The Foundation of the American Academy of Ophthalmology
Museum of Vision & Ophthalmic Heritage

Conversation Between Paul Lichter, MD and William Tasman, MD
In Partnership with StoryCorps, San Francisco CA, October 24, 2009

Drs. Paul Lichter and William Tasman recorded this conversation on October 24, 2009 during the Annual Meeting of the American Academy of Ophthalmology, in San Francisco CA.

Dr. Lichter is a glaucoma specialist from Michigan and Dr. Tasman is a retina specialist living in Pennsylvania.

You are invited now to listen to excerpts and read the complete transcript below.

Here Dr. Lichter describes his first glaucoma patient.

In this **excerpt** Dr. Tasman describes his time working with Gerd Meyer-Schwickerath, MD and photo coagulation.

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DR. PAUL LICHTER: I'm Paul Lichter. I'm 70 years old. It's October 24th, 2009. We're in San Francisco, California, and I'm talking to Bill Tasman, who has been a long-time friend and colleague and fellow department chair for many, many years, and fellow officer of the American Academy of Ophthalmology in the past, and we're here to have a conversation.

DR. BILL TASMAN: I'm Bill Tasman. I wish I was a kid like Dr. Lichter. I'm 80. Today's date is October 24th, 2009. We're in San Francisco, and my relationship with Dr. Lichter is friend and colleague. As he just said, we have served together on the American Academy of Ophthalmology Board, the American Board of Ophthalmology and the AOS.

DR. LICHTER: Well, how did you get interested in ophthalmology, Bill?

DR. TASMAN: My father was an ophthalmologist, and although I don't think he put any direct pressure on me, I felt that there was some. I really wanted to write and produce movies, and that really became a cropper. It was during the Second World War, and in those days you didn't have cars because there was gas rationing, and to take a girl out on a date you went to a movie, got a soda and came home. I came home one winter night, and I'd forgotten my key. I rang the bell and my father came to the door and he said, 'What do you want?' I said, 'What do I want? It's cold out here. I want to come in.' and he said, 'Well, if I let you in will you get serious?' So I said, 'Yes, I'll get serious.' So I went in and got serious. One thing led to another and when I got to the internship I found I thought I was interested in orthopedics, but after a rotation on orthopedics I gravitated to ophthalmology, and it's something I've never regretted.

DR. LICHTER: So after you decided to do ophthalmology was it all set that you would do your residency at Wills or were you considering other possible places of training?

DR. TASMAN: No, I kind of figured it would be Wills and that's where I ended up. Before I could start a residency, in those days you had to take a graduate course for a year at Penn, and while I was in the middle of that I was drafted. Because I'd had a year of ophthalmology, even though it wasn't hands-on, other than in the clinic, they made me an ophthalmologist. And so I did it for two years in the U.S. Air Force from 1957 to 1959, and then the die was cast, I went to Wills.

DR. LICHTER: Where were you stationed in the service?

DR. TASMAN: I was in Wiesbaden, Germany, at the 7100th U.S. Air Force Hospital.

DR. LICHTER: And did you know enough to be an ophthalmologist?

DR. TASMAN: I was very fortunate because when I got there the senior ophthalmologist was a fellow named Jorge Buckston, who maybe you knew…

DR. LICHTER: Sure.

DR. TASMAN: …a well-known cornea surgeon in New York. And he couldn't have been nicer. He really taught me a lot during the four months that we overlapped. And when he left there was another Board certified ophthalmologist named Jim Curtis, who came in. But Buxton, before he left, said, 'Look, if you have a problem there's a guy up in Bonn who is working on this funny light, and he's treating people's eyes, but he's very good, you can take the patients up there, I do that a lot, and he'll give you a consult.' And that was Meyer-Schwickerath. So between Curtis and Meyer-Schwickerath I had a good experience.

DR. LICHTER: Well, tell us about your experience with Meyer-Schwickerath. Isn't he a legend in ophthalmology?

DR. TASMAN: He was, and we became very good friends. I would go up there at least once a month. And it was interesting because he was not the Chairman. The Chairman was a man named Müeller, and Müeller was old-school German. He had saber scars from one of the dueling fraternities on his cheek. And he was famous for treating tumors. But Meyer-

Schwickerath was working on a photocoagulator at the time, and so I used to watch him. And a lot of what he did, for example, photographing the retina in diabetics before he treated, to document where the changes were. Patients would come back a few months later and their exudates would be gone, and everybody said, 'Oh, you had the wrong eye.' And they would bring out the pictures and you could see the difference. At that time, we didn't fluorescein yet, so the idea was to shoot the red, any little red dot, and it worked out.

DR. LICHTER: Now… so I'm remembering stories that Meyer-Schwickerath first did photocoagulation on the roof of his building with a lens capturing the sun…

DR. TASMAN: That's correct. That was immediately after the war ended. The war ended in Europe in May of '45, and in July of '45, there was an eclipse. He was in Hamburg, Germany then at the Hamburg Eye hospital. There was an eclipse, and this young student had looked at it and burned one macula. So his mentor (who was Marchesani) had this young man write a thesis about it, and that's where he [Meyer-Schwickerath] got the idea to use the sun as a light source. He fashioned a Galilean telescope, tried to focus the sun's rays, but with the rotation of the earth and the clouds it was difficult. Patients were up there at 12 noon with a phone to the clinic, and the patient would call down when the sun came out. But when it didn't work he finally got the Zeiss people to build him a real instrument.

DR. LICHTER: And describe what the first xenon laser looked like.

DR. TASMAN: Well, before I describe it, I'll tell you the predecessor to the xenon had a carbon arc filament, and that was the light source. But when it got real hot it would blow up, and then you would have soot all over the place. While I was there they got the xenon bulb developed by Zeiss. It was white light. There was a little door on the side of the instrument that you would open to adjust mirrors that would help focus the direct ophthalmoscope. Meyer-Schwickerath inadvertently looked at the xenon bulb and photocoagulated his own macula. So then they installed a safety device. But he actually, I think, in the long run, if anybody ever deserved the Nobel Prize for Medicine, Meyer-Schwickerath did, because that was a huge contribution. And of course it led to lasers.

DR. LICHTER: And did you at that time, did you have the actual commercial model of the xenon laser when you were there?

DR. TASMAN: Yes.

DR. LICHTER: And describe the size of it and what it looked like.

DR. TASMAN: We called it Big Bertha. You know, during World War I the Germans had a huge gun that they moved back and forth on flat cars. It was known as Big Bertha. It was a huge housing and it was heavy. It was on rollers, but nevertheless it took a couple people to move it around. Once you got it positioned over the patient you used a direct ophthalmoscope to focus. And at that time indirect was beginning to come into the picture, especially through Schepens in the United States, although they did use an indirect in Germany, but it was monocular. It was called the Bonoscope, not for Bonn, Germany but for Professor Bonn, who developed it.

DR. LICHTER: But the machine actually stood five feet or so off the ground, didn't it?

DR. TASMAN: About four-and-a-half feet high, I would say.

DR. LICHTER: About four feet long?

DR. TASMAN: …three-and-a-half to four feet long and two feet wide.

DR. LICHTER: And with this big arm coming out. Yeah. It was the first laser I used, as well. It wasn't a laser, really…

DR. TASMAN: No, it was not a laser. It was a light coagulator.

DR. LICHTER: Yes.

DR. TASMAN: The word spread around the world, and a very famous man you know from out here in San Francisco, the late Dohrmann Pischel, called me one day in the clinic in Wiesbaden. He had a Navy seaman with a hemangioma on the optic nerve, and wanted to send him over to our hospital

to get him treated. It didn't work too well, though. But even today that's a hard lesion to treat.

DR. LICHTER: So that sort of brings us back to the states and to Wills. After the great experience with Meyer-Schwickerath, you went to Wills, you completed your residency…

DR. TASMAN: Yes.

DR. LICHTER: …and then what did you do?

DR. TASMAN: Then I took the fellowship in Boston with Charles Schepens at the Mass Eye and Ear.

DR. LICHTER: How long was the fellowship?

DR. TASMAN: One year.

DR. LICHTER: And afterwards?

DR. TASMAN: I came back to Philadelphia and went into practice.

DR. LICHTER: Well, tell me a little bit about your impression and experience with Charles Schepens, of course also another legend in ophthalmology.

DR. TASMAN: It's not often that you get a chance to work with two legends, but he was, and of course he had a career that was unbelievable. During the war he had been in the underground in France, and in some ways he had ice water in his veins. I don't know how he did it. Dr. Schepens was in the air force in Belgium when the war started, and they had a spy in Gestapo headquarters who told him that, 'You're on the list to be picked up.' So he went to Paris where he had friends. They sent him to Southern France, to Vichy where there was a deserted lumber mill. Dr. Schepens resurrected and made it functional. It was really a cover to smuggle people out of France into Spain and back to England.

He was a very demanding and sometimes intimidating teacher. We had to do very careful drawings of the retinal detachments, and then Dr. Schepens

would check them, and you just hoped you didn't miss a hole. Now, no one called him by his first name, it was always Dr. Schepens. But I remember one time in the OR, I was the fellow and a very well known ophthalmologist… oh, I can say who it was, Herb Kaufman, was the resident. Herb already had a big reputation because of corneal herpes. So he and I scrubbed in, it was a re-op, and it was one of those cases where you felt, you wish you could faint and be carried out. It went on for hours. And at one point Dr. Schepens was trying to get a suture into the sclera flap, way, way back, and he'd go from one side of the table to the other and then back. And the third time he got it in, and when he did, Herb Kaufman said, 'Charley, I knew you could do it.' Well, you could have heard a pin drop in that OR, but no one said anything.

DR. LICHTER: Now, was your time with Dr. Schepens shortly after he developed the indirect ophthalmoscope?

DR. TASMAN: Yes. It was '60, '61, and he had developed the scope in the forties.

DR. LICHTER: 1961?

DR. TASMAN: Yes, and he had developed it during the war, actually, because… there's a long story about how he almost got arrested by the Germans and his good friend Oleg Pomerantzeff got him over the Pyrenees into Spain. Prior to that, he had told his contact, 'Never come to my house.' And he came home one night and there was this fellow's bicycle outside his house, he went in and the fellow said, 'Don't worry, the Germans aren't watching.' 'They were watching,' Schepens replied. And that night Oleg took Dr. Schepens over the Pyrenees and on to London. The Germans watched the house thinking that he would return, but he did not. And then a few weeks later Oleg came back for Mrs. Schepens, who was pregnant, and their other child.

DR. LICHTER: In London.

DR. TASMAN: He was going to start a residency at Moorfields but it was hit by a buzz bomb the night before he was to start. The next morning Dr. Schepens scrounged the wreckage to find metal to build his prototype scope. And that one you can see that's in the Smithsonian.

DR. LICHTER: Fascinating.

DR. TASMAN: Yes.

DR. LICHTER: Fascinating. So you've had… as you say, you were privileged to be closely involved with two legends in ophthalmology, and then you of course were at Wills with other famous people. What sticks out from your training as a resident at Wills?

DR. TASMAN: Clinical experience. There was an old saying: Wills might not be the first to describe something, but they'll have more of them than anybody else. And so you saw a myriad of things. And the other big thing that was, I think, a plus—you had nine chiefs, each with a little different way of doing things. So you got exposed to various techniques rather than just one or two, because there was a diversity of instruction, and that was, I think, something very unique.

DR. LICHTER: Who was your chief at Wills? Who trained you?

DR. TASMAN: Well, there were nine of them, and they were…

DR. LICHTER: Who was the Chair of the department at the time?

DR. TASMAN: They didn't have a Chair. It was before chairs. I would say the dominant chief was Irving Leopold, who was probably the smartest guy I've ever known in ophthalmology. He was unbelievable. He'd get up and he'd give a lecture for an hour without a slide, quoting references with no slides, and no notes. Then Rob McDonald was a very respected Chief at Wills. George Spaeth's father was a chief at Wills. My father was, but by the time I got there he was out, he was no longer Chief. And they were the primary ones.

DR. LICHTER: And then after you finished and went to… you went to Boston, came back to Wills on the staff.

DR. TASMAN: Right.

DR. LICHTER: Why don't you tell us about your early years at Wills, when you came back? The Retina Service was already under way?

DR. TASMAN: Yes. McDonald was just in the process of establishing it. It was the first vertical service at Wills, followed shortly after by glaucoma. And McDonald was the head of Retina. When you went through that service… we followed the same protocol as Schepens did. I mean, you had to draw all the retinas and use his procedure. McDonald and Schepens were very good friends, and when I first got to Boston Dr. Schepens was using a polyethylene tube around the eye, which was rigid and would work its way through the wall of the eye and intrude. Dr. McDonald suggested to him, 'You might want to switch to silicone.' And he did and that was what we use still today. Although the age of buckles is giving way to vitrectomy.

DR. LICHTER: So were you the second person in the service, then? McDonald took you as the second person on the Retina Service, is that right?

DR. TASMAN: No, Bill Hanesley was the first. Bill was a protégé of Robb McDonald, and he was four or five years older than I was, he was trained by McDonald, and was a very good retina surgeon. He is now retired.

DR. LICHTER: And then over the years, of course, the retina service grew.

DR. TASMAN: Yes.

DR. LICHTER: And who came after you?

DR. TASMAN: The next one after me was a fellow named Charlie Rife, from Lancaster, Pennsylvania. Charlie was a resident at the Mass Eye and Ear when I was a fellow. And he was very good with indirect ophthalmoscopy. It was a time when the general ophthalmologists didn't do indirect, and some of them couldn't make the switch. I have to back up. Charlie was on before me because he came down from Boston and started practice before I finished the fellowship.

DR. LICHTER: But he wasn't there for long, was he?

DR. TASMAN: Well, yes he was. He was there for many, many years, but only one day a week.

DR. LICHTER: I didn't know him.

DR. TASMAN: Well, he never wrote and didn't like to go to meetings and talk, but he was excellent in what he did. He had gone to MIT and he's still alive. He must be in his upper 90s by now. And he would come down from Lancaster one or two days a week.

DR. LICHTER: So now we've got the four of you there, and now the Service has grown over the years to how many?

DR. TASMAN: Oh, well, let's say… counting Julia or not counting Julia?

DR. LICHTER: As many as you want to count.

DR. TASMAN: There are 20 of us.

DR. LICHTER: My goodness, and how many offices do you cover now?

DR. TASMAN: I'd have to stop and think about that, but at least seven or eight.

DR. LICHTER: So now, as you developed your own retina practice, you began to get an interest in retinopathy of prematurity, didn't you?

DR. TASMAN: It actually started when I was up with Schepens, only because he got a few patients who had detached retinas. They weren't infants, they were young people, who had had retinopathy of prematurity, then known as retrolental fibroplasias. And he operated. I found it fascinating with the changes in the retina, and I pursued that field of interest. And then I dealt mostly in the changes that occurred as they got older. Then when cryo came along I got interested in the acute ROP that occurs in infants.

DR. LICHTER: So tell me a little bit about retinopathy of prematurity or previously called retrolental fibroplasia, in terms of the discovery of what the cause was and how it's been dealt with in nurseries.

DR. TASMAN: Well, it was first described by Terry in Boston back in ’42. He wrote an article in the *AJO*, and, interestingly enough, if you go back and look at that article, they didn’t use fundus photography. It was available. But he had beautifully painted plates, and sometimes when I talk about it now I will show one of the plates and then a photo of the same thing. It was a pretty faithful portrayal.

Dame Kate Campbell in Australia figured out that it was due to oxygen exposure in the nursery. But it’s going through an evolution now, and, in fact, we know now it’s really gestational age and birth weight that are the critical factors for retinopathy of prematurity.

STORYCORPS FACILITATOR: And what is that?

DR. TASMAN: It means that the retina in these babies, some of which weigh a pound-and-a-quarter, have only had a 26-week gestation when the norm is 40, and have not developed vascularization to the peripheral retina. Depending on how much of the retina does not have a blood supply determines the severity to some degree of the condition and whether or not it needs treatment. And that was the big thing. For a long time we didn’t have treatment. I’ll back it up for a minute… because Arnall Patz, who I always give credit to for his work with retrolental fibroplasia, made some landmark contributions when he examined babies in the nursery in Washington. He would see patients who were not premature, whose retinas were dragged. That means that they’re displaced, often to the temporal side, and yet they didn’t have prematurity in their history, so he postulated that maybe full terms could get retrolental because the oxygen concentration in room air was higher than in utero. Well, that was kind of a cockamamie theory when you think about it now. And of course, you know, most of these turned out to be familial exudative vitreoretinopathy**,** which was not described until 1968, over 20 years later. And I even went back and looked at Ida Mann’s history of congenital retinal folds. I think they were fever, too.

DR. LICHTER: Really? Interesting. So you’ve been at Wills for a very long time, and you’ve written the *History of the Wills Eye Hospital*.

DR. TASMAN: Yes.

DR. LICHTER: Wills is a famous institution of ophthalmology in this country. Tell me a little bit about the history of Wills, the highlights, in your mind, of when it started and what it developed into, and how it developed that way, and where it is now.

DR. TASMAN: Wills just celebrated its 175th anniversary, so it's nice you're asking me that question. It was founded in 1832 as the result of a bequest from a Quaker grocer who lived on Chestnut Street, which is a main artery in Philadelphia. He died at the age of 48. But he was good friends with a doctor named Joseph Parish, and I believe Parish probably talked him into leaving money to establish this hospital. It was about $106,000 then, and it was to be for the indigent blind and lame. Now there are no commas there, so it's not indigent, comma, blind, comma, and lame. You had to be indigent blind and lame. It wasn't called the Wills *Eye* Hospital. It was the Wills Hospital, but as it evolved it was purely for treatment of eyes. It was the first real facility dedicated only to eyes. The New York Eye and Ear is the oldest, then Mass Eye and Ear, and then Wills. But they were eye and ear. We were just eyes. And I sought for a long time to find a picture of the Wills Grocery, which is not easy to do. We were looking through street elevations at the historical society. I found two buildings that he owned, and I do have pictures of those. But then Alice Lea, my wife, went on the board of the Historical Society. I had spent a lot of time in there looking for things before that, but when you know someone on the board people get interested, and they recently found a receipt from 1797, from the Wills grocery, and to me that was a great find.

But there were a lot of famous men that went through there over the years. There's a very famous artist in Philadelphia named Eakins. He did a painting called *The Gross Clinic.* Gross was chief of surgery at Jefferson back in the late 1800s. Then, 15 years later, the Penn medical students commissioned him to do the Agnew Clinic. Everybody thinks of Agnew as a general surgeon. There weren't that many people doing just ophthalmology in those days, but a lot of the general surgeons thought if they did cataracts it would enhance their reputation—working on a tiny area. I found out that Agnew, between 1864 and '68, I think, did 69 cataracts at Wills. And he is listed on the staff at Wills Eye. So I was pleased to find that. He had been a real hero, by the way, in the Civil War. He fought with McClellan in the Peninsula Campaign, and at Antietam. And he got Lincoln's attention at one point because Lincoln wanted to put him in charge

of a hospital in Washington. He also was involved with James Garfield when he was assassinated. Agnew was one of the surgeons called in consultation. Garfield lingered for about three months, but all the docs went and probed the wound looking for the bullet. They knew about sterility, but they didn't practice it. They finally got him infected and Garfield had a heart attack and died. The general consensus today is that had they left him alone he would have lived, because the bullet was near the spine, didn't damage it, was encapsulated.

DR. LICHTER: Well, that brings us up to 1900, maybe. But how did Wills develop its subspecialty fame, really, with all of the chiefs of the different services and so forth? How did that evolve?

DR. TASMAN: Well, that's an interesting question, because there was resistance, and everybody thought they could do everything. And the truth of the matter was, especially with retinal detachments, if they couldn't do indirect ophthalmoscopy, they couldn't do it. I remember one chief would have the resident find the tear and then take a Schweigert perimeter to locate the meridian where the tear(s) were located.

DR. LICHTER: No.

DR. TASMAN: You don't remember that?

DR. LICHTER: A Schweigert perimeter? No.

DR. TASMAN: It's a handheld perimeter. You could do a field on a patient in bed. You would figure out the meridian where the hole was, and draw it there, and that's how they found the retinal tear. I mean, I hate to bring it up. It's so primitive by today's standards.

DR. LICHTER: Right.

DR. TASMAN: But the… as I said, once it took off, retina was the first one and that was successful, and then glaucoma, and George Spaeth was made head of glaucoma after one of the chiefs retired. So when those two services got going then the next thing, I think, was plastics, and then pediatric ophthalmology followed.

DR. LICHTER: And oncology and…

DR. TASMAN: Yes. Well, that was the biggest thing of all. Oncology started in the 60s when Jerry Shields was a resident, and he decided he was going to go to the AFIP and study with Lorenz Zimmerman, and they came back to do oncology.

DR. LICHTER: That's the Armed Forces Institute of Pathology.

DR. TASMAN: Armed Forces Institute of Pathology, and Zim was the man in that area. Well, you know his contributions. So Jerry started looking at tumors and treating them, and it just grew and grew – the Service, not the tumors. And to make a long story short, Jerry met Carol, who was a resident, and he married her, and she's as much a dynamo as he is. I call it the Jerry and Carol Show. But I really think that they've got the biggest tumor service in this country, if not the world. So that… I always said any practice can leave Wills and we'll fill their shoes with somebody else. The one that always worried me was the Shields, because that would not have worked. You wouldn't have found somebody that could do what they do.

DR. LICHTER: Right. Tell me a little bit about how you became the head of the Wills Eye Hospital and then all the things that you did when you were the head.

DR. TASMAN: Well, I actually was offered the Scheie Eye Institute in the 70s, but when I talked to them, I finally turned it down. And then Wills came to me in 1980, when Tom Duane retired, and for whatever reason he liked me, so he put my name forward. And then the search committee offered me the job, but they wanted me to give up practice, and I said, 'Well, look, I worked too hard on this practice to get it where it is. What if in six months you don't like me and I'm out?' So I didn't get it because of that. And then they went in another direction and after a few years the position was once again open, and this time there were no stipulations.

DR. LICHTER: So that was in what year?

DR. TASMAN: '85.

DR. LICHTER: So you took over Wills in 1985, and at that time… describe the facilities of the Wills Eye Hospital at that time.

DR. TASMAN: Well, we were still… no, we had moved… Wills has had four homes. The first one was on what we call Logan Square, and if you go to Philadelphia that's where the Four Seasons Hotel now is. It would have been nice to hold on to that real estate. Then we went to the second location in 1932 at 16th and Spring Garden. And in 1980 we moved down to Ninth and Walnut because we became part of Jefferson, at least their Eye Department. We're still an independent facility with our own board, but we serve as their Ophthalmology Department. Then about ten years ago we built a new facility, which is primarily outpatient, across the street from the Wills. So this is our fourth home. And it's been interesting. You know, you think back to what you might have done differently, and there are things I would have done differently.

DR. LICHTER: Like what?

DR. TASMAN: I wouldn't have moved out of the one that we went into in 1980.

DR. LICHTER: Because…?

DR. TASMAN: Well, I think… this gets into a whole business thing about the kind of advice you get. You get people that come in, and they're consultants, quote/unquote. And you know what? They're not always right and they can mislead you. And there were some things I didn't like, but the Board was pretty well determined to do it. And they basically didn't think we could make it in their facility because we didn't have in-patients any more. But we were doing well because we had all the neurosurgical patients from Jefferson in our hospital. But the other interesting thing about that, Paul, was that since I was the head physician, the head of neurosurgery reported to me, and I don't know if you've dealt with neurosurgeons. They kind of go their own way. It's very hard to get them to dictate their oral reports on time and their discharge summaries, and I couldn't get him to, you know, crack the whip, and so I had to be the one that cracked the whip.

DR. LICHTER: And so you dictated all the neurosurgery…

DR. TASMAN: No, I did not. I badgered them to do it.

DR. LICHTER: Now, you know, in a city like Philadelphia, of course, a big city and a lot of academics going on, how was the relationship between the Wills Eye Hospital and the Scheie Eye Institute been over the years? And describe maybe any involvement you had in those relations.

DR. TASMAN: To me it seemed like a natural that Wills and Scheie should get together.

DR. LICHTER: Of course, Scheie being the University of Pennsylvania's Eye Hospital.

DR. TASMAN: Yes. And I started on that even before I was ophthalmologist and chief. I talked to the dean there several times… real nice guy, but we could never get it off… get it moving. Then a fellow named Bill Kelly… does that mean anything to you?

DR. LICHTER: I'm afraid it does.

DR. TASMAN: Came to Philadelphia and became head of Medical Affairs at the University of Pennsylvania. And he called me up one day. He said, 'I've got a great idea.' I said, 'What?' He said, 'I think Wills and Scheie should get together.' I said, 'I've had that idea for a long time. I talked to your predecessor about it but it never went anywhere.' He said, 'I want to come over and see you.' So he came over to my office…

DR. LICHTER: He was dean and CEO, wasn't he?

DR. TASMAN: CEO, yes, he was the big chief. So he came over to my office and we talked, and I said, 'Now, one thing I won't do… I just… I want to do this, but I've got to tell my board and the Dean, because I do believe in loyalty. And I think that we've been with Jefferson for a long period now…' and he had made it clear that Jefferson would be the secondary partner and be like an adjunct to Penn. I said, 'You can't do that.' And I said, 'We've got a big service here, we've got a lot to offer,' and I said, 'there's no reason why one chairman can't represent both institutions.'

So I took it to our board and the president of Jefferson and the Dean. Well, they chopped me up pretty good. And the head of our board asked to come with me, and he did. It was like being in the witness chair, you know. And when it was all over I said to our board chair, I said, 'You were a big help. You didn't say anything.' And he said, 'What did you think would happen?' So I guess I was a little naïve, but I thought I could sell it but I couldn't.

DR. LICHTER: And so that… what year… that would have been what, 19…?

DR. TASMAN: Probably the late 80s or early 90s. I was in the office at the hospital at Ninth and Walnut on the second floor. And I had a real predicament when I first met with Dr. Kelly. I don't know whether to put it on tape, though.

DR. LICHTER: Why, sure. Why not?

DR. TASMAN: Well, it was… I could ask you what you would have done in this situation.

DR. LICHTER: All right.

DR. TASMAN: I was sitting at my desk and he's sitting across from…

DR. LICHTER: He being Bill Kelly.

DR. TASMAN: He being Bill Kelly.

DR. LICHTER: Who had been the Chair of Internal Medicine at the University of Michigan.

DR. TASMAN: So the whole time we're talking I happened to notice his fly was wide open.

DR. LICHTER: Yes.

DR. TASMAN: So the question is, do you tell him or not? I did not.

DR. LICHTER: Now did you go back to him after… of course, after the Wills board said, 'No, no way, no how,' with the merger, did you call him on the phone or did you go back and talk to him in person? Do you remember?

DR. TASMAN: No, I didn't have any face-to-face with him after that. It was on the phone.

DR. LICHTER: Do you think that's a dead issue now, Wills and Scheie coming together?

DR. TASMAN: I don't think anything's ever dead. They've just gotten a new chairman, as you probably know, Joan O'Brien, and she's interested in tumors. I think she has the facilities for some great research, and with the clinical material that Jerry and Carol have I would never rule out that type of a possibility.

DR. LICHTER: Sure. Right. In terms of your relationship with the Academy, just in a brief few moments, when did that start?

DR. TASMAN: At… you know, I can't give you a precise date, late 70s, I would say, on the program committee.

DR. LICHTER: That's right, you were on the Program Committee…

DR. TASMAN: And you were the head of the Program Committee.

DR. LICHTER: Yeah, that would have been… that would have been something like 1980, yeah. But we used to meet in Ann Arbor.

DR. TASMAN: Yes, I remember that. I remember one of the meetings in Ann Arbor.

DR. LICHTER: Yeah.

DR. TASMAN: Do you remember where you took us for dinner?

DR. LICHTER: Chinese restaurant, is that the one you remember?

DR. TASMAN: And I was about to put something in my mouth, you said, 'You want to swallow these.' And I just swallowed it. Well, I never had a fire like that inside.

DR. LICHTER: There was nothing you could do to get it out.

DR. TASMAN: Right.

DR. LICHTER: I once did that in Pakistan. Oh yeah.

DR. TASMAN: You don't forget those experiences.

DR. LICHTER: But then you went on in the Academy to ultimately become the President of the Academy [in 1999].

DR. TASMAN: Yes.

DR. LICHTER: What do you remember from that?

DR. TASMAN: Well, it was a great year. I think what I remember is being able to talk to that many people and say what you think when the President gives his little spiel. And I remember there was some issue. I don't remember exactly what it was, but I was trying to get the audience going, and I asked, 'Are you with me?' And I got a tepid response. And I asked them again, and they responded with gusto.

DR. TASMAN: This is Bill Tasman, age 80. Today's date October 24th, 2009. We're in San Francisco, and I'm about to talk to a very good friend and colleague, Paul Lichter, who I've known for many, many years.

DR. LICHTER: And I'm Paul Lichter, age 70. It's October 24th, 2009. We're in San Francisco and I'm talking to Bill Tasman, a colleague and friend for… of long standing in many aspects of ophthalmology and social activities, so…

DR. TASMAN: Well, it's a pleasure to be here with you, Paul, and I can see some similarities in our backgrounds. I had trouble getting out of Philadelphia. It looks like you had trouble getting out of Michigan.

DR. LICHTER: And I did.

DR. TASMAN: How did that come to be? I mean, you grew up there.

DR. LICHTER: I grew up in Detroit, went to the University of Michigan undergraduate school, medical school, went to San Francisco to intern at the… what is now the Pacific Medical Center but at one time was Stanford University Hospital, but when I got there it had just changed to the Presbyterian Hospital. Then I went back to Ann Arbor, University of Michigan, for my residency, and then went back to San Francisco to do a fellowship in glaucoma, under the auspices of Robert N. Shaffer and the University of California at San Francisco, and then went back to the Navy in Bethesda for two years, and then joined the faculty at the University of Michigan. I've been there ever since.

DR. TASMAN: Was Dohrmann Pischel at the California Presbyterian when you were there?

DR. LICHTER: Yes, he was.

DR. TASMAN: He was a fine gentleman. Did you get to know him at all?

DR. LICHTER: I didn't get to know him well, but he actually was an examiner of… when I took the American Board of Ophthalmology examination he was an associate examiner, and I remember him examining

me. Of course, he was such a revered retina specialist and a lovely, lovely man, and he was very gentle on the examination. But he was in practice when I was a fellow.

DR. TASMAN: And I seem to have a recollection, and maybe it's apocryphal, I don't know, that before the Golden Gate Bridge was built he would row across the bay to get to his office?

DR. LICHTER: I know nothing about that, but my goodness.

DR. TASMAN: So we can't confirm that.

DR. LICHTER: No, not by me.

DR. TASMAN: So who else did you get to have as mentors while you were in San Francisco?

DR. LICHTER: Well, in Bob Shaffer's office… of course, he was by then really an internationally known glaucoma expert, it was really a privilege to be a fellow under his tutelage. Jack Hetherington, who was his partner at the time, was very much involved in my glaucoma training and in my glaucoma tennis playing. Dr. Shaffer liked to take fellows who could play tennis because he was an avid tennis player, as were his partners. Jack Hetherington, Bill Ridgway were tennis players. We used to play tennis regularly and…

DR. TASMAN: Great.

DR. LICHTER: Yeah, it was a wonderful addition to the fellowship, actually.

DR. TASMAN: Well, let's back up for a minute. Was there somebody in your residency at Michigan who pointed you in the direction of glaucoma or piqued your interest?

DR. LICHTER: No. Actually, my interest in glaucoma was serendipitous, I guess; if you could say that. It has been good to me. As a first-year resident at Michigan I was on what was called the Private Service, and the Private Service, first-year residents would be the hand maidens, in a sense, to the

professors in their private practices. So at that time Dr. Fralick, F. Bruce Fralick, who was my chief, was seeing a patient who was a schoolteacher from Grand Rapids, Michigan, and I remember her name to this day, because she was responsible in a sense for my career. And this young schoolteacher had very severe glaucoma, very high pressures, and no one could figure out what in the heck was wrong with her. She was about 25 years old, and I was doing a visual field on her as part of my duties, and I was very struck by this. And at that time, just shortly before that Hans Goldmann had described steroid glaucoma, which was caused by the use of eye drops in the eye of cortical steroids, and of course could be caused by ointment. So I asked this woman, while I was doing the visual field, if she happened to be using any sort of eye drops in her eye, and she said no. And I said, 'Well, could you be using any ointment on your eyelids?' Well, it happened that she was. Her eyes itched for whatever reason and she was rubbing this cortical steroid on her eyelid and it was getting into her eye. And I said to Dr. Fralick just very sheepishly, because I thought maybe I was wrong, I told him what I had found out and he said, 'Of course, that's what it is.' And the medicines were stopped and her glaucoma got better. She had lost a lot of vision by that time, but I expect she had a life with vision.

So that got me interested in glaucoma, and she also had, in her gonioscopy examination of the filtering angle of the eye, she had a lot of iris processes. And I mentioned that to Dr. Fralick, I said, 'Do you think that means anything?' And he said, 'Well, why don't you do a study?' So I did. I did a study of students, medical students and nursing students, I think I got, and I did a lot of gonioscopy on these students and wrote a paper and it ended up leading to my interest in glaucoma and my fellowship with Dr. Shaffer.

DR. TASMAN: Have you ever heard from the patient recently…?

DR. LICHTER: The teacher? No, I have no idea where she is, but I should probably look her up sometime, yeah.

DR. TASMAN: Did you ever get to know Harold Falls or was he…?

DR. LICHTER: Harold Falls was there at the time and was a very important mentor to me as a resident, and then later on when I came back on the faculty. Harold Falls is an interesting person. You know this, I'm sure,

quite well, Bill, but Harold Falls really was the father of medical genetics in the United States, not just ophthalmic genetics, but Harold Falls was a resident at the University of Michigan in the early 40s, and it was during the war. And he had an interest in genetics that he kind of got, he said, from his grandfather who raised him, who was a farmer. And the different colors of corn and so forth got Harold Falls interested in genetics and in differences, and he carried that forward in medical school and in his residency. And so during his residency he was involved in a… what was a very primitive genetics program that was run by a man named Dice, D-i-c-e, who was a PhD. In any case, though, when Harold Falls finished his residency these other men had gone off to the war, and Harold became the head of what was the first genetics heredity clinic in the United States, at the University of Michigan, and so from there he went on to do some very, very important genetics research. And this genetics clinic was the forerunner of the Department of Human Genetics at the University of Michigan, which was also the first such program in the country. And Harold Falls really discovered a whole lot of genetic diseases. In fact, even before Mary Lyons discovered Lyonization, Harold Falls actually was the first to describe it. He didn't know the name Mary Lyon, so he didn't call it Lyonization. It really was Falls-ization.

But anyway, Harold Falls taught us as residents to pay attention to differences. He taught us that when we shake the patient's hand to look at their hands, that you can see a lot in a person's hands. And if we get to it as we talk, I can tell you a story about that and how it affected something I did later on in my life in ophthalmology. But Harold Falls was a real important mentor to me.

DR. TASMAN: Is it true that he used to tell students that the diagnosis for your patient may be in the waiting room?

DR. LICHTER: Yeah, the members of the family, yeah, right.

DR. TASMAN: Bring them in and look at them.

DR. LICHTER: Bring them in and look at the family. He was a person who was way ahead of his time in genetics. He was just a real great, great man in ophthalmology who, as far as I'm concerned, hasn't gotten the credit that he

deserves, but he was really an important force in ophthalmology and in ophthalmic genetics and in genetics, in general.

DR. TASMAN: Now, how long was your fellowship in San Francisco?

DR. LICHTER: My fellowship was one year, but that one year was critical for my entire career, my relationship with Bob Shaffer.

DR. TASMAN: Tell us a little bit about Bob and Virginia.

DR. LICHTER: Yeah. Well, Bob and Virginia were wonderful people. Bob died a year ago and Virginia's still alive, in her… well, it must be mid 90s. But Bob and Virginia, when they had a fellow, the fellow really became kind of part of their family and the closeness was always there. They invited Carolyn, my wife Carolyn and me, and our kids, to come to their home, they would take us on a boat, we did a lot of things together.

DR. LICHTER: So we were very much a part of their family. Bob had a very busy glaucoma practice. He was very organized. He saw his patients, was very careful to complete his dictation at the end of the day, there wasn't anything left, his desk was always clean. He was an excellent observer. He was very kind to his patients and kind to his fellows. We worked very, very hard. I remember realizing very quickly in my fellowship that he wrote very excellent letters to referring physicians and he had a way of telling a referring physician that they didn't know anything about what they were saying, but he said it in such a nice way that it was really to try to teach them to do gonioscopy, to look at the optic nerve carefully, to pay attention to the things that really make up a glaucoma diagnosis. And of course that was, you know, 40 years ago. Nowadays these things are more taken for granted, but at that time, really, there wasn't very much sophistication in the general ophthalmic community about dealing with glaucoma, and Dr. Shaffer got patients from all over. But he wrote these wonderful letters, and so I learned from those letters, and it got to the point that I used to take records home from his office. We couldn't do that today. It's against HIPAA regulations, but I actually did a number of studies with him, and over the course of that year I looked at every single active patient record in his office and read every single referring physician letter that he wrote, and it made a great deal of difference to me in how I practiced, even to this day.

DR. TASMAN: Yes, that's a great story. How did you and Carolyn meet? Did you marry in medical school?

DR. LICHTER: No, actually, we didn't live that far from one another, but we went to different schools. But we met on a double date with, obviously different people, and then somewhere we…

DR. TASMAN: It just bloomed.

DR. LICHTER: Yeah, we began to date and… yeah, that was that.

DR. TASMAN: Well, you know, behind every successful man…

DR. LICHTER: That's right, and 49 years later we're still going strong.

DR. TASMAN: And she's been a big help to you, she's terrific.

DR. LICHTER: Yeah, a great help.

DR. TASMAN: But you've done so many great things you hardly know where to start. I mean, let's talk a little bit about the Academy and the Program Committee where you started, and then you moved up to become president.

DR. LICHTER: Well, the Academy, just like for you, has been a very big thing for me in my career. I got started in the Academy really through the Shaffer Fellowship. Ken Richardson, who was a Shaffer fellow before I was, was involved in some education things in the Academy. Ken was a wonderful…

DR. TASMAN: Did he go to Alaska?

DR. LICHTER: He went to Alaska. He was at Pittsburgh, and then he went to Alaska to live an outdoor life. But Ken was a wonderful educator. He had some great ideas and so forth. And he was a little bit older than I was, but he knew I had an interest in education. And he got Bob Reinecke, who you know, of course, very well from Wills, and before that, too, but Bob Reinecke was involved in education in the Academy, and he… Ken

Richardson recommended me to Bob to be on a… I think some sort of medical education committee in the Academy, I can't recall exactly, and this goes back to perhaps 1970. And so I was on that committee and I did a… I did some sort of a slide tape program on glaucoma or something like that, and Bob liked it. And just like anything else, if you deliver on promises and you do well, you get asked to do something else, and so I kept getting asked to do more. And I believe it was Brad Straatsma who was very… was involved in the Education Secretariat of the Academy, who got me involved as… oh, some sort of a… I was a Secretary for General Medical Education. There was an Academy Home Study Course, and the home study course you remember very well, and we took it. There's still, of course, an aftermath of that going very strong, a Basic and Clinical Science Course, but before, it was called the Home Study Course, and there were sections in the Home Study Course, and I noticed that there wasn't one on general medicine. So I proposed to the Education Secretariat that perhaps we ought to do something on general medicine, so I was asked to do it. And so I had started a committee on writing a basic science… a home study booklet on general medicine for everyone.

DR. TASMAN: For ophthalmology.

DR. LICHTER: Yeah. So … then I got into the Program Committee, chairing the Program Committee for the Academy, for the annual meeting. And just at that time it kind of began to evolve as the Annual Meeting Committee, but I don't think it was that when I stepped down, but became that. And then after that I became Editor of *Ophthalmology*, the Academy's journal. And I wonder… in my mind I always wonder how in the heck that happened. I do know, when I was on the Academy Board as Program Chair, Annual Meeting Program Chair, I wrote something that caught the attention of, I believe, David Shoch, who was on the Board at the time. And when Paul Henkind became ill, a new editor needed to be appointed, and there was a search committee. I had no idea I was a candidate, but one night at home I got a call from Kenneth Swan, who was Chair of Ophthalmology at the University of Oregon, Oregon Health Sciences Center, and he started to talk to me about the Journal and writing and editing, and I kind of wondered where in the heck this came from, and the next thing I knew he offered me the job as Editor of *Ophthalmology*.

DR. TASMAN: Well, you did a fantastic job as editor. I loved your editorials.

DR. LICHTER: Thank you.

DR. TASMAN: You know, to me that's a Herculean task. I don't know how you ever did it all, and did it so well. But it's only one of the many things that you've been successful at doing. I mean, you built a huge, wonderful department at Michigan, and buildings going up left and right. Are we going to have a Lichter building there pretty soon?

DR. LICHTER: I don't have enough money to have a Lichter building.

DR. TASMAN: But I've been impressed with how good you are at accomplishing things like that. Has it been a pleasure trying to get these buildings built?

DR. LICHTER: Well, you know…

DR. TASMAN: Or is it more of an ordeal?

DR. LICHTER: No, it's… you've taken on your challenges, the same kind of challenges, and you know them well. But when I became chair in 1978, one of the things… we had a very small department, there were seven faculty members, I believe, at that time. And we had a small facility, really, just as part of an out-patient building at the University of Michigan Medical Center. In addition, we had a couple of laboratories in different locations, and I believe I counted up the different places where we had some little part of our operation. I believe it was nine different little hovels where we… you know, a little office here and little there, so I wanted to try to bring everything together. And at that time there were some very well known eye institutes in the country, eye centers—of course, Wills being one of them, Jules Stein Eye Institute, the Bascom Palmer Eye Institute, the Massachusetts Eye and Ear Infirmary—and I thought, you know, one can think big, and if you think big you may have a chance to get at least partway there. So I asked the Dean and the Director of the hospital, when I was negotiating for my chair package I didn't ask for the money for an eye center, but I asked for the support, to be able to try to raise the money. And so they gave it to me, and we chose a site, part of it was to renovate a couple

of older, existing buildings. And interestingly, the university hospital put in a million dollars for that renovation. The renovation ended up costing 2.3 million, we raised the rest, and then we built in additional research building that cost about 8-and-a-half million, and we raised all of that. There was no money from the medical school in that at all.

But we did get an eye center, and then began to… complete that space over time with NIH construction grants and additional philanthropic dollars—still no money from the medical school—and my faculty. I mean, as you well know, nothing happens without wonderful people. You can be… you can kind of be the orchestra leader and the catalyst, but you can't do all the work. And so I've been really very, very lucky over the years to have a wonderful supportive faculty, who haven't had as their primary interest making a lot of money. They enjoy where they are. Ann Arbor is a jewel of a city to live in. We have a wonderful staff. We attract people like ourselves, I suppose, but we really do have a terrific faculty and staff, and it's been a great ride for me.

DR. TASMAN: How many people were there on the staff when you took over?

DR. LICHTER: Well, besides seven faculty members there couldn't have been more than 20 other people on the staff.

DR. TASMAN: And today?

DR. LICHTER: Today, there are a few hundred, and 64 faculty. So it's gotten quite big. And now, of course, we're adding close to 50% more space, so we should grow the size of our faculty and staff.

DR. TASMAN: Well, I think what you're doing is a great tribute to you. I really do admire you for what you've accomplished.

DR. LICHTER: Thanks.

DR. TASMAN: I'd like to ask you a couple of things about some of your research, because I know you've been involved with some of the most important glaucoma trials. Is there one in particular that you are really

proud of the results that came out of it, or pleased? I don't know how to put it, exactly.

DR. LICHTER: Well, the one… the trial that's most meaningful is the one that I organized, really, the Collaborative Initial Glaucoma Treatment Study, CIGTS.

DR. TASMAN: Okay.

DR. LICHTER: So that trial came out of realizing that patients who have glaucoma and are using eye drops, would often say to me after they had surgery—they failed the eye drop treatment and they needed more… they needed surgery—and after they had surgery to control the glaucoma, and they didn't need to use the drops anymore, they would tell me how wonderful they felt compared to the way they felt when they were using all of these eye drops. So I went to one of the professors in the School of Public Health and told them about this, and told them I'd like to do a study to find out the effects on patients' quality of life of using eye drops relative to surgery. And his name was Marshall Becker [?]. He has since… he's since deceased, dying, unfortunately, at a young age, but Marshall told me that in order to do a proper study you really needed to take glaucoma patients right when they're newly diagnosed and see how they did. In any event, we designed a study that looked at quality of life in newly diagnosed glaucoma patients, comparing initial treatment with medicine to initial treatment with surgery. Now that, at that time and even today, almost, is anathema in this country. And that's because, I think, we're driven a lot by what industry does and the relationship of physicians and our industry—it really goes all across medicine. But we're driven as ophthalmologists and glaucoma treaters to use eye drops and to stay really away from surgery. Now, in Europe surgery as an earlier initial procedure for glaucoma is much, much more common than in this country. In any case, though, we developed this study, and it took a while to get it approved, but I started out, actually, with a blue ribbon committee of about 20 people to test the idea with them. They approved… they bought the idea, they thought it would be a worthwhile study, and it was very helpful to me in getting approval from the National Eye Institute to do this study.

And in any case we… the study is now finished, we're still reporting data from the study, but I would say the one thing that has come out of the study

that I think is most meaningful is that in patients with moderate or more advanced glaucoma as an initial diagnosis, that treating the patient surgically is probably better for their outcome in the long run than treating them initially with medicine. We've also found in the study that keeping the pressure at a very even level over time is important, rather than up and down fluctuations, and that may be where the benefit of surgery in these more advanced cases comes in, because surgery keeps the pressure at a more even keel than the pressure is with eye drops, where it goes up and down between the time the drops are used.

DR. TASMAN: Your comments about the eye drops and our conditioning to use the eye drops is a good segue into another area where I've really admired you, and that's your stand on ethics and the relationship between medicine and industry. I always think it's like Eisenhower after the war: You know, beware of the Military Industrial Complex.

DR. LICHTER: Yeah, well, it's, you know, I think it was Arnold Relman who coined the phrase 'the medical industrial complex.'

DR. TASMAN: Really?

DR. LICHTER: Yes.

DR. LICHTER: No, there is a medical industrial complex in this country, no question about it. You know… well, of course ethics… all of us feel we're ethical people, you know, that ethics kind of starts with the individual in many ways. But ethics is cultural, as well, and ethics, of course, is a broad term. In medicine, ethics goes from determining the end of life to dealing with patient's terminal situation, to dealing with our colleagues, referrals, ghost surgery, on and on and on.

DR. TASMAN: Well, I was thinking back to your article… well, the study you did for the Academy and the article that you wrote.

DR. LICHTER: Yeah. Well… but, yeah, where I have gotten mostly recently in ethics does relate to the interaction between physicians and industry. And I chair a committee at the University of Michigan now on this subject, to recommend policy for the University. But I think we all have concern about how much we should be related to industry. Industry's goals

are not the same as the physician and patient's goals. When you run a company, a large pharmaceutical or device company, for example, your goal is to make a profit. Publicly-held companies respond to their shareholders, as they should. Shareholders are looking for profit on their investment. While companies can do good with their money, they are always giving that money to have a business purpose and a profit motive. There is no medical ethic in a pharmaceutical or medical device company. The ethics and business, in a sense, are only confined by the law. If it's legal you can do it. And, really, the pharmaceutical and devices companies, and the biotech companies, succeed because of what we as physicians do, right?

DR. TASMAN: Absolutely.

DR. LICHTER: We buy the equipment, we write the prescriptions, we order the test, and if we don't do those things these companies don't make any money. So it's Marketing 101 to really market, in this case, to physicians. Patients can't go out and buy a very expensive prescription drug or buy an expensive MRI or order expensive biotech testing. It's the physicians who do it. So the companies really direct their efforts toward us. And how do they do it? They bribe us. They bribe us in the legal sense. They can't bribe us, of course, illegal, but they can do it in a legal sense by courting favor with us, by giving our departments a lot of money, by giving us samples of expensive drugs to give our patients, and so on. And I think… you know, I did do a report, as you said, for the Academy. I was appointed the head of a taskforce, I think the Academy got more than they wanted from it, but I asked some very well-known ophthalmologists to be on that taskforce, and that information that we presented to the Academy is under lock and key, but, really, we ended up telling the Academy that, you know, the organization ought to take a harder look at its relationship with industry.

Now, many organizations in medicine today are looking at those relationships, and the Council on Medical Specialty Societies is in the process now of writing its own guidelines to try to respond to an anticipated push from Congress to lessen these ties, because research has shown very, very clearly that these ties drive up the cost of medical care without necessarily improving the quality of care or the results of care. So we're spinning our wheels a lot, we're ordering a lot of expensive tests, we're buying a lot of expensive equipment, we're ordering… prescribing a lot of expensive prescription drugs without good evidence that all of this care is

improving the quality of life, the length of life, the health of our citizenry. So this policy development by the CMSS, Council of Medical Specialty Society, is going to be very interesting to see what comes out of that, and if our profession gets to the point of actually having some guidelines that medically-run organizations, like the American Academy of Ophthalmology, will stick to, to try to separate themselves a little more from industry. I mean, here we are today talking amidst the American Academy of Ophthalmology Annual Meeting, which is extremely commercial, and one has to wonder, if one tries to think objectively of it all, is this best for our patients?

DR. TASMAN: It would be a totally different meeting if it were not for the exhibits and… I did notice, now that you… you know, it's changing, you don't get any free pens anymore, no pens in the bag, and I, my own experience, when our daughter had her second child up in New York, my son-in-law had a red eye, and they weren't going to let him in. I said, 'Well, wait a minute. Let me look at this.' And I said, 'No, that's an allergic conjunctivitis, he can go in.' and I said, 'I'm going to run over and get some eye drops.' And I went over to a First Avenue pharmacy and I got some… I won't even mention the name, but I got eye drops for itchy eyes and allergy, and it was $90 for a little bottle. And sometimes do you think that the physicians, when they're writing these prescriptions, do they really understand the cost involved?

DR. LICHTER: No, we don't, and probably you've done this, as I have. You start thinking sometime and ask one of the residents to go check out the cost of the drugs in the pharmacy, and report to the department about it, and we do this every several years, and it's quite astonishing. In fact, you know, you bring it up, it's timely because the head nurse in our operating room just sent a memo around to all the physicians in the department, telling them the cost of one of the very common combination antibiotic steroid ointments that we use commonly—I don't, but my colleagues have been doing it in the operating room—and the cost is astonishing, compared to one that's much cheaper that's off-patent, not… you know, not advertised. And the cost, as I recall, the cost of the one I'm talking about was $90 a tube and the cost of the cheap one was $5 a tube. So I think as physicians, in general, I think we are not aware of the cost of the drugs we prescribe. This alone could be something very important, to make sure that we always knew this, but I don't know how we really could go about it.

But if you look at the Academy exhibit floor, actually, I don't have a problem with the exhibit myself from the ethical point of view, because I think the exhibit floor when you walk in there you know that there are things to be sold and things to be bought. And in a sense it's not in the patient relationship—it's not visiting me in my office, it's not making me think I'm some special expert. Anyone who walks in the exhibit hall, they can look at things, and it's a great mart for looking at equipment you might want to buy and so forth. So I don't have a problem with the bright line, as I walk out on the exhibit floor. I do have a problem with people standing up at a booth giving a talk, wearing a badge that they're a member of the American Academy of Ophthalmology and Board of Trustees, and giving a talk that touts some product in an exhibit booth. And hopefully our organization will see fit to stop that at some point because most of the other ones have, I think, stopped that kind of thing.

DR. TASMAN: Well, it's obvious that you love ophthalmology, you love what you're doing. What kind of things do you like to do for fun?

DR. LICHTER: Well, I guess one of… my favorite passions is golf. I've played golf since I was about nine years old, so I love to play golf. It's relaxing, and it takes a lot of time so I don't play very much, but I still like it when I play. I like photography, and I… you know, you take a lot of pictures, and you never look at them. I say that the joy for me in photography, some of it is just taking the pictures, figuring out the shot itself. So I take a lot of pictures that I often don't look at, because nowadays, of course, with digital cameras it's not like film, where we took it to the drug store or the photo place and we had pictures and we did look at them. Now you have to make an effort to print them up and look at them, so…

DR. TASMAN: Well, I take the chip over to the store.

DR. LICHTER: Yeah, you take the chip over to the store and give it, but I… I take too many. I have to edit them out. You know, now you just go click, click, click, and you end up with hundreds of pictures you don't care about. So the time it takes to edit them, that's the trick. But I like that, I enjoy going to movies, don't do that much, I enjoy reading, don't get a

chance to do that as much as I would like, because there's so much reading, medical reading we all do.

DR. TASMAN: Any kind of book that you prefer? Do you like novels? Do you like history? Do you like…?

DR. LICHTER: I'm eclectic. I would say I tend to read novels more than anything else because I like to try to not have to concentrate so much when I'm reading something outside of medicine, because of having to concentrate so much when we read medical things. I've been very much active in reading about ethics, though, of late, and some books around it. There's a book called *Hidden Persuasion*, that was written in the 1950s, that talks about Madison Avenue marketing, how companies get us to do things that we don't want to do, buy soap or cars, and it really is applicable today. So I've enjoyed reading these kinds of books, reading books about prelateships between physicians and industry, how drug companies work. I've read, actually, quite a lot about that. It keeps me from reading novels.

DR. TASMAN: Well, I think… I can only compliment you on what you've done with your career and your life, and you should be very proud of everything you have accomplished.

DR. LICHTER: You know what you need to do, though, before we finish? You must have a favorite Winston Churchill story that you could tell me. You haven't told me one lately. You know, you're a Winston Churchill historian.

DR. TASMAN: Did I ever tell you the one about his son-in-law?

DR. LICHTER: No.

DR. TASMAN: Well, he had a daughter who was an actress, and she married a vaudevillian named Victor Oliver, and Churchill couldn't stand him because he always called Churchill 'Popsie,' and it drove Churchill nuts. So one night at dinner he turned to Churchill and he said, 'I say, Popsie, who is your favorite statesman of all time?' And Churchill thought for a moment and he said, 'Well, that would have to be Mussolini.' And the son-in-law said, 'I say, Popsie, Mussolini? How so?' 'Because he had his son-in-law shot.' And he did. His son-in-law was Count Ciano, who

wanted to get Italy out of the war in ’43 before Mussolini was ready to get out, so he had him shot, and Ciano’s son wrote a little story about the day that Granddad had Daddy shot. And Ciano’s wife was a member of the Pucci family, they became big designers of women’s dresses after the war. But that was a true event. He was a character. I think he saved England in World War II, I mean, no question, his speeches kept them going when times were really bad.

DR. LICHTER: Yeah. Well, it’s been terrific to have a chance to visit, and, you know, we didn’t get to talk about Alice Lea. You can give a minute about all the things she’s done for you, like Carolyn has done for me.

DR. TASMAN: Oh, well, she’s… she just never stops. She’s got more projects going than anybody I know. And Governor Rendell, when he was mayor of Philadelphia, ran something called Art and City Hall, and she was the one that put it on for him once a month. They have artists put on a show in City Hall, and he would always come out and say a little something and he used to call her the Energizer Bunny.

DR. LICHTER: Yeah, she is.

DR. TASMAN: She didn’t like that.

DR. LICHTER: Yeah, but she’s got a whole lot of energy…

DR. TASMAN: She does.

DR. LICHTER: She’s done a lot, I know to help Wills and to help the Academy.

DR. TASMAN: Well, I’m lucky, we’re both lucky.

DR. LICHTER: We have been lucky.

DR. TASMAN: Yes.