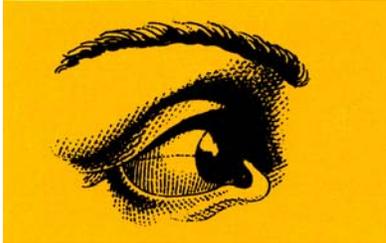


The Foundation of the American Academy of Ophthalmology
Museum of Vision & Ophthalmic Heritage

Conversation Between Thomas A. Weingeist, MD and Aaron P. Weingeist, MD
Orlando FL, October 22, 2011



Drs. Thomas and Aaron Weingeist recorded this conversation on October 22, 2011 during the Annual Meeting of the American Academy of Ophthalmology, in Orlando, FL

Together this father and son discuss their family history and experiences, building on the museum's

[Legacy Project](#) which celebrates families with multiple generations of ophthalmologists.



In this excerpt [Dr. Thomas Weingeist](#) describes an extraordinary lunch with his father and colleagues during the 1968 annual meeting.
(.mp3 file)

Here, [Dr. Aaron Weingeist](#) discusses his interest in politics. (.mp3 file)

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THOMAS WEINGEIST: Well, I'll start. I'm Tom Weingeist. This is October 22, 2011, and we're attending the annual meeting of the American Academy of Ophthalmology in Orlando, Florida.

AARON WEINGEIST: This is Aaron Weingeist, in Orlando, Florida, on October 22.

TOM: I think I'll tell a little bit about the uniqueness of our situation. Our relationship is not unique, father and son, but Aaron is now a third-generation ophthalmologist. Not only was my father, Samson Weingeist, an ophthalmologist but his other grandfather Charles Perera, was an ophthalmologist, and both practiced in New York in very different kinds of environments. Not only that—and I don't know the direct relationship, maybe, Aaron, you could figure this out—his uncle, Dr. May, was the inventor of the May Ophthalmoscope, a direct ophthalmoscope that was made sometime in the late 20s, 30s, that is similar to the ophthalmoscope that is either battery-operated or connected by electrical wire to an outlet. If that weren't enough, Aaron's grandmother, Fausta Weingeist, practiced with Samson in New York as an orthoptist and worked also at Einstein Medical Center, volunteering for over 25 years teaching residents and medical students about orthoptics. Then his mother, Carol, became an orthoptist, followed by his aunt, my sister, Leslie Weingeist France, who practices orthoptics at the University of Wisconsin.

So I used to tell Aaron before all of this evolved that he had a hereditary disorder, and that it was dominantly linked, and that he was a third-generation ophthalmologist, and it was just a matter of how he was going to do that. He's been in private practice and he'll tell you more about that.

AARON: Well, I guess I would just clarify for...excuse me...that Charles May was Charles Perera's uncle by marriage and that they practiced together starting in the late 1920s, and that I was able to get some of the letters from

Charles May and his practice from David Abramson, who ended up being in the same practice. And so I have been surrounded by ophthalmology my entire life.

I'm not sure exactly when my...when I became interested in pursuing ophthalmology as a career but it's been...I've been soaking in it for 45 years, and it...I've had well-adjusted relatives who love what they do, and it's...Maybe it's not genetic, maybe it's infectious.

TOM: And I could say that I never pushed Aaron to either go to medical school or to certainly study ophthalmology. But I was enthusiastic about it, and was on the faculty at the University of Iowa. And it was fun to have a student who was in medical school to be your son, and periodically encounter students that he was with and be involved in teaching them. And then to hear faculty say, 'Oh, we'd love to have him in cardiology,' or, 'We'd love to have him in surgery,' or whatever the area of medicine he was going through as a medical student. So as a father that was very nice to hear.

And I think one of the things that probably got him involved more in ophthalmology was probably taking an elective at the University of Washington in Seattle. At that time Bob Kalina was the chair, and that may have cemented the area of medicine that he wanted to go to.

AARON: That was really my first major clinical involvement in ophthalmology. I had started doing some clinical ophthalmology in Ed Stone's lab and beginning to examine some of the patients who had inherited eye diseases and learned to use a slit lamp and... Yeah, that was my first real clinical taste in any major way, at the University of Washington, and that was the final straw.

TOM: So let me step back a little bit, because historically I think it's interesting. It's not a unique story, but to have parents who were from Europe—my dad was from Poland, but as a child moved to Vienna. And he was the youngest of eight children, and he had an older brother who was some 20 years older, and six sisters, so he was doted over by these sisters, and then when he went to Vienna with them he had most of his education in Vienna. He wanted to study ophthalmology, but he was Jewish, and at that time there was a lot of anti-Semitism in Austria, and so he was not able to do that. He did some surgery. He did some anesthesia. He graduated at a very

young age, 23, and then he met my mother, just by coincidence, who had a friend who turned out to be one of my dad's cousins. And my dad was visiting her in the hospital, she had [had] some minor surgery, and my mother happened to be there. And she was 10 years younger. They started to see each other and fell in love. And my father realized that things were heating up in Europe and he had to leave. And he begged my grandfather, who was a big shot in a pharmaceutical company, or a chemical company, in Austria, to leave, but he said, like many other Austrians, 'This isn't going to last long, and I'm...besides I'm an Austrian, not just a Jew.' And unfortunately he ended up dying in a work camp. But he was very supportive of my father, who left, went to New York, and didn't speak English at the time but studied very hard, and read *The New York Times*, and took his exams for licensure in New York City. And before he even knew whether he had passed or not (and in those days they were all written exams, not multiple choice scored by a computer) he told my grandfather through a telegram to send my mother to London, and that they would get married and he would get a visa and they would come back to the States. He didn't know any of that...whether any of that could happen, but he did arrive in England. My mother had left Austria and they got married on the 3rd of March 1938. And the reason I mention that date is the Anschluss, the combination of Nazi Germany invading and taking over Austria was on the 12th. So if she had waited just a few more days she would not have been able to leave, and Aaron and I might not be here talking.

In any case, they moved to New York. And my dad then later on felt an obligation to do his part, and he joined the military in 1942 and then was stationed in the south as a medical officer. And actually, without having had specific training, [he] became the head of the EENT—that is, the Eye, Ear, Nose and Throat Clinic in Fort Bragg, North Carolina. You can imagine how difficult that may have been. Here is a fellow who is bright, outgoing, has a German accent, and is in a military camp in the middle of the war. He was horrified by some of the things that he encountered at that time, the most important of which was that there was still segregation in our country, and even the military was segregated. But because he was the head of the clinic he was able to take down the segregation signs that said 'White' on one side, 'Colored' on the other. This, you know, was very courageous, and he had many stories to tell.

Anyway, he ended up going back to New York and practicing in Astoria, Long Island, a part of Queens, which was a working class neighborhood. And I spent many hours with him as a kid just tagging along on weekends and during the summer.

AARON: So, some of my earliest memories are ophthalmology-related. I mean, beyond snippets of growing up in New York and going to Cape Cod and summers in Iowa, but running down the halls in the university hospital trying to keep up with you when we walked in to see patients on Saturday or Sunday mornings, and hanging out, or going to the electron microscopy lab and seeing your technician, Vergene Gregory, going to ARVO and playing on the beach in Sarasota.

And so you spent a fair bit of time in the office with your dad when you were young?

TOM: Yeah, as a matter of fact, you know, I was probably 11 or 12. I remember my dad was, as far as I know, the only ophthalmologist, maybe very few people in medicine, who had office hours twice a week at nighttime, because he didn't feel that the average working guy or gal should have to take the day off to go to his office. And so we would start offices at 4 o'clock on Tuesday and Thursday and work until he was done, which was often 10 or 11 o'clock at night. It was very unusual.

Medicine has changed so much. When my dad first started in New York in family medicine kind of thing, general medicine, I know his office visits cost \$2 a visit. When he was established and was doing ophthalmology, even before...well, probably just after having passed the boards here in ophthalmology, his office charged, I think \$25 for a first visit and \$15 for a follow-up visit. That already was increased because he had a partner who felt that their initial \$5 or \$10 and \$15 charge was not enough for the degree of care that they were providing—this was before Medicare, also—and urged him to increase his fees. My father said he would go broke, that no one would want to come anymore, but the fact was that they got twice as many patients. But they stayed in that same office and practiced general ophthalmology.

And my dad, Samson Weingeist, had a real interest in strabismus and ran a clinic at the New York Eye and Ear Hospital and headed a strabismus clinic.

And then my mother joined as an orthoptist working there, as well as Einstein Medical Center, which my dad was asked to be the first chair of the new medical school at Einstein...which he did while doing his private practice.

AARON: In ophthalmology?

TOM: ...but he was...in ophthalmology, yeah. And he was...he was, you know, somebody who was in private practice and then just attended and had some residents and so on, some of whom have long since retired. And I maintain friendships with them.

But he was the chair just before Paul Henkind was made to be the full-time chair—very interesting man, very strong personality, brilliant mind, photographic memory, interest in science, sometimes annoyed people at meetings because of his incisive questions. And his detractors referred to him not as Dr. Henkind, but as Dr. Unkind. Unfortunately, Paul died many years later of a brain tumor, but he was a remarkable person, having also studied at Moorfields Hospital in England.

AARON: I don't think that my grandfathers really passed any time together as colleagues and crossed paths at all as ophthalmologists in New York City. Is it true that they didn't really meet until you and Mom met at college?

TOM: Well, Grandpa, Charles Perera, was well known. He was a professor at Columbia, and not to say this in a disparaging way, but he was on a different side of the track, so to speak. Samson was a physician to the poor and to the middle class and some wealthy people in New York, but Charles had a Park Avenue practice, was associated with Columbia University, was a brilliant man who spoke multiple languages, and they knew of each other and they were in some organizations together, but didn't really know each other until your mother, Carol, and I met and then got married in 1963. And so then Aaron was born in 1966, and we lived in an apartment overlooking the Hudson River that was directly over the highway that extended into the Washington Bridge, and so there was always a lot of activity on the river. And I still remember Aaron as a small child peeking over and looking at the river from being a toddler, and then his sister, Rachel showing up in 1968, but just about a year before we moved out to Iowa.

The reason that we were in New York at that time in what was called Washington Heights was that I was in a PhD program with a man who actually worked in the Harkness Eye Institute at Columbia University, George Smelser. And just by chance—and life is so filled with these coincidences that you think if somebody had written a novel that it would be corny—but he went to the same college that I went to, and subsequently Aaron went to, a small Quaker school in Richmond, Indiana called Earlham College. And his mentor was a very well-known scientist who actually got the Nobel Prize, but we didn't do anything that fancy. But I learned electron microscopy and worked at Columbia on my PhD for six years before running into Bruce Spivey at one of the ARVO meetings on Longboat Key, and that's a story I can tell later. But another coincidence—because Bruce was interested in strabismus, and my dad was, so they knew each other—and so just by coincidence, again, we had an opportunity to talk and he asked me what I was interested in doing, and I had decided that I wanted to go to medical school.

That was at an ARVO meeting, as I said, and he said, 'Well, come out to Iowa,' where he was. And I said, 'Well, I'm too busy now. I'm finishing up my thesis, and I don't know how I'm going to do it,' and I left it at that. But Bruce, who everyone knows, he was not only the Dean of Pacific College of Medicine in San Francisco, became the EVP of the American Academy of Ophthalmology, had been a faculty member in Iowa, invited me to come. And when I arrived back in New York a letter was there saying 'come out to Iowa and give some talks.' And that's how I started to get more involved with Iowa, and eventually to go to medical school there, and to remain on the faculty.

I could talk for a long time about various aspects of this. You know, my life has been very involved with the American Academy of Ophthalmology. And I think there are many highlights of that, but one of the earliest was having been associated with George Smelser, who was doing research in ophthalmology, and having done my PhD. There was an ARVO meeting just before the main meeting started of the Academy. In those days many of the meetings were in Chicago at the Palmer House. It's hard to imagine that the whole Academy could function in one hotel or two hotels, and now we probably stretch things at McCormick Conference Center. As we are now we are only able to go to a few cities, like Orlando, Chicago, San Francisco, New Orleans. But at that time ophthalmology had just divided from ear,

nose, and throat. Prior to that time they were together and shared the facilities, and the program was divided so that you might have ophthalmology in the morning, and otolaryngology in the afternoon. And then actually Dr. Fred Blodi, who was my mentor in Iowa, was the president for, I think, two years, at which time he helped make the transition so that we became separate specialties.

But one of the most memorable times for me at the Academy was having gone in 1968 to give a paper at the ARVO meeting, and then my dad, who knew many, many people, and was a very outgoing fellow said, 'Let's go to lunch.' And we'd usually go down to the pub in the Palmer House, but it was so occupied and we decided we had such limited time we would just go out on Michigan Avenue and find a place to eat. Well, along the way we ran into Bill Spencer, a very well-known ophthalmic pathologist from California, and invited him, and then Fred Blodi was there, and we invited him, and so we had this very nice group. And we stopped at someplace I don't remember, and my dad said to Fred, 'So did the kid get into Iowa?' And Fred said, 'I don't know.' He says, 'Well, call up and find out.' And sure enough, Fred went to the telephone, called, and he came back and said, 'He's in!' And so, you know, we had a celebratory drink of beer or whatever, and that's how it all started in terms of our deciding then to move from New York out to Iowa City. Friends for the next decade or more kept saying, 'Are you still in Iowa?' as if it were a terminal state. And then they would ask how did I get there, and I would say things like, 'By covered wagon,' because Iowa was well known because of Braley and because of Blodi, but people didn't know very much about Iowa City and as *The New Yorker* cartoon showed, didn't know very much west of the Hudson River. They considered that Native American land in their snooty way, but I loved it right away. It's been a great place to live and to raise four children, who I said were very fortunate to have gone through public school and do very well. As far as I know, none of them is a serial killer.

AARON: We're trying to keep that from you.

So there wasn't an official match when you got into ophthalmology, though, right? That was a later development.

TOM: No, there wasn't an official match. There were a lot of strange things that happened. One year Braley accepted like eight residents, forgetting that

he only had positions for five or six, or I don't remember what the number was, so he had to parcel them out and they spent a year on what was called the Glaucoma Bus, traveling through small towns in Iowa, checking pressures and looking at farmers' and other people's eyes to see whether they had glaucoma. This was just before the era when actually Mansour Armaly did some of his wonderful studies in Des Moines related to glaucoma, which were very important in the coming years in terms of management of patients with glaucoma.

The match made a terrific difference. Unfortunately, in the beginning, the departments all had different application forms, which meant that medical students spent a tremendous amount of time during medical school filling out these applications, which was not worthwhile, and fortunately The Association of the University Professors of Ophthalmology changed that so that there's a universal application. That's caused people to submit 50 or 60 applications, but it gets sorted out, and it's a much fairer process.

I'll tell you an interesting story. Larry Yannuzzi, a retina specialist in New York—terrific guy—was at Harvard as a medical student, and he went to a lecture, and Dr. DeVoe, who was the head of ophthalmology at Columbia, was giving a lecture there. And so Larry was outgoing—very bright guy—went up to Dr. DeVoe and told him he was interested in ophthalmology, and DeVoe said, 'Oh, why don't you come down? We've got a place open and why don't we arrange for you to come and I'll get you interviewed and maybe you can join us?' Well, Larry was overjoyed. So that was like on a Friday, and on Monday he took the train down from Boston to New York, and he went to the Eye Institute at Columbia, which was a very nice building, at that time unusual because there weren't that many eye institutes. And he went to Dr. DeVoe's office—had some very nice leather chairs and sofas there—and the secretary said she would tell Dr. DeVoe. And so Larry dutifully waited. And the whole day passed with him sitting there, and he was willing to do that, thinking he would have a good opportunity for this residency, which was well known. And the whole day passed. And finally he was ushered into Dr. DeVoe's office, and DeVoe sort of wanted to know why he was there, and he reminded him that he had invited him. And DeVoe then said, 'I'm sorry, we've already filled that position!' And the reason I know this story was that Larry related it to a whole group of ophthalmologists when I was asked to come back to Columbia and give the DeVoe Lecture.

But that was the days before there was a structured way of reviewing applicants, and so all kinds of things must have happened. I'm sure people made all kinds of donations and did various kinds of things, which were not thought to be, today, to be very ethical.

AARON: That was...when I applied there were still a couple of programs that were outside the match, or outside the universal application process. But I had a very close call in not making it into ophthalmology because I tend to go over things a lot and submit them at the last minute. And I had submitted my universal application just before the due date with overnight mail, not knowing that if it arrived on Saturday that it might be delivered to a different address. And I arrived home from my rotation late on Monday evening to a flashing voicemail on my answering machine. And I got a message from Dr. Colenbrander telling me that my application hadn't arrived and was I still planning on applying, with very few hours to get it done. And fortunately was able to go down to a copy place and get other copies sent out and overnight mailed it to a different address.

TOM: Well, Gus Colenbrander, who came from The Netherlands, was also from Iowa and on the faculty, but he was really instrumental in running this ranking system. And not only was he able to do this and develop it into a finely honed instrument by computer, but he put his personal effort into it so that he would make a phone call like that. There were all kinds of crazy things going on later, with spouses trying to match in the same city. Prior to that time, you know, you could get a match in Minneapolis and in Iowa and then the couple had to decide what they were going to do. Now there's a match that will enable people to apply to programs in a given city and hopefully at least match in the same city. But Gus was very, very good at doing that kind of thing and actually had a couple of physicians who participated at the time of the final match to check that all of the details were in place. And I happened to be there one day when that was going on, and it was very carefully done, you can't just rely on the computer. So ophthalmologists owe Gus a tremendous debt and gratitude for the efforts that he put into it. And now I haven't gone through the exact details, but it's all done online, and very streamlined, and there's still some problems. People complain that they had to go to the West Coast one weekend and the East Coast another weekend, and that's sometimes costly and inefficient.

But most people are very happy with it, and it's made for a much fairer process for the medical students.

I might tell a little anecdote. Aaron came down to ARVO that...it was in Sarasota—and he mentioned that, you know, he was there as an infant, and I can remember that we were throwing potato chips up in the air and the seagulls were getting them—and then in medical school he came down with us, and he was going to go to a particular meeting. And somebody was supposed to pick him up, and they didn't.

AARON: I was...I had been working at Stone's Lab after college for a year, and I was presenting a poster with Ed, who was supposed to pick me up at the Longboat Key Club.

TOM: Well, he didn't pick him up, and so he went out to the main strip there, started walking. And in those days we had big books of all the abstracts, and I remember it was a bright yellow covered book. Anyway, Aaron was walking along and the car started to come by and stop to pick him up. They asked him if he was going to the meeting, which—that book showed that he was probably going to the meeting. Anyway, he got in, and after they were driving for a little while the fellow driving leaned over and said, 'I'm Mort Goldberg. Who are you?' And Aaron said, 'I'm Aaron Weingeist.' And Mort had been at Longbow Key or one of the resort hotels when Aaron was wearing diapers and throwing potato chips up at the seagulls, and he almost drove off the road. And probably this small group of ophthalmologists has experienced all kinds of things like this, where our children are seen later on, and the years have gone by so quickly we just didn't notice. But that's a story that probably Aaron will always remember. And I remember it because it was so startling to see somebody transformed from diapers to being in medical school so quickly.

AARON: Wasn't the hotel that you used to stay at—was it the Sandcastle?

TOM: Yeah, the Sandcastle.

AARON: Yeah.

TOM: So, you know, Aaron and I have had very different kinds of careers. I did my residency in Iowa under Fred Blodi and then specialized in retina;

did a year-and-a-half fellowship in surgical and medical retina, working with Bob Watzke, Tom Burton, Jim Diamond; and stayed on the faculty and have remained on the faculty ever since. So I just retired from academic medicine—starting in 1976 and finishing in 2006—after 19 years of being the chair of the department, phased retirement and then retiring a year ago and helping out at the VA. But Aaron's been in private practice, so I'd like to know, you know, how you got there and what you think of the differences.

AARON: Well, my early training was, you know, at home and in the hospital on weekends and with my grandparents and with family and discussions about the Academy as such a warm, interesting place to be. And I was a little bit late to going into medicine. I didn't really decide to pursue medicine until I had done a six-month foreign study program in Spain during my sophomore year of college. And I came back to the States thinking that my initial inclination to go and do a degree in biology was not what I wanted, and contemplated going into...becoming a Spanish major and doing something else. And then realized that it wasn't...that it was a passion of mine at the time but that it wasn't really going to be a career choice. And so I ended up being late to the application process and had to sit out a year to be able to get some of my studies done to be able to take the MCATs.

And then got to work with Ed Stone in the early Molecular Ophthalmology Lab at the University of Iowa, along with being involved with blood draws and EKGs and family research, and DNA extraction, [I] was the chief painter and early supply purchaser in the lab, which kept things very interesting.

And then in terms of...I interviewed all over the country, and ultimately, after spending time at the University of Washington, really felt like it was going to be an excellent fit for me, as sort of a small, intimate program where I felt like I could develop relationships with people who would be my mentors. And it turned out to be an excellent place for me to be, and Seattle was a great community.

My real passion in ophthalmology—besides just taking care of patients day-to-day—has been the politics of eye care. And my first practice...My employer happened to be that year's president of the State Association. And I became outraged by a scope of practice issue and wrote an inflammatory

letter to one of the senators, trying to participate in the process, and got a nasty-gram in return and shared that with my employer, and ultimately was designated to be the Legislative Chairman of the Washington Academy of Eye Physicians and Surgeons before I was advised that I was going to be given that role. And I agreed to take that position in partnership with somebody else who ended up not participating at all.

So it's now 11 or 12 years later, and after starting that and being involved early on in some scope of practice legislation in Washington, I applied for and got a position in the Leadership Development Program at the AAO, which I finished in 2002. So I think I was in the fourth graduating class of that. And one of the biggest political eye opening experiences that I had was at my first Mid-Year Forum, where... I had become very passionate about the politics of eye care, and going to that meeting in Leadership Development was really amazing for me. And that's when I started to begin to know everybody who I saw in the halls at the Academy meetings, and it was great to be able to spend the time at the meetings with you. That was actually the year that you were President of the Academy, so at that time, when you knew everybody in the halls, being able to be introduced to those folks who had been around a lot longer and some of the luminaries in ophthalmology was really very interesting.

But I continued to participate in the politics of eye care, and am currently the president of the Washington Academy of Eye Physicians and Surgeons and continue to be very involved in scope of practice legislation; was on the State Governmental Affairs Committee, and the regional representative for the Northwest for six years—had to hang on for an extra year for remediation. But that's been my real passion outside of direct patient care, and I feel like I have a very strong sense of... I don't know, [let's say] the differences between the practices of ophthalmology and optometry. And that's a struggle and an area of interest that I've had from very early on in private practice.

TOM: Well, many people would think, “Well, that's an easy thing to do,” take on working on the various aspects of the differences between ophthalmology and optometry. But it's a big sacrifice—which most people don't recognize, or they recognize and that's why they shy away from it—because it's very difficult to have any patients referred from an optometric practice after you've been branded as somebody who's trying to define the

differences and informing the public, as you did. So I'm sure that has impacted your practice and your partners probably are aware of that. But there are plenty of patients out there, and sometimes doing the things that are the least popular become the most gratifying and help you to succeed in the kinds of things that you enjoy.

AARON: I would say that building a practice is a difficult thing to do in many cases, and I was fortunate to be in a practice from early on that didn't really depend on optometric referrals. And so my political activities never impacted my practice because I never had any referrals to begin with. And I can still say that I can probably count the number of referrals that I've received from optometrists on two hands after 14 years. And so my practice has evolved, really, out of my relationships with patients, partners and referring medical doctors. And so I remain relatively immune to what optometrists think of me in my legislative role.

TOM: It's interesting to consider if optometry and ophthalmology might work in-sync with each other in the future. There's...Certainly if we go towards having universal healthcare (which I think eventually will happen, as it has in most countries in Europe) there are more patients than we can take care of. And so we certainly should be working together, not to treat necessarily the same patients, and somehow we've got to get past this stage. But, you know—not to make light of it—it's analogous to the Israelis and the Palestinians, or the Catholics and the Protestants. We're not all that different, and we should be working more together, and yet any efforts to do that taint you. And I think it's been very courageous of you to work on this, and I know from telephone conversations and others that we've had, that it's very hard to get volunteers to help in the slightest—not even to contact somebody or sign a letter or make a small donation—because people want to avoid conflict. And you understand that, but it puts a tremendous burden on those people in the Academy, particularly who feel that it's important to make the public aware of what the differences are.

AARON: Well, there have been some great people involved in political fights in the Academy. And Mike Brennan and Cindy Bradford and Dan Briceland have all worked harder than anybody could possibly imagine. It's been... You know, they've had amazing dedication to the practice of ophthalmology and trying to make sure that the public is appropriately informed, that the public and legislatures are appropriately informed about

the differences in eye care providers and their training, and they've been amazing role models. It's amazing to me that I've been performing this role in Washington State for 11 years now. It seems like—really, I didn't finish training that long ago—so it's crazy to think about.

TOM: You know, you mentioned that I was the Academy president, and that was certainly a great honor, and also being able to represent the training program at the University of Iowa. But I would say that the most satisfying area that I've worked in for the Academy—and still enjoy the most—is participating in the educational program, just tremendous people to work with at the staff level. The physicians who participate, whether they're from academe or private practice, put in countless hours developing these programs which have become the mainstay for residents in training. And to see that evolve has been very gratifying. Oftentimes ophthalmologists are perfectionists, and they worry about whatever is being done isn't quite perfect. And we've seen time and time again you have to get something done, and then over the following years it reaches perfection, but you can't go there immediately. And a perfect example is the *Basic Clinical Science Course* volumes that initially started with “know the layers of the cornea,” and now represent textbooks, in effect, giving every detail about the layers of the cornea, the physiology of diseases that are involved. And to see that evolve and to participate in it is probably the most exciting thing that I've found in working for the Academy.

AARON: You were Secretary of Education before you were president, and you were also the first editor of EyeNet, and that was part of that process, wasn't it?

TOM: Yeah. I would have stayed on being Secretary of Education as long as it was allowed. I think I did it for something like eight years, and the terrific thing was to get younger people involved and watch their careers go. Many residents from throughout the country you would hear giving a talk or a presentation on something, and then get them involved and put that effort into it. The Academy is a big family and it's getting bigger and bigger in the sense of their involvement in education at a time when politicians are talking about decreasing support for education, and we can't allow that to happen to us. And fortunately the Academy has been very carefully managed economically without having to raise dues, you know, to a point where people are unable to pay for them, and still get high quality materials, both

written and audio and now on computer. And it'll be very interesting in the coming decade to see how this evolves. Now we're starting to use iPads and other technology, which make it accessible to everyone in the world.

AARON: I think one of the things that you did that really involved members of the Academy are the editorials that you wrote in EyeNet during those first few years. And I'm amazed at how much time must have gone into that and with such regularity on a monthly basis for...was it four or five years?

TOM: Yes.

AARON: But those were...those pieces really got people...got people's attention, and that was, you know, an interesting time. That's, I think, what I heard most from other people—that they were reading your pieces...

TOM: I think both your grandfather Charles Perera and Samson Weingeist would have been astonished, and probably worried, with some of the comments that I made in some of those editorials, and yet the positive response was overwhelming. There were very few times when somebody wrote a negative response, but I was probably out on the edge a number of times—and complaining about people opening up a Lasik clinic in a shopping mall, which may be appropriate, but when it first occurred didn't seem to be appropriate to have it right next to the Sears store.

But tell me about what's going on in terms of leadership in some of the state societies, your role in terms of optometry, the battles that you face in terms of the difficulties you have in getting other people involved as they feel that their income is being threatened.

AARON: Well, I think probably it's always a complicated time in medicine, but it seems particularly complicated now, where I think we're facing a combination of things. The primary problem in politics and eye care is that ophthalmologists as a whole are too busy, and I think really feel like they're participating in people's lives and doing good on a daily basis. And they don't really have time to participate politically, and they're also concerned about referral practices. It's very difficult to get people to step up and participate, whereas I think that optometry has a culture of participation outside of their practice, and they have really for many years made it a role of the optometrists to participate politically in the grassroots of people's

campaigns. And for whatever reason, ophthalmology hasn't been very successful until more recently in getting members to participate in the dirty politics of eye care.

TOM: And now we have, for example, optometrists taking calls in emergency rooms because ophthalmologists don't want to go to the emergency room, and it's just a very slippery slope.

AARON: I think the practice of medicine has changed since when you trained and even when I finished training in 1997. I mean, I think there was some evolution, but you really were expected to dedicate your life to the practice of medicine. And I think that that is becoming less and less the case, and I think it's very reasonable that there begin to be some limits on hours that doctors in training are required to give to provide adequate medical care, because there's certainly a lot of sleep deprivation and there are dangerous things that happen when people don't sleep.

But it also changes as the limits have developed. First limiting work hours to 80 hours, and now to 65 hours a week. I think it changes the way that doctors as a whole are going to perceive their lives and the way that they practice medicine. I still am on call for my own patients every day, 24 hours a day, except when I'm away and have arranged call coverage with one of my partners. And I think that people leaving training now who work 65-hour weeks are going to be accustomed to really handing off the care or, really, more shift work and, I think, less looking at the practice of medicine in the same way that we have. And I think that that's going to make it more difficult politically.

TOM: You know, it's very clear if we go to a single payer system or what is referred to today as Obama Care that there's going to be reduction in the income of physicians, or at least in the fees that they are able to collect. People should remember that many physicians thought they would be destitute when Medicare went into effect, and if we didn't have Medicare in ophthalmology we would be broke, because these people by and large don't have the funds that are provided through Medicare.

So things are going to be changing not only with regard to reimbursement, but the institution of electronic medical records. One of the problems, a major problem as I see it, and it's already too late to really change anything,

is that we haven't, as physicians, participated enough to make certain that there would be an open system, so that right now it's as if you went to Sears to buy a washing machine, and you had to say I want a GE because my home plug only accepts a GE, not a Kenmore, or whatever. And each one of these programs has its weaknesses and its strengths, instead of making an open system where perhaps multiple vendors could be working on subspecialty areas that they are expert in, rather than the whole part that has to do with scheduling, has to do with internal medicine and so on. But it's going to be very interesting to see how this evolves, and even when there are places in big cities that have electronic medical records in a given institution, they may not be able to send the information that they glean in their record to an associated hospital. So how much is it really helping to prevent people from duplicating the information, duplication [of] tests, and so on? It's going to be very interesting to see how that evolves.

AARON: Well, one of my duties at this meeting will be to look at some of the electronic medical records for my practice, so it's going to be...I'm in the process of learning and I'm optimistic that some of the new standards will help that evolution. But it's going to be complicated for everyone, I think.

TOM: So with regard to technology, I know, Aaron, you didn't learn during residency the details of doing refractive surgery, and yet you are doing them. You took courses; you've had people mentor you. How did you go about developing expertise in these kinds of things that weren't available in your residency?

AARON: Well, just like my optometric colleagues would say, "It was a weekend course!" [Laughter] No, it's a process. When you have done hundreds of intraocular surgeries in training, learning new techniques is still challenging, but you get to build on the skills that you learned in other techniques, and it's not...In many cases you can learn some of these techniques in a short period of time and add them to your skill set. Refractive surgery is something that's evolved considerably since radial keratotomy in the 70s and 80s, and it's a much safer, more reproducible procedure that you can still provide as a part of the practice as a comprehensive ophthalmologist and no longer probably need to specialize in because of the evolution of the technique.

TOM: You know, as a specialist in retina, it's amazing to see the evolution. When we started doing scleral buckling procedures as a resident in 1975, the patients were admitted two days before to do a careful drawing to identify the peripheral retinal tears. And the faculty looked the next day and checked everything out, and these very careful drawings were made. If you didn't note something, even if you saw it, it was considered that you didn't see it. And we spent hours and in effect, you know, the patients felt tortured, but it was important to the success of the surgery to identify every hole.

Then vitrectomy procedures were begun, and now it's even less important to find the holes, because almost every patient has a vitrectomy air fluid exchange, intraocular laser to the peripheral retina, and the patient is sent home the same day or the following day. And so at the University of Iowa, for example, we had 70 beds when I started, and now we have the availability of two or three beds if we need them, and those are usually for cases where the patient needs antibiotics intravenously or had a combined orbital neurosurgical procedure.

So things have changed very rapidly. It's going to be very interesting to see how they change in the future with all kinds of pharmacological advances, such as the one being used for neovascular age-related macular degeneration with anti-VEGF drugs. But these things will evolve and our practice is going to be changing. And that's one of the exciting things and one of the things that the Academy has stressed, so-called LEO, Lifelong Education in Ophthalmology. You can't be a properly functioning clinician without maintaining certain standards and learning along the way, and that's one of the things that makes the Academy so valuable for each practitioner.

AARON: And the availability of new information online on the Academy site has been...is a huge help for people, and I'm sure that...We all depend more and more on the Academy for our continuing medical education, but that process with the online component is really going to continue to increase, I think.

TOM: And to put in another plug for the Academy, when people say the Academy, they think of the annual meeting. 'I'm going to the Academy. I'm going to the annual meeting.' What they don't realize is that there's a large staff of professional people backed up by hundreds of volunteer physicians, and that the Academy is active throughout the year—whether it's in its

political arena, whether it's in education, whether it's a museum and maintaining exhibits of different kinds of instrumentation in the evolution of the specialty, internationally, magazines, the journal. It's just incredible how much is provided not only to our specialty but, for example, guidelines for the family physician that were produced initially by Jonathan Trobe in Michigan. It's probably one of the best-selling educational items available and is used worldwide. So we're having an international impact, which is exciting, too.

So do you think your daughter, who is going to be five in December, is likely to be a fourth-generation ophthalmologist?

AARON: At the moment that's what she says. She says that she wants to come and work in my office, but she hasn't said that she wants to be an ophthalmologist, so we'll see...

TOM: Can she spell it?

AARON: No, but she can say it, which is pretty good. It was one of her first words, I think we have that on a videotape, "ophthalmology", "ophthalmologist," yeah. She's certainly detail-oriented and has an amazing ability to stick to one activity at a time that I don't see in most four-and-a-half, five-year-olds. So if she's interested it would be great. If she's not interested that's fine, too. I don't have any inpatients for her to come and visit with me, though.

TOM: Aaron mentioned going to the hospital with me, and in those days—as David Noonan would remember because he was in Iowa, also—the corridors were long and they had linoleum, and so it made a terrific place for a kid with a vehicle that was propelled through the corridors by legs, scooting down as fast as they could. I'm sure that in this generation there are probably some kids that have done it with a...What do you call those boards...the roller boards or...?

AARON: Skateboards.

TOM: ...skateboards, but I haven't seen that.

AARON: Did I do that?

TOM: You did it...He had a little plastic horse that had a handle on the front of the head on either side, and four wheels—and you could sit on it, and with your legs propel yourself, scooting down the hallway—which he did many times.

AARON: I don't remember that, but...

TOM: On weekends, especially. And in those days we had our inpatient area right next to the clinic area and so, you know, the patients would come out and look and see this little kid scooting down, you know, and were very excited to see that.

AARON: I remember distinctly walking past the otolaryngology clinic on the way to get to the ophthalmology clinic, and being impressed by the patients sitting out in the hall in chairs waiting to be seen, but smoking in the hallways, in the hospital. And particularly some of the people who were very disfigured from head and neck cancer who were still out in the halls smoking, waiting to be examined.

TOM: Well, when your grandfather, Charles Perera, was at Columbia, they had cigarette vending machines in the hospital and Charles was...(his parents were Jewish but he was not a practicing Jew. In fact, he started going to college at age 16 at Princeton, to show you how bright a guy he was, and he became a Quaker.) And the Quakers were always against smoking and interested in health and human rights and so on, so he got a lot of flack for opposing those vending machines. And fortunately now it's 2011, probably in the last couple of years at our institution, and many hospitals around the country, you're not allowed to smoke in the hospital, but...

AARON: Or on the grounds.

TOM: ...or on the grounds, but that took a lot of effort because people, you know, said you can't take that away from patients. In fact, I remember my wife being hospitalized and a patient in the same room (there were just two in the same room) was a smoker. And she couldn't get that person to either smoke outside the room or stop smoking. So things are changing, but you're right, you used to be able to see patients smoking through their ostomy in their throat, a very bizarre thing. I guess by that time it didn't matter.

So, Aaron, having lived in Iowa, now in Washington, and having participated in medicine, we know there are regional differences in care and the way it's administered. What are the differences that you've noticed between Iowa and Washington?

AARON: Well, it's now been 18 years since I was in Iowa, so I'm sure that there have been some other changes, but I think that Iowa is a little bit more of a—dare I say—homogenous population than we have in Washington. And that's not just that the state is flat, because it really isn't, but in Washington there's... There are very big differences between coastal areas, and inland areas, and mountain areas, and lower areas, and Eastside, and Westside, and the different parts of the economy and the populations that live in these areas. So probably... I don't think healthcare is easy in any place now, but it's probably... It's probably different in Washington in terms of the care that people get, just related to those geographical things. I think in Iowa probably the different levels of care are probably provided in urban versus rural areas, but that's probably similar across the whole state in terms of that dichotomy. And I think that, as I remember the system in Iowa, that the state, the DSHS coverage there seemed like it was a pretty good service to the patients. And maybe my memories are... Maybe they're too distant to be able to tell exactly what the differences are, but it seems like there are more challenges now with the state care in Washington than what I remember there being in Iowa.

TOM: Yeah, well, obviously there's a difference in population. Iowa has less than 3 million people, and when I started on the faculty there were virtually no retina specialists in the state outside of the university. And now there are probably 15 or 20 retina specialists, in addition to the ones in the university. And, interestingly, the state paid \$30 million to the hospital, which had to be billed for so-called the indigent care, and that amount of money over the last 35 years has not increased, it's stayed at \$30 million. And losing that would be a tremendous loss.

I want to wrap up with something from my standpoint, and that is how I... I mentioned how I got to Iowa, but one of the things that happened was that Dr. Braley had been the chief in New York, and he was associated with Columbia University. And because they had the surgical operating room

lockers alphabetically he got to know Fred Blodi. Well, Fred Blodi came from Vienna just like my father, but they didn't know each other. And it was Braley who invited Fred Blodi out to Iowa. At first his wife Otty hated it. After two years Fred could have gone almost anywhere in the world, and she didn't want to leave, and she stayed. Fred, unfortunately, had a stroke in the 1990s and passed away in about 1997, but his wife Otty has just celebrated two days ago her 94th birthday.

I just want to mention this. My wife and I have heard stories from her, we visit her frequently. And Cathy had a friend who was in the writer's workshop involved in screenplay and playwriting, who had been successful. So she asked her whether she might be interested in this fascinating story about the Blodis, and she was. And she found a producer to help support her to write a screenplay, which has been written, and Otty has been interviewed, and we have videos, about 12 hours of videos of her not...which will not be used for the movie, although they made a trailer that's about five minutes long describing the story a little bit to go with the script to try and raise money, and the producer is a very well connected person. So we hope that one day there'll be a full-length Hollywood kind of production of Otty Blodi and Fred Blodi and what their lives were. Actually, it ends just before they go to Iowa, and it's comical because Otty had come to the States to live with her mother, joined the WACs, the Women's Army Corps, was sent out to Des Moines, hated it, went to Europe, found Fred, brought him back as a male war bride. And then eventually at Columbia Fred had to say to her, 'We're going to Iowa.' And that's how the play ends.

But it's an extraordinary story and Otty is very, very pleased about it. And of course her children, Barbara Blodi and Chris Blodi, who are both ophthalmologists and practice retina, are very happy to hear these stories in detail, some of which they knew a little bit about, now being recorded. And when I saw Otty, one of the things I said to her, 'So who do you imagine playing your role?' and she said, 'I don't know who that would be, but it should be somebody who is feisty.' And that really describes Otty. At 94 she's still feisty, has all her faculties and is a very, very good and personal friend of ours.¹

¹ Update: In 2014 Otty celebrated her 97th birthday. She is living in an assisted living facility with people who are two to three decades younger. Her two children visit often from Des Moines and Madison and she is doing well although, like many younger, is more forgetful and still "feisty."