuck by it. If you look at some of the minutes of the Board, some of the action items are simple mundane things, like approving resolutions for signatures, which are requirements. But it would be things like spending \$200,000 on promoting the value of specialty care that would be decided by the Board.

Hughes: I see. But the debate itself would not be part of the minutes?

Hoskins: We don't feel that helps in terms of minutes. Maybe it would help historically. One can imagine the debate. You can fill in behind the scenes, if you see the actions.

Spencer: Do you provide back-up materials for the Board to read in advance of the meetings to come up to speed on a particular issue?

Hoskins: Right. The agenda book is about three inches thick. The Board members will tell you themselves that they don't all read it all; we don't expect them to. But, we provide enough detail so that whatever they're interested in, they can understand the issue.

Spencer: Are those materials archived?

Hoskins: I don't know whether we archive our agenda books.⁸

Spencer: Not the agenda books—the background materials.

Hoskins: That would be the agenda book. That would be about this thick [spreads his thumb and forefinger]. So, in a year's time you get this much paper [spreads his hands a foot apart].

Hughes: How does it work in terms of the implementers of the policy?

Hoskins: The implementers understand the goal and they understand our value system.

⁸ All Board minutes and agenda materials are in the collections of the Archives of the American Academy of Ophthalmology.

Hughes: How do they get that understanding?

Hoskins: The implementers are our vice presidents and the committee of secretaries. They are there during the discussion. They hear the debate and they understand the goal. Because, usually, the recommendations have come from them. So the Board, usually, is acting on a recommendation that comes up from the lower parts of the organization. Occasionally they'll act on issues de novo, but not often.

Hughes: So there isn't a slip, in most cases, between policy and implementation?

Hoskins: Always. [laughter] But again, what we're trying to do is achieve the goals. If the goals are clear, then the implementation might take a slightly different turn than whoever designed the program thought it might. But that's okay, if it's still aiming toward the goal.

Hughes: What is the recourse if it's felt not to be?

Hoskins: Oh, then we'd put it back on track.

More on Planning Mechanisms

Hoskins: Getting back to the three types of planning—proactive, reactive, and resiliency. The proactive concept basically says you can plan ahead, and gear up for it to make it happen. With reactive planning, you have something land on the table and gear up to react to it. “Resiliency” says that when you know that things are going to happen in certain areas, you create an infrastructure that can react in those areas and be effective quickly when it happens.

And that's kind of what we do. We recognize, in certain areas, we can be proactive long-term—like promoting the value of specialty care. It's a five-year concept, if we undertake it. That's proactive. We make it happen. Reactive: A practice expense issue landed on our lap and, all of a sudden, we had to gear up a whole new mechanism to deal with it because it came out of the blue. We knew it was coming, but it was just much worse than anybody anticipated. So we went off and built this specialty coalition. The coalition happened to have been in place. We funded it, basically. We gave it the money, set up a steering group and decided how to move into this political arena quickly and effectively. That's reactive. Resiliency is kind of like when the State of Idaho optometry board says optometrists can use lasers. We already have a state infrastructure and relationships in place. It's just a matter of dealing with it. It's not really reactive; it's being ready to deal with problems when they come up, and then dealing with them. Obviously, we can't predict all the problems we'll have to deal with.

The Educational Trust Fund

Spencer: Let's move to an area that you haven't discussed—the Academy's Educational Trust Fund.

Hoskins: The Educational Trust Fund was developed, originally, because it was recognized that the cost of education was going to increase. The members might have to pay more and more, with less and less income. And also a recognition that the political activities of the Academy could be a black hole that could absorb all the resources of the Academy. The idea was to create within the Academy's Foundation some money that could subsidize education and be protected from being spent for political activities.

Bruce Spivey, [Dr.] Brad Straatsma, and [Dr.] Ed Norton got together and created the Educational Trust Fund.⁹ In the past five years we've funded it. We raised almost \$7 million for this fund, to be used to support educational efforts.

We're branching out now. We're going to bring lay people on to the Foundation [Foundation of the American Academy of Ophthalmology] Board, which now resides under the Academy Board directly. It used to be spun off as a separate organization. There was concern about funding that with significant dollars, because it might go off and do things that the Academy didn't want to do. Since the Academy members were funding it, we thought the governance ought to be more in a straight line. So, now, we're bringing on lay people to get them involved in activities, do public service, help sponsor research and continuing education. Those are the three major thrusts of the foundation. As one person said, fifty million dollars is not an unreasonable amount to seek. Probably not in my tenure. [laughs]

The Work Force Study

Hoskins: There was something else I wanted to cover. Oh, yes. One of the early decisions we had to make was whether we should do a work force study. People were talking about an oversupply of physicians and specialists. Obviously, there are a lot of concerns about doing that. One, is that the FTC [Federal Trade Commission] could come down and say this is restraint of trade; you're trying

⁹ The creation of the Educational Trust Fund occurred in 1991. Bradley R. Straatsma was Chairman of the Foundation Board of Trustees, Edward Norton was Vice Chairman for Resource Development and Bruce Spivey was the Executive Vice President of the Academy.

to influence the production of providers. So, that was an issue. The other thing, everybody said no matter what comes out, you lose. If you say there aren't enough ophthalmologists, the rank and file, who are convinced there are too many, will get mad at you. If you say there are too many, the Federal Trade Commission might get mad at you. We did it, anyway. As I've said, we're a little more risk tolerant, maybe, than we were years ago.

Hughes: Does that philosophy stem from you?

Hoskins: Oh, I think it's the Board. It may be possible, to some degree, from me. Part of the thing is, I'm here a lot more than Bruce was. I have an opportunity to be involved in a lot more. The other is, I'm sort of at the end of my career—not at the middle or the beginning of it—and I think I'm more tolerant. The Board, ultimately, makes the decisions.

Hughes: Is that slightly more risk tolerant attitude a question of mix of personalities, or are external circumstances driving toward riskier behavior?

Hoskins: I think it's a combination of the two. I think that external circumstances demand it. It's also the fact that our Board is willing to do it. So, I think it's both. We did the work force study, but what we did was involve optometry in the study. So, we looked not just at ophthalmology, but [also] optometry. What we found—or what RAND Corporation [a think tank] found because they did the study, and we gave them total autonomy in doing the study—was that both professions are probably oversupplied. Ophthalmology is going to have to respond to this, because of what's happening with the funding. But optometry isn't; they're just continuing to crank them out in large numbers.

Hughes: How will ophthalmology respond?

Hoskins: The government has just come up with a great new plan to subsidize corn, in the form of specialty residents. They're going to pay programs not to produce residents. It started with New York, and now its going to go across the country. So it will change. I don't know what the exact impact will be. My personal concern is that if we shut down residency programs in really excellent teaching centers, optometric programs will just burgeon, even though they don't have as much access to patients as ophthalmologists, and they don't have interaction with other types of physicians—they lack comprehensive medical teaching. So, again, it requires some bold thinking. We have some groups in the Academy beginning to develop some bold ideas that I prefer not to go into right now, because there are some risks you don't need to take. [laughs] I talked to an optometrist today, and I asked, "What's happening with your schools?" He said optometry schools are continuing to just grow and grow and grow. He has a working and teaching position and hires people. He said one recent optometry graduate came in and said she was \$150,000 in debt after finishing optometry school. And he had no

idea how she was ever going to pay that off. He said that it is getting more difficult to find jobs for optometry students, also. So, I think, eventually, they will come to a realization of this, and we'll find some sanity. We need to ask questions. How do we train people more efficiently? Does it make sense for these two professions to be fighting with each other all the time over scope of practice? Isn't there a way we can resolve that through an educational credentialing process, rather than a legislative process? I don't know. [laughs]

Hughes: You must be a spokesman for that approach.

Hoskins: I like to approach it by asking questions. I don't know that anybody's smart enough to figure out the answer right now. But, if you ask the question—"Is somebody going to go \$150,000 in debt if their income is going to be \$80,000 to \$120,000 a year?"—that's talking about [the] high end of optometry, low end of ophthalmology. Are we doing the right thing by turning out practitioners who aren't fully qualified to manage the diseases that they are required to deal with? Is that the right thing to do? Do we need two credentialing organizations for eye care providers? Does that make sense? Those kinds of questions. Are we better off shutting down ophthalmology residency training programs—which have all those interactions with pathology, neurology, neurosurgery and all those other physician interactions—in order to train our ocular providers out there by themselves in an optometry school? Does that make sense? Isn't there a better way to do that? If you get enough people thinking about those questions, maybe we'll come up with some ideas.

Hughes: I think another concern with cutting back or eliminating residency programs is that it will make more tenuous the connection between ophthalmology and academic medicine, where a lot of things happen that don't happen in clinical practice.

Hoskins: Personally, I think that would be terrible. The ophthalmologist achieves most of his or her basis for interaction with the patient through the medical school and residency process. It's very different from what is formed through any other process. I would hate to lose that.

Hughes: I also think of the university as a font of knowledge. That's where the basic and clinical research occurs.

Hoskins: Absolutely.

Hughes: Bill [Spencer], do you have a comment?

Spencer: Not succinct.

Hoskins: You could imagine a program that says, “Okay, optometry gives you a good foundation in the basics of eye care. Now, let’s move them into an ophthalmic residency where they’ll have some opportunity to spend a little bit of time in some general medical courses and spend a couple of years there.” These are all speculations. Who knows where it will go?

Spencer: If the goal is to serve the public, you come back to that word quality. Ask anyone who has knowledge of how medicine works, who they would want to see if they had a particular eye disease; they would certainly want the best qualified person. Unfortunately, that does not seem to be the way things have been evolving.

Hoskins: No. It’s very scary, because it’s evolving very rapidly. We kind of set as a goal the premise that whoever treats a patient knows what they are doing as a result of education and experience and that they have enough volume of experience. Because if you don’t have a concentrated broad exposure in a learning setting, you don’t get enough information to know how to treat the patient, and you can’t enhance your skills.

Spencer: I find it interesting historically, that the Academy started as a place where practicing eye doctors could learn their trade. At that time, the universities did not provide postgraduate courses in specialty care. Their postgraduate courses were primarily on general medicine. For ophthalmologists, the Academy’s educational programs filled the continuing educational vacuum left by medical schools. Later, the universities gradually expanded their continuing education activities for the specialties. In ophthalmology, their continuing education courses have been excellent. But now we seem to be in a situation where the medical schools are backing off from continuing education in the specialties, and the Academy is back where it started as the primary place for ophthalmologists in practice to obtain the latest information.

Hoskins: It’s fascinating. I hadn’t thought of it that way. I was thinking of the Refractive Surgery Interest Group—it’s a subgroup of the Academy interested in refractive surgery. One can deal with a new technology or technique by stonewalling it, and that was a little bit of our attitude about refractive surgery early on. It forces those who believe in it to go elsewhere. We decided that the debate on this issue belongs within the Academy. Ultimately, we’ll achieve a balance. In terms of the ongoing education of the practitioner that you were just talking about, we’re more open to looking at these new techniques within the Academy, rather than forcing it to go elsewhere. We’ll see how it plays out.

Hughes: Is there an area that you feel we haven’t covered?

Hoskins: It’s a new and changing world with new and changing ideas. The Academy today is different from what it was five years ago, and the Academy five years ago was different from what it was five years before that. The Academy of tomorrow will

be different five years from now. The resiliency of the Academy to adapt to change, keeping its goals, its mission and its values intact, is what makes it such a great organization.

Spencer: I think it's interesting that you chose five-year cycles, because I suspect your eventual successor will choose five-month cycles.

Hoskins: [laughs] Yes, that's right. In preparing for this interview, I asked the Academy staff to put together lists of major events within the Academy during the last five years. When I look at them, I realize things are changing pretty fast.

Hughes: What would you like to be regarded by your successors as your main contributions to the Academy?

Hoskins: That's a tough one. I think I would like to be thought of as being open and fair more than anything else. Open to new ideas. Open to new people. And figuring the way we involve those people when we make judgments and allocate our resources. I think if we do that, then we'll be all right.

Hughes: Thank you very much.

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ACADEMY CHRONOLOGY¹

- 1938 Harry Gradle creates Ophthalmology Basic Science Home Study Course.
- 1942 Gradle initiates Ophthalmology Clinical Home Study Course.
- 1942 William Benedict elected Executive Secretary-Treasurer.
- 1950 Benedict becomes first full-time Executive Secretary-Treasurer.
- 1968 Benedict retires.
- 1968 C. Michael Kos becomes Executive Secretary-Treasurer, serving until 1978.
- 1969 Home Study courses reorganized as Continuing Education in Ophthalmology.
- 1970 Bradley R. Straatsma elected Secretary for Continuing Education.
- 1970 Practitioner self-assessment program first presented to practicing ophthalmologists; 1,800 participate.
- 1972 Practitioner assessment program is combined with in-training examination as the Ophthalmic Knowledge Assessment Program (OKAP).
- 1972 David Paton elected chair of new Basic and Clinical Science Course.
- 1973 Cassady-Smith motion is made to ballot members regarding separation into two academies.
- 1975 Bruce E. Spivey succeeds Bradley R. Straatsma as Secretary for Continuing Education.
- 1975 Robert D. Reinecke elected AAOO Secretary for Ophthalmology.
- 1975 Melvin L. Rubin elected Ophthalmology Secretary for Instruction.
- 1975 OKAP examination administered in conjunction with American Board of Ophthalmology's written qualifying examination.
- 1975 Stanley M. Truhlsen succeeds W. Howard Morrison as Editor of *Transactions of Ophthalmology and Otolaryngology*.

¹This abridged list of the temporal order of Academy events is limited to topics discussed by the participants in this oral history series.

- 1976 Creation of AAOO divisions of Ophthalmology and Otolaryngology, each with an Executive Vice President (Spivey/Kos).
- 1977 Academy Council becomes Board of Directors.
- 1977 Division of Ophthalmology opens Office of Governmental Relations in Washington, D.C.
- 1978 Academy files articles of incorporation with state of Minnesota under IRS code 501(c)6.
- 1978 Bruce E. Spivey becomes Executive Vice President and CEO, serving until 1992.
- 1979 Ophthalmology officially separates from Otolaryngology, each forming an independent academy.
- 1979 Term limits are established for AAO elected officers.
- 1979 Committee of Secretaries (chaired by Bruce E. Spivey) consists of:
Secretary for Program (Robert D. Reinecke),
Secretary for Instruction (Melvin L. Rubin),
Secretary for Continuing Education (David Paton),
Editor of new monthly journal, *Ophthalmology* (Stanley M. Truhlsen).
- 1980 Paul Henkind succeeds Stanley M. Truhlsen as Editor of *Ophthalmology*.
- 1980 Foundation of the AAO is incorporated under IRS code 501(c)3.
- 1980 Secretariat for Governmental Relations is formed and chaired by Robert D. Reinecke, who also serves as Secretary for Program.
- 1980 American Association of Ophthalmology merges with Academy.
- 1981 Paul R. Lichter succeeds Robert D. Reinecke as Secretary for Program.
- 1981 A new Council is formed to formally discuss issues and make advisory recommendations to Board of Trustees. Council Chair and Vice-Chair sit on Board of Trustees.
- 1983 David Paton is succeeded by William H. Spencer as Secretary for Continuing Education.

- 1984 Committee on Public and Professional Education, which had functioned in both AAOO and AAO, is replaced by a new Secretariat for Public and Professional Education (George Weinstein).²
- 1984 Implementation of Academy Code of Ethics. Jerome W. Bettman, Sr. serves as first chair of AAO's Ethics Committee from 1984 to 1988.
- 1986 Melvin L. Rubin is succeeded as Secretary for Instruction by H. Dunbar Hoskins, Jr.
- 1987 Restructuring of Secretariats, to be implemented in 1989, is voted.
- A. The Secretariats concerned with education (Program, Instruction, Continuing Education) are replaced by:
Secretary for Annual Meeting (H. Dunbar Hoskins, Jr.),
Secretary for Instruction (Dan B. Jones),
Secretary for Continuing Education (Ronald E. Smith).
 - B. The Secretariat for Governmental Relations is renamed the Secretariat for Representation (Hunter Stokes).
 - C. The Secretariat for Public and Professional Information is continued (George Weinstein).
 - D. A new Secretariat for Practice is formed (B. Thomas Hutchinson).
- 1990 Master plan for education is approved by Board of Trustees.
- 1991 First joint meeting of AAO with Pan-American Association of Ophthalmology (PAAO).
- 1991 Board of Directors establishes Ad Hoc Committee on Organizational Design, chaired by George Weinstein.
- 1992 Final report of Ad Hoc Committee on Organizational Design (as modified by Board actions) is published. Committee recommends that AAO work to shape the future of eye care delivery in the United States, and greater emphasis be placed on socioeconomic research and strategic planning within the Academy.

²Truhlsen, SM: History of the Secretariats of the American Academy of Ophthalmology. *Ophthalmology* 1996 (suppl); 103: S159.

- 1992 Further restructuring of Secretariats occurs. Three new Senior Secretariats are created:
- A. Senior Secretary for Clinical Education (Thomas A. Weingeist), assisted by three Secretariats and the Editor of *Ophthalmology*,³
 - B. Senior Secretary for Advocacy (Stephen A. Obstbaum), assisted by three Secretaries and three committees,⁴
 - C. Senior Secretary for Ophthalmic Practice (David A. Durfee), assisted by the Ophthalmic Practice Group.⁵
- 1993 H. Dunbar Hoskins Jr. becomes Executive Vice President and CEO.
- 1993 LEO (Lifelong Education for the Ophthalmologist) is formed as a framework to help ophthalmologists meet their individual educational goals. LEO includes ProVision, a self-assessment program including Preferred Responses in Ophthalmology, LEO Clinical Update Courses, and Clinical Topic Updates. LEO also provides educational materials for residents in ophthalmology, allied health personnel in eye care, medical students and other MDs providing eye care.
- 1993 Mid-Year Forum is initiated. Provides mechanism for discussion and debate of proposed policies and programs, as well as acquisition of input from leaders of state and subspecialty societies, special interest groups, and outside experts.
- 1993 Ethics primer is published.
- 1993 Academy publishes first managed care text, *Managed Care: The Evolving Challenge for Ophthalmologists*.
- 1994 First Subspecialty Day meeting.
- 1994 Academy staff is reorganized. Head of each staff group is designated as a vice president

³The Senior Secretary for Clinical Education supervises the Secretary for Annual Meeting (William S. Tasman), Secretary for Continuing Education (Ronald E. Smith), Secretary for Instruction (Dan B. Jones), and Editor of *Ophthalmology* (Paul R. Lichter).

⁴ The Secretary for Advocacy is assisted by the Secretary for Federal Affairs, the Secretary for State Affairs, the Secretary for Public Service and Information (replacing the Secretary for Public and Professional Information), and by the committees for Third Party Advocacy, Relations with the Media, and Relations with Industry.

⁵The Ophthalmic Practice Group includes the Secretary for Practice Management, the Secretary for Quality Care, the Committee for Managed Care, and the Ethics Committee.

- 1995 Academy leadership structure is again reorganized. Board of Trustees now includes:
Senior Secretary for Clinical Education,
Senior Secretary for Ophthalmic Practice,
Senior Secretary for Advocacy.
- 1995 Report of AAO-commissioned RAND study estimating national eye care provider supply and workforce requirements is distributed. Study indicates a sizable surplus of eye care providers.
- 1995 Debut of Academy website.
- 1995 Academy initiates outcomes database with a pilot study assessing clinical and functional results of cataract surgery.
- 1996 Centennial Annual Meeting. Attendance reaches 25,000.
- 1996 ProVision interactive CD-ROM is introduced.
- 1996 International clinical education products account for over 20% of sales revenue.
- 1996 Academy forms Senior Ophthalmologists Interest Group to meet the needs of members over age 65.
- 1997 Academy participates—as a founding member—in discussions of Surgical Specialty Care Coalition (S₂C₂). Consortium of surgical specialty societies meets quarterly to discuss issues of mutual interest.
- 1997 Meetings department organized into a division.
- 1997 PrimeSight, an ophthalmology-led national eye care contracting organization, is formed. PrimeSight signs two-year contract with Cole Vision that covers 40 million lives.

Notes on the Board of Secretaries 1956 to 1962

Daniel Snyder, M.D.¹

Since the general functioning and impact of any organization is a reflection of the dominant members of that organization, it seems worthwhile to characterize my impressions of these men. There were three of them: William "Bill" Benedict, Dean Lierle, and A. D. "Ruedy" Ruedemann.

Bill Benedict was physically a big man; he was reasonably polite, and listened a good deal before making any judgments. If any Academy members came to him with a complaint, he listened attentively, perhaps making a note, and if the matter was unimportant forgot about it. He paid attention to Lierle and Ruedemann, and the three of them would decide on a course of action. Of course, matters of real importance were brought before the Council, which generally would follow his suggestions.

Ruedy Ruedemann was an explosive person who had a rough manner of speech, but under this rough exterior he was a warm, compassionate human being. He was passionately dedicated to what he thought was good for the Academy.

Dean Lierle was a reasonable man; his judgment was good, and he was very fair.

Other members of the Board of Secretaries were Ken Roper, Gene Derlacki, Glenn Gibson, and myself.

The Board of Secretaries usually met three times a year; at the Annual Meeting when we met with the Council, in January, when we met with the Program Committee, which consisted of the Secretaries and the officers of the Academy, and in the summertime, when we would meet at a resort hotel. The favorite summer meeting place was at The Broadmoor in Colorado Springs. The summer meetings were at the expense of the Academy, but since, to my knowledge, none of us except Bill received any remuneration, this did not seem out of line.

The Annual Meetings of the Academy of this period were held at the Palmer House in Chicago. Bill Benedict had a suite, which I am sure was courtesy of the hotel. This was our unofficial headquarters where, if we had any free time, we would meet. Any discussions were informal and usually held over a card game called "frisch," a non-gambling version of five card draw poker. Secretaries worked hard during the meeting, particularly Ruedemann, who was in charge of the instructional courses.

The January Program Committee meetings usually lasted three days and were strictly business. These meetings were also held at the Palmer House. Usually there was a group dinner in one of the Palmer House dining rooms.

¹ Dr. Snyder added these typewritten notes on August 28, 1997.

The summer meetings at the Broadmoor were given over to business meetings in the morning, at which each Secretary would give a report of his activities, and in which there would be general discussion on any problems or proposed new programs. The men played golf in the afternoon and, if my memory is correct, there were no scratch golfers. The evenings were given over to a cocktail party before dinner with wives and then a group dinner.

All members of the group were dedicated to the Academy and to making its meetings successful. It is also true, as Dr. Stan Truhlsen has said, that it was "an old boys' group," the members of which were picked by Dr. Benedict.² He thought that any meeting of a subspecialty group would detract from success of the main meeting, and therefore strictly forbade such meetings.

² See oral history with Dr. Truhlsen in this volume.

Additional Recollections by Mr. Zupan Regarding American Association of Ophthalmology Activities

National Eye Institute

When the original Eye Institute bill was introduced by Congressman Fred B. Rooney of Pennsylvania, few Washington observers or science writers gave the proposal any chance of being enacted—let alone being reported out of committee. Eye research was already being conducted under the National Institute of Neurological Diseases and Blindness; therefore, a separate institute was not a priority objective of H.E.W. (Health, Education and Welfare).

Research to Prevent Blindness, Inc. (RPB) spearheaded support of the Rooney bill. Other medical organizations that supported the establishment of an eye institute were: American Medical Association (AMA), American Association of University Professors of Ophthalmology (AUPO), Association for Research in Ophthalmology (ARO now ARVO), and the American Association of Ophthalmology (AAO). After hearings were held before the House Committee on Interstate and Foreign Commerce, chaired by Harley O. Staggers Sr. (West Virginia), he informed our witness, Dr. Ralph W. Ryan, of Morgantown, West Virginia, that the committee was well aware of medicine's unanimous support of an Eye Institute, but grassroots response from the public was needed to offset the H.E.W. officials and the Surgeon General's vigorous opposition to the proposed legislation.

Dr. Ryan, through personal effort and at his own expense, sent letters to every Lions Club in the United States soliciting their support of the bill through resolutions, petitions, letters, and telegrams directed to the committee. The response of the Lions was overwhelming and their support helped gain Congressional approval. President Johnson signed into law the bill that established the National Eye Institute.

I wish to point out that Dr. Thomas D. Duane, of Jefferson Medical College in Philadelphia, released his report in 1965 based on a two-year study sponsored by RPB, Inc. Among several criticisms of eye research activities that he cited, Dr. Duane also reported that it was "imperative" that the federal government now plan for the eventual establishment of a separate National Eye Institute. Mr. Rooney identified Dr. Duane as his good friend and neighbor in Pennsylvania. He also said that Dr. Duane's report opened the eyes of many legislators to the fact that the government's investment in eye research had created a rebirth of interest and activity in the search for knowledge of the eye and the problem of visual loss.

The Duffy Amendment

When physicians' assistant (P.A.) bills were being sponsored by state medical organizations and introduced in the legislatures as an approach in providing additional health care personnel, optometry became concerned. The AOA (American Association of Optometry) informed its

members that the physician assistant was the greatest threat to optometry since the exemption of physicians in the optometric practice acts. Dr. Gordon V. Duffy, an optometrist, who was a member of the legislature, authored the amendment to the P.A. bill enacted in California. The Duffy amendment prohibited the P.A. from performing the following:

“The measurement of the powers or range of human vision or the determination of the accommodation and refractive states of the human eye or the scope of its functions in general, or the fitting or adaptation of lenses or frames for aid thereof;

The prescribing or directing the use of, or using any optical device in connection with ocular exercises, visual training, vision training, or orthoptics:

The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.”

The Duffy amendment was promulgated as the model to be used by state optometric associations when P.A. enabling legislation was introduced, but the Duffy amendment itself was defeated.

American Optometric Association’s attempt to have a commemorative stamp issued

In the early '70s the American Optometric Association petitioned the Postmaster General, seeking a national stamp issued by the United States Postal Service to commemorate the AOA’s 75th anniversary with the statement: “Optometry — your first line of defense against blindness.” The American Association for Ophthalmology (AAO) did not argue the merits for a commemorative stamp for optometry; it protested the issuance of a stamp that would identify optometry with the diagnosis or treatment of disease or injury. The AAO appealed to the Postmaster General to reject optometry’s petition. The proposal for an optometry stamp was referred to the Citizens Stamp Advisory Committee for consideration. Optometry did not get a national stamp issued in 1973 or, to my knowledge, later.

“I Care” public relations program

In the late '70s the Association launched a national public relations program conducted by Foote, Cone, Belding public relations company. The program was designed to inform the public, opinion leaders, and the medical profession on the role of the ophthalmologist in diagnosis and treatment of eye disease. Funding for the program came from an appeal made to ophthalmologists, members and nonmembers throughout the U.S., asking for a contribution of \$100. The theme of the special fund raising was “I Care.”

The Foote, Cone, Belding public relations program was in operation for two years and included an aggressive national campaign of newspaper articles, magazine features, participation on radio and television talk shows, and public service spots on television and radio. The “I Care” project was successful in that it brought ophthalmology’s message to millions, but the initial advertising organizational expenses of Foote, Cone, Belding meant we were receiving \$1 of advertising for each \$3 spent. Over \$600,000 was received from “I Care” appeals. The program was dropped in

1979 after the Association employed its own director of communications as a cost-effective measure.

Allied Health Personnel in Ophthalmology

I recall when Dr. Harold F. Falls, the Academy's delegate to the AMA and an officer of the Association, introduced a resolution at the annual business meeting of the AMA Section on Ophthalmology held in San Francisco, recommending that a joint committee of representatives from the AMA, the Academy, and the Association be established to study the training and utilization of ophthalmic medical assistants. The motion was adopted and the Joint Committee (on Ophthalmic Assistants) was to report at the next Annual Meeting. The executive committee of the Section appointed Drs. Joseph M. Dixon of Alabama, Theodore G. Martens of Minnesota, and James F. O'Rourke of Washington D.C. to the Joint Committee. At the following year's business meeting, Dr. Dixon, chairman of the Joint Committee, presented a comprehensive report covering definitions, legal status, etc. The Section approved the report.

After the Association of University Professors of Ophthalmology was formed in 1966, a representative of the AUPO was added to the Section's Joint Committee on Ophthalmic Assistants. The Joint Committee proposed the formation of an American Commission on Allied Health Personnel in Ophthalmology, which was subsequently incorporated as the Joint Commission of Allied Health Personnel in Ophthalmology (JCAHPO) in 1969 to promote and coordinate the training of medical assistants in ophthalmology. JCAHPO has provided excellent continuing education courses in connection with the Academy's annual meeting. Certification of assistants is available through JCAHPO by written/oral examination.

Each of the founder organizations contributed toward funding the costs of establishing JCAHPO by a special formula. When the AMA considered withdrawing its support (\$10,000), officers of JCAHPO and Association officers, together with their spouses, demonstrated at the annual meeting of the AMA in Atlantic City. Delegates to the AMA House of Delegates were handed large red and white buttons which read "Support Ophthalmology Now." AMA financial support continued, so the activist role paid off.

An offspring of JCAHPO is the American Association of Certified Allied Health Personnel in Ophthalmology (AACAHPO), an association of skilled persons qualified by academic and clinical training and certification, conferred by JCAHPO.

I bring this up for the record because few people, if any, realize what Dr. Falls had put in motion in 1964 and how JCAHPO was conceived.

AAO slogan

A Cincinnati psychiatrist, a friend of Dr. Barnet R. Sackler of our board of trustees, suggested a communicative statement that could be used as a slogan: "An ophthalmologist's examination may not only be sight saving . . . it may be life saving." The Association adopted the statement as its slogan during its formative years and incorporated it as a postage meter message on all outgoing mail. The board subsequently approved having the slogan published on a dignified laminated plaque which was made available to members for display in their reception rooms.

Association highlights

1. The AAO established and maintained a National Registry of Ophthalmic Medical Assistants. One of the benefits of the registry was to facilitate contact between potential employers and the trained and experienced ophthalmic assistants who became available for employment. The registry was later designated the American Registry of Ophthalmic Medical Assistants. A certificate of membership was issued to all qualified registrants. A lapel pin reading "Ophthalmic Medical Assistant" was designed and made available at the nominal cost of \$3.00.
2. Officers of the Association, by invitation, conferred with officers of the National Association of Blue Shield Plans after the Plan announced it had adopted a comprehensive scope of benefits, including vision care.
3. The AAO cosponsored a conference on learning disabilities in Atlantic City, in cooperation with the New Jersey Education Association, to bring together for the first time a panel of experts in education and medicine on a subject of vital interest.
4. The AAO sponsored the first seminar on Prepaid Medical Eye Care Programs for representatives of local, state, and regional ophthalmological associations.
5. The AAO established the Rychener Memorial Award, presented to the lay author of the finest article or essay on eye care published in a newspaper or magazine of general circulation.
6. The AAO sponsored an annual "Open House" for ophthalmology residents and their spouses, an informal program on "Tips on Starting Yourself in Practice." Mr. George S. Conmikes, a nationally known medical management consultant, was the featured speaker. These sessions were held at Academy Annual Meetings.
7. The AAO offered and sponsored a series of practice management workshops entitled, "Establishing Yourself in Medical Practice," for residents (and fellows). The two-day workshops were scheduled in various cities throughout the country and were conducted by Conomikes Associates, Inc.

8. The AAO cooperated with the Division for the Blind and Physically Handicapped of the Library of Congress in the development and printing of a leaflet entitled "Visual Loss and Talking Books."
9. The AAO developed scientific and public health exhibits on eye disease, eye safety, and other eye care subjects for viewing at medical meetings or lay organization conventions.
10. The AAO was represented on the panel establishing ophthalmological services in the AMA Current Procedure Terminology (CPT) revisions. The Association also published a mini-CPT booklet covering only ophthalmological items and mailed them to members without charge.
11. In 1970, the AMA recognized the Association as a national specialty organization, qualified to be represented on the AMA Section council on ophthalmology, and listed wherever specialty societies are referred to in the AMA Directory.
12. The AAO participated in the White House Conference on Aging.
13. The AAO participated in the White House Conference on Children.
14. The AAO was represented on the American National Standards Institute (ANSI).
15. The AAO developed "I Have Glaucoma" identification cards which were furnished to ophthalmologists without cost for distribution to their glaucoma patients.
16. The AAO consulted with the Food and Drug Administration on impact resistant lenses, contact lenses and other issues.
17. The AAO consulted with the Federal Trade Commission on rules for the optical trade industry and other consumer issues.

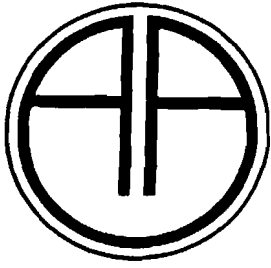
Conclusion—In and out of focus

To paraphrase Dr. Rychener, with some modification, during the twenty four years that have elapsed since the six hundred ophthalmologists decided to establish the National Medical Foundation for Eye Care, we have found many vital functions to perform for ophthalmology—functions which no other national ophthalmological organizations had been designed or committed to perform. Unfortunately, I was not around when the Academy was founded in 1896, nor on board when the NMFEC was founded in 1956; however, I have a pretty good historical perception to be added to much of what is going on in the political and legislative arena today.

One of the pleasant perks of retirement is that it offers one an excellent opportunity to recall the past and to appreciate those persons and events that have had a positive effect on our lives. There were good times and there were bad times during my service with ophthalmologists.

There were happy events and there were sad events. There was harmony, but there was also friction and dissent. Although I lost my Association and my staff, the merger (with the Academy) was in the best interest of ophthalmology. It is unfortunate that more ophthalmology special societies are not considering merger to eliminate duplication and permit the Academy to speak as the voice of ophthalmology.

In retirement, I honestly believe, with no pun intended, the founders of NFMEC and the six hundred who met in Chicago in 1956 really had vision. Who knows—if the Association had not challenged optometry's incursion of medical practice and served as a roadblock over the years, today's ophthalmologist might be limited to surgical practice only and the optometrist would have become the optometric physician. This can still become a reality if organized optometry can succeed in having any physician exclusion provision deleted from the state optometric practice acts. They succeeded in gaining the use of diagnostic and therapeutic drugs—so what's next?



American Academy
of Ophthalmology®

Strategic Plan

1997

American Academy of Ophthalmology

Strategic Plan For 1997

INTRODUCTION

In 1986, the Academy developed its first Strategic Plan. That document has been evaluated and revised each year since, and significant progress has been made on accomplishment of the goals defined in it.

The Plan consists of the following:

- a **mission** statement, which says why the Academy exists,
- a **values** statement, which describes the underlying guiding principles of the Academy's Board of Trustees
- **strategic goals**, which describe the most critical outcomes to be achieved over the next three to five years
- **five major functions**, the primary areas of emphasis of the Academy
- **strategic goals** for each function, which describe long-term results or outcomes the Academy should work to achieve.

The Strategic Plan focuses on long-term results or outcomes. **The fact that ongoing Academy programs are not specifically mentioned does not imply that they should receive any less emphasis in the future.**

Individual members and staff will be asked to take ongoing responsibility for developing plans to work towards accomplishing the strategic goals. Those plans will be evaluated vis-à-vis ongoing programs of the Academy and integrated into annual plans and budgets. Progress on the plans will be monitored and feedback provided, and the Strategic Plan will be re-evaluated annually.

MISSION:

The mission of the American Academy of Ophthalmology is to achieve accessible, appropriate and affordable eye care for the public by serving the educational and professional needs of ophthalmologists.

VALUES:

The American Academy of Ophthalmology is committed to:

- | | |
|--------------------------|--|
| LEADERSHIP... | to plan strategically and act to improve the future of ophthalmology and eye care; |
| PUBLIC SERVICE... | to put the public first and act with care and consideration of others; |
| EXCELLENCE... | to provide products and programs of the highest quality to our members and others; |
| HONESTY... | to be fair, open and trustworthy; and |
| ACCOUNTABILITY... | to be an association that is effective, efficient and relevant to our members. |

ACADEMY STRATEGIC GOALS:

- to ensure patient access to high quality, appropriate ophthalmologic care
- to identify ophthalmologists as the preferred providers of comprehensive eye care
- to identify the Academy as the pre-eminent source of education, data and information about eye care
- to develop broad consensus on how eye care should be provided in order to meet public needs
- to promote excellence in eye care through education and dissemination of information

FIVE MAJOR FUNCTIONS:

- **CLINICAL EDUCATION**
- **ADVOCACY**
- **OPHTHALMIC PRACTICE**
- **OPHTHALMIC RELATIONS**
- **MEMBER SERVICES**

STRATEGIC GOALS FOR EACH FUNCTION:

CLINICAL EDUCATION

- to be the leader in clinical education for the ophthalmologist, providing the member with cost-effective, practice-based, self-directed learning opportunities that meet individual educational needs
- to be a primary resource of clinical education for ophthalmologists in training and health care providers who work with ophthalmologists
- to be in the forefront of medical specialty societies in adapting new education technologies and methods to deliver clinical education including “on demand” access
- to seek new audiences for clinical education material, including increasing international availability of Academy products

ADVOCACY

- to establish ophthalmology as the most respected and effective advocate for quality eye care with the public, federal, state and local governments, regulatory agencies, coalitions, consumer groups, managed care organizations, purchasers of eye care and other health care decision makers
- to maintain patient access to high quality, appropriate eye care by establishing ophthalmologists and ophthalmologist-led teams as the preferred providers of comprehensive eye care
- to have the majority of US ophthalmologists actively involved in governmental affairs, or health care organizations, as advocates for quality eye care
- to establish the Academy as the leading source of information about eye care with the public and the media
- to educate the public concerning the value of quality eye care, vision, and the advances made by ophthalmology in protecting their visual health and function

OPHTHALMIC PRACTICE

- to ensure that all member ophthalmologists can readily obtain the practice-related information, knowledge and skills they need to establish themselves as the preferred providers of eye care in their communities
- to establish the Academy as the recognized leader with regard to the quality of eye care, with Academy-defined preferred practice patterns and outcome measures widely accepted as the standards for eye care within the United States
- to establish the Academy as a leader with respect to standards for the ethical practice of medicine, in particular ophthalmology, with educational materials and resources for practitioners and others, in the United States and internationally

OPHTHALMIC RELATIONS

- to be recognized by individual ophthalmologists as the primary umbrella organization for ophthalmology in the United States
- to achieve broad recognition of the Academy as a catalyst for cooperation among organizations in eye care and providers to meet the needs of the public
- to enhance the role of the Academy in international ophthalmology and eye care by cooperating with and supporting activities of groups active in blindness prevention and education of ophthalmic professionals in developing countries and by providing services to international members
- to foster effective relationships with ophthalmic industry, to our mutual benefit

MEMBER SERVICES

- to maintain at least 90% of all practicing US ophthalmologists as members of the Academy
- to serve members with high quality programs and products, assuring that benefits of membership are effective and relevant, meeting member needs
- to develop a member services system that meets and exceeds member expectations
- to expand the Academy's global presence as the pre-eminent source of education, data and information about eye care in collaboration with international organizations

Approved, Board of Trustees, September 8, 1996

**REPORT OF THE AD HOC COMMITTEE
ON ORGANIZATIONAL DESIGN**

June, 1992

American Academy of Ophthalmology

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MEMORANDUM

TO: Board of Directors

FROM: George W. Weinstein, M.D.

DATE: June 10, 1992

RE: Report of the Ad Hoc Committee on Organizational Design

As requested by the Board, the Ad Hoc Committee recommends changes in the Academy's organization and functions which are thought necessary to assure effective pursuit of the Academy's mission and implementation of its Strategic Plan.

Attached are the executive summary report, detailed recommendations of the Committee, a description of the process and participants of the organizational design efforts. We will present these recommendations at the Board meeting.

As most of you heard at the Board briefing and at the Resource Group on Organizational Design Meeting this past weekend in Chicago, the Committee recommends an integrated organizational design which is intended to be more relevant to the members' pressing needs for the future. These recommendations are designed to build upon the Academy's existing strengths and to take proactive steps so that ophthalmologists and the specialty can lead eye care delivery. The desired outcome of the design is to develop a new organization which is ready for the problems and challenges of a rapidly changing world for ophthalmology.

A number of controversial concerns were referred to the Committee, including those which caused significant strife between the Board and the Council last year. The Committee has made its best efforts to resolve these concerns in the context of an optimal organizational design. The desire for broader member input, democratic participation and open communications is emphasized in the new design recommendations. In addition, the fundamental principles of leadership and efficient decisionmaking which are needed for expedient and orderly response have been followed.

It has been a lengthy and arduous process. I wish to commend all the members of the Ad Hoc Committee on Organizational Design for dedicating their extraordinary efforts, time and excellent ideas to this effort. The committee members included Drs. David Durfee, Dunbar Hoskins, Monica Monica, Steve Obstbaum, Mike Redmond, Ron Smith, David Townes, Ken Tuck, Nick Vincent and Bob Waller. We came from virtually all segments of ophthalmology practice and often had differing viewpoints and experiences. Everyone was extremely collegial and open minded. Our ultimate recommendations were unanimous in nearly every instance. The final recommendations were unanimously endorsed by the Committee. Gratitude is also due to all of those who contributed their ideas to the process, particularly the Board, the Council and other members of the Resource Group on Organizational Design.

The Committee met immediately after the Resource Group Meeting in Chicago to consider comments made at the meeting. While there was clearly a great deal of support for the overall organizational design, there were also some significant concerns raised, particularly about the recommendations relating to Advisory Councils. The Committee reviewed and discussed these concerns at length, and revised parts of its draft report. While we have not changed our primary recommendations, we would strongly recommend that the Board of Directors continue to obtain comments and feedback on these and other concerns from the Council, Resource Group and other members.

In addition, the Committee also recommends that the Board give consideration to the issue of ophthalmic relations as an integral part of the overall organizational design. The Committee spent much time discussing the importance of strengthening relations with members and ophthalmologic groups, such as state societies, subspecialty societies, other national ophthalmologic groups, and organized special interests among the membership. The Committee agrees that this function was very critical for furthering unity within the profession and recommends that the Board specifically address how to enhance ophthalmic relations as part of its strategic planning.

I know that all of you will thoughtfully consider the recommendations in this report. I look forward to hearing your responses. I speak for myself as well as the rest of the members on the Ad Hoc Committee on Organizational Design when I state that we stand ready to assist you and to help answer your questions.

American Academy of Ophthalmology
Ad Hoc Committee on Organizational Design

Committee Report

Part 1: Executive Summary

In September 1991, the Board of Directors of the American Academy of Ophthalmology established an Ad Hoc Committee on Organizational Design with the following charge:

to recommend to the Board of Directors by June 1992 any changes in Academy organizational structure and function necessary to assure effective pursuit of its mission and implementation of its Strategic Plan.

This action came in response both to some specific issues that had been raised related to governance of the Academy and to general concern about whether the current Academy structure and processes would serve the organization well in the future.

Immediate Past President George W. Weinstein, MD was named to chair the Committee. In November, he sent a mailing to Academy leaders asking them to suggest members to serve on the Committee and on a larger Resource Group that would provide input to the organizational design process. The Committee and Resource Group met first in January 1992, initiating a process described in more detail in Attachment A.

To provide perspective for organizational design, the Committee evaluated the future health care environment and assessed the wants and needs of various constituent groups that will be most critical to the future of the Academy (Attachment B contains report of surveys and research for organizational design activities). It also solicited ideas and comments on an ongoing basis from not only the Resource Group but also other leaders of the Academy and state and national ophthalmologic organizations.

One conclusion reached by the Committee based on the research is that there is both an opportunity and a need for ophthalmology to provide greater leadership for eye care. The Committee recommends that ophthalmology and the Academy work to shape the future of eye care delivery in the United States. This leadership role will require a greater emphasis within the Academy on socioeconomic research and strategic planning. To be effective, the Committee believes the Academy must be more future oriented and more proactive. It specifically recommends that the Board, Secretariats and staff focus more of their time and energy on strategic planning.

It is also clear that the Academy cannot shape the future of eye care by itself. It will need to communicate and work more closely with state, subspecialty and other national ophthalmologic organizations and strive for greater **unity within ophthalmology**. The Committee recommends that the Academy establish a Secretariat to focus on helping to develop state societies of ophthalmologists, which have a critical role to play in the future.

To lead eye care effectively, the Committee believes that the Academy must also look beyond ophthalmology and establish close working **relationships with outside groups**, including other key eye care organizations, other physicians, government leaders, third parties, public advocates, etc. Only if we are working with other interested parties and decision makers toward common goals are we likely to be successful.

One major issue addressed by the Committee was the tension between the Academy's traditional commitment to **clinical education** and the growing demand that it devote more resources to **political and socioeconomic activity**. The Committee considered suggestions that separate organizations be formed to focus on each of these two major functions. However, it agreed to recommend that ophthalmology would be better served by **one unified organization** handling educational, socioeconomic and political activities.

The Committee recognized the need to **enhance advocacy** for ophthalmology, not only to federal and state governments, but also to third parties, the rest of medicine, the public and other decision makers and groups that influence access and payment for eye care. It is clear that the environment for ophthalmic practice will change dramatically no matter how effective we are as advocates and that the Academy needs to do much more to **help members prepare** for these changes. At the same time, the Committee believes that it is critical that the Academy continue its commitment to **excellence in clinical education** as a top priority. It therefore recommends that the Academy's programmatic activities focus on the following **three major functions: clinical education, ophthalmic practice and advocacy**. The Committee specifically recommends that Senior Secretaries be elected to take ongoing responsibility for leading each of these three functions, and that the current Secretariats and Committees be reorganized to report to these Senior Secretaries.

Another major issue addressed by the Committee is: Who should have ultimate responsibility for leading, directing and controlling the Academy? Based on extensive review of a wide variety of possible governance models, both within and outside of medicine, the Committee concluded that the Academy should have a **single governing body**. With the rapidly changing environment, it has been demonstrated that neither a large body, such as a House of Delegates, nor dual governing bodies with shared authority can make decisions on a timely basis or lead an organization effectively. The Committee recommends that the governing body be a **Board of Trustees**, which would focus on strategic planning and major policy issues, as well as oversight of management and operations. The Board would include three **external Trustees** selected from among the leaders in government, third parties, ophthalmic industry, etc. who could provide a broad and unbiased perspective to its deliberations.

At the same time, the Committee believes that the Academy must create more effective ways to obtain **input into policy making** from individual members, from groups of members with shared interests, and from state, subspecialty and other national societies. There should be clearly defined mechanisms for **informal input** throughout the year from as many sources as possible. There should also be a coordinated process for obtaining **formal input**, research and analysis, and development of proposals for consideration by the Board.

The Committee recommends that the Academy have **two or more Advisory Councils** charged with facilitating input to the Academy from groups of members and with enhancing two-way communications and cooperation between the Academy and those groups. Initially, there would be one **Advisory Council for State Societies** and one **Advisory Council for Subspecialty Societies and Specialized Interests**. The diverse interests of state societies, and subspecialty and other specialized interests would be served through identifying their specific needs in separate forums. Suggested responsibilities for these Advisory Councils and descriptions of how members and leaders would be elected are included in the detailed recommendations.

The Committee also recommends that an **Issue Analysis Group** be formed with representatives from the Advisory Councils and Secretariats to coordinate research and analysis and development of proposals for dealing with issues referred by the Board. The Board is also encouraged to establish **ad hoc advisory committees and resource groups**, similar to those that have worked on organizational design, to focus on specific issues and concerns. The Committee recommends establishing a **leadership development program** and generally increasing opportunities for **membership involvement and participation** in the organization.

With regard to governance processes, the Committee recommends that all Academy members on the Board of Trustees be elected by the **full voting membership of the Academy by mail ballot**, with the exception of the Executive Vice President, who would be appointed by the Board. The Nominating Committee would nominate four individuals for the two **Trustee-At-Large** positions to be filled each year and one individual for **President-Elect** and the other Board positions with more specific responsibilities and qualifications.

The Committee recommends that the Academy **Bylaws** be streamlined to describe only the essential items relevant to the membership, and that a **Rules and Procedures Manual** be developed that describes functions and processes that may need to be changed more often. Bylaws changes would also be approved by the **full voting membership by mail ballot** following discussion at the Annual Business Meeting, with pro and con arguments included in the materials mailed to members. The Committee believes the use of a mail ballot will give more members a voice in the Academy than is possible at the Annual Business Meeting.

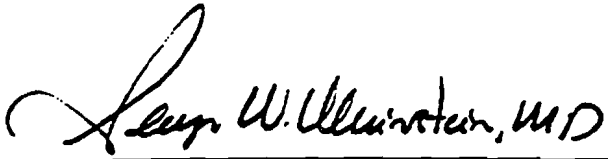
The last page of the summary is a simplified diagram which shows the major elements of the recommended organizational design.


The Committee's recommendations on other issues referred to it and more details with regard to the recommendations summarized above are included in the detailed recommendations in Part 2.


Report of the Ad Hoc Committee on Organizational Design
Part 1: Executive Summary


6/10/92

The draft report of the Ad Hoc Committee on Organizational Design was approved
by the full committee on June 7, 1992:



George Weinstein, M.D.

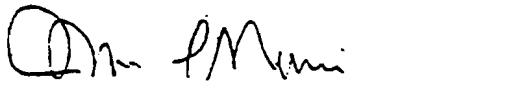

Ronald E. Smith, M.D.



David A. Durfee, M.D.



David E. Townes, M.D.


H. Dunbar Hoskins, M.D.

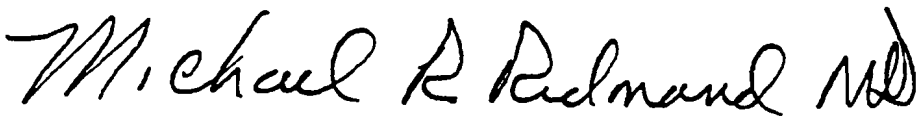

Kenneth D. Tuck, M.D.


Monica L. Monica, M.D.

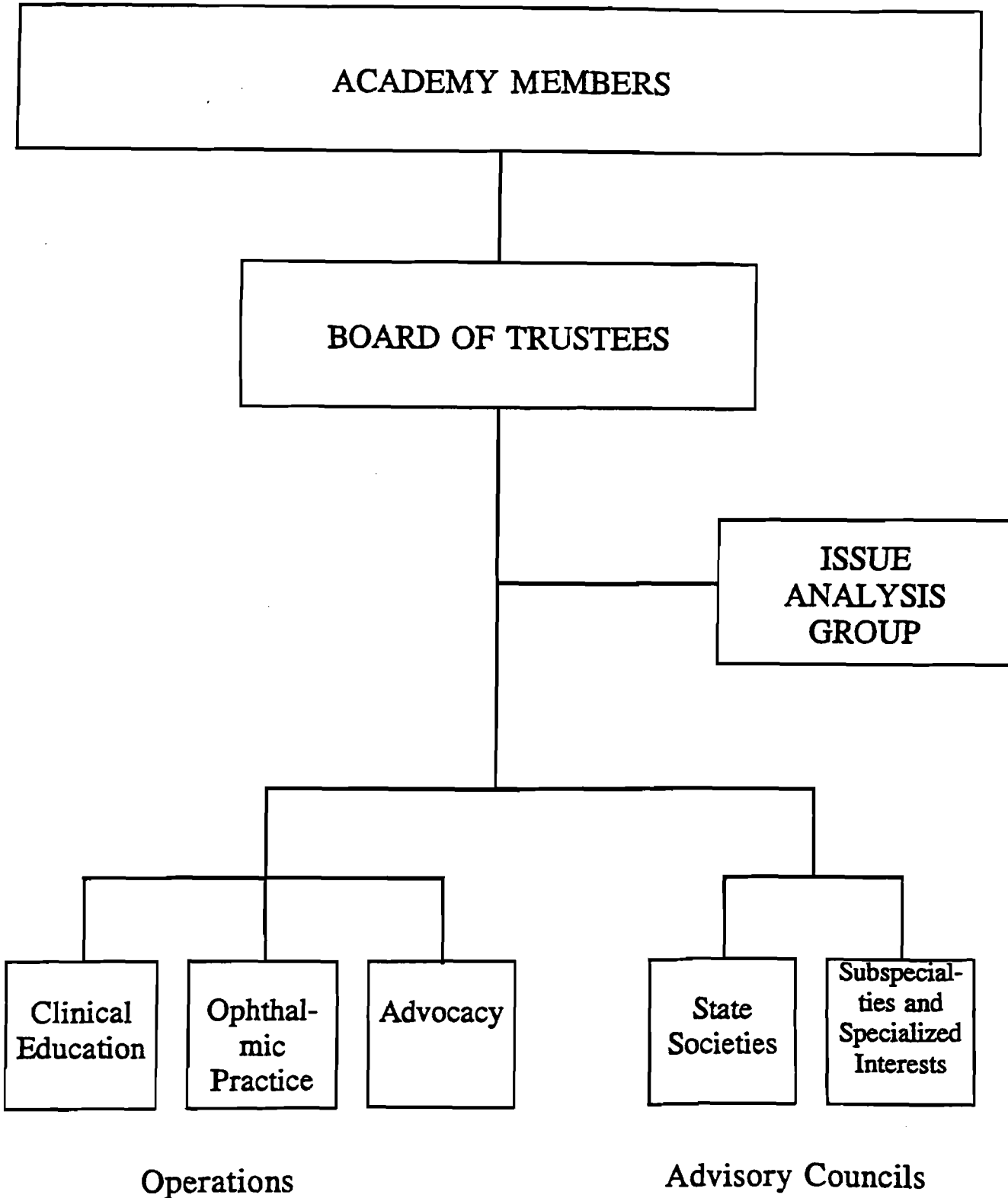

Nicholas J. Vincent, M.D.


Stephen A. Obstbaum, M.D.


Robert R. Waller, M.D.


Michael R. Redmond, M.D.

PROPOSED ORGANIZATIONAL STRUCTURE



American Academy of Ophthalmology
Ad Hoc Committee on Organizational Design

Committee Report

Part 2: Detailed Recommendations

This part of the Committee report lists the detailed recommendations of the Committee with regard to each part of the organizational design process. Definitions, explanations and rationales are included where appropriate in italics.

Future Directions and Primary Functions for Ophthalmology

1. Future Directions for Ophthalmology:

(To provide perspective for organizational design of the Academy, the Committee evaluated the future environment for eye care and the needs of various constituent groups. The results of this research are reported in an earlier Committee report. The research provided perspective for assessing possible future directions for the specialty of ophthalmology. Obviously, the Academy cannot decide on such directions unilaterally, but must seek to develop consensus with other organizations and individual ophthalmologists. Still, the Committee feels that it is appropriate to make recommendations regarding the future of ophthalmology for consideration by the Academy and other groups.)

The Ad Hoc Committee on Organizational Design recommends that:

- * 1a. The specialty of ophthalmology in the United States strive to shape the future of eye care delivery.
- * 1b. Ophthalmology serve as the leading advocate for the public with regard to their eyes and vision.
- * 1c. Ophthalmology serve as the leader of eye care at the national, state, community and practice levels.

* Primary recommendations are marked by an asterisk.

2. Primary Functions of Ophthalmology:

(For ophthalmology to fulfill the leadership role defined above, the Committee considered what the major, continuing functions of the specialty should be and what organizations and groups should have responsibility for carrying out these functions. The Committee sent a mailing to the Resource Group and leaders of national and state ophthalmologic societies asking for their opinions on responsibilities for the functions of ophthalmology. A composite of the results is shown on page 3).

The Ad Hoc Committee on Organizational Design recommends that:

2a. The following major functions be defined for the specialty of ophthalmology in the United States:

- Clinical Research
- Clinical Education:
 - ▶ Of Ophthalmologists
 - Residents and fellows
 - Continuing medical education
 - ▶ Of medical students
 - ▶ Of other physicians
 - ▶ Of allied health providers
- Certification of Ophthalmologists
- Definition and Promulgation of Quality and Ethical Standards
- Socioeconomic Research and Planning:
 - ▶ Assessment of Public Needs
 - ▶ Planning for Eye Care
 - ▶ Planning for the Future of Ophthalmology
 - ▶ Policy Development
- Socioeconomic Education: (about the environment and practice)
 - ▶ Of ophthalmologists
 - ▶ Of those who work with ophthalmologists
- Delivery of Eye Care (patient care)
- Public Service
- Advocacy: (for the specialty and for the public)
 - ▶ Government Relations
 - ▶ Third Parties Relations
 - ▶ Relations with the Rest of Medicine
- Public Information
- International Liaison (with regard to research, education and patient care)

- * 2b. The Academy work with other ophthalmic organizations and members to develop consensus on relative responsibilities for different primary functions of ophthalmology, along the lines indicated in this chart:

Primary Function	AAO	Other Nat. Orgs.	State Soc.	Local Soc.	Incl Ophth
Clinical Research	X	LXXX			XX
Clinical Education	LXXX	XX	X	X	X
Certification of Ophthalmologists	XX	LXXX			
Definition and Promulgation of Quality and Ethical Standards	LXXX	X	XX	XX	XX
Socioeconomic Research and Planning	LXXX	X	XX		X
Socioeconomic Education	LXXX	X	XX	X	
Delivery of Eye Care	LXX	X	XX	X	XXX
Public Service	LXXX	X	XX	XX	XX
Advocacy: - Federal Govt.	LXXX	XX	X		X
- State Govt.	LXX		XXX	XX	X
- Third Parties	LXX	X	XXX	XX	XX
- Rest of Medicine	LXXX	X	XX	XX	XX
Public Information	LXXX	XX	XX	XX	XX
International Liaison	LXXX	XX			X

Key : L = Leadership role
 XXX = Primary responsibility
 for involvement

 XX = Major, critical involvement
 X = Some involvement, participation

- 2c. The Academy ask other organizations and individual members to commit to carrying out the responsibilities defined, providing that the Academy provides support to help them.
- 2d. A mechanism of accountability be established to assure that the organizations and individual members carry out the responsibilities to which they have committed.

(While these recommendations may seem to be outside the purview of the Committee, it believes that the Academy cannot be successful unless there is a clear understanding of its responsibilities vis-a-vis those of other organizations and individual members. In the past, there has been a tendency to assume that the Academy will deal with all problems confronting ophthalmology and ophthalmologists. That assumption has created unrealistic expectations among both members and other organizations: it is neither realistic nor practical, given the broad scope of activities, current number of organizations and different interests involved in ophthalmology, to expect the Academy to do everything.

The Committee believes that it is critical that responsibilities of the Academy, other organizations and individuals members be clearly defined and that there be a mechanism to assure that the organizations carry out these functions. Only if there is a clear agreement about who should be responsible for what is it realistic for ophthalmology as a specialty to achieve its goals for the future.)

Future Directions and Primary Functions for the Academy

3. Future Directions for the Academy:

(At the start of the organizational design process, the Committee circulated the Academy's Strategic Plan for comment. More than 100 responses were received, and the Plan and broad future directions for the Academy were discussed at the January conference. Based on that input, evaluation of the environment, assessment of the needs of constituents and consideration of future directions and primary functions for ophthalmology, the Committee considered broad directions for the future of the Academy.)

The Ad Hoc Committee on Organizational Design recommends that:

3a. The Academy reconfirm its mission:

The mission of the American Academy of Ophthalmology is to assure appropriate, affordable and accessible eye care for the public by serving the educational and professional needs of ophthalmologists.

(The Academy must serve not only its member ophthalmologists but also the public and the specialty of ophthalmology.)

- * 3b. **The Academy stimulate, lead and support ophthalmology's efforts to shape the future of eye care delivery in the United States and to establish ophthalmology as the leader of eye care and as advocate for the public.**
- * 3c. **The Academy develop consensus on a vision for eye care in the future and define an improved system of eye care delivery.**
- 3d. **The Academy work to develop consensus on a clear definition of ophthalmology and to promote broad understanding and acceptance of that definition among providers, consumers and decision makers.**
- 3e. **The Academy provide leadership, support and coordination of the following functions of ophthalmology in the United States:**
 - **Clinical Education**
 - **Definition and Promulgation of Quality and Ethical Standards**
 - **Socioeconomic Research and Planning**
 - **Socioeconomic Education**
 - **Delivery of Eye Care**
 - **Public Service**
 - **Advocacy:**
 - ▶ **Government Relations**
 - ▶ **Third Parties Relations**
 - ▶ **Relations with the Rest of Medicine**
 - **Public Information**
 - **International Liaison**
- * 3f. **The Academy become more proactive, anticipating the needs of members and other constituent groups, defining clear goals for the future and taking action to assure that those goals are accomplished.**
- 3g. **The Academy not only provide support to members and help to meet their needs but also strive to lead and activate individual members.**
- * 3h. **The Academy develop more and better ways to obtain input from, and foster two-way communications with, individual members, state societies, subspecialty and other national societies, and all segments of the membership.**
- * 3i. **The Academy implement a leadership development program and increase opportunities for member involvement and participation in the organization.**
- 3j. **The Academy work toward unity within ophthalmology.**

- * 3k. The Academy lead, activate and help develop state societies of ophthalmologists, as well as providing support and addressing their needs.
- * 3l. The Academy communicate and interact more effectively with subspecialty societies and other national organizations of ophthalmologists.
- 3m. The Academy recognize regional, local and city ophthalmologic societies and encourage them to work in cooperation with state societies where appropriate.
- 3n. The Academy encourage the organization of ophthalmologists at the appropriate levels (regional, state or local) where they can be most effective. (For example, where states are very small (e.g. Wyoming) it may be more effective for several states to organize regionally. Where states are large (e.g. California) local or regional organizations within the state may be needed, in addition to statewide organizations.)

4. Primary Functions of the Academy:

(Based on its consideration of future directions for the Academy and the Strategic Plan, the Committee attempted to define what the primary functions of the organization should be. This is necessary in order to recommend the structure and processes required to carry out those functions.)

One Organization:

(The Committee recognized that, since the merger with the American Association of Ophthalmology in 1981, the Academy has taken responsibility for both educational and socioeconomic/ political functions. This has created significant conflict in terms of allocation of resources: as environmental forces have greater impact on the practice of ophthalmology, there is inevitable pressure to shift resources from educational to socioeconomic/political activities. Some leaders and members have expressed fears that, faced with this pressure, the Academy would de-emphasize education and therefore move away from its greatest strength. Concerns have been expressed that it will become mainly a political organization and will therefore lose the strength of membership, credibility and influence it now has as a prestigious, educational organization.

(The Committee has also recognized that the Academy is really a hybrid of an educational organization (the old Academy) and a political one (the old Association) and that different organizational structures and processes may be appropriate for educational and political organizations. Some have suggested that separate organizations be formed, one to handle education and one to deal with socioeconomic/ political functions. The Committee carefully considered the pros and cons of this option, and agreed that ophthalmology would be better served by one organization in which these functions are integrated.)

The Ad Hoc Committee on Organizational Design recommends that:

- * 4a. The Academy continue to handle educational and socioeconomic/political functions within one organization, recognizing that different kinds of structures and processes may be needed to carry out different functions.
- * 4b. The Academy work to increase its effectiveness at socioeconomic and political activities while maintaining its commitment to excellence in clinical education.

Primary Programmatic Functions:

- * 4c. Three primary programmatic functions be defined for the Academy:
 - clinical education
 - ophthalmic practice
 - advocacy.
- 4d. That the goals (i.e. broad results to be achieved) for each of these functions be defined as follows:

Clinical Education: to help ophthalmologists and professionals who work with them obtain the clinical knowledge, attitudes and skills necessary to provide optimal eye care to the public.

Ophthalmic Practice: to define what constitutes appropriate, ethical eye care and to enable ophthalmologists to provide high quality, comprehensive, cost-effective care to their patients.

Advocacy: to establish ophthalmology as the most respected advocate for quality eye care with the government, third parties, the public and other decision makers.

- 4e. That the following major activities/programs be included under each of these functions:

Clinical Education:

- Of Ophthalmologists
 - Of Residents and Fellows
 - Of Practicing Ophthalmologists
- Of Medical Students
- Of Other Physicians
- Of Allied Health Personnel

Ophthalmic Practice:

- Practice Management:
 - ▶ Socioeconomic education of members about
 - how to practice efficiently
 - the future environment
 - dealing with managed care
 - how to be an advocate, a leader, etc.
 - ▶ Definition of Practice Models
 - ▶ Emphasis on primary eye care and comprehensive ophthalmology
 - ▶ Membership services related to practice
- Ethics
- Quality of Care
- Coding, Terminology
- Assessment of New Procedures
- Evaluation of New Technology

Advocacy:**Federal Government Relations**

- State and Local Government Relations
- Relations with Third Parties
- Relations with Medicine
- Relations with Ophthalmic Industry
- Public Information
- Public Service

(The activities and programs may change from time to time, but the three major functions are expected to remain the same.)

Ophthalmic Relations:

- * 4f. That another major function of the Academy be the enhancement of relationships with members and other ophthalmic organizations.

(If ophthalmology is really going to "shape the future of eye care delivery in the United States," the Academy cannot do this alone. It will require coordinated, proactive efforts by the Academy and other national, state and local organizations and individual members to achieve this. Therefore, a major function of the Academy will need to be enhancing relationships with these groups.)

- 4g. That the goal of this function be defined as follows:

Ophthalmic Relations: to work toward unity within ophthalmology and cooperation among all those involved with eye care through proactive efforts to enhance relationships with members and other ophthalmic organizations and providers.

4h. That the following activities be part of this "ophthalmic relations" function:

- Relations with members in general and groups of members with special interests (including national organizations of ophthalmologists other than subspecialty societies)
- Relations with state ophthalmologic societies
- Relations with subspecialty societies
- Relations with other ophthalmic organizations and providers (including public service organizations, organizations of allied professionals, etc.)

Socioeconomic Research and Strategic Planning:

* 4i. Socioeconomic research and strategic planning receive much greater emphasis throughout the Academy in order to stimulate and help the organization to be more proactive.

4j. The goal of this activity be defined as follows:

Socioeconomic Research and Planning: to obtain and analyze information and data needed and to define the strategies and plans required for ophthalmology to serve as the primary advocate for the public and leader of eye care.

4k. That socioeconomic research and strategic planning include such activities as:

- assessment of the needs of the public, third parties, purchasers, government, industry, etc.
- assessment of the needs of ophthalmologists, state societies, subspecialty and other national societies, etc.
- market research
- stimulation of clinical research to meet the needs of the public
- sponsorship of socioeconomic research on how to meet the needs of the various constituents
- definition and testing of possible alternative systems for the provision of eye care
- development and testing of models for ophthalmologists' practices
- exploration of strategic alliances with other interests within and outside of eye care
- development of proposed policies, strategies and possible programs.

4l. That the relevant governance, management and operational groups within the Academy specifically be assigned responsibility for both socioeconomic research and strategic planning related to their area of responsibility.

4m. That the Executive Vice President be asked to establish a staff unit that will:

- coordinate broad research and planning efforts for ophthalmology and the Academy, and
- provide support for the efforts of individual Groups, Secretariats and Committees, including assessment of the needs of constituent groups.

(In addition to the functions listed above, the Committee recognizes that there are other functions of the Academy, including those carried out as part of governance and management. These functions are addressed in later sections of this report.)

Operational Structure

(The Committee recognizes the importance of distinguishing among the following major groupings of Academy activities:

- *governance*
- *management*
- *operations.*

Governance is a system of structures, mechanisms and processes that provide leadership and direction for an organization.

Management consists of the chief executive officer and other individuals and systems responsible for assuring that the directions and policies established by governance are carried out.

Operations encompasses those groups and individuals who implement the policies and programs of the organization. In the current organizational structure, operations includes the Secretariats, Committees and staff departments devoted to carrying out Academy programs.

This section of the report focuses on operations. Subsequent sections focus on governance and management.)

5. Operational Structure:

The Ad Hoc Committee on Organizational Design recommends that:

- * 5a. the Academy redefine its physician operational structure as follows:

CLINICAL EDUCATION GROUP:

Senior Secretary for Clinical Education

Secretary for Continuing Education

Secretary for Instruction

Secretary for Annual Meeting

Editor for Ophthalmology

OPHTHALMIC PRACTICE GROUP:

Senior Secretary for Ophthalmic Practice

Secretary for Quality of Care

Secretary for Practice Management

Committee on Managed Care

Committee Chair of Ethics*

ADVOCACY GROUP:

Senior Secretary for Advocacy

Secretary for Federal Affairs

Secretary for State Affairs

Secretary for Public Service and Information

Committee Chair of Third Party Advocacy**

Committee Chair of Relations with Medicine**

Committee Chair of Relations with Industry**

* Committee Chair of Ethics reports to Board but is administratively placed in Ophthalmic Practice Group.

** Committee chairs report to the Senior Secretaries but chair committees, not Secretariats.

Position	Charge (related to Strategic Plan Goals)	Primary Responsibilities	Committees
<i>Senior Secretary for Clinical Education</i>	To help ophthalmologists and professionals who work with them obtain the clinical knowledge, attitudes and skills necessary to provide optimal eye care to the public.	To provide broad planning, leadership, organization, and oversight of Academy educational activities and materials and to chair the COS for Education.	• <i>Committee of Secretaries for Clinical Education</i>
Secretary for Continuing Education	To promote the provision of high quality, comprehensive eye care through continuing medical education to ophthalmologists in practice.	To assess the clinical educational needs of ophthalmologists; to plan and develop new, quality educational programs which meet the needs of ophthalmologists in practice; to coordinate and oversee ongoing educational activities; to monitor the effectiveness and to update existing educational materials in order to maintain their quality and relevance.	• Self-Assessment; • COVE; • Focal Points; • Ophthalmology Monographs; • POACE; • Regional Update Courses; • Special Focus/Skills Transfer Courses
Secretary for Instruction	To advance the basic understanding of ophthalmology through education of medical students, ophthalmology residents and fellows in training, other physicians in training and practice and allied health personnel.	To assess the clinical educational needs of medical students, residents, fellows, other fellow physicians and allied health personnel; to plan and develop programs to meet these needs; to coordinate and oversee ongoing educational activities; and to update materials in order to maintain their quality and relevance.	• BCSC; • Medical Student Education; • OKAP; • Resident & Fellow Education; • Professional Liaison • Allied Health Educ.
Secretary for Annual Meeting	To provide the best opportunity for ophthalmologists to update their knowledge and skills, and to see demonstrations of latest innovations at the Annual Meeting.	To assess the educational needs of members that can be met at the Annual Meeting; to select, organize, oversee and evaluate the educational opportunities at the AM, both clinical and nonclinical.	• Program Advisory • Skills Transfer Adv.; • Instruction Adv.; • Laser & Light Hazards
Editor for <i>Ophthalmology</i>	To promote the spread of knowledge about scientific advances to ophthalmologists through broad dissemination of research findings in a peer-reviewed journal.	To assess needs for dissemination of information; to evaluate, select and organize articles of scientific merit and relevance; and to oversee the production of <i>Ophthalmology</i> .	• Editorial Advisory

(italicized text in following tables indicate new or renamed committees or Secretaries)

Position	Charge (related to Strategic Plan Goals)	Primary Responsibilities	Committees
<i>Senior Secretary for Ophthalmic Practice</i>	To define what constitutes appropriate, ethical eye care and to enable ophthalmologists to provide high quality, comprehensive, cost-effective care to their patients.	To provide broad planning, leadership, organization, and oversight of Academy ophthalmic practice activities and materials, and to chair the COS for Ophthalmic Practice.	<ul style="list-style-type: none"> • <i>Committee of Secretaries for Ophthalmic Practice</i>
<i>Secretary for Quality of Care</i>	To define, promote and defend what constitutes quality eye care.	To assess needs to assure quality eye care to the public; to develop a comprehensive program for Academy leadership in quality of care guidelines and standards for ophthalmology and acceptance of this role by members; to develop, monitor and oversee quality of care and clinical effectiveness initiatives; and to update existing materials in order to maintain their relevance.	<ul style="list-style-type: none"> • <i>Quality of Care;</i> • <i>Ophthalmic Procedures Assessment;</i> • <i>Ophthalmic Instrument & Device Standards;</i> • <i>New Technology Assessment</i>
<i>Secretary for Practice Management</i>	To help ophthalmologists to acquire the skills needed to lead eye care teams and to provide comprehensive eye care efficiently in a changing environment.	To assess members' needs for nonclinical information and skills which will help them adapt and be successful in their practices; to develop a comprehensive practice management program that enables members to obtain necessary knowledge, skills and attitudes; to help members deal with and negotiate with third parties; to monitor, oversee and evaluate existing practice management programs and services; and to update existing materials and activities in order to maintain their relevance.	<ul style="list-style-type: none"> • <i>Practice Management;</i> • <i>Coding and Terminology;</i> • <i>Managed Care and Third Parties</i>
<i>Committee Chair of Ethics</i>	To serve the best interests of patients by advancing ethical knowledge, skill and behavior for ophthalmologists.	To develop an educational program pertaining to the Code of Ethics; to develop and update materials and guidelines on ethics; to administer the Code of Ethics, consider inquiries and challenges regarding ethics, and make recommendations for actions to the Board directly; and to evaluate the Principles, Rules and Administrative Procedures for Ethics periodically.	<ul style="list-style-type: none"> • <i>Ethics</i>

Position	Charge (related to Strategic Plan Goals)	Primary Responsibilities	Committees
<i>Senior Secretary for Advocacy</i>	To establish ophthalmology as the most respected and effective advocate for quality eye care with government, third parties, the public and other decisionmakers.	To provide broad planning, leadership, organization and oversight of Academy advocacy activities and materials, and to chair the COS for Advocacy.	<ul style="list-style-type: none"> ● <i>Committee of Secretaries for Advocacy</i>
<i>Secretary for Federal Affairs</i>	To establish ophthalmology as the advocate for quality, cost-effective eye care to the federal government.	To assess the needs of the federal government; to develop a comprehensive strategy for enhancing advocacy and communication to the federal government; to coordinate, evaluate and oversee existing ongoing advocacy activities; and to educate ophthalmologists in political action activities.	<ul style="list-style-type: none"> ● <i>Federal Economic Policy (HCFA);</i> ● <i>Research & Regulatory Agencies;</i> ● <i>Federal Health Manpower</i>
<i>Secretary for State Affairs</i>	To help state societies establish ophthalmology as the advocate for quality, cost-effective eye care to state governments.	To assess the needs of state governments; to develop a plan for advocacy to state governments; and to provide support for society development.	<ul style="list-style-type: none"> ● <i>State Affairs;</i> ● <i>State Society Development</i>
<i>Secretary for Public Service and Information</i>	To develop public service programs to address unmet public needs and to inform the American people about the prevention and treatment of eye problems and the role of ophthalmologists in providing eye care.	To assess public needs for eye care and information, and identify unmet needs; to develop a comprehensive plan for public service and education; to develop new programs to meet these needs; and to coordinate, monitor and oversee existing activities in public service and education.	<ul style="list-style-type: none"> ● <i>Public Service;</i> ● <i>Public Information;</i> ● <i>Eye Safety & Sports Ophthalmology;</i> ● <i>Media Information;</i> ● <i>Public Health;</i> ● <i>Indigent Care</i>
<i>Committee Chair for Third Party Advocacy</i>	To establish ophthalmology as the advocate for quality, cost-effective eye care to private third parties and managed care plans.	To establish relations with major private third parties; to foster relations on local levels; to use data on quality & efficacy of ophth. led services.	<ul style="list-style-type: none"> ● <i>Third Party Advocacy</i>
<i>Committee Chair for Relations with Medicine</i>	To establish close, mutually supportive working relationships between ophthalmology and the rest of medicine.	To share information and be involved in issues of mutual concern in medicine; to develop alliances for support and help states develop relations.	<ul style="list-style-type: none"> ● <i>Relations with Medicine</i>
<i>Committee Chair for Relations with Industry</i>	To establish a relationship with other groups involved in the ophthalmic industry in order for the Academy to be more aware and informed of external developments.	To identify major ophthalmic groups and their representatives; to define areas of shared interest; and to develop relations for exchange of information, input and possible cooperation.	<ul style="list-style-type: none"> ● <i>Relations with Industry</i>

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- * 5b. Specifically, that the position of **Senior Secretary** be created, with overall responsibility for each major programmatic function: clinical education, ophthalmic practice and advocacy, and with the following responsibilities relevant to their functions:
- obtain input from members, state and subspecialty societies and other groups, both within and outside of ophthalmology;
 - assess the needs of members and other constituents;
 - conduct socioeconomic research and develop programs as necessary to support the Academy's leadership with regard to the function;
 - coordinate strategic planning for the function (e.g. advocacy) and for the programs that fall within the function
 - coordinate activities among the Secretaries within the Group and with others outside the group
 - assure effective communications with members and others both within and outside of ophthalmology
 - evaluate the programs and activities that fall under the program periodically and modify as needed.
- 5c. Each **Senior Secretary** be responsible for overseeing and coordinating the work of **Secretaries and Committee Chairmen**, who would have responsibility for the major activities/ programs that fall under that function.
- 5d. **Secretariats** be established only for major continuing programmatic activities of the Academy that have two or more significant subdivisions. (Programs that are not major or do not have significant subdivisions would be handled by Committees.)
- 5e. The **Senior Secretaries** be designated in the Bylaws and elected by the members, but that the Board have the authority to create or eliminate Secretariats and Committees as needed.
- 5f. The **Senior Secretaries** and the **Secretaries and Committee Chairs** who report to them be referred to collectively as **Groups** (e.g. the Ophthalmic Practice Group), with each Group meeting together as needed.
- * 5g. Specifically, that a **Secretariat for State Affairs** be established and charged with responsibility for helping state ophthalmologic societies develop stronger organizations and serve as effective advocates at the state and local levels.

5h. That the **ophthalmic relations** function and the following activities should be referred to the Board for determining how this should be carried out within the new operational structure: (See recommendations 4f to 4h.)

- Relations with members in general and groups of members with special interests (including national organizations of ophthalmologists other than subspecialty societies)
- Relations with state ophthalmologic societies
- Relations with subspecialty societies
- Relations with other ophthalmic organizations and providers (including public service organizations, organizations of allied professionals, etc.)

(The Committee believes that obtaining input from these groups through Advisory Councils and other means is not enough to assure strong relations with these groups. The Committee feels that one or more groups within the operational structure should be charged with assessing the needs of various constituents and defining proactive strategies and plans for strengthening relations with them.)

5i. The Board direct the Executive Vice President and Senior Secretaries for Advocacy and Ophthalmic Practice to define how responsibilities for relations with third parties should be divided up between the Advocacy and Ophthalmic Practice Groups. (The Committee believes the Advocacy Committee on Third Party Advocacy should focus on educating third parties about the benefits of ophthalmologic care, and the Ophthalmic Practice Committee on Managed Care should focus on helping individual members deal with third parties. However, coordination between these two groups is critical and a certain amount of overlap between the two Committees might be helpful.)

(The Committee recognizes that different kinds of organizational structures and processes are likely to work best for clinical education, ophthalmic practice and advocacy. For example, clinical education may be handled well with a traditional committee structure, but advocacy may require much more input from other organizations and outside of ophthalmology.)

* 5j. Senior Secretaries be charged and held accountable for defining and maintaining mechanisms and processes appropriate to their function to obtain input from and consider the needs of:

- members in general and members with special interests
- state societies
- subspecialty societies
- other ophthalmic organizations and professionals.

(The staff unit responsible for Research and Planning would provide support for these activities.)

- 5k. For each part of the structure (e.g., Secretariat, Committee) the outcomes to be achieved be defined clearly, i.e. its charge, how it relates to the Strategic Plan, major goals and objectives, responsibilities and plans.
- * 5l. For each position in the structure (e.g., Senior Secretary, Secretary, Committee chairman, Committee member), there be a specific description of the responsibilities of that position and the qualifications (knowledge, experience, skills) necessary to fill that position.
- 5m. The Executive Vice President be charged to work with the Senior Secretaries and staff to define and recommend to the Board specific organizational structures and processes for clinical education, ophthalmic practice and advocacy, covering the Secretariats and Committees that fall under each. (These structures would include charges, responsibilities, qualifications, mechanisms for input, etc.)
- * 5n. A well-defined, ongoing leadership development program be established to identify potential leaders and help them obtain the experience and skills needed to fill these positions:
- there be a clear ladder or route defined to top leadership positions in the Academy based on skills, abilities and accomplishments (e.g. serve in the state society, then on an Academy advisory body, then as a committee member, then as a Committee chairman, etc.)
- 5o. Selection of individual members to serve on Secretariats and Committees be based primarily on whether they have the skills, experience and record of accomplishment necessary to carry out the responsibilities and meet the qualifications defined for the position. (Other factors, such as demographics, should be taken into consideration, but should not be the primary consideration.)
- 5p. Appointment of members to Secretariats and Committees be handled as follows:
- Senior Secretaries recommend Secretaries and Committee Chairs who report to them to the Executive Committee and Board for approval
 - Secretaries recommend any Committee Chairs who report to them to Senior Secretaries, who in turn recommend them to the Executive Committee and the Board for approval
 - Committee Chairs recommend Committee members to their Secretary or Senior Secretary, who recommend approval to the Executive Committee and Board
 - The President-Elect recommend Chairs of Committees that don't report to Secretaries or Senior Secretaries to the Board for approval
- 5q. The Executive Vice President be directed to develop a staff operational structure and support services needed to support this physician operational structure.
- 5r. Secretaries be appointed for three-year terms with a maximum of two terms, and Committee Chairs be appointed for one-years terms with a maximum of five terms.

Governance

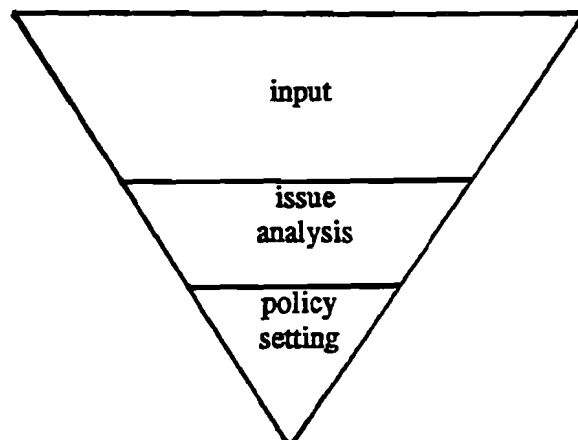
6. Governance Principles:

(As a basis for recommending governance structure and processes, the Committee first discussed principles that relate to governance.)

- * 6a. The governance structure should be **strategically driven** and look to the future, as well as addressing the current needs of members and constituent groups.
- * 6b. There should be multiple groups or bodies involved in policy development for the Academy, but one body ("the governing body") should have the **ultimate responsibility** for setting direction and policy and for control of the organization.

(In the rapidly changing environment, it is not possible to decide everything by consensus in a timely fashion and have an effective organization. With more than one body responsible for setting direction and policy, there is inevitable conflict, delay and inefficiencies. At the same time, it is appropriate for the governing body to delegate parts of governance and critical to have input from a variety of sources.)

- * 6c. There should be an organized and coordinated process for policy development within the Academy:
 - the process should have three components:
 - ▶ input,
 - ▶ issue analysis, and
 - ▶ policy setting
 - there should be:
 - ▶ as many sources of input as is practical;
 - ▶ a coordinated process for considering input, conducting research and analysis and recommending policy;
 - ▶ one group with final authority for setting policy:



Input:

- * 6d. There should be input into policy development from as many sources as possible within ophthalmology and the organization, including, but not limited to:
 - individual members
 - state ophthalmologic societies
 - all subsets and special interest groups within the membership (e.g. women ophthalmologists, young ophthalmologists)
 - regional and local societies
 - subspecialty societies
 - other national ophthalmologic organizations

- * 6e. The Academy should also obtain input to a much greater degree than currently from outside groups related to eye care, including:
 - industry
 - scientists
 - government officials
 - the rest of medicine
 - third parties
 - public service/public health organizations
 - allied eye care providers and their organizations
 - other eye care professionals and their organizations.

- 6f. Individual members and segments of the membership and shared interest groups should have opportunities to provide input directly, without having their input filtered through another group that does not share the same interests. (For example, retina specialists should be able to provide their input directly and not have it filtered through a group of different subspecialists.)

- 6g. This input from within and outside of ophthalmology should be obtained and considered at all levels of the organization: governance, management and operations.

- 6h. Operational groups (Secretariats and Committees) should define mechanisms and processes for obtaining input from appropriate sources within and outside of ophthalmology. (The mechanisms may be significantly different for different functions, e.g. advocacy versus clinical education.)

- * 6i. There should be ongoing formal mechanisms for the members, special interests among the members and state and subspecialty societies to have formal input on issues.

- 6j. It is appropriate to have advisory groups that provide input as a collection of shared interests (e.g. state societies or subspecialty societies):
 - it is helpful if these groups can develop consensus, but this should not keep the opinions of individuals and smaller interest groups (e.g. members in Wyoming) from reaching those who formulate policies;

- if all such groups (e.g. state societies, subspecialty societies, other member interests) meet together, it will be difficult to develop consensus, because their needs and interests are significantly different. Trying to get everyone to agree may actually increase conflict and divisiveness and prevent timely decision making.
 - advisory groups should provide their input directly to those responsible for formulating policy. Input should also be provided to the governing body when requested.
- * 6k. There need to be clear and visible mechanisms of two-way communications for members and others to express their concerns and receive a response.

Policy Formulation:

- * 6l. There should be a single, coordinated process for policy development, with the following components:
- solicitation and consideration of input
 - informal, but coordinated discussion and debate
 - research, analysis and development of proposals
 - formal discussion, deliberation, and debate
 - policy recommendations
 - policy setting.
- (If there are two or more policy development processes that are not integrated, this will result in duplication, conflict and lack of effectiveness.)*
- 6m. There should be a group with responsibility for coordinating the policy development process and recommending policy to the governing body.

Policy Setting:

- 6n. Because the organization must be able to react quickly and move rapidly, there should be a small group of leaders in whom the members and other groups place their trust: a smaller group tends to make decisions more efficiently than a larger one.
- 6o. The governing body should have the following primary responsibilities:
- leadership
 - strategic planning (also carried out by management and operations)
 - policy setting
 - oversight and evaluation of management.
- 6p. The governing body should not be directly involved in management or operations because this will divert its focus from leading the organization. It may want to delegate oversight and evaluation of management to an executive committee.

- 6q. The governing body may need advice on policy decisions from both inside and outside the organization. It should select the individuals and groups who provide advice.
- * 6r. **Conflicts and disputes** about policy should be resolved during the policy formulation process as much as possible. (The more that the governing body is involved in conflict, the less that it will be able to lead and the less effectively the organization will function.)
- * 6s. Leaders should be selected based on clearly defined **responsibilities and qualifications** for fulfilling those responsibilities.

7. Governance Structure:

(With the principles above in mind, the Committee considered a variety of possible models for governance structures.)

Advisory Councils:

The Ad Hoc Committee on Organizational Design recommends that:

- * 7a. The Academy have two or more **Advisory Councils** representing shared interests among the membership.

(The Committee believes that Advisory Councils are important for the organization to have a forum for constituent groups to provide their specific input into policy development in a formal manner).

- * 7b. Initially, there be:

- **An Advisory Council for State Ophthalmologic Societies, and**
- **An Advisory Council for Subspecialty Societies and Specialized Interests.**

(The Committee believes that the interests of state societies and the interests of subspecialty societies and specialized interests among the membership are very different. It seems most appropriate that input to the Academy be specific to each of these constituent groups, rather than be diluted in any way by other groups' conflicting interests. Otherwise, compromise positions are reached which do not fully represent one or the other constituency group's needs. As the specialty grows more specialized and diverse, the Academy can represent ophthalmology as a whole only if it can meet the specific needs of different groups within ophthalmology. The integration of specific and diverse interests is an appropriate function of governance. The desired outcome is for specific interests and needs among different groups in the membership to be identified in the policy development process. The Board's major task is to integrate these interests in the broader perspective of promoting the welfare of the entire membership.)

- 7c. In the future, consideration be given to forming additional Advisory Councils representing:
- individual members and groups of members with shared interests who have not created formal organizations
 - other organizations involved with eye care and allied eye care professionals.
- 7d. Criteria for participation of organizations in the Advisory Councils be recommended by the Councils and approved by the Board.
- * 7e. The charge of each Advisory Council be to facilitate input to the Academy from various ophthalmic organizations and groups of members and to enhance two-way communications and cooperation between the Academy and those groups.
- 7f. The authority, responsibilities and expectations of the Advisory Councils be clearly stated and understood, and the Councils be held accountable for carrying out those responsibilities and meeting the defined expectations.
- * 7g. Responsibilities of each Advisory Council include:
- solicit suggestions and comments from their respective organizations and constituency groups and provide input to the Board, Issue Analysis Group, Secretariats, Committees and staff;
 - initiate proposals to address the needs and problems of constituents as part of the Academy policy development process, and thereby give constituents a formal voice in the Academy;
 - respond to requests for input on specific issues from the Board, Issue Analysis Group, or individual Secretariats, Committees or the Executive Vice President;
 - serve as a two-way communication link between constituents and the Academy, letting the Academy know the needs and concerns of constituents and letting constituents know what the Academy is doing;
 - stimulate members and other societies and groups to support and implement Academy programs and policies;
 - support the Academy and work toward unity within ophthalmology and cooperation among eye care providers;
 - carry out other responsibilities that may be defined and approved by the Board (e.g. support development of state societies or implementation of specific programs);
 - recommend such rules and procedures as necessary for the conduct of their affairs to the Board for approval.

- 7h. Advisory Councils encourage, and in no way limit, input from individual members and societies directly to the Board and the relevant Secretariats, Committees and staff.
- * 7i. Individual Councillors and Advisory Councils as a whole provide informal input to the Board, Issue Analysis Group or individual Secretariats and Committees at any time during the year.
- * 7j. Advisory Councils provide formal input through the annual policy development process (See Governance Processes). As part of this process, the Advisory Councils:
- assess the needs of their constituents each Fall, with the help of Academy staff;
 - meet separately during the Annual Meeting to assess the environment and identify critical issues of their constituents;
 - participate in regional meetings in March and April along with the Board and other members to discuss the issues and possible ways to address them;
 - communicate the decisions made in this process to constituents;
 - encourage constituents to support the policies and programs that result.
- 7k. Advisory Councils be encouraged to focus on the future and to generate creative and innovative ideas.
- 7l. Each Advisory Council prepare an annual plan defining how it will carry out its responsibilities. (Management should both support and monitor implementation of the plan and adherence to the budget.)
- 7m. Like Secretariats and Committees, each Advisory Council submit an annual report in January stating what it accomplished the previous year. (The Executive Committee would review these reports along with other annual reports, make recommendations to the Board as necessary and provide feedback to the Advisory Councils.)
- * 7n. The Advisory Councils be composed of representatives of each of the constituent groups, following the same guidelines as the current Council.
- * 7o. Councillors serve two-year terms, with a maximum of two terms for a total of four years.

(The Committee believes that it is very important to provide a mechanism to allow more people to become involved in the Advisory Councils. The desired outcome would be greater member participation and development of more future leaders for the Academy and ophthalmological societies. This could be accomplished without sacrificing continuity by providing for a maximum tenure of 4 years for Councillors. An orientation and leadership training program would help new Councillors to be prepared and able to contribute as soon as possible in their initial term.)

7p. Councillors have clearly defined responsibilities and be held accountable for carrying out those responsibilities.

7q. Responsibilities of individual Councillors include:

- Actively assess and listen to the needs of constituent groups;
- Encourage constituents to report their needs and provide input directly to Board, Issue Analysis Group or specific Secretariats, Committees and staff;
- Also report needs themselves directly to the responsible individuals within the Academy at any time;
- Participate in Advisory Council meetings at the Annual Meeting and regional meetings in March/April, as part of the annual policy development process;
- Participate actively in meetings and other deliberations and activities of constituent groups (i.e. the groups they represent);
- Report to constituents on Academy policies, programs and activities;
- Encourage and stimulate constituents to support Academy policies and participate in Academy programs.

- * 7r. Councillors be elected by members of the constituent groups represented in that Council by mail ballot, based on a clearly defined list of responsibilities and qualifications, with re-election based on performance of those responsibilities.

(The Committee believes that it is important that election procedures be consistent across Academy positions. In order for a Councillor to be a representative of the interests of a constituency group, it is important for members of the constituency group to feel vested in the election of their representative.)

7s. Each constituent group form a nominating committee, which will nominate two candidates for each Councillor position.

7t. All Councillors participate in an orientation on the Academy and on the responsibilities of the Advisory Councils and individual Councillors.

(This orientation and training would allow Councillors to develop the knowledge and skills early and thus avoid a lengthy delay for learning on the job).

7u. Councillors who are effective be given primary consideration for other positions of responsibility in the Academy.

- * 7v. Each Advisory Council elect a chair and vice chair to coordinate activities of that Council. Coordinating Committees may also be formed as needed.
- * 7w. Advisory Council chairs and vice chairs serve one-year terms, with a maximum of three terms.
- 7x. Each Advisory Council form a Nominating Committee, which will nominate at least two individuals to serve as chair of the Council.
- 7y. The chairs be elected by mail ballot of all Councillors, with the candidate receiving the most votes being elected. (Tie votes would be decided by drawing lots.)
- 7z. The chair preside over the annual meeting of the Advisory Councils and handle any administrative responsibilities as required:
 - All items for consideration at the annual meeting be submitted to the chair, and the chair prepare the agenda for each annual meeting.
- * 7aa. Board members be involved in all meetings and deliberations of the Advisory Councils, in order to maximize effective communication and coordination and to minimize conflict:
 - The Senior Secretary for Ophthalmic Practice and the Senior Secretary for Advocacy be named ex-officio members of the Advisory Councils.
 - In the case of when the two Advisory Councils meet at the same time, the two Senior Secretaries rotate their attendance at each Advisory Council. If they meet at different times, both Senior Secretaries attend each meeting.
 - The Advisory Councils invite selected Board members to attend specified meetings when specific issues are on the agenda.
 - All members of the Board be welcome guests at all meetings of the Advisory Councils. (The President and the Executive Vice-President, of course, may attend any meetings of the Advisory Councils).
 - The meeting agendas of the Advisory Councils be set by the Advisory Councils according to criteria and procedures established by the Board of Trustees.
 - The Board of Trustees may place specific issues of concern on the agendas of the Advisory Councils for comment and input.

Issue Analysis Group:

- * 7ab. An Issue Analysis Group be formed with the following charge:

to analyze issues of importance to the Academy and its members and make recommendations to the Board on selected issues, including broad strategic directions, positions, programs and allocation of resources.

(The Committee believes there needs to be a group created by the Board to help structure formal deliberation and debate, thus improving the understanding and evolution of ideas into policy proposals. The desired outcome is to have an improved and coordinated policy development process which considers input from constituent groups, members and Secretaries in the framework of strategic directions and principal functions of the Academy, refines policy proposals and resolves conflicts. There needs to be a dedicated group which coordinates the process and performs the research, analysis and development of selected policy recommendations.)

- 7ac. The Issue Analysis Group have the following responsibilities:

- **Oversee and manage an annual policy development process (See "Governance Processes") with the following components:**
 1. obtain internal (within ophthalmology) and external input
 2. coordinate informal discussion and debate
 3. oversee research, analysis and drafting of proposals
 4. coordinate formal discussion and debate of proposals
 5. develop recommendations
 6. final action by Board;
- **Work to match the strategic directions set by the Board with the operational concerns of the Secretariats and issues raised by Advisory Councils;**
- **Actively seek input from members, shared interest groups of members, organizations, the Advisory Councils, Secretariats and Committees and others through such means as surveys, focus group interviews, meeting, etc.;**
- **Consider issues raised by members, by the Advisory Councils and by other groups outside of the annual policy development process (i.e. at other times in the year), conduct research and analysis, and develop proposals and recommendations as needed.**

7ad. The Issue Analysis Group be composed of the following:

President-Elect (chairman) (one-year term)

Executive Vice President (ex officio)

A Representative for Clinical Education (two-year term)

A Representative for Ophthalmic Practice (two-year term)

A Representative for Advocacy (two-year term)

A Representative of the Advisory Council for State Societies (two-year term)

A Representative of the Advisory Council for Subspecialty Societies and Shared Interests (two-year term)

Ad Hoc Members (terms based on need)

(The Committee believes that the Issue Analysis Group should be composed of members who provide continuity and strategic direction, who have an intimate knowledge of the operational functions of the organization and who are representative of the major constituency groups, as well as ad hoc members who can provide the necessary expertise and experience as specific issues arise. The desired outcome is to have a broadly constituted group who can consider issues and ideas from a comprehensive perspective of the best interests of ophthalmology and the Academy.)

- * 7ae. Representatives of the Clinical Education, Ophthalmic Practice and Advocacy Groups on the Issue Analysis Group be selected by their respective Senior Secretaries, and Representatives from the Advisory Councils be selected by their respective Councils.

7af. The Board appoint additional ad hoc members to the Issue Analysis Group as necessary for addressing specific issues.

Board of Trustees:

- * 7ag. A Board of Trustees be the governing body of the Academy, with ultimate authority for setting policy, for allocation of resources and for control of the organization.
- * 7ah. The Board focus on strategic planning and high level policy setting. It should also oversee and evaluate management and operations. (This change in emphasis from the current Board is reflected in the change of name from Board of Directors to Board of Trustees.)

* 7ai. The responsibilities of the Board of Trustees be as follows:

A. Policy Setting:

- Direct and manage the business and affairs of the Academy
- Develop and approve the Strategic Plan
- Develop and approve priorities among major goals/functions
- Develop and approve policies based on input from within and outside of ophthalmology
- Develop and approve programs, annual plans and the budget

B. Oversight:

- Hire and evaluate the Executive Vice President
- Oversee and evaluate management
- Exercise responsibility for financial management
- Carry out legal and regulatory responsibility
- Be accountable to the membership

C. Leadership:

- Develop and select volunteer leadership
- Maintain relationships and communications with members and other groups within and outside of ophthalmology

* 7aj. The Board of Trustees have the following members and terms of office, all with a vote on the Board:

- President (one year term)
- President-Elect (one year term)
- Immediate Past President (one year term)
- Executive Vice-President (ex-officio)
- Senior Secretary for Clinical Education (three-year terms, maximum of two terms)
- Senior Secretary for Ophthalmic Practice (three-year terms, maximum of two terms)
- Senior Secretary for Advocacy (three-year terms, maximum of two terms)
- Editor of Ophthalmology (three-year terms, maximum of two terms)
- Secretary for the Annual Meeting (three-year terms, maximum of two terms)
- Six Trustees-at-Large (three-year term, one term only)
- Three External Trustees (three-year term, one term only)
- Chairs of each Advisory Council (one-year term, no more than three years)

- * 7ak. The three External Trustees be selected from leaders in industry, government, third parties, public service, etc.

- 7al. The Board of Trustees' primary activity and primary focus of their meetings be strategic planning, focusing on:
 - Assessment of the environment;
 - Future of eye care;
 - Future of ophthalmology;
 - Future of the Academy and its Strategic Plan;
 - Specific issues (e.g., new technology, managed care, allied health personnel)

- 7am. The Board of Trustees be responsible for developing and revising the Academy's Strategic Plan on an annual basis.

- 7an. The Board of Trustees charge one Trustee with ongoing responsibility for leading and coordinating strategic planning activities.

- 7ao. That the Board of Trustees appoint ad hoc advisory groups as needed to examine specific strategic planning issues and major policy issues and concerns (e.g. Ad Hoc Committee and Resource Group on Organizational Design). These advisory groups may be from within ophthalmology, from outside or a combination. Most would be chaired by a Board member.

- 7ap. The Board specifically form a committee to examine issues related to planning for and shaping the future of eye care.

- 7aq. The Long Range Planning Committee no longer exist as a standing committee of the Board because the Board has undertaken its responsibilities for strategic planning.

- 7ar. The Board specifically appoint a public advisory group from outside of ophthalmology, including individuals from groups such as ophthalmic industry, government, third parties, the rest of medicine, public services, etc.:
 - the advisory group have a clear charge and responsibilities and specific strategic issues to discuss; it should not just be pro forma.
 - the Board select members of the advisory group, based on specific job description and qualifications

- 7as. The Board of Trustees have an Audit Review Committee separate from the Executive/Finance Committee, which would focus on assuring that an appropriate audit is conducted and the auditors' recommendations are followed by management.

Executive Committee:

- 7at. The Board delegate some oversight of management and finances and minor policy decisions to its Executive Committee, freeing the Board to focus on leadership, strategic planning and major policy issues. (The Board would still have an opportunity to ratify or reverse decisions of the Executive Committee, but would not discuss every specific item. For example, the Executive Committee could review and approve Committee chairmen and members and send them on to the full Board for ratification. The Executive Committee could also approve annual plans, review annual reports, etc.)
- * 7au. That the Executive Committee of the Board of Trustees be composed of the following members:
- President (one-year term)
 - President-Elect (one-year term)
 - Immediate Past President (one-year term)
 - Executive Vice-President (ex-officio)
 - One Senior Secretary (two-year term, the most senior individual who has not already served on the Executive Committee. In the case of a tie, selection would be determined by lot)
 - One Trustee-At-Large (two-year term, the most senior Trustee-At-Large who has not already served on the Executive Committee. In the case of a tie, selection would be determined by lot)
 - One Advisory Council Chair (one-year term, the most senior Advisory Council Chair who has not already served on the Executive Committee. In the case of a tie, selection would be determined by lot)
- * 7av. The Executive Committee have the following responsibilities:
- Oversight of management and operations;
 - Oversight of financial management;
 - Oversight of investments;
 - Appropriate referral of input from Advisory Councils, other groups and individuals;
 - Evaluation and oversight of Advisory Councils;
 - Evaluation and oversight of the Issue Analysis Group;
 - Review and approve recommendations for new committee chairs and members; and
 - Review and approve recommendations for new Secretaries.

- * 7aw. The Executive Committee be charged with the overall function of managing the affairs and business of the Academy in between Board of Trustee meetings in a manner consistent with the general policies and directions set by the Board. All decisions of the Executive Committee be subject to ratification by the Board of Trustees.

7ax. The Executive Committee also serve as the Finance Committee.

Nominating Committee:

- * 7ay. The Nominating Committee be composed of:

Past President (chair, ex-officio)

Two of the Four Senior Secretaries or Secretaries serving on the Board who are not serving their last year of term of office (in case of tie, selection would be determined by lot)

One representative from each Advisory Council, with a maximum of two total representatives (appointed by the Advisory Councils)

Three Trustees-at-Large (two Trustees-at-Large in their second year of term of office, and one Trustee-at-Large in the first year of his or her term who is selected by lot)

Executive Vice President (ex-officio, without vote)

8. Governance Processes:

Nomination and Election of Board Members:

- * 8a. All members of the Board be elected by the Academy membership, except the Executive Vice-President, and Outside Trustees, who are appointed by the Board.

(The Committee believes that it is very important that ophthalmology leaders on the Board of Trustees be elected by the Academy membership. The desired outcome is that the membership would be more involved and feel more vested in the selection of nearly all leaders on the Board of Trustees, and that the elected Trustees would be responsible for discharging their responsibilities in the interests of the entire membership, and not just a particular segment of the membership. The only exceptions are the Executive Vice-President, who must be carefully selected according to specific, unique qualifications and who is held directly accountable by the Board of Trustees, and the external Trustees who may not be known to the general membership and provide a perspective outside of the specialty.)

- * 8b. The Nominating Committee nominate all members of the Board, with the exception of the chairs of Advisory Councils, who would be nominated by election by each Council.
- * 8c. There be specific job descriptions and qualifications for each member of the Board, and that individuals be selected on that basis.
- * 8d. All members, constituent groups, Councillors, Secretariats and Committees be asked and actively encouraged to suggest names for possible Board members for consideration by the Nominating Committee.

- * 8e. There be **one candidate** nominated for each position for Senior Secretary , for the President Elect, Editor, Secretary for the Annual Meeting and each Chair of Each Advisory Council.
- * 8f. There be **four nominees** each year for the two positions of Trustee-at-Large.
- * 8g. Other members may become candidates for the Board by submitting petitions with signatures of at least 50 voting members.
- * 8h. Trustees be elected by mail ballot, (with the exceptions noted in 8a) with biographical information and statements from the candidates included with the mailing of the ballot.

(The Committee believes that, in keeping with one of its principal objectives for enhancing member involvement, mail balloting would offer the greatest opportunity for members to participate and shape the direction of the organization. Generally, a minute proportion of the membership attends the Annual Business Meeting, and therefore, under the existing rules, a very small minority can make very significant decisions which affect the entire membership. As economic pressures increase, there may be more and more members who cannot travel to the Annual Meeting because of time or financial considerations and thus, cannot exercise their right to vote. The desired outcome of mail balloting is that it would make voting accessible for a greatly increased number of members to participate in major decisions about their leadership representation.)

- * 8i. Candidates for the Board be provided equal time to describe their qualifications and viewpoints at a scheduled time during the Annual Meeting without conflicting programs, and equal space in ARGUS. Any election campaigns will conform to policies which are established by the Board of Trustees.
- * 8j. If there is more than one candidate for a position, the candidate receiving the most votes be elected. If there are more than two candidates for two positions, then the two candidates receiving the greatest number of votes be elected to office.
- 8k. If there is a tie in the number of votes received for an election, it be resolved by drawing lots.

Bylaws and Rules:

- * 8l. The Academy Bylaws be streamlined to describe the essential items of relevance to the contract between the Academy and its membership.
- * 8m. That a **Rules and Procedures Manual** contain more detailed information about the Academy's functions and be updated more frequently by the Board of Trustees without a vote required by the members.
- * 8n. Bylaws changes not recommended by the Board of Trustees be considered when submitted to the Executive Vice President 90 days prior to the Annual Meeting with signatures of at least one percent of the voting fellows and members of the Academy.

- * 8o. The amendment of Academy Bylaws, Articles of Incorporation and Code of Ethics be by mail ballot of the full membership, with both pro and con arguments included in the presentation of materials to the members.

(The Committee believes that, in keeping with one of its major objectives for enhancing member involvement, mail balloting would provide for the greatest opportunity for members to participate in and shape the organizational Bylaws. The Bylaws is a very important document because it constitutes a contract between the Academy and the membership. Generally, a minute proportion of the membership attends the Annual Business Meeting, and therefore, under the existing rules, a very small minority can make very significant changes in the Bylaws which affect the entire membership and alter the rights of members. As economic pressures increase, there may be more and more members who cannot travel to the Annual Meeting because of time or financial considerations and thus, cannot exercise their right to vote. The desired outcome of mail balloting is that it would make voting accessible for a greatly increased number of members to participate in major decisions about their membership rights and basic organizational structure.)

- * 8p. Time be allotted for discussion of proposed changes in the Bylaws, Articles of Incorporation and Code of Ethics at the Annual Business meeting.

Policy Development Process:

- * 8q. There be many opportunities for informal input to the Academy both from within and outside of ophthalmology, including mechanisms established by Secretariats and Committees. The mechanisms for input should be clearly defined and communicated.
- * 8r. Individual members, constituent groups and Councillors be encouraged to provide input at any time to the Executive Vice President, Secretariats and Committees, the Issue Analysis Group or Board.
- * 8s. The Executive Committee facilitate appropriate referral of input to an appropriate place in the organizational structure and follow up to assure that those providing input receive a response.
- * 8t. A formal, annual policy development process be established for dealing with major policy concerns which require broad input and expanded debate and discussion and which do not require more efficient and expeditious handling through other means of policy development.
- 8u. The policy development process for the Academy have the following components:
 1. internal (within ophthalmology) and external input
 2. informal discussion and debate
 3. research, analysis and drafting of proposals
 4. formal discussion and debate of proposals
 5. development of recommendations
 6. final action

8v. The annual policy development process proceed as follows:

<u>Time:</u>	<u>Activity:</u>
Sept. - Nov.	Advisory Councils solicit input and ideas from their members and meet separately the Annual Meeting to identify issues.
January	The Executive Committee refers this input to the Secretariats, the Board of Trustees or the Issue Analysis Group, depending on the urgency and scope of the concerns. The Executive Committee provides feedback to the Councils on the disposition of concerns.
Feb. - March	The Issue Analysis Group conducts research and analysis on these issues to develop specific proposals. (It may form ad hoc groups of Councillors, Secretaries and others to do this).
March-April	The Board convenes the Advisory Councils, the Secretaries and Committee chairs and invites members-at-large to 4-5 Regional meetings for discussion and debate on these issues. Different categories of issues would be addressed in separate sessions, coordinated by ad hoc committees appointed by the Board.
April-May	The Issue Analysis Group deliberates on the Regional Meeting discussions and develops specific recommendations. These are submitted to the Board of Trustees, and reported to the Advisory Councils and Secretaries.
June	The Board of Trustees considers these recommendations for action. It reports its rationale and decisions to the Issue Analysis Group, Advisory Councils and other interest parties.
July-August	Approved policies are then incorporated into annual plans and budgets.
September	The Board approves the annual plans and budgets, which incorporate approved policies and priorities.

8w. The strategic planning process proceeds as follows:

<u>Event:</u>	<u>Time:</u>	<u>Activity:</u>
Broad Input	December	The Board circulates the Strategic Plan for comment to the Advisory Councils, the Issue Analysis Group, Committee Chairs, Representatives, leaders of allied organizations and members-at-large.
Evaluation	January	The Board has a Strategic Planning Retreat to re-evaluate long range directions and consider input by various groups.
Identification of New Directions	February	The Board defines new long range directions for the Academy.
Research and Analysis	February – March	The Board appoints or assigns ad hoc committees or staff to conduct research and analysis on new directions, and to begin to develop the best strategies and preliminary program plans, if appropriate.
Communication of New Directions	March – April	The Board brings appropriate issues to the regional meetings of the IAG, Secretaries and Advisory Councils in order to communicate any changes in directions and to help inform the policy debates and discussions.
Approval of New Plan	June	The Board approves a revised Strategic Plan in keeping with its new directions and priorities.
Integration of New Directions in Planning and Budgeting	July	The Board directs the Secretaries to include new strategic priorities and program plans in their consideration of program prioritization, annual planning and budgeting.
Implementation	September	The Board approves annual plans and budget which incorporate new strategic directions.
Annual Reports	Next January	Annual reports are submitted to the Board by Secretaries, Committees and Representatives describing their accomplishments, particularly related to Strategic Plan objectives.
Feedback	Next February	The Board reviews these annual reports and provides feedback related to Strategic Plan objectives and recommends any changes to those responsible.

Specific Issues Referred to the Committee

9. Specific Issues Referred to the Committee:

Issues Not Addressed Elsewhere in This Report:

Council Participation in Budget Development:

- * 9a. The chairs of the Advisory Councils be invited to participate in program planning, prioritization of Academy programs and the early stages of budget development.

Council Input Into Program Development:

- * 9b. Each Senior Secretary develop mechanisms for direct input of the Advisory Councils and other groups and members into development of new programs as needed.

Annual Business Meeting:

- * 9c. The deadline for nominations for the Board of Trustees by petition (Section 3.03 of the Bylaws) continue to be 60 days prior to the Annual Business Meeting.
- * 9d. The deadline for petitions for Bylaws changes (Section 8.01 of the Bylaws) continue to be 90 days prior to the Annual Business Meeting.
- * 9e. The Board of Trustees refer items of business proposed by members for consideration at the Annual Business Meeting (Bylaws Section 2.04) to the Councils for consideration if that is considered appropriate.

Proposed Amendments From the Society of Geriatric Ophthalmology:

- * 9f. The proposed Bylaws amendments from the 1991 Annual Meeting from the Society of Geriatric Ophthalmology not be approved because they are superseded by the organizational design recommendations.

Proposed Bylaws Amendments of the Board of Directors:

- * 9g. The proposed amendments from the Board of Directors from the 1991 Annual Meeting be recommended for approval, except in the case that the new organizational design recommendations by the Board would supersede these proposed amendments.

Special Interest Groups:

- * 9h. The Board address the issue of establishing special interest groups or sections of members on an ad hoc basis.

Issues Addressed Elsewhere in This Report:

Voting Privileges of the Board of Directors:

- * 7aj. The Board of Trustees have the following members and terms of office, all with a vote on the Board:

President (one year)

President-Elect (one year)

Past President (one year)

Executive Vice-President (one year)

Senior Secretary for Education (three-year terms, maximum of two terms)

Senior Secretary for Ophthalmic Practice (three-year terms, maximum of two terms)

Senior Secretary for Advocacy (three-year terms, maximum of two terms)

Editor of Ophthalmology (three-year terms, maximum of two terms)

Secretary for the Annual Meeting (three-year terms, maximum of two terms)

Six Trustees-at-Large (three-year term, one term only)

Three External Trustees (three-year term, one term only)

Chairs of each Advisory Council (no more than three years)

Nominating Committee:

- * 7ay. The Nominating Committee be composed of:

Past President (chair, ex-officio)

Two of the Four Senior Secretaries or Secretaries serving on the Board who are not serving their last year of term of office (in case of tie, selection would be determined by lot)

One representative from each Advisory Council, with a maximum of two total representatives (appointed by the Advisory Councils)

Three Trustees-at-Large (two Trustees-at-Large in their second year of term of office, and one Trustee-at-Large in the first year of his or her term who is selected by lot)

Executive Vice President (ex-officio, without vote)

Council Override of Board Veto:

- * 7ag. A Board of Trustees be the governing body of the Academy, with ultimate authority for setting policy, for allocation of resources and for control of the organization.

Secretariat for State Affairs:

- * 5g. Specifically, that a Secretariat for State Affairs be established and charged with responsibility for helping state ophthalmologic societies develop stronger organizations and serve as effective advocates at the state and local levels.

Mail Balloting:

- * 8h. Trustees be elected by mail ballot, (with the exceptions noted in 8a) with biographical information and statements from the candidates included with the mailing of the ballot.
- * 8o. The amendment of Academy Bylaws, Articles of Incorporation and Code of Ethics be by mail ballot of ythe full membership, with both pro and con arguments included in the presentation of materials to the members.

"Unslotting" Positions of Directors-at-Large:

- * 8f. There be four nominees each year for the two positions of Trustee-at-Large.

10. Implementation:

(The Committee also discussed how its recommendations, if approved, should be implemented.)

The Ad Hoc Committee on Organizational Design recommends that:

- * 10a. A subcommittee of the Ad Hoc Committee on Organizational Design be formed to help the Bylaws Committee in translating the final recommendations into Bylaws language, if approved by the Board. The members constituting this subcommittee be Drs. David A. Durfee, H. Dunbar Hoskins, Jr., and Michael R. Redmond.
- * 10b. To the extent possible and practical, the organizational design be implemented as quickly as possible, and all at once, rather than in phases spread out over several years.
- * 10c. 1993 be considered a transition year, with many of the new structures and processes being created while the old ones continue to operate.
- * 10d. The Board establish an ad hoc committee to develop recommendations for forming the new Advisory Councils as quickly as possible so that they could begin to function in 1993.

Organizational Design Process and Participants

The Organizational Design Process:

1. Evaluate the future environment and assess the needs of groups that are most critical to ophthalmology and the Academy:

- the public
- government
- third parties
- individual ophthalmologists
- the specialty of ophthalmology
- state and subspecialty societies

2. Define the future directions and primary functions for the specialty of ophthalmology.

3. Define the mission, future directions and primary functions for the Academy.

4. Define the organizational structure and processes needed to carry out the primary functions of the Academy and achieve its mission:

- a. Define goals and criteria for evaluating possible organizational structures.
- b. Define possible operational structures for carrying out the primary functions; evaluate options and define a preferred structure.
- c. Define possible governance structures; evaluate options and define a preferred structure, including roles and responsibilities of various groups.
- d. Develop recommendations on specific organizational issues referred to the Committee that have not been addressed in the steps above.
- e. Develop recommendations for implementation of the proposed organizational design, including whether it should be implemented in phases or all at once.

The Board of Directors established an Ad Hoc Committee on Organizational Design in September 1991, with the following charge:

To recommend to the Board of Directors by June 1992 any changes in Academy organizational structure and function necessary to assure effective pursuit of its mission and implementation of its Strategic Plan.

Immediate Past President George W. Weinstein, MD, was named to chair the Committee and members were appointed in December 1991. To broaden the Committee's perspective through a range of viewpoints and perspectives, a Resource Group that included the Board of Directors, the Council and members at large was created. The Resource Group first met in January 1992 to learn about the organizational design process and to provide input to the Ad Hoc Committee about where they thought the organization should be heading for the future.

In its earliest deliberations, the Committee determined that its approach would be to create an optimal organization design that would serve the Academy into the next century. To accomplish this challenging task, the Committee employed a systematic process for organizational design. The Committee met together in January, March, April, May and June, and also participated in a few conference calls in order to pursue the activities and discussions necessary to develop a new organizational design. The Committee also actively solicited input and suggestions throughout the process, and received and considered 31 letters from various members in its deliberations.

STEP 1 Evaluate the future environment and assess the needs of groups that are most critical to the Academy and ophthalmology

The first step was to evaluate the future environment for health care and for ophthalmology and assess the needs of various groups. Outside experts, commissioned research and literature searches were used to assess the critical needs of important groups: the public, government, third parties, individual Academy members, the specialty of ophthalmology, and state and subspecialty societies. Significant progress was made in this area at the Conference on Future Directions for the Academy and Organizational Design, attended by both the Committee and the Resource Group in January.

STEP 2 Define future directions and primary functions for the specialty of ophthalmology

Following the environmental analysis, future directions and primary functions of ophthalmology were defined. Findings from the Conference on Future Directions and the various research efforts provided the foundation for this step. A survey on responsibilities for various functions in ophthalmology was sent to the entire Resource Group and leaders of state and subspecialty societies. A total of 96 responses were received and tallied to provide a profile of relative responsibilities for primary functions in ophthalmology. The results showed that there are a variety of ophthalmologic organizations and individual ophthalmologists who have important responsibilities in carrying out the primary functions for the specialty, not just the Academy.

STEP 3 Define the mission, future directions and primary functions for the Academy

Early in the process, the Committee circulated the Academy's current Strategic Plan to the Resource Group and other Academy leaders for comment. More than 100 responses were received. In addition, the plan and broad future directions for the Academy were discussed at the January conference. Based on that input, the environmental analysis, a broad assessment of constituent needs, and the future directions and primary functions for ophthalmology, the Committee defined the mission, future directions and primary functions of the Academy

STEP 4 Define the organizational structure needed to carry out the primary functions of the Academy and achieve its mission

The last step of the process was to define an organizational structure that would carry out the primary functions of the Academy and achieve its mission. This step included several specific activities. With the input of the Resource Group, goals and criteria for evaluating possible structures were established. The participants in the January Conference rated each of the criteria on a scale of 1-10, with 10 being the most important. The most important goals included:

1. Facilitate achievement of Academy long range goals and objectives and performance of its primary functions (9.4)
2. Be flexible enough to respond to future changes in the environment and the needs of members. (9.3)
3. Maximize the efficiency and effectiveness of the organization, while minimizing bureaucracy. (9.2)
4. Preserve and enhance the Academy's educational efforts. (8.9)
5. Enhance socioeconomic/political activities. (8.7)
6. Minimize unproductive internal conflict and divisiveness, and maximize unity within ophthalmology. (8.5)

7. Maximize member involvement and input and responsiveness to members' needs. (8.1)
8. Facilitate communications within the Academy and ophthalmology. (7.8)
9. Facilitate communications and relationships with groups outside the Academy, including the rest of medicine. (7.2)
10. Democratize the election process. (6.3)

Next, the Committee defined possible operational structures for carrying out the primary functions. This included evaluating a variety of possible options and then reaching agreement on a preferred structure which fit the needs of the Academy best. Once the operational structure had been defined, the Committee considered the structure and processes necessary to govern it. This included defining possible governance structures, evaluating options and defining the preferred structure and processes, including the responsibilities of various groups.

Several specific issues were referred to the Committee for consideration within the larger context of its deliberation on organizational design. Many of these issues were addressed by recommendations related to operations and governance. However, the Committee carefully reviewed each of the concerns referred to it to assure that each had been addressed.

Finally, the Committee developed some general recommendations regarding implementation of the organizational design. The Committee believed that it was important to expand the Resource Group to include Secretaries and committee chairs, state and subspecialty society Presidents for even broader input and to convene the group again to provide feedback on the Committee's recommendations. Preliminary recommendations were presented for review and comment by the Resource Group on June 7, 1992.

The Committee considered the discussions and comments by the Resource Group prior to completing its report for the Board. The Committee discharged its official responsibility to the Board with a completed report of recommendations in time for consideration at the June 13-14 meeting of the Academy Board of Directors.

Organizational Design Process Participants:

(Includes members of Ad Hoc Committee on Organizational Design, and the Resource Group on Organizational Design, which includes the Board of Directors, the Council, and Members-at-Large)

Thomas Aaberg, MD	Georgia
Phillip Aitken, MD	Vermont
John Alper, MD	Texas
Penny Asbell, MD	New York
William Atlee, MD	Maine
Sterling Baker, MD	Oklahoma
Charles Baltimore, MD	North Carolina
Hal Balyeat, MD	Oklahoma
Alan Baribeau, MD	Texas
J. Bronwyn Bateman, MD	California
Alan Baum, MD	Texas
Norbert Becker, MD	Illinois
Deloris Bell, MD	Kansas
Robert Black, MD	California
Steven Bloom, MD	Kentucky
William Bohart, MD	Texas
C. Richard Bowers, MD	Kentucky
R. Larry Brenner, MD	Texas
Scot Brower, MD	Washington
Bernice Brown, MD	California
Martin Bruhl, MD	Minnesota
Winston Bryant, MD	Pennsylvania
John Bullock, MD	Ohio
John Burns, MD	Ohio
Peter Cannava, MD	Alaska
Franklin Chu, MD	Washington
Leo Chylack, Jr., MD	Massachusetts
John Clarkson, MD	Florida
Jackson Coleman, MD	New York
David Cook, MD	West Virginia
Claude Cowan, MD	Washington, D.C.
Raymond Croissant, MD	Minnesota
Howard Cupples, MD	Washington, D.C.
Oliver Dabezies, MD	Louisiana
Doug Dehning, MD	Missouri
John Detwiller, MD	New Hampshire
Thomas Deutsch, MD	Illinois
William Deutsch, MD	Illinois
Jack Dodick, MD	New York

David Dow, MD	Texas
Robert Drews, MD	Missouri
David Durfee, MD	Oregon
Richard Eiferman, MD	Kentucky
Andrew Eller, MD	Pennsylvania
Forrest Ellis, MD	Indiana
Warren Fagadau, MD	Texas
Martha Farber, MD	Oregon
Stephen Feman, MD	Tennessee
James Ferguson, MD	Virginia
Elliot Finkelstein, MD	Massachusetts
Michael Fischer, MD	Nevada
John Flynn, MD	Florida
Max Forbes, MD	New York
Gary Foulks, MD	North Carolina
Melvin Freeman, MD	Washington
Miles Friedlander, MD	Louisiana
Alan Friedman, MD	New York
F. Hunter Fuerste, MD	Iowa
Wayne Fung, MD	California
Walter Gager, MD	Wisconsin
Pamela Gallin, MD	New York
Charles Gannon, MD	Arizona
George Garcia, MD	Massachusetts
James Gentry, MD	Colorado
Craig George, MD	Ohio
Frank Gilroy, MD	New York
Sam Gold, MD	New Hampshire
Daniel Goldberg, MD	New Jersey
Russell Gonnering, MD	Wisconsin
James Good, MD	Montana
Richard Goodwin, Jr., MD	South Carolina
Cono Grasso, MD	New York
W. Richard Green	Maryland
Kevin Greenidge, MD	New York
John Griffiths, MD	Nebraska
W. Sanderson Grizzard, MD	Florida
Froncie Gutman, MD	Ohio
Roy Hager, MD	Alabama
William Hagler, MD	Georgia
Varant Hagopian, MD	Massachusetts
Donald Ham, MD	New Mexico
Kenneth Hansen, MD	Virginia
Terry Hansen, MD	Idaho

Thomas Harbin, MD	Georgia
John Harrington, MD	Texas
Eugene Helveston, MD	Indiana
Robert Hepler, MD	California
Bruce Herron, MD	Tennessee
Peter Hersh, MD	New York
Eve Higginbotham, MD	Michigan
Paul Honan, MD	Indiana
Rich Hopkins, MD	Montana
H. Dunbar Hoskins, MD	California
Robert Hughes, MD	Arkansas
B. Thomas Hutchinson, MD	Massachusetts
Barry Hyman, MD	Texas
Edward Isbey, MD	North Carolina
Lee Jampol, MD	Illinois
William Jarrett, MD	Georgia
Allan Jensen, MD	Maryland
Randolph Johnston, MD	Wyoming
Dan Jones, MD	Texas
Robert Kalina, MD	Washington
Stephen Kamenetsky, MD	Missouri
Joel Kaplan, MD	Illinois
Marian Mascai-Kaplan, MD	West Virginia
David Karcher, MD	Virginia
Gary Karlstad, MD	North Dakota
Barrett Katz, MD	California
Gordon Kelly, MD	Vermont
Shalom Kelman, MD	Maryland
William Knauer, MD	Florida
Guy Knolle, MD	Texas
Allan Kolker, MD	Missouri
Richard Koop, MD	Ohio
Manus Kraff, MD	Illinois
Louis Kurland, MD	Florida
Gregory Kwasny, MD	Wisconsin
Peter Laibson, MD	Pennsylvania
Roy Levit, MD	Texas
Philip Levy, MD	California
MaryLou Lewis, MD	Florida
Paul Lichter, MD	Michigan
Daniel Long, MD	Louisiana
Robert Mallette, MD	Mississippi
Robert Maloney, MD	California
George Malouf, MD	Maryland

Karl Marchenese, MD	New York
William Martin, MD	Georgia
W. Andrew Maxwell, MD	California
Ron May, MD	Illinois
David McIntrye, MD	Washington
Robert McKinlay, MD	Ohio
Shauna McKusker, MD	Wyoming
Richard Meissner, MD	Nebraska
Henry Metz, MD	New York
John Milam, MD	Mississippi
Marilyn Miller, MD	Illinois
Neil Miller, MD	Maryland
Richard Mills, MD	Washington
T. Glendon Moody, MD	Arizona
Thomas Moore, MD	Arizona
Robert Moorman, MD	Alabama
Monica Monica, MD	Louisiana
Sanford Moretsky, DO	Arizona
Donald Muenk, MD	Michigan
S. Deborah Murphy, MD	Rhode Island
Christine Nelson, MD	Michigan
Marietta Nelson, MD	Nevada
John Norris, MD	New Jersey
Stephen Obstbaum, MD	New York
William Offutt, MD	Kentucky
Luis Oms, MD	Puerto Rico
James Orcutt, MD	Washington
Paul Orloff, MD	New York
Sam Packer, MD	New York
Paul Palmberg, MD	Florida
David Parke, MD	Connecticut
William Penland, MD	Indiana
Joseph Philipp, MD	Kansas
Frank Piper, MD	New York
John Purcell, MD	Missouri
Harry Quigley, MD	Maryland
Richard Quinones, MD	Illinois
Michael Redmond, MD	Florida
John Reeves, MD	Kentucky
Robert Reinecke, MD	Pennsylvania
John Retzlaff, MD	Oregon
Willard Rice, Jr., MD	Massachusetts
F. Tempel Riekhof, MD	Utah
Joseph Robertson, MD	Oregon

Fane Robinson, MD	California
Lisa Rosenberg, MD	Illinois
J. James Rowsey, MD	Oklahoma
Gary Rubin, MD	Illinois
Melvin Rubin, MD	Florida
Richard Ruiz, MD	Texas
Stephen Ryan, MD	Rhode Island
Whitney Sampson, MD	Texas
Michael Sansone, MD	New York
Michael Sarno, MD	Iowa
Peter Savino, MD	Pennsylvania
Ralph Sawyer, MD	Maryland
Y. Jacob Schinazi, MD	Rhode Island
Donald Schwartz, MD	California
Dave Scott	Colorado
Richard Sherry, MD	Delaware
David Shulman, MD	Texas
E. Rand Simpson, MD	Ontario
Lawrence Singerman, MD	Ohio
J. Geoffrey Slingsby, MD	South Dakota
Stephen Slocum, MD	Missouri
Ronald Smith, MD	California
Gilbert Smolin, MD	California
Thomas Souders, MD	Pennsylvania
George Spaeth, MD	Pennsylvania
Abbot Spaulding, MD	Ohio
Bruce Spivey, MD	California
David Stager, MD	Texas
Reggie Stambaugh, MD	Florida
Robert Stamper, MD	California
Ralph Stewart, MD	Indiana
Rhoads Stevens, MD	Hawaii
Robert Stofac, MD	Colorado
Hunter Stokes, MD	South Carolina
Bradley Straatsma, MD	California
Joel Sugar, MD	Illinois
Shigemi Suguki, MD	Hawaii
James Swartley, MD	Idaho
Charles Sydnor, MD	North Carolina
William Tasman, MD	Pennsylvania
Bruce Taylor, MD	Texas
Kim Taylor, MD	Utah
Shahane Taylor, MD	North Carolina
Spencer Thorton, MD	Tennessee

Saul Tischler, MD	New Jersey
David Townes, MD	Kentucky
Mark Tso, MD	Wisconsin
James Twist, MD	New York
Kenneth Tuck, MD	Virginia
Floyd Tukel, MD	Michigan
James Twist, MD	New York
Barry Uhr, MD	Texas
E. Michael Van Buskirk, MD	Oregon
Mylan Van Newkirk, MD	Nebraska
Nicholas Vincent, MD	California
Nicholas Vondrak, MD	Nebraska
Robert Waller, MD	Minnesota
Leo Watson, MD	Indiana
Robert Webster, MD	California
Robert Weinberg, MD	Virginia
George Weinstein, MD	West Virginia
Robert Whinery, MD	Iowa
Thomas Whitaker, MD	South Carolina
Mark Whitten, MD	Washington, D.C.
Curtis Whittington, MD	Mississippi
George Williams, MD	Michigan
R. Sloan Wilson, MD	Arkansas
Nicholas Zakov, MD	Ohio

Outline of Surveys and Research Considered in the Organizational Design Process

I. Needs of the Members

Academy Membership Survey, January, 1992

II. Needs of State and Subspecialty Societies

Academy State and Subspecialty Leader Survey, March, 1992

III. Needs of the Public

Findings from Current Public Opinion Polls

Academy Market Research Surveys of Consumers, performed in 1988

IV. Needs of Third-Party Payers and Managed Care

Findings from Current Literature and Surveys of Insurers, Employers and Managed Care Executives

Academy Market Research Surveys of Employee Benefit Managers and Managed Care Executives, performed in 1988

V. Needs of the Government

Academy Survey of Federal Government, March, 1992

VI. Organizational Structures

Academy Surveys of Major Medical Societies, January, 1992

Findings from Literature on Organizational Theory and Design

Report of Surveys and Research For Organizational Design Activities

The following report summarizes the major research efforts considered by the Ad Hoc Committee on Organizational Design as a foundation for suggesting the future directions for the specialty of ophthalmology and the Academy. The outcomes of these studies are also intended to enhance ophthalmology's efforts to meet these various groups' needs and to work with them towards solutions to problems in eye care delivery.

I. Results of the Member Survey

A. Description of Survey

In January 1992, the Academy commissioned The Research Alliance, an independent research and survey firm, to conduct a survey of Academy members. The objectives of the survey were to determine members' perceptions of the effects of various developments on their practice, to find out what members think are the most important needs for the future, to discover what members' attitudes were towards the Academy and the Academy's performance and to find out what members thought was important to improve the profession of ophthalmology. A self-administered written questionnaire was mailed to all U.S. Academy members, 16,755 in total. This included retired and active members, and members-in-training.

Altogether, 5,588 surveys were returned completed, representing a 33% response rate. This sample size has an error factor of 1.41%. The demographic characteristics of the sample closely matches the profile of the membership-at-large in terms of geographic distribution and proportion of general ophthalmologists to subspecialists. About half of the sample indicated that they practiced general ophthalmology, and 44% were in solo practice. An equal number were practicing in groups or in HMOs. About 77% of respondents stated that they belonged to a state subspecialty society, and 36% stated that they belonged to a subspecialty society.

B. Findings

The respondents indicated that the most important future needs for the profession of ophthalmology were public trust and respect and a leadership role in eye care delivery. In addition, other important needs selected were greater unity within the profession and enhanced overall ethical conduct. Members' perception of the most important needs of the public were for quality eye care, a free choice of eye care provider and knowledge of how to find qualified eye care providers. Less than half of survey respondents thought that continuity of eye care services, affordability of services and convenient access were extremely or very important to the public.

Economic concerns were very prominent in the respondents' minds. About half reported that their practice was doing worse now than five years ago. About 28% said that they felt better about their practice. This dissatisfaction was greater as the number of years in practice increased. The most important future needs for the individual ophthalmologists were cited as help in dealing with government regulations, growth and stability of income and sufficient patient volume.

Government regulation, reimbursement cutbacks and commercialism were all viewed as having a great impact in the next five years. (This emphasis might also reflect the timing of the survey, which was mailed when the Medicare Fee Schedule was first implemented). Managed care was perceived to be increasing in importance in the next 5 years. Individual respondents were not as concerned about advocacy to third parties and competition with optometrists.

This emphasis on governmental activities is reflected in respondents' ranking of Academy efforts. Government representation, clinical education and informing the public about ophthalmology were rated as the three most important Academy efforts to the individual ophthalmologist. Also important to the membership were representation of all members by the leadership and support of ethical standards.

Overall, survey respondents seemed satisfied with the Academy, largely derived from the overwhelmingly positive evaluation of the Academy's educational activities. The great majority (> 80%) rated their overall attitude towards the Academy as either very favorable or somewhat favorable, with just an 8% share characterizing their attitude as somewhat unfavorable.

About 60% rated the governance of the organization as good to excellent, with about 5% giving it a poor rating. About half of the respondents rated the representation of the best interests of all members as good to excellent by the Board and the Council, with about 10% giving it a poor rating.

The member respondents rated education extremely high, with 77% of all respondents rating it as excellent or very good, by far the highest rating of Academy activities. About one-third of members rated representation of federal government as excellent or very good, with 15% rating it as fair or poor. Members indicated there was room for improvement in other Academy activities, including relations with medicine, third party advocacy and support of state governmental relations.

A significant share of respondents (20% - 40%) were not knowledgeable about the Academy's activities, particularly about the leadership, state society and third party activities. Respondents were most knowledgeable about Academy efforts in education, member communications, representation and informing the public about ophthalmology.

C. Implications for Future

The environment is rapidly changing and is influenced by the thinking of third party payers, managed care, employers and government. The Academy is challenged to think in new ways and to develop new activities in order to help members meet the challenges of these new environmental changes.

Ophthalmologists are obviously undergoing significant economic stresses and are very much unfamiliar and uncomfortable with this new order. They feel that their practices have suffered significantly as a result, primarily because of government regulations and reductions in reimbursement. They are looking to the Academy for representation of their interests to the government and others. Certainly, the Academy will be expected to enhance its effectiveness in advocacy efforts on behalf of its members.

To assist members proactively in adapting successfully in this environment, there will need to be a greater and sustained commitment towards monitoring and evaluating ongoing trends and forecasting future developments. Members will need a great deal more information, practical aids and perhaps detailed instructions on how they can be successful and competitive in their practices.

Members will also need help in looking towards the future for solutions and/or prevention of the current problems. Most important of these solutions appear to be more efficient practice management in order to meet the mandate for more cost-effective care, and the provision of "value-added" service to allow ophthalmologists to be more market-oriented towards patients and payers, and to deal more proactively with the changing demands of the health care system.

The most important needs of the profession are seen to be regaining public trust and respect, developing a leadership role in eye care delivery and establishing unity within ophthalmology. Respondents viewed the needs of the profession as more long-range and public-oriented concerns. In order to gain public trust and respect, a renewed dedication to principles of patient care and quality must be evidenced at both organizational and individual levels. This might call for a stronger commitment to public service and public education, initiated by the leadership and permeating down to the grassroots level.

If ophthalmology is to establish a leadership role in eye care delivery, it will need to be much more proactive and forward-thinking about the broad issues in health care delivery. This will call for research and development of ideas for changes in eye care delivery and will require coordinated efforts with other key players, including not only the public but also the government, third parties and other eye care providers. Communications and relationships will need to be strengthened across ophthalmology, including state societies, subspecialty societies and other special interest groups if ophthalmology is to speak with one voice.

A clear distinction is drawn between representation of individual members and representation of the best interests of all members. In terms of Academy efforts, respondents consistently placed representation of the entire membership ahead of their own interests. The survey results showed that it is more important for individuals to feel that the best interests of the profession are well represented than for them to feel that they as individuals are represented and have a direct voice. The organization needs to be responsive to the individual and his/her needs, but at the same time, promote what is in the best interests of all the membership as a top priority.

Communication with the membership is crucial, especially during rapidly changing times. Members need to be better informed about ongoing Academy activities, because many indicated a lack of knowledge or familiarity with what the Academy does. Communication efforts need to be targeted more effectively and in various media forms in order to encourage member involvement in Academy activities.

II. Results of the State and Subspecialty Society Survey

A. Description of Survey

In March, 1992, the Academy commissioned the Research Alliance, an independent research and survey firm, to conduct a survey of leaders of state, subspecialty and other national ophthalmologic organizations. The purpose of these surveys was to assess the importance of external developments, to identify the most important activities societies offer to their members, to learn their most important needs and priorities, and to determine what Academy activities were most useful to these societies. A total of 235 state society leader surveys and 60 subspecialty leader surveys were mailed out. Replies were received from 95 state society leaders and 34 subspecialty or national ophthalmological organization leaders.

B. Findings

State society leaders thought that the most important developments to their members were reimbursement reductions, government regulation and expanded scope of optometric practice. Subspecialty society leaders thought that reimbursement and income reductions were also important to their members, but not to as great a degree as the state society leaders thought. They were also more concerned about health care reform and new technology and research advances. Neither group ranked competition among ophthalmologists or growth of managed care as very important influences.

The most important state society activities for members were found to be the third-party reimbursement committee, relations with state government and the annual scientific program. The least important activities were practice management services, public service programs and patient referral services. The most important activity of the subspecialty societies, by far, was the annual scientific program. Other important activities were the third-party reimbursement committee and relations with other ophthalmology groups. Practice management and public service programs were also not seen as very important to the subspecialty societies.

The greatest limitations on state societies were insufficient member involvement and interest, and not the lack of financial resources. Also noted as serious limitations on effectiveness were legislators' lack of knowledge about medical issues and the lack of public concern about ophthalmology. Subspecialty societies did not think that the listed factors related to member involvement, staffing or financial resources, posed any significant hindrance to their effectiveness.

Major priorities for the state societies were to deal with legislation proposing expanded scope of practice for optometrists, to enhance member involvement, to strengthen third party liaison and to educate legislators. The highest priority for subspecialty societies was to educate members. Other priorities included determining training standards,

strengthening third party liaison and determining standards of care. Both groups ranked public relations and public service as low priorities.

State societies were aware of many of the listed Academy activities and two-thirds of the respondents were familiar with five activities listed: the Academy Leadership Conference, the State Affairs Committee, the Office of State and Subspecialty Relations, society visits from Academy leaders and the State Leadership Resource Manual. In contrast, fewer of the subspecialty leaders participated in Academy activities, with the most participation in the cosponsorship of scientific programs at the Annual Meeting and in the Academy Leadership Conference.

State society leaders rated the State Affairs Committee, Council representation, the Academy Leadership Conference, the Office of State and Subspecialty Relations and society visits by Academy leaders as the most important Academy activities to them. Subspecialty societies rated far fewer Academy activities as important to them, and selected the scientific program co-sponsorship and Council representation as the two important activities.

Possible Academy services in which state society leaders would be interested were a newsletter to legislators, focus group interviews with legislators, and assistance with media relations. Subspecialty society leaders were interested mostly in the Academy's possible coordination of government representation for subspecialties. There was also interest expressed by both groups in assistance with strategic planning and clinical education courses.

Both groups rated the Academy as good to very good in meeting their needs and providing information. The Academy was seen as most effective in informing state society leaders about federal issues. However, the respondents also indicated that the Academy could become more responsive to the needs of state societies and subspecialty societies by providing specific information on state and subspecialty-specific issues. In particular, the subspecialty societies noted that the Academy could help more in providing information about activities in other subspecialty societies.

C. Implications for Future

The results clearly show that the state and subspecialty societies have very diverse needs and priorities. The state societies are focused on state governmental activities, namely optometric expansion legislation and third-party reimbursement concerns on a state and local level. In contrast, the subspecialty societies' major concern is clinical education of its members with a growing interest in coordination of third-party representation on a federal level.

Currently, there are several Academy activities which are helpful to the state societies. Not nearly as many activities are targeted towards helping the subspecialty societies. Many resources and services do not appear to be equally beneficial to both groups. The Academy will need to respond to both of their needs in an appropriate and perhaps separate manner.

The Academy can play a very useful role in providing information to these societies on specific state and subspecialty-related issues, as it has already for federal and general specialty issues. It has fulfilled an important function in allowing societies to network and learn from each other's experience. In particular, based on the survey responses, the Academy could be useful in providing a forum for subspecialty societies to find out more about each other's activities.

Many of the problems faced by state and subspecialty societies are specific to the society, i.e., a lack of member involvement, not enough member interest or not enough legislative experience among physicians. Thus, the Academy is seen to be most useful in providing overall guidance and leadership, and training of future leaders through its Academy Leadership Conference. Also, more visits to societies by Academy leaders may be encouraged as a means of enhancing familiarity with the Academy's activities and communication between the Academy and these societies.

III. Research on Needs of the Public

A. Description of Research

The primary constituency group of ophthalmologists is, of course, the public. Ophthalmologists' highest responsibility is to provide quality care in the best interests of the patient. In order to better understand the needs of the public for eye care, the Academy commissioned Mr. Humphrey Taylor, President and Chief Executive Officer of Louis Harris and Associates, to speak at its Conference on Future Directions and to provide a paper on the needs of the American public. Based on his vast experience with public opinion surveys and observation of trends over the past few decades, Mr. Taylor identified key needs of the public and the changes in their attitudes in the past several years. The Academy also commissioned its own market research on public attitudes towards eye care in 1988.

B. Findings

1. *Mr. Humphrey Taylor*

Based on evidence from nationwide public opinion polling taken from several sources, Mr. Taylor has drawn the following conclusions:

The American public wants four necessities of health care: **accessibility; quality; affordability; and security.**

Patients want to have easy access to quality health care at an affordable price. They want the peace of mind that they will not lose their health insurance coverage, and that they will not be wiped out financially by catastrophic health care costs. Most people are satisfied with the quality of care and services that they use. The great majority are also satisfied with their own access to health care, but think that many people in this country do not have insurance. Virtually everyone believes that this situation is unacceptable and thinks that health insurance is a right to which everyone should be entitled.

The American people are **dissatisfied with the costs of health care, out-of-pocket costs to the consumer, costs to the taxpayers and costs to the employers.** The proportion of the public who say they did not have enough money to pay for medical or health care sometime in the previous 12 months has increased rapidly in the past few years to 27% in 1991. Health care also topped a list of expenses as the most difficult to afford for the first time in recent polls.

The public is growing more **insecure about their insurance coverage.** The numbers of uninsured have been rising by about one million every year since 1981. Fear of losing one's health insurance has become a major concern, with one in seven Americans reporting that they switched jobs or remained in their jobs because of concerns about their health insurance.

The public is mainly interested in **improving access to care and cost management**. Although on an individual basis, people are satisfied with their own care, they are very dissatisfied with the overall health care system. The American public is almost unanimous in believing that **major reform of the health care system** is needed in order to achieve universal coverage and better value for the money spent.

In a poll taken in November, 1991, about 42% of the American public thought that we should completely rebuild our health care system, 52% thought that fundamental changes were needed, and only 6% thought that the system worked pretty well. There also has been a growing belief that a major federal government initiative is needed - not that people like or believe that government will do the best job but because nobody else has stepped up to do the job. Polls have been measuring public attitudes to various forms of National Health Insurance for 40 years. These polls now show that support for national health insurance is stronger than it ever has been before.

The public is very concerned about rising costs and the difficulty in finding funds to pay for universal coverage. The public thinks that costs can be reduced significantly without affecting quality and favors price controls on physicians, hospitals and drugs over increased out-of-pocket costs, rationing of expensive technologies and tax increases as cost control measures.

2. *Academy Research:*

The Academy obtained valuable information about the needs of patients from a major market research study which it commissioned in 1988. This study formed a basis of factual and attitudinal information about current and potential patients of ophthalmologists and sources of referral of eye care patients. A broad sample of 400 consumers in different geographic and market-size regions were interviewed.

Nearly everyone contacted had seen an eye care professional, either an ophthalmologist, independent optometrist or an optometrist in a vision care chain. Patients most likely to be treated by ophthalmologists were female, over 55 years of age, college graduates and employed as a professional/executive. Patrons of vision care chains were most likely to have children and be under the age of 35 years.

About one-third of interviewees attached significance to the costs of the eye care examination, preferring the least expensive eye care examinations available. About half of the respondents thought that having prescriptions for lenses and glasses filled right on the premises was important. Convenience and economic issues about the cost of examinations were more important for patients 35 years of age and younger than to older patients. The vast majority of people selected their eye care providers by asking a friend or a relative.

The cost of eye care does not appear to be a primary issue to most consumers. It may be that vision care is perceived to be a relatively limited expense and not a catastrophic one, so that the cost difference between adequate and excellent care is readily justified. Also, **communications** is paramount to the consumer's perception of the competence and concern of their eye care provider, far more important than economic or convenience issues. The **medically-based aspects** of an examination and the thoroughness of the evaluation were also very desirable components of eye care services for patients.

C. Implications for Future

These studies indicate that ophthalmologists can have a very important role to play in shaping eye care delivery. The public places high priority on the quality of care it receives, and associates medical eye care and ophthalmology with high quality. But the public is very dissatisfied with the present health care system and wants a better system with universal access and cost controls.

The public is seeking direction and leadership for a future health care system that is equitable and provides value for their money. In the absence of any other leaders stepping forward, the public is now looking to the government for solutions. If ophthalmology can lead in developing a rational solution to problems in eye care delivery, then it will be in the forefront.

Patients are also interested in thorough, **comprehensive eye care**. Wherever possible, ophthalmologists who can coordinate eye care and provide comprehensive services at one site or refer to other specialists as necessary will be making eye care much more convenient and accessible to patients. For example, expectations of younger Americans for more convenient hours and on-site dispensing of glasses are important concerns to be considered. This will entail changes in practice style in order to accommodate more patients in primary care led by ophthalmologists. The actual cost of services may not be a significant barrier, if the services are demonstrated to be of superior value to the patient's satisfaction.

IV. Research on Needs of Third Parties and Managed Care

A. Findings

1. Current Literature:

From a variety of research sources and surveys, the Academy has evaluated the attitudes of third-party payers and managed care plans. Recent literature on trends in managed care and third-party payers was evaluated and revealed the following information. Although eye care coverage will broaden in the near future, insurers are in the mood of contraction, not expansion. This means that insurers will be seeking opportunities to narrow their selection of providers to those who provide the most cost-effective care and to negotiate a discounted fee schedule or a capitated fee arrangement if possible.

Managed care organizations and insurers are looking for the most appropriate and less expensive means of care. There appears to be a widely held perception that ophthalmologists are more specialized, highly paid providers. Third-party payers also view optometrists as having a significant and appropriate role in vision care.

Pressures to contain costs will lead to the near total demise of traditional fee-for-service. Only a small segment of the population who can afford to pay for specialists' services will be paying fee-for-service. The next predominant reimbursement system will likely be outcomes-based. But this could be only an interim step before wide implementation of a capitation-based system.

Managed care has grown to dominate the delivery of care overall. If health care reform is passed, it will probably rely to a large extent on managed care plans to contain costs. Managed care plans will become larger and consolidated across several states. According to a 1991 Deloitte and Touche Survey, managed care executives are most interested in managing costs and secondarily in managing quality. The most important tools for managed care organizations are the use of a gatekeeper, control of physician referral, prior authorization and analysis of costs and volume of physician services. Physicians will be increasingly held accountable for their volume and costs of care, either in financial terms or in credentialing.

Employers seem more keen about offering vision benefits to their employees. A 1990 survey by Hewitt Associates found that the number of U.S. companies offering vision coverage doubled from 31% in 1985 to 61% in 1990. This is viewed as an affordable and predictable benefit which is attractive to employees. Adding vision coverage also helps to soften the blow from greater cost shifting onto employees.

The principal component of vision care plans is a discounted arrangement with providers, both on the price of examinations and of eyewear. Increasingly, vision care will be managed, either independently or assumed under major managed care plans. There has

also been a trend towards an extended role of optometrists, not only examining eyes and fitting for glasses but also treating eye conditions. For example, Vision Service Plan's Primary Eye Care Program pays optometrists for treatment of eye conditions which were formerly treated only by ophthalmologists. There are an estimated 90,000 beneficiaries covered under this plan.

2. *Mr. Humphrey Taylor:*

Mr. Humphrey Taylor of Louis Harris and Associates, Inc. conducted a written survey of the 12 largest health insurance companies in January 1992. Eight of the largest insurers responded. The findings indicated that about a 10% increase in the number of persons covered for eye care services is anticipated within the next five years.

For the next five years, the single biggest changes anticipated included the following:

- ▶ Smaller, tighter networks of providers;
- ▶ Managed care style networks for eye/vision benefits to obtain cost savings;
- ▶ Provision of eye care benefits by more employers; and
- ▶ Offering of discount cards to individuals and employers by optical outlets.

The top three priorities for insurers were negotiating discounted prices, moving towards capitation and offering eye care as part of a flexible benefits plan. Insurers also viewed eliminating ophthalmologists who are seen to "over-provide" and increasing cost-sharing by patients as important priorities. No insurer rated the measurement of the quality of eye care or limiting ophthalmologists' fees per episode of care as one of the top three priorities.

Mr. Taylor also reported to the Academy on the attitudes of business employers, based on findings of major polls of employers. Their major concerns are about health care costs, which have been rising as fast as 20% or 25% each year. They need information and help to solve their rising costs and utilization, because they don't understand what is happening to them and because previous solutions have not worked. They also need help in establishing directions and strategies for the future, because they have not focused on the underlying causes of their problems but have been dealing more with immediate issues.

3. *Mr. Jay Gellert:*

To better understand the needs of third parties, particularly managed care organizations, the Academy invited Mr. Jay Gellert, formerly President and CEO of Bay Pacific Health Plan, a regional HMO, to speak at the Conference on Future Directions on the attitudes and needs of third party payers. Mr. Gellert conducted an informal, candid survey of managed care executives' attitudes towards ophthalmologists. The following perceptions of these executives were discovered:

There seemed to be a prevailing perception that a more efficiently run system might require fewer ophthalmologists. Also, there was a belief that there are more opportunities to

provide eye care services than other services where there is a more valid and objective measurement of care given. There was also the suspicion that the supply of ophthalmologists may be a factor in driving up the demand for eye care services.

The group held the perception that others, e.g., paraprofessionals, can adequately provide at least some of the same services that ophthalmologists provide. The added value of an ophthalmologist-provided service was not perceived to be very significant. There was a belief that eye care services, led by ophthalmologists with a group of paraprofessionals, could be organized into efficient units to provide care on a capitated basis. This appears to be one of the easiest medical services to provide on a capitated basis.

4. Academy Research:

The Academy also obtained significant information about the needs of third party payers from a market research study commissioned in 1988. This study gathered factual and attitudinal information about third-party purchasers of eye care services, including employee benefits managers and managed care executives. Fifty individual interviews were conducted with corporate benefits managers. All of the respondents were either responsible for the final decision or were consulted for recommendations on their company's benefits programs.

The proportion of companies providing their employees with coverage for primary eye care services was about one third, with larger companies (more than 250 employees) more likely to provide this coverage. Still, more than half of large companies did not provide vision care, and only about one quarter of those not doing so already were interested in providing primary eye care coverage in the future. Among those companies covering primary eye care, nearly all covered visits both to optometrists and ophthalmologists. And almost three out of four companies said they would provide insurance covering ophthalmologists even if they were charged a higher price.

Interviews with major executives from 11 major HMOs and 11 major PPOs across the nation were conducted to find out the actual and potential roles of ophthalmologists in vision care and what ophthalmologists could do to enhance their position as primary eye care providers. The consensus among this group was that the appropriate role for ophthalmologists in managed care organizations was as providers of specialty care. In some environments, ophthalmologists were seen as playing useful roles as managers of primary eye care. This was viewed as an efficient use of ophthalmologists' time. The managed care executives also expressed a concern whether there would be a cost barrier to having physicians perform refractions and other primary eye care procedures.

B. Implications for Future

In this rapidly changing environment shaped by third-party payers and managed care, a commitment to monitoring and evaluating external trends is essential for successful planning and adaptation. The Academy is in the role of translating the imperatives of the environment and of major players in health care to its members. This information is vital

enough to be communicated to all members in a comprehensive and digestible manner. This will require new approaches to education and may incorporate others who are more knowledgeable outside of ophthalmology to teach and consult.

Payers, patients and others are demanding more objective evidence of costs, outcomes and effectiveness. If ophthalmology is to prove itself to others, a significant investment in quantitative research will be necessary. This will benefit all of ophthalmology, and can be used to enhance ophthalmology's effectiveness in dealing with third-party payers. The need for **quantitative information** on costs, outcomes and quality will require a significant investment in research activities on behalf of the entire specialty.

Research and information itself will not be enough to help members in this new and unfamiliar terrain of managed care, heightened competition and increased market consciousness. Ophthalmologists are undergoing significant economic stresses and have grave uncertainties about how to deal with changes. Members will probably need more directive guidance and practical tools in order to adapt and to succeed.

A close relationship with major third-party payers and managed care is highly desirable in order to understand the needs of third-party payers and to develop approaches in which ophthalmology can best meet those needs. Much of the research, development and implementation will require the efforts of very specialized individuals, many of whom will be found outside of ophthalmology and outside the academic world. Physician leaders will need to delegate more to individuals chosen for their particular knowledge in ophthalmic practice activities.

Third-party payers are very concerned with costs and efficiency, but can also appreciate the long-term value of enhancing patient outcome and satisfaction by raising the level of quality of care. It will be important to structure constructive relationships with allied health personnel in order for ophthalmology to assure appropriate and affordable eye care which will appeal to third-party payers' emphasis on value. In the absence of another economical alternative, third-party payers and managed care plans may turn to organized plans without ophthalmology leadership. The team concept with the ophthalmologist as leader of eye care delivery needs to be fostered through educational and advocacy activities, both to ophthalmologists and non-ophthalmologists.

It has become obvious that HMOs, PPOs and other forms of managed care dominate the delivery of health care today. This is more evident in some areas of the country than others, but is likely to spread rapidly to all areas in the country, particularly if national health care reform is enacted. It is vital that ophthalmology is actively involved and leads eye care delivery in managed care plans across the country in order to assure its position. There will need to be a stronger emphasis on an effective strategy for ophthalmology's activities in managed care, and new efforts should be made to educate members more about managed care.

V. Results of the Government Survey

A. Description of Survey

In March, 1992, the Academy commissioned The Wirthlin Group, a well-established research and survey organization in the Washington, D.C. area, to conduct a study of attitudes of opinion leaders in Washington regarding health care priorities, ophthalmology and vision care. The Wirthlin Group conducted 34 telephone interviews with senior staff members and administrators in the Congress and Administration. The purpose of the interviews was to assess national health care priorities, to evaluate awareness and credibility of ophthalmology and the American Academy of Ophthalmology, and to evaluate the potential leadership role of ophthalmology.

The sample of interviewees was carefully chosen to be representative of the groups and committees which deal with eye care concerns on a federal level. Although members of Congress were not interviewed, the Wirthlin Group's experience with surveys of this type has been that the opinion of senior staff members can accurately represent the views of these members of Congress.

B. Findings

The major priorities of government are cost control and accessibility. Half of respondents believed cost control was the single most important government health care priority to be addressed in the short run, ahead of accessibility of health care. Health promotion and disease prevention will become a major priority in the next five years. Most thought that major health care reform will take place in the next five years. All believed that the federal government's influence in health care delivery will increase significantly in the next five years. Most also believed that state government influence would increase, but to a lesser extent.

In terms of needs of groups for increased national commitment and resources for health care, respondents ranked pregnant women, children, and minority groups as very high priorities. About one-third felt that eye care should have greater national resources and commitment. Nearly all of these health care leaders believed that eye care services should be coordinated and delivered in an integrated fashion, but were evenly divided on whether eye examinations should be included under a universal coverage plan. There did not appear to be a consensus on the role of primary eye care in a universal health care plan.

Health care leaders gathered their information about ophthalmology from several sources. The most prevalent source of information cited was personal and professional activities, followed by health care industry sources and lobbyist contacts. A majority of these respondents were familiar with the ophthalmology profession. Out of several ophthalmology and eye care organizations, the National Eye Institute was perceived most favorably (79.3), while the American Academy of Ophthalmology received a favorable rating

of 63.0, similar to the results seen in an earlier study conducted in 1991. This rating was higher than for the American Medical Association (50.7) and the American Optometric Association (58.2). The American Medical Association had the highest level of familiarity, but the respondents were the least favorable towards this organization.

Overall, respondents felt more favorable towards ophthalmology than optometry by nearly a three-to-one margin. The most commonly cited reasons were because ophthalmologists were medical doctors and had medical training and provided a broad range of services. Those who felt more favorable towards optometrists were impressed by their cost efficiency and affability and were disturbed by their perception that ophthalmologists were overutilizing and preoccupied with reimbursement.

About half of the interviewees described optometry's image to the government in positive terms because they worked with cost containment, they were less expensive and they were effective and trying to improve. An almost equal number of interviewees perceived ophthalmology's image to the government as positive and as negative. Those who believed it was favorable cited reasons that ophthalmology has been knowledgeable and respected. Those who believed it was unfavorable thought that ophthalmology was portrayed negatively in the press, that ophthalmology was resistant to change and that ophthalmology had very high payment rates under Medicare.

Overall, half of the health care leaders interviewed stated that they did not know if the image of ophthalmology is cohesive or fragmented. Less than one-quarter of respondents perceived the image of ophthalmology as cohesive. The rest saw ophthalmology's image to the government as fragmented.

Officials recommended that ophthalmology could improve communication, participate with government to develop solutions and organize more cohesively. They rated information on effectiveness of procedures as the most helpful tool to them. Also, information on costs, the development of practice patterns, information on new technologies and information on outmoded technologies were rated as very helpful. General information on the profession or provider qualifications was not viewed as very helpful in their decisions on health care policy.

The interviewees were asked what was the most important thing that could be done by ophthalmologists to take a positive leadership role in eye care. They stressed that public education on eye care and prevention. Also important were efforts to control costs, to make eye care more accessible to the public, and to promote regular eye examinations.

C. Implications for Future

The most important priorities for the government are control of costs and improving access. They are seeking information on costs and effectiveness which will help them better manage the health care system, and are also seeking help from physicians in educating the public and providing them with more regular eye care.

One of the most valuable efforts that ophthalmology can do to enhance its image and effectiveness with government is to be perceived as a player - participating with the government in finding solutions to these mutual problems. Currently, others are perceived as more cooperative and open to working with the government than ophthalmology.

If ophthalmology is to take a leadership role, the focus must clearly be on the public - education about eye care, promoting access to eye care and providing more routine eye care and evaluations. The perception that ophthalmology is preoccupied with reimbursement significantly compromises its image in the eyes of government decisionmakers. The priority of ongoing activities in public information and education by ophthalmology may need to be emphasized more clearly.

The findings showed that eye care is not a top priority or concern in the minds of the federal government officials. It may enhance awareness and recognition of eye care issues if communications are framed in the context of broader issues which are seen as most important to the government, such as cost control, access to care, pediatric care and care of minority groups' health problems.

Ophthalmology can provide policymakers with useful information - data on effectiveness and costs, development of practice parameters and information on technologies. Much of this is underway or accomplished already by the Academy and other organizations, and perhaps needs to be more visible. But it will also require a concerted dedication to research and evaluation of ophthalmic practices, and a more critical assessment of both new and old technologies in order to yield the desired information which will be most useful to achieving the goals of cost control and appropriate care.

VI. Other Research

A. Summary of Responses on Medical Specialty Organizational Structures

At the beginning of the organizational design process, Dr. Weinstein wrote to major medical specialty societies requesting information about their organizational structures. As of mid-March, 1992, six replies were received from the following organizations: The American College of Physicians; The American Academy of Neurology; The American Society of Plastic and Reconstructive Surgeons; The American Academy of Physical Medicine and Rehabilitation; The American College of Radiology; and The American College of Obstetricians and Gynecologists.

Questions: The societies were all asked to respond to the following questions:

1. What does your organizational structure look like?
2. How does this organizational structure meet the various needs of the membership? In particular, how does the current structure balance educational and socioeconomic priorities?
3. What are the major strengths of your current organizational structure?
4. What are the weaknesses of your organizational structure?
5. If you were to change anything to improve the structure, what would you change?

Findings: The organizational structures reflect a broad range of scientific, education and socioeconomic interests. The operational divisions for the volunteer leaders were:

- Management; Communications; Socioeconomic; Membership Services; Convention
- Education; Research; Service; Product/Services; Administration/Representatives
- Medical Education; Research; Scientific Program; Membership; Medical Practice; Health Policy and Legislation; Marketing and Communications
- Education; Health Care
- Economics; Education; Government Relations; Human Resources; Marketing & Public Relations; Research & Technology Assessment; Standards & Accreditation
- Educational Policy; Finance; Health and Public Policy; Membership Policy; Publication Policy

Four organizations have special interest groups or membership sections. Although there is no elective body to develop positions, the American Academy of Neurology carries out formal member needs assessments and its Nominating Committee is diligent in seeking diversity. The American College of Physicians relies upon careful review of issues by policy committees before decisionmaking by their Board of Regents. The American College of Obstetrics and Gynecology includes one member of the public on its board.

The American Society of Plastic and Reconstructive Surgery has a separate foundation which deals strictly with education and research. The society handles all socioeconomic concerns and a single staff supports both organizations. However, this creates difficulties in coordination and management, particularly for the support staff.

Other organizations are also in a period of change. The American Academy of Physical Medicine and Rehabilitation reported that it was going through a similar exercise with a Task Force on Structure and Governance. The American College of Radiology recently reorganized its commissions and committees. The American College of Obstetrics and Gynecology is reviewing its two-commission structure, and deciding whether one or three commissions are needed.

B. Organizational Theory and Design

Beginning in January, 1991, extensive research was conducted on the literature of organizational theory and design. Particular attention was paid to organizational structure of membership organizations and medical specialty societies. Many different organizational designs were delineated and analyzed for their strengths and weaknesses. Also, evaluation of various organizational processes was conducted, including policy development, leadership development, decisionmaking, and strategic planning. As a result of these efforts, many principles of organizational structure and process were identified and found to be significant in helping to guide the Ad Hoc Committee on Organizational Design's efforts.

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