

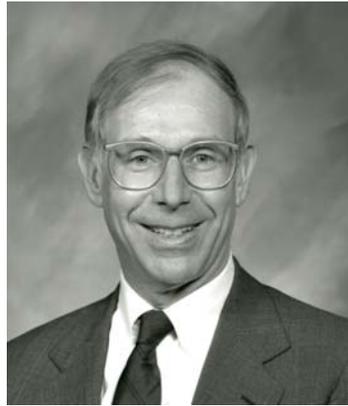
The Foundation of the American Academy of Ophthalmology
Museum of Vision & Ophthalmic Heritage

Conversation Between Alfred Sommer, MD MHS and Daniel M. Albert, MD
Chicago IL, October 15, 2010

Drs. Al Sommer and Dan Albert recorded this conversation on October 15, 2010 during the Annual Meeting of the American Academy of Ophthalmology, in Chicago, IL.

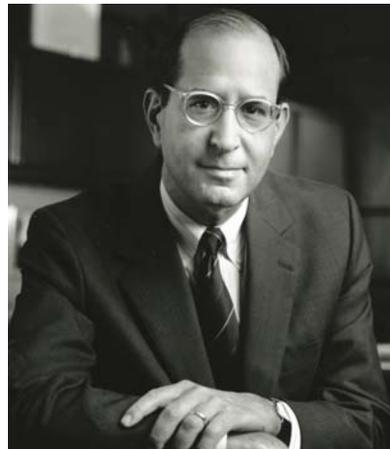
Dr. Sommer is a glaucoma specialist from Baltimore and Dr. Albert is an ophthalmic pathologist living in Madison.

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



[Here](#), Dr. Albert discusses why he chose to study both pathology and ophthalmology.

In this [excerpt](#), Dr. Sommer describes how he became involved with epidemiology and public health.



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ALFRED SOMMER: I'm Al Sommer, and I am 68, and I am speaking with Dan Albert.

DANIEL ALBERT: I'm Dan Albert, I'm 73, and I have the pleasure of speaking with Al Sommer.

AL: So, Dan, should we start off with our roots?

DAN: Okay.

AL: So you grew up on the other side of the river from where I was born...

DAN: Right.

AL: I was born in Brooklyn and you were born in...?

DAN: Newark, New Jersey.

AL: Did you go to public schools there or...

DAN: Yes, I did. And yourself?

AL: Yes, same thing. They had good public schools in those days. I went to public schools in Brooklyn and then just my last two years of high school in Queens. And they had accelerated math, experimental math programs and science programs and tracking and all kinds of terrific opportunities, which I gather young people, unless they are going to a very good, very expensive private school these days don't have.

DAN: Newark didn't have the specialty type schools that New York did, but it was sound education. I ended up at Weequahic High School, which was made famous in *Portnoy's Complaint*...

AL: Oh, yes.

DAN: ...the author being three years ahead of me in school, and...

AL: But it wasn't modeled after you or anyone you knew, other than, perhaps, him?

DAN: Actually, there were some individuals in it we knew. But I thoroughly enjoyed it. It was a good high school and I enjoyed it very much.

AL: Let me ask you something that people always ask me and I'm sure they always ask you. Did you always know you wanted to be a doctor?

DAN: I decided pretty early on. I wanted to be a country doctor and I wanted to practice medicine, sort of modeled after our general practitioner. So, yes, I had that in mind and I really don't know what planted it there, but it must have been a role model type thing. And how about yourself?

AL: I knew from about the age of three because my grandmother told me. I was the eldest grandchild and I was told from day one that I was going to be a doctor. And she varied what kind of doctor I was going to be, I think, with which ever doctor she had last gone to, who seemed to be making more money than the one before. So periodically I was going to be a cardiologist. But for me none of that made any sense, it was just, 'All right, I'll be a doctor.'

DAN: You went to Union College, is that right?

AL: Right.

DAN: Small liberal arts...

AL: Small liberal arts college. I wanted to be a doctor, I had that implanted in my brain, probably a chip. And I figured, 'Let's see, a small liberal arts, all male college, I would probably buckle down and be more serious about what I was doing than I would at a co-ed school or a larger school.' And that worked for me. What about for you?

DAN: Well, I went to Franklin and Marshall College in Lancaster, Pennsylvania. My older brother was the first in our family to go to college and the principal had suggested... for the same things you realized yourself, he sort of told my parents that it was a good school, Christian school with good morals, no women, and no distractions, and it felt...

AL: Well, F and M was on my list. That's one of the other places I considered.

DAN: Well, I went there, and never regretted it. I enjoyed it tremendously.

AL: What did you major in there?

DAN: I was a biology major. And yourself?

AL: Yep, same.

DAN: And you graduated summa cum laude, I saw.

AL: Yeah. Well, it was a small school. Somebody had to graduate summa.

DAN: That was before grade inflation. I think I was sixth in my class, but I was only cum laude so we had...

AL: Did you actually like biology or did you... would you have preferred to do something else if you didn't do that to go to medical school?

DAN: No, I thoroughly enjoyed it. I had the opportunity to do an honors thesis my last year. And HeLa cells had just been introduced, which you may know about...

AL: Ah, yes, very current, with a new book.

DAN: ...and my brother was a medical student at Georgetown... oh, I'm sorry, George Washington, and was able to procure a flask for me and...

AL: Wow.

DAN: But I really enjoyed comparative anatomy, physiology, and so on. It convinced me that I was on the right track.

AL: Yeah, I enjoyed biology, too, but I really enjoyed history, as well. And if I didn't have this chip implanted in my brain, I could fantasize occasionally of becoming a history professor at a small school like Union or Franklin and Marshall, and smoking a pipe and wearing a tweed jacket and being reflective and having students come over in the evening.

DAN: That's interesting. I, oddly enough, had no use for history. I completely ignored it and went out of my way to avoid it. And then when I got into medicine and started knowing about the history of medicine, I just had a hunger for learning history...

AL: Here's the difference, I was interested in history and did nothing with it. You weren't and became a star.

DAN: Hardly a star, but I enjoyed that quite a bit. What made you decide on going on to Harvard Medical School?

AL: It's interesting because I hadn't thought of that in a while. I applied to essentially every school in New York City because my folks...were in New York City, and my girlfriend from high school, who's now been my wife for 47 years, was in New York City, and so I figured, rightfully or wrongfully, there was only one school worth not being in New York for and applied to Harvard. And I essentially got into all but one of the schools in New York. The one I didn't get into is the same one that did not even give me an interview. That was Cornell, which was a very different institution in those days than it is today, because I remember, in my freshman class at Harvard there were maybe six of us in a row in one of the early lab sessions, and of course you start comparing 'Where did you apply?' 'Where did you get in?' 'Where did you think you might go?' And not one person in the row of the six of us, and I think we all just happened to be, by alphabetical order Jewish, none of us had gotten an interview at Cornell, all of us had gotten into Columbia, others who applied to Yale, to Yale, and of course we were all at Harvard. It was a different time.

DAN: It was. I only applied to one school. The dean of Penn, a man named John McCain Mitchell, was a Franklin and Marshall alumni and he used to come out to F and M and interview the pre-meds. It was a different era then and within a few days you would learn your fate. So I was still filling out applications and I...

AL: When you already knew?

DAN: ...got a letter and it said I was accepted to the University of Pennsylvania, and I was just very pleased with that and...

AL: Well, I would have been very pleased with it, too. You got yours in a rational order. In New York, there was this thing called a regent scholarship, which, if you scored high on the test and went to medical school in New York, any medical school, you got pretty much a free ride. At least it was tuition-free. And I had gotten one of these regent scholarships and Columbia accepted me very early on and so I told my parents that I was going to go to Columbia and they said, 'Well, now wait a minute, you know, you thought you would go to Harvard if you got in there.' And I said, 'Well, you know, I got a free ride, and Jill's in New York and, you know, I don't care.' And I think maybe really I didn't want to be disappointed. So I actually sent in my \$250 or something, and then three days later, the way Harvard did it then is they sent you a telex, so you get a telegram at the fraternity house that I was in; this telegram was read to me over the phone. The next day you get this formal letter. And so I wasted \$250 and my parents paid the first half year; and then we were married, and Jill put me through the rest of medical school.

DAN: You must have enjoyed Boston—it's hard not to—but you eventually found your way to Baltimore after your internship. Did you have a good experience there?

AL: Well, we were very lucky. We were actually married three weeks before I began medical school. We were looking for a place to live and we had looked at several apartments which we couldn't afford, and were not particularly close to the medical school and we didn't have a car. We visited the medical school, and they had a random list of apartments. It turned out there was a small apartment house right on the same block as the medical

school on Longwood Avenue, and they only had six apartments. It was only for Harvard medical students, residents and interns, and one was open. And we couldn't believe it: We walked in, and it had two bedrooms, one of which of course would become my study so I wouldn't bother Jill when I was up all night memorizing anatomy, and it had a wood burning fireplace, and it was \$75 a month. So we had sort of died and gone to heaven. And we lived there for six terrific years, and it was easy for me to get to work.

Jill taught out in Newton, so we eventually got a car at the end of the first year. We did a delayed honeymoon, picked up a car in England, a little Triumph. We had angst over should we get a Beetle which is originally what we thought we would get, but for \$150 more we could get a Triumph sports car. And the Harvard Co-op had some deal going with Europe by Car, where they had these really tremendously discounted prices so we ended up... I remember going to one of my faculty... you know, I'm a first year medical student, and this is a very famous physiologist, and I went to him and I asked if he could think of some way I could work in a lab in Europe for the summer between my first and second year. We had very long summer intersession then; 12 weeks, I think. And he said, 'What do you want to do that for?' I said, 'Well, because I've never been to Europe.' So he said, 'Well, go to Europe. Don't waste your time in a lab.' I thought, 'Now see, a Harvard medical professor is telling me that I shouldn't waste time in a laboratory? This is too good to be true.' I said, 'I really can't afford to do that.' He said, 'Well, go to Europe for six weeks and then I'll pay you the same summer stipend we pay everybody for six weeks in the lab.'

DAN: That's a great opportunity.

AL: It was fantastic. We had a great time.

DAN: Emily and I, my wife for the last 50 years, were engaged when I went to medical school and we married our second year. And later on when we were in Boston, she taught in Newton, as well. She taught at Solomon Schechter Hebrew Day School in Newton. When did you start to think about ophthalmology?

AL: I was going to ask you that. I actually did two years of internal medicine at Beth Israel in Boston with a bunch of my buddies from medical school, and I really thought I was going to be an internist. And one of the embarrassing things is that those friends of mine who went directly into ophthalmology, I used to make fun of them. I said, 'That's not a real doctor.' I mean, like you, I was the first person in our family to go to college. So a doctor wore a stethoscope and listened to hearts and lungs and that type of thing, and so I was going into internal medicine. And at the end of the middle of my second year of internal medicine residency, I started to decide, 'You know, there are all these hundreds of academic internists around me who are, to my perception, working 24-by-7 in order to get to the place that the other guy's going to get to two days earlier because they're all concentrating.' I said, 'You know, maybe this is not really the field I ought to be in.'

I headed off to the Countway Library one evening because I had a case that I wanted to read up on, and I had probably been awake for 36 hours or something and fell asleep in a wing chair. When I woke up, totally by accident, I saw sitting on a little side table next to me a little booklet. It turned out to be a survey or an assessment that was the first thing that was commissioned by Research to Prevent Blindness about 10 years earlier, on the status of academic ophthalmology in America. So maybe it was written in 1962 or something like that, 1960, '59. And according to the executive summary, when that was written, there were 12 full-time academic ophthalmologists in the United States. I looked at that and said, 'Huh, 12? I mean, there are hundreds of internists in the Harvard system that are all academics, full-time, and here's 12 in the entire country. Maybe ophthalmology is a place where I can make a difference. I mean, it looks like there's got to be a lot of room there.'

And that's more or less when I started to think about going into ophthalmology. I called Henry Allen who had been my... everybody during their first year in medical school had a tutor, and he was at that... and for a brief stint was chair of the department at the Mass Eye and Ear. I went over to see him in my white coat. You know, I had a two hour break from the BI and I went across town on the MTA. And he was really, terrifically warm and supportive and threw me an indirect ophthalmoscope, and said, 'Al this is terrific. You'll come here, spend three years, and then you'll spend two years with the Retina Associates. We'll make you the world's greatest retina

surgeon.’ And I tried to explain, I said, ‘Dr. Allen, I don’t think I really want to be the world’s greatest retina surgeon. I’m really interested more in why people get disease, how to prevent them from getting disease.’ And he said, ‘Ah! This is going to be terrific Al—three years as a resident and two years in the Retina Associates—so we’re going to make you the world’s greatest retina surgeon.’ And I thanked him, was walking down the steps of the old Eye and Ear, figuring, ‘All right this was a mistake, ophthalmology is clearly not for me.’ But I had spent a one month rotation with David Cogan, and I said, ‘You know, before I sort of chuck this, let me see if Dr. Cogan is in.’ I went upstairs and he was and he gave me a warm welcome, and I said, ‘So I was thinking I might go into ophthalmology, but Dr. Allen wants to make me the world’s greatest retina surgeon.’ And David said, ‘Al that’s the problem with ophthalmology, too many damn surgeons. You want to go into ophthalmology.’ And that’s how I ended up in ophthalmology.

And, again, you were talking about it being a different era, I, with some reticence, told my Chairman of Medicine at Beth Israel. I figured he’s going to go epileptic that I’m going to go into ophthalmology, and he said, ‘Al this is really good because ophthalmology needs some people who aren’t interested specifically in surgery.’ When he saw me about two weeks later on morning rounds and said, ‘So what have you done about ophthalmology?’ Well, I actually hadn’t done anything. It was still an idea that was percolating in my brain. And I said, ‘Well I haven’t done anything quite yet.’ Three days later I had a note in my mailbox from Howard Hyatt, and it said, ‘I’ve just had a conference call with David Cogan and Ed Maumenee at Wilmer and we’ve decided you will do your residency at Wilmer.’ That doesn’t happen anymore, but these were terrific people, they were supportive, they told me what I was going to do with my life, and that’s what I did.

Now how did it work out with you?

DAN: Well, it’s curious, you know, Ed Maumenee and David Cogan knew each other through eye pathology and through the Verhoeff Society so...

AL: Did you go to pathology or ophthalmology...

DAN: Well, you know, when I was in high school my dad developed bladder cancer, and they told him at the time... it was so extensive they had to remove the bladder, and it was before they used the bowel as a substitute, and he was given a 12% chance of survival. And it was a day when I visited him and I got lost in... he was in Sloan-Kettering, Memorial Sloan-Kettering, and I wandered through the wards as they had them then, and saw the cancer patients, and just came home and said, 'You know, how can this be? How can people being in such pain and be so sick?' And at that point, I said to myself, 'Well, I want to work... I wanted to study cancer and try to know more about it and try to advance a treatment.' And at that time pathology was sort of the cutting edge. And when I talked to doctors that we knew, they said, 'Well, you know, the big advances are going to come in pathology.' So I retained that interest throughout college, and when I got to medical school I was hell-bent on being a pathologist. And I worked with Irv Ziegman and Dale Coleman who were senior pathologists, and in my senior year I applied for a pathology residency and was accepted.

But I always was fascinated with the eye. And Francis Heed Adler, who you may remember him, had given us our eye lectures, and in the interim Harold Shea became chair. So I had a six-week elective in my senior year and I signed up for ophthalmology. I already had accepted a position as a path resident. And it was love at first sight. I just fell in love with the eye. I thought the... looking at the fundus was just one of the most exquisite things I had ever seen. And I guess Shea appreciated the chemistry that was going on, and at the end of the six weeks he called me into his office and he said, 'You know you really should retain your interest in pathology, but do it through ophthalmology.' He said, 'We have wonderful models with tumors, and you can do everything you want in pathology but you can combine it with your love of the eye.' And he called his secretary in, Miss Bueher, and said, 'Dan's going to dictate an acceptance to the residency program.'

AL: Hey, those were the days!

DAN: And he said, 'Type it up and have him sign it.' And I came home that day and when my wife and I sat down to dinner and I said, 'I have something to tell you.' I had left that morning headed for pathology, and I said, 'No, we have to make a detour and I accepted an ophthalmology residency.'

And then following that, I went to the AFIP and I spent... I also was at the NIH, but I was able to work with Al Rabson at the National Cancer Institute—he was an outstanding pathologist—and I sort of did my pathology training there, and then was able to launch a career in eye pathology.

AL: Well, you certainly did a very famous one, and very productive one.

Was that time in NIH and the AFIP in lieu of Viet Nam?

DAN: Yeah, we were facetiously called the Yellow Berets...

AL: Yes. Yes.

DAN: ...as you may remember. Dr. Shea was a very interesting guy, and he was a general in the reserves. And somehow I had a gut feeling... I didn't want to... almost everybody in the residency was in his reserve unit, and he was just itching to have them all called up and get back into active duty, and I somehow didn't...

AL: It didn't appeal to you.

DAN: It didn't. Didn't seem the way I wanted to go. So he said to me, 'You know there is an alternative.' He said some derogatory things about the alternative...but he said, and I think he envisioned my coming back to Penn at the time, 'Why don't you train with von Solomon down at the NIH and then work with Zimmerman?' And similar to what Dave Cogan did for you, he wrote some letters and I filled out my forms, and the next thing I knew I had my next three years planned.

AL: Yeah, when I was a first-year medical student, and, of course everyone remembers where they were when Kennedy was shot, and I was in physiology lab pithing a frog or something. And smoking up one of those drums so that you could trace the...

DAN: Oh, yeah.

AL: And probably because of that... I'm not sure that was the driving force, Jill and I decided we wanted to go into the Peace Corps. And one of the star faculty actually, a Nobel prize winner, Tom Weller, who taught tropical medicine, one of his former students, a former Harvard medical student, was then the chief physician for the Peace Corp. And so I was telling him that I thought we would like... when I was done with my medical training go into the Peace Corps. So he said, 'Well, you ought to go down now and talk to so and so.'

I think I was probably in my second year of medical school when we went down, had this interview, both of us, and got accepted to the Peace Corps for when I finished medical school, and my internal medicine residency, and we were very excited about that. We even got to choose where we were going to go. And the one thing I remember about that interview, that was fascinating- there was a last question, this would show you how long ago that was, but I'm afraid politically were going back to the same era. If you remember, that was an era when you could not buy a contraceptive in Connecticut, at least not officially. People did but, in fact, it was against the law. And you certainly couldn't get an abortion legally in the United States, anywhere in the United States. The last question they asked me for this interview was, 'So you do know as the Peace Corps physician to a country, you report directly to the Ambassador. And he needs to know everything important and relevant to the Peace Corps workers.' And I said, 'Okay.' And he said, 'Now, a young lady in the Peace Corps comes to you one day and tells you that she's pregnant. What are you going to say to her?' 'Well, the first thing I would say to her is 'do you want to have this baby or not?' And if she says no, she does not want to have this baby, I would tell her to get on the next plane to Sweden and have it taken care of.' 'And what are you going to tell the Ambassador?' I said, 'It's none of his business. I ain't telling him anything.' He said, 'Thank you Dr. Sommer, would you wait outside?' And I figured, 'Well, that's that.' They came out in two seconds and said, 'Congratulations, we would love to have you in the Peace Corps.'

DAN: Very good.

AL: Yeah, it was good. But when I was in my second year of residency waiting to go into the Peace Corps, we got this letter in the mail that said 'we do have to inform you they just changed the draft law, and you will be

drafted out of the Peace Corps and sent to Vietnam.’ That didn’t seem so cool. So, literally, there was one week left to find a Yellow Beret position before those applications came to an end. And they were roughly—what?—50-, 60 draft-fulfilling positions in NIH. There was a similar number at CDC in the Epidemic Intelligence Service. And while I knew I was going to go into academic medicine, not into private practice, not being at all certain what I was actually going to contribute to academic medicine, but that was what I wanted to do, and I knew I was hopelessly incompetent in the laboratory, so I figured that this epidemiology thing might be something that I could do and find interesting. And so I applied and was fortunate enough to be accepted into the EIS.

And that’s how I ended up having this epidemiology public health thing. Before that I had never thought about epidemiology and public health. We got down to Atlanta, and within the first month or two we had our first child, Charles. But the office that I was assigned to was really boring. Now, there are a lot of really exciting programs but the one I was assigned to was really boring. And it was such a big mismatch for me because here I had been running like you do when you’re a medical student, an intern, a resident for six years. So I was looking for things to do, and I obviously must have been very manic because the guy who was the head of this office came to me the second week and said, ‘Al we voted for you to take the next two weeks off and calm down.’ So, all right, so I was waiting for our first kid to be born, so I took two weeks building baby furniture and so forth. At the end of that, soon after I came back, two people were visiting, they were very senior people, and provided the epidemiologic infrastructure for what was then called the Cholera Research Laboratory in what was then East Pakistan. They were so excited about the work they were doing, and they were looking for another epidemiologist to replace the junior person who was rotating out. Despite the fact that I knew there were two things that I really didn’t like, tropical weather and rice, I immediately applied for this position, came home and told Jill. She said ‘it’s a 100 degrees-plus most of the year with 100% humidity, is this really what you want to do?’ I said, ‘Well you know, we wanted to go into the Peace Corps. This is sort of like going into the Peace Corps.’ It meant signing up for an extra year. So I called Ed Maumenee and I said, ‘Professor Maumenee, can I put off my residency for a year?’ I did that two or three times over the course of the next few years. And Ed, who was just a terrific person, who really liked oddballs, said ‘Oh,

all right, we'll work it out somehow. Sure, take the year off.' We went to live in Dhaka, East Pakistan. And we were there for the cyclone disaster that wiped out over a quarter-million people in one night.

DAN: I think your first couple of papers were on that cyclone.

AL: My first real published paper was on that cyclone disaster. I think that's the longest paper that was ever published in *Lancet*. It was the first epidemiologic study of a natural disaster... And it all began largely because the government asked our government, the American government, to supply them with a dozen field hospitals and 20 x-ray machines and so forth, and the Ambassador, quite appropriately, came to us at the lab, and said, 'Do they need these things?' And I had actually gone out with three other people, on a voluntary basis, thumbing rides down to the devastated area, taking all the food and equipment that we could find in the American commissary and the German commissary and the English commissary so that we could start relief activities. So I had actually been out there and I saw there was nobody hurt, because if you were young, weak, frail, elderly, or somehow damaged, you were swept away. The only people left were the healthiest population. They could hold on to a tree when this wall of water washed in and then rushed out again. A quarter-of-a-million people were lost that evening.

We were subsequently there through part of their civil war, and were eventually evacuated. To show you how long ago that was, we were safe havened in Tehran. We spent three months in Tehran. Eventually, when the war was over, I was sent back to finish up and help control a mammoth smallpox epidemic.

And by the end of all those experiences, which had been terrible for the Bengalis, but extraordinary for us socially, intellectually, a bunch of research papers, doing sort of seat-of-the-pants epidemiology because I hadn't had a single formal course in epidemiology by then, but I was hooked. I knew this is really what I wanted to do. And so, again, I asked Ed Maumenee, 'Well, I know I'm supposed to start my eye residency in a couple of months, but I would really... you know, before I go into the OR and have my first orgasm and forget about public health, I really would like to be formally trained in epidemiology and biostatistics; can I put it off for one more year so I can get

a degree at the School of Public Health and then I'll start my residency?' And he, again, being very supportive, said, 'Well, okay we'll work it out, don't worry about it, and sure go ahead and...'

DAN: That's interesting. I wondered about the curious sequence of...

AL: It was...

DAN: ...the fellow in epidemiology before you... that explains...

AL: Most of my life has been serendipitous. I tell students and junior faculty this all the time. When they come to you and say, 'What should I do with my life?' or 'What should my career goals be?' I say, 'I can't tell you what yours should be. I can tell you what mine were- other than wanting to be a physician, everything else was happenstance.' And I quote Yogi Bera, 'If there's a fork in the road, take it.' Life is filled with forks in the road, and you can't angst about which fork you're going to take because you can't do a randomized trial on forks in the road. You do the one that seems most interesting at the time, and if it turns out not really what you want to do, there will be another fork in the road pretty soon. And then, again, you do what seems most interesting.

DAN: It's easy to see that from our perspective now when you look back. At the time you're going through this, it looks like...

AL: It's tough.

DAN: ...you know, there... you have your big chance and you don't want to...

AL: Well, we've been lucky. We've taken, pretty much, the right forks. And the right forks have presented themselves, and we've had the opportunity to take them.

DAN: There were two people that I met during the years I was at the NIH and the AFIP that really influenced my life. One was Dave Cogan. And that was really serendipitous. Dave came down... I think he was a consultant to the AFIP, and he and Zim were good friends. And somehow he took a shine

to me, and really spent time and gave me advice. And in the way that only Dave Cogan could inculcated me with his priorities and his feeling for what's important in medicine and what's important in life. And we stayed friends until Dave's death.

AL: Well, I hadn't realized we both had this common phenomena built around David. I mean, I would not be in ophthalmology if it hadn't been for David. And for one month I had with him during my fourth year of medical school, inspired by him...

DAN: When I got to... eventually got to the Mass Eye and Ear, I had David's office, and one of my fellows put a little bronze plaque on the... there was a swivel chair. You probably remember it...

AL: Un-huh.

DAN: ...that you could lean way back in, and so on, and it said, 'The Cogan Chair.' And I think of all the chairs I ever sat in, literally or figuratively, that meant the most.

The other person who really had a lot of impact on me was Dr. Zimmerman, who will soon be celebrating his 90th birthday. And he taught me a couple of things that I think you've probably found true. One was that the principal instrument that you have is your brain. And just looking through a microscope and observing things and thinking about things you can make important contributions and find entities that have been totally missed, even after a couple hundred years of people doing this. And he also showed me the importance of being a lumper. Zim really looked for common themes in disease...

AL: Not a splitter.

DAN: ...so... yeah, so those two individuals really impacted how I did things for a long, long time.

AL: Yeah. Well, you know, so for me, again, David had the original impact. And then Ed Maumenee, when it came to doing this... I remember when I first went to him and said that I wanted to take time off and do this

public health thing and actually get a degree and get these tools that I would then apply, and so he said, 'Well you ought to go across the street where the School of Public Health is and talk to the dean... no, don't talk to the dean. He's kind of dumb. No, you ought to talk to the Chairman of Epidemiology. Let me just... I'll call up Dave Lillianfeld.' And Dave Lillianfeld was very much the same person as David Cogan was, and had gotten... his big area was chronic disease, particularly cancer research, before he had come back to the school. And he was the one who was very encouraging. And I had applied for an NIH fellowship to be able to do this, but it wasn't clear that I would get it. And so he had arranged that I would be funded for that year under his cancer research funding. And then he told me after... I did get that NIH fellowship, but he told me after, this was really quite humorous, because they came to him and they said, 'Well, why should we fund this guy?' And he said, 'Well, because you don't have anybody in ophthalmology who is doing epidemiology.' And they said, 'But he hasn't done his ophthalmology yet. Maybe he won't do it.' And Dave, apparently said to them, 'Well, you've got to take a chance because you don't have anybody else, you know. And he's probably going to do it, but, you know, that's not like a huge risk to take that he might not do it.'

And I have to say, every year when we have the new physicians coming to the School of Public Health to do... whether a Masters degree, which is what most of them do or a doctoral degree, I warn them when I welcome them that they're going to find the first three months very difficult, because they have spent their entire careers so far instantly focusing on a single sick patient and what they need to do for them. And in public health what you're doing is thinking about populations of patients and populations who you don't want to be patients, and numerators and denominators. And I said, 'So you're going to find this very difficult, but I promise you that by Thanksgiving the switch will go on.'

So I had exactly the opposite reaction. So I did my degree in public health and then I started my residency. And, fortunately, all the other residents that year had all been red-shirted, as people used to call us, because we were older than everybody else. We were older than our chief resident. And I remember my first morning on rounds, my first day, and, you know, the person who was a first year resident, now it's the first day of their second year of residency, is telling about the most interesting case that came in the

night before. And it's a woman with a red eye. And so here are... you know there were four other residents in my group, but you had the second year residents and the occasional third year, so there may be 10- or 12 people in the room hearing this presentation. And I'm listening to this thing and they are, you know, quoting the latest literature and arguing about this, and I said, 'I don't believe this. Why am I here? I mean, I've just for the last three years been making decisions that affect the lives of millions of people, and here are 12 really smart people arguing about a red eye, and it's only one red eye.' And so the next three months... those first three months of my first year of residency were very difficult for me, because I was trying to make this transition from millions of people...

DAN: There are two ways of approaching science—you can be Galileo and look at the heavens or you can look through a microscope and see the individual cell. And each one has something to be...

AL: Well, at the end of those three months I could get excited about a red eye, too.

So, Dan, you've had a much more varied ophthalmic career than I've had in some ways, and I've actually been at one institution, at least ophthalmologically speaking, my whole career. You've not. So can you tell us a little bit about what were the highlights and opportunities that each one of those presented and why you moved from one to the other type of thing?

DAN: Sure. When I got out of the AFIP there were three openings for ophthalmology—one was at Duke, one was at the University of Rochester and one was at Yale. And I went down to Duke and the Chair took me out to a tobacco field and he rolled a tobacco leaf in his hands and he said, 'Smell this.' He said, 'This is what makes Duke great.' So I looked at Rochester, and we landed in a snow storm in September, and ended up in Buffalo and took a bus back. And my wife...

AL: This is quickly becoming a no-brainer.

DAN: So I ended up at Yale, and I loved the place. It was fun and we liked the community, and our kids were little and they fit in well. But, unfortunately, Yale is sort of in a valley between New York City and

Boston, medically, and particularly in terms of ophthalmology, and it was just a three-man department when I was there. I saw myself really headed for a career as a comprehensive ophthalmologist, which was not what I had in mind. And there were, unfortunately, very poor town-gown relationships, so every eye tumor that was seen and interesting cases in pathology that were seen outside of our three-man practice either went to Boston or New York.

And I finally figured if you can't fight them, join them, so I went up to Boston. And when I first got there I sort of felt like I joined the New York Yankees. There were these storied individuals and great heritage and history. And I enjoyed it and was very, I think, productive, and I thought I would be there forever. And then Fred Blodi retired from Iowa, and Fred had been a very good friend and he invited me—this is after 17 years in Boston—invited me to be interviewed for his position which I, at the time, really was not interested in, but out of deference to Fred I went up there. And I had never looked at a Big-10 School before, and I didn't know anything about the Midwest, and I liked it, and I really thought it was... all the things that started to degrade at Harvard—the lack of the team spirit, the lack of collegiality, the intense competition and so on—it was the opposite situation. There were downsides, too, but I just was very impressed. And I called my wife and I said, 'Ellie, you've got to come here. This is a really interesting place.' And she came out. But at that time our kids were in high school, and I was working with Ted Dryja the cornea-retinal glaucoma — it was just the wrong time to move, but we really talked it over and decided that we would like to spend the last few decades in a place that offered a real community and offered the sort of support and collegiality that you find in that sort of school. And then a few years later Madison became available, and I went out there as a chair, and I think I continued to be productive in terms of the path lab.

I never had a large surgical volume, but when I became chairman I gave up surgery and really kept up with my pathology, and served two terms. I know you served three terms as the dean and then became chair emeritus, and I guess the motto is, 'forgotten but not gone.'

AL: That's true.

DAN: Now I run my path lab, and we started an eye research institute which you may know about. It's a cross-campus institute, and it has been very strongly supported by Alice McPherson. And that's been a real challenge and really exciting.

AL: And, again, commonalities... I mean, Alice McPherson has been very generous and supportive of the International Council of Ophthalmology's programs, fellowship training programs, as well, she's a terrific person.

DAN: But the thing that really impressed me in looking at your resume was in 10 years you went from being an instructor at Hopkins to being Dean of the School of Public Health. But before you tell me about that, I did want to ask you what was Hopkins like when you were a resident? It had so many larger than life figures in it, and...

AL: It was very interesting. It was a great place to train, obviously, but you know, in retrospect, it was a small place. When I first started my residency there were maybe five full-time faculty members. And they had some... you know, some historic people who had been doing basic research then left, but from like Hubel and Wiesel and Cufler were there when I interviewed, when I went by for my nominal interviews, as I was already told I was going to do my residency there. So they were gone. John Dowling was running the bio-chemistry lab. Art Silverstein stayed and he was running all of his important immunology activity. So they had a big research enterprise, largely from a basic research prospective. But the number of clinicians was really quite small, and probably Ed Maumenee did half the surgery and brought in half the income. He also wasn't there most of the time. And we had this joke amongst the residence that one way we could get to see him more is one year we made him the visiting professor. It was a one week slot for visiting professor, and we gave that to Ed.

I found your comment about the collegiality of Iowa in comparison with that of Harvard not dissimilar from the comparison with Hopkins, which you wouldn't expect, because Hopkins' people are, you know, very competitive. But they are very outwardly competitive, not internally, institutionally competitive. So it's a unique... really quite a unique culture, and I have no idea how it... it's exactly the same at the medical school as School of Public Health. And they're pretty much overlapped, you know, half the faculty at

each school have an appointment at the other school, so that's not a surprise. And so there are a whole bunch of Harvard, you know, transplants at Hopkins and we would sometimes try to figure out why is Harvard so competitive internally and Hopkins, with people who are just as competitive externally are so collaborative, and they'll give you the shirt of their back. Whereas you go up to Harvard, I remember when I interviewed there for a possible job, you know, people made it quite clear that that was their chair, and don't you possibly sit in that chair or that spot. And I don't really know the difference. One person summarized it as saying the difference was that everybody at Hopkins wanted to save the world and everybody at Harvard wanted to be famous. That may be too simplistic a response.

But that rapid ascension actually, it was interesting because when I looked at the opportunity... when I came back from overseas, because I had trained at Wilmer and then we had had such an extraordinary time overseas we wanted one more experience before our children sort of entered adolescence, and that's when I began my vitamin A work and we went and lived in Indonesia for three years, and I had a year left on a grant and so we then spent a year in London, and then we had to decide where we were going to go. And much like you, there was sort of three places that were... I don't know why things come in threes, but there were three places that were interested in a pathologist when you were looking and three places that were interested in an epidemiologist when I was looking, and one was UCSF, one was Harvard and one was Hopkins. And it was pretty much the same thing. Although I must say, the UCSF deal, it was a gorgeous day in San Francisco, and I remember spending a couple days here with some old friends and mentors, and then we went back to their office after running around town about 2:30 in the afternoon on a Thursday and there was nobody there. And I said, 'Where is everybody?' And they said, 'Well it's a beautiful day. They're out on the bay.' And I figured, 'I'm not going to get any work done here.' And they joked and said, 'You know, you're really a bazaar character. You've lived everywhere in the world, but won't live on the West Coast of your own country.' And then I went to Harvard, where I chatted with you and got some good advice from you. And I think it was early April, and it was a cold, miserable three days, you know, the trees didn't have a single leaf on them, and then I went back down to Hopkins, and of course it was a beautiful sunny day and the azaleas were out and the dogwood were blooming. But in truth, you know, that was the last place that I had been and

so my network was closest there, and both... Arnold Patz had now become chair—Ed was still very much around, but Arnold was now Chair of Ophthalmology, D.A. Henderson was Dean of the School of Public Health, and they really worked very hard to convince me that Hopkins would be the place that would most facilitate this bazaar idea I had of starting a unit that was dedicated to preventative ophthalmology, to epidemiologic and preventative ophthalmology. And that my starting rank was very low to begin with, but it would move very quickly. It was just... that was a way to just get me on board and not have to go through all the hoops that you have to when you become an associate or a full professor.

And that really was one of the most productive 10 years of my life. And I had this fantasy... well, it wasn't a fantasy, it was based on articles I had been reading, you know, what were most people's thoughts in internal medicine at the time, you know, what did they want to do when they grew up? What kind of a unit would they like to have? And it was interesting, they had done a poll and almost nobody wanted to be a chairman of the department any longer. They wanted to do their own thing and maybe build a small group of two or three like-minded individuals. And that was really what my goal was, two or three.

But it was a wide open space. Nobody was working on it and it hit, again, one of those just lucky times when... so John Wilson and Ed Maumenee had put together the Agency for the Prevention of Blindness, WHO had just become a blindness prevention unit, there was money for blindness prevention, and so I was able to muster the funds. Arnold had tried to get a foundation to give money to the new Ed Maumenee Building they were trying to construct, and took them around to meet the different people in the different units, in the Retina Unit and the Walter Stark and the Cataract Corneal Surgery Unit. And then I was parked a sort of broom closet with Hugh Taylor, and the site visit was being made by the head of the foundation, but also Charlie Dana who was the Chairman of the Board. And he asked me what I was doing and I said, 'Well, I was planning to get people who are interested in ophthalmology to then also study and get involved in public health epidemiology and marry the two, and get people in epidemiology and public health interested in ophthalmology.' And he said, 'Do you really think you can do that?' And I said, 'I'm absolutely certain I can do that.' I don't know what got me to be so confident, or at least seem

so confident, because I certainly didn't feel so confident.

And at the end of the day, the bottom line is he came to Arnold and said, 'I want to fund something that's related to what Al Sommer is doing,' which was a great disappointment because they were building what was largely a big clinical facility. So Arnold asked me would I mind taking over the whole floor of the original Wilmer Building, and much like you had David Cogan's office, I would have Dr. Wilmer's, Wood's, Maumenee's, and Patz's original offices. And that he would give me that, and if that would satisfy me, and I told the foundation it satisfied me it would satisfy them and they would pay for a floor in the Maumenee Building. And I was more than satisfied to have this beautiful, old, elegant space, instead of a low ceilinged cubical in a modern kind of building. So that launched our unit and quickly attracted some very bright people who were in ophthalmology. But very importantly, initially, straight out of... well some who were doctoral students and did their doctoral thesis with me, some who were straight out of their doctoral degrees in epidemiology and in biostatistics, who all now, every single one of them, are full professors and have endowed chairs. I don't have an endowed chair, but my graduate students all now have endowed chairs, which had nothing to do with me. It's just because I was good at picking really smart and compulsive people.

And so in that 10 years... and with Hugh Taylor very importantly as the co-director of that unit, we took on trachoma, onchocerciasis, river blindness, xerophthalmia, and then we each had our own area of clinical interests, cataract and glaucoma, and it's, I think, fair to say that that 10-year period we changed the paradigm for every one of those entities by a very collegial group that by the time the 10 years were up were over 40 people between staff and faculty from laboratory supportive work to largely epidemiologic studies in the field. And the key, now global approaches to the control of certainly trachoma, xerophthalmia and onchocerciasis were all developed during that 10-year period by our group. I mean, it really was an extraordinarily generative time, with each of us bouncing off the wall everybody else's ideas and throwing them back at them and then lobbing them back. So we were really... we weren't all working on the same thing, but we were all critiquing one another's work, presenting ideas and what have you.

And so that 10 years went quickly, and, I mean, it was the first three years that I became a full professor was within three years. And I was having a wonderful time. I had certainly no plans for higher administrative office. In fact if anything, I was frustrated that I was... now we had over 40 people and we were working in four or five major areas and I was no longer in the trenches. And the younger people were all in the trenches, and I was mostly raising money and running around and, you know, visiting sites, which was all right, seeing patients two days a week, operating half-a-day a week when I was in town, and then doing this research and stimulating people and going to WHO meetings.

And then D.A. Henderson stepped down as Dean of the School of Public Health, and I was one of the two medical school representatives on the search committee, the other one being a wonderful guy, Dick Johnson, who was head of Neurology but had had a lot of overseas experience and done a lot of epidemiology. And we found lots of terrific people in that search committee to be the new dean, but we had a new president of the University, who actually was a health economist and therefore knew people in public health, and he did not like a single person that we had found, even though we thought they were terrific. And so one day the provost called me and said, 'President Richardson would like to have lunch with you on Monday.' So I knew what that was sort of going to be about. And I had seen a mentor of mine be appointed the Dean of Harvard by the president while the search committee was out doing their search, and he never really recovered from that. And so I said, 'Okay, you know I've been beaten up enough...' a lot of School of Public Health faculty would come to me and they would say, 'You know, these are terrible people. You ought to be the dean.' And I could only explain it by the fact that since I was in the School of Medicine I had never competed with them for space or money or anything, and that's why they thought I would make a good dean. And the long and the short of it was, I said, 'Okay, I'll tell you what, I'll have lunch but only after you reconvene the search committee without me on it, you put me through all the things—you know, give a lecture, meet with alumni—that we put everybody else through, and then if the search committee recommends me... and I understand from somebody that it was not like a unanimous recommendation, but nonetheless, '...then I'll have lunch.' And I had lunch and I became Dean of the School of Public Health.

And while it's not really what I had wanted to do, I have to say, you know, again, luck works well. It was probably a good time of my career because I could see what could be done. I had done a lot of international work and obviously a lot of stuff in epidemiology so I sort of knew what a lot of the school was about and what a lot of people were interested in. And the stock market was going up not down. The economy was flourishing. And the School of Public Health, when I first became dean, while it was the oldest, largest School of Public Health in the world, it really was an orphan of the university. And I thought I was being really smart—before I agreed to take the job, I said, I want to see the budget for the last two years, and it looked like they were losing maybe \$150- to \$200,000 a year, but on a budget of what was almost then a hundred million dollars I figured, 'Well, that's... you know, that's a rounding error. You beat the band a little bit and you get rid of a few extraneous staff, and that's not a hard thing.'

So I became dean and the first shock was about the third week when this nice young lady who was deeply buried in the bowels of the financial part of the school came up and said, 'Do you know about the budget here?' I said, 'Well, I looked at it.' She said, 'No, no we actually have been losing \$3 million a year every year for the last 10 years. We have practically no endowment left.' And I was... then I... that was very... that was a difficult year, because all I could think of every night when I tried to go to sleep and couldn't was, 'So the largest, oldest School of Public Health in the world is going to go out of business on my watch, in about three years when we use our last bit of money.'

DAN: In reviewing your CV and in the years I've known you, there are two comments I would make. One is that when you look at your more than 200 publications and you look at the titles, you really stayed focused. I mean, there's glaucoma and there's cornea and there's infection and there's vitamin A. And it's sort of like the themes in the symphony, and they keep intermixing and recurring.

The other thing that I've always marveled is in spite of your protestations that Hopkins at heart is a kind and gentle place, I've known many people from Hopkins and people in epidemiology, and you achieved what you achieved and got where you got and have the admiration and the affection of the people that are working with you and under you, and I think that's a real

achievement.

AL: Well, that's what kept those publications going, is because of the young people who would... you know, they would come over to the house once a week or once every other week truly to drink wine out of my wine cellar, but the rationale was is that we... and we really did, and that perhaps some of the most fun was going over data together and trying to tease-out what the data was telling us, and then planning for the next series of experiments. They're the ones who did them. But at least I could get intellectually, keep intellectually involved by doing them.

How did you get involved with the Academy and what have you seen of the Academy over the years. I mean, this is for the Academy. We ought to say something about the Academy. Good or bad we should say something.

DAN: A word from our sponsor.

AL: What was your first experience with the Academy?

DAN: My first experience with the Academy was when I was a first-year resident, the alumni would send the four first-year residents at Penn to the Academy. And it was held here in Chicago, and we were given reservations at the Palmer House...

AL: Woo! This is a good alumni association.

DAN: ...and we were given each a... \$200 or some fantastic amount of money to go and have a good time. And we had such a good time on the way from Philadelphia, we drove together in a car to Chicago, that when we got here our reservations had been given away at the Palmer House, so we ended up at the YMCA. But it was just a grand week and I learned a lot and saw a lot and really enjoyed it.

The second time was more daunting. I was a fellow with Ludwig von Solomon and we had done... I was working in the laboratory of Al Rabson, and we had induced ocular tumors with SV-40 virus and Adenovirus 12, and Dr. von Solomon said this should be presented at the Academy, and this was in 1964. And I sat in the back and saw the sea of people, and I thought, 'My

God, was this ever a mistake.’ But I was in luck because my paper was the last one on the schedule and they were running late, and by the time I got up on the stage to give my paper there were a few hundred people left in the audience.

AL: So that was when it was still the American Academy of Ophthalmology and Otolaryngology...

DAN: That’s correct. We were still...

AL: So there were a lot of people there.

DAN: Yes, during most of the time. But I think the topic, perhaps the speaker and the late hour combined to make it sort of an anticlimactic affair.

But after that I don’t think I’ve missed an Academy. I’ve really enjoyed it. And how about yourself?

AL: Well, my first coming to the Academy was much more climatic than yours was. I was a second year resident, so you beat me here by one year in residency training to do that. Of course, Ed Maumenee had orchestrated the plenary opening session was going to be on global blindness prevention, and he had luminaries like Sir John Wilson, and he asked me to talk about my work on vitamin A. This is the opening meeting of the AAOO, and it was in Dallas, I guess. We were going to Dallas for five years. The Academy had some special deal with Dallas. And I looked out and it seemed to me that there were like 15,000 people sitting out there. And I’ll never forget—you’ll see why this has made such a lasting impression on me—the screen seemed to be about 30 feet by 30 feet, and you were this little thing in front of the screen. Now, I was as nervous as could possibly be, since this was the first time I was going to the Academy, addressing the Academy, opening the plenary session, and it was clearly not a subject that people usually talked about. It was about vitamin A deficiency. It was early work that I had been doing as a resident. And I wanted to be sure that I didn’t screw up my slides, so I put each of them in a glass case so they wouldn’t get scratched or bent, and they would fall when they were supposed to fall. And so I click on my first slide, looking out at these 15,000 people, and go to point to the slide and my slide is suddenly turning brown and then it’s crinkling and then

smoke is coming out up, and it catches on fire. And I say, 'Well, that was a map of...' and I go to the next slide and the same thing is happening to the next one. And what I didn't realize that everybody else clearly knew, is that because that hall was so huge, they had these high intensity projectors and you never put them in glass slides because the glass trapped the heat and burned your slides. And every one of my slides caught fire. So that was, you know, like an embarrassing experience. And I figured that was the end of anything I was ever going to do with the Academy.

But at the end of residency, I went back overseas, as I said, to Indonesia and so forth, and so I sort of reemerged, literally reemerged on the American ophthalmologic scene, and came to my first real Academy meeting in 1980 when we came back from London, three years in Indonesia and a year in London. And I got called to the Executive Vice President's office, Bruce Spivey, and he said that they were thinking of forming a public health committee. I have no idea who, because I had nothing to do with the Academy before then. David Noonan I'm sure knows. And he said, 'And we want you to chair it.' So I said, 'Okay, I mean, what would you like it to do?' Well, they didn't... quite sure what they liked it to do, but I could go have some meetings. And the Academy had money then so you could go out and have nice meals, and you could have good wine, and you could invite your friends who thought like you, and knew who would be interested in it. So we had this public health committee.

And the most striking thing I could remember of the public health committee because I believe he's being interviewed also in this cycle, is Byron Demorest, so... well Stanley Truhlsen was the president when I got appointed to this, and he of course didn't know me at all. So he called me one day and said, 'You know, I understand you're going to chair this new committee.' I said, 'Yes.' He said, 'Well, do you mind if I sit in on your first meeting?' And I said, 'No of course you can sit in on our first meeting. You can sit in on all our meeting if you want.' And he was reassured enough after the first meeting that that was okay.

And one of the things we were thinking about doing was, you know, issuing alerts when... you know, those were the early days of IOLs and some of them were badly made, some of them were contaminated, if you remember, some of the solutions were, and so we would issue those alerts. And soon

thereafter HIV made its appearance, and so we were quite concerned because people could find the virus in tears. So did that mean that... you know, how are you going to handle your tonometer tips and things like that? And so we issued an alert about proper cleaning and handling of tonometer tips in this age when, you know, AIDS was a new disease that had just been discovered. It was due to HIV and it was contagious. And Byron was the new president, and the meeting was in San Francisco. And I wasn't supposed to go for two days, and I get a phone call from a panicked David Noonan, who said the president, Byron Demorest, who is from the Bay Area was really upset about us issuing an alert about HIV and sterilization of equipment and so forth, and he needed to talk to me immediately. Could I come tomorrow or today, even? And I couldn't go that day, but I came a day before I had planned to in order to meet with the board and assure them we were not causing unnecessary concern and hysteria, and that until we knew more this... I mean, we weren't telling people not to see patients. We were just telling them you had to wash your hands better, you had to soak your... to have more than one tonometer tip—maybe that's what bothered people.

And then I got to know Byron to some degree. And the next event in my experience with the Academy that was significant to me, and to some degree perhaps to the Academy, is the next year there was what's now the Mid-Year Forum, I don't know that it was officially a Mid-Year Forum in those days, and there were maybe 50 or 60 people who were invited to go to a retreat, and they were going to have breakout sessions and just sort of think about things. And one of the things actually was close to public health, one topic, but I wasn't assigned to that topic. Another topic was quality of care, and I was assigned to that one which sort of surprised me, but, okay, whatever. I do what I'm told. I always do what I'm told. And it turned out that Byron actually was facilitating that session, and it was sort of an open discussion and people talked about, what do you think about quality of care? What are the major issues? I don't know that we thought of anything particularly brilliant or compelling at the time, other than we knew that, you know, evidence-based medicine was just beginning to be whispered about. And then it was dinner and then the next day there was a plenary session, which Byron was running because he was the president, and he announced at this session that a decision had been made that there would be a quality of care committee and that Al Sommer would chair it. Now, mind you, we had had

no such discussion whatsoever, and even more disturbing, the staff came over to me and told me, 'You know that whole meeting on the quality of care was a mistake. It wasn't supposed to happen.' The board had been concerned that quality of care might get too many people upset so it had been scratched from the agenda, but the agenda they handed out was the old agenda, so this meeting to discuss quality of care had occurred by mistake, and from that ended up being a committee that I was chairing. And that was enormously interesting.

So I decided because I didn't know quite what anybody wanted, I actually made appointments to meet with every member of the Board of the Academy individually, just before their next meeting. It was at the site of their next meeting. And I and the staff persons working with me sat there for 10 minutes and said, you know, what do they think this quality of care committee would do? And nobody, basically, had a clue, nor did I. So we got together as a... again, you go and find your friends who you think, think roughly the way you do, and I asked for suggestions from the School of Public Health, if somebody... well, somebody I knew that was very senior to come and give us some advice. And the person I had asked was a very, very senior person, and trained that person, and they said, 'He's very expensive. You don't want him. But we have a junior faculty member...' who is now very senior and highly regarded... 'junior faculty...' who we made our guru and he would come to the meetings. And then we suggested books for reading.

And that led to our product, what we eventually came to doing, what's now the PPP. It was the Preferred Practice Patterns. And how did that get that crazy name was because clinical guidelines were just coming... they were in their infancy. And I think the Academy can take great pride in the fact that we probably did more, faster and earlier than any other sub-specialty group did. But I was told right from the start we could not call it clinical guidelines because that's cookbook medicine. So we sat around thinking about what we would call this. We finally decided, 'Let's see, preferred, so that means you don't have to do it this way. Practice patterns, so that means every patient isn't treated this way. But on average, if somebody comes to you with a cataract or newly diagnosed open glaucoma, on average this is what you would do.'

And then we spent the next year-and-a-half, two years trying to work through exactly how we would put these things together, what topics we would take on, expanding... we had the small core group and then we expanded it with specialists in, initially, four or five areas. We recognized you couldn't do everything in ophthalmology, so we figured we would choose those things that were most common or cost the most amount of money or were most serious, and we would limit it to something like 18, which is roughly what it's limited to today. And it wasn't nearly as rigorous a process as is used today, but it was all evidence-based. And I did the first one. I said, 'All right, I'm going to lead this charge. Glaucoma is going to be the first one that we're going to do.' And then there were these couple of others that trailed behind it.

And the Board was concerned, the Council was very concerned. And there were a few members of the Board who I would literally have phone calls with at 1 o'clock in the morning. You know, how are we going to plot the next thing we're going to do and keep people reassured? And we were able to move that forward. And then came this great reckoning when I would have to go before the Council, which was then a very different kind of an organization, largely representing ophthalmologists' interested at the state level, and I knew we were going to have a problem. Everybody knew we were going to have a problem. And so I asked the other members of the committee, I said... so we worry about every word, because this is a guideline and it's based on evidence, 'What would you consider doing if this was taken, rewritten but our names were still on it?' Everyone agreed that would be unacceptable. So we agreed that if anything but, you know, sort of grammar was changed that we would dissolve as a committee and we would have nothing to do with the enterprise. So then I was up there facing the Council, and a wonderful supporter... almost everybody involved with this core activity on the Board or off the Board, were ultimately president of the Academy except for me, and... just like I don't have an endowed chair, I've never been President of the Academy. And Tom Hutchison was terrific. He was moderating this, so he was trying to keep me out of trouble. And there was one guy who was not going to give up the microphone and was opposed to this whole thing. And he said, finally, at the end, 'Dr. Sommer, you do realize that we can take this, we can change the wording, we can do anything we want with this, because we are the council?' And I said, 'Yes, I understand that and the committee understands that and the committee has

discussed that, and if you change a single word we dissolve ourselves.’ So the standing joke for the next week was, ‘Watch out, any moment now he’s going to dissolve.’

But the following year the Board approved them. The first few were issued that year. Nobody had seen them yet because everyone was at the Jackson lecture at the opening session. And Doug Anderson’s first three slides... he was the Jackson lecturer that year...

DAN: I remember that.

AL: ...it was straight from the Glaucoma PPP. And that’s what got the whole idea of target pressure in glaucoma going. We invented that in that PPP.

DAN: That’s terrific. Obviously, the Academy has been a big part of your life.

The two areas where it really affected me, and hopefully I contributed were when I was on the American Board of Ophthalmology we were instituting the... we knew either the ophthalmologists had to institute recertification or it would be done at a state level. And we interacted with the Academy in working out a process by which people could be prepared and get the information and have confidence that the areas they tested in would be relevant to their practice. And that was a major focus...

AL: And that was a major turning point. I know there was a lot of concern amongst the members about what this was going to mean and how it was going... was it going to be relevant? So I think that was a tremendous contribution.

DAN: Dave really deserves the bulk of credit with his interaction with the Academy.

The other area... we were talking earlier about history, and when the Academy was preparing for their centennial celebration they created a committee about five or six years in advance to see that every aspect of American ophthalmology was looked at and the role the Academy played in

it was looked at. And Dave Cogan played a major role in that, and Dave brought me along, and that spun off into the Cogan Ophthalmic History Society. And it culminated in a book I wrote on the history of American Ophthalmology...

AL: Oh, I have a copy of that book.

DAN: ...which, I don't know if there will ever be a second edition, but it really crystallized my interest in ophthalmic history. So those two aspects of the Academy were very important.

I wanted to ask you, speaking of books, I see you have a new book out on *You Get What You Deserve*...

AL: Well, that was Hopkins Press desiring to be popular. That was not... my thing was, you know, *Health—The Bottom Line*. They decided it would more exciting if it was *Getting What We Deserve—Health and Medical Care in America*.

DAN: What is the... I haven't read it yet...

AL: Well, it's basically a mini course in public health for the interested layman. And it was fun. It's an integrated series of talks that I give all the time, so it was easy and fun to write. And it basically starts with, you know, how did the world... you know, very many people recognize this. I don't think I did until a few years ago, somebody showed me a demographic graph that for 2,000 years the population was flat, about a couple-hundred million people, half-a-billion people in the world, and then, suddenly, in the early 1700s we have this skyrocketing population. And that's all about public health. So it starts with, what does that all mean? How does that go about? It talks about, where's the future? Genome versus, what I call the environment, you know, bacteria, and what you eat, and what you smoke and so forth. And then there's one chapter, because you had to put it in, about the American healthcare system, and in broad terms, where it needed to go, as opposed to... you know, the reform was just being discussed that came out... it wasn't going to influence the reform at all but, the average layman could understand what the issues were. And that was at a 35,000-foot level, so it's pretty much irrelevant to what was passed, other than we didn't pass

what we needed to pass, which was a single payer and not a piece meal, you get paid for piece work kind of pre-industrial craftsmanship, which is the way medicine is run now, with no relationship to where the population is and what their needs are, and to make matters still worse, you know, so many people don't get care who need that care.

Well, I guess they've asked us to do this oral history to officially confirm and make us recognize we are, now, senior ophthalmologists.

DAN: Well, in the time we have left in this interview and in the time we have left in our professional lives, what major challenge do you intend to take on, or what do you see yourself...

AL: Well, I'll give you a half-minute and you give me a half-minute. My half-minute is probably to try and stimulate and encourage and mentor future leaders in the field. And you?

DAN: Well, pretty much the same in eye pathology, to see that eye pathology survives. Through the years I've had over 70 fellows, some of whom have taken major positions. But, also, I'm still at treating tumors. We've come a long ways, but we still have a ways to go. And one of the wonderful things about eye pathology, or pathology, is that it really encompasses so much in terms of genetics, in terms of the stem cell potential, in terms of immunology. You know, when you start out you try to learn all of this, but then you start collaborating. And there's still a lot to be done and a lot of challenges that I feel I can personally get involved in.

AL: Well, this is great. It shows we can be senior but it doesn't mean we have to quit.

DAN: Right. Very good.