

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

Conversation Between David W. Parke, Sr. MD and George E. Garcia, MD
In Partnership with StoryCorps, San Francisco CA, October 25, 2009

Drs. David Parke, Sr. and George Garcia recorded this conversation on October 25, 2009 during the Annual Meeting of the American Academy of Ophthalmology, in San Francisco CA.

Dr. Parke is from Connecticut and Dr. Garcia is living in Florida, both are retired ophthalmologists.

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



In this [excerpt](#), Drs. Parke and Garcia discuss the relationship between ophthalmology and optometry in 1980.



[Here](#) Drs. Parke and Garcia talk about how they became residents.

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DR. DAVID PARKE: I'm David William Parke. I'm 87 years old. Today is October 25, 2009, and we are talking in San Francisco, and my relationship to George Garcia is that we are fellow ophthalmologists.

DR. GEORGE GARCIA: And I'm George Edward Garcia. I'm 79 years old. Today is October 25th, 2009. We're at the American Academy of Ophthalmology meeting in San Francisco, California. David and I have been friends for many years and have shared a lot of experiences together in the evolution of the Academy, advocacy, and since we're both from New England we've shared some experiences with the New England Ophthalmological Society (NEOS), the Mass Eye and Ear Infirmary (MEEI) and Wilmer Eye Institute.

DR. PARKE: Yes, many good relationships that we've had over the years, George, and it's been a pleasure to have known you for all these years.

DR. GARCIA: Thank you.

DR. PARKE: And for all the things that you have done for ophthalmology, for good patient care and for ethics and integrity in our profession, I think we all owe you a great debt of gratitude.

DR. GARCIA: Well, I think it goes the same way in reverse. Some of the things that you've done have been enormously helpful to maintaining the integrity of the profession and keeping people's minds where they should be in terms of the responsibilities that we have as physicians.

In terms of historical events, I guess it would make the most sense to start off either with the American Association of Ophthalmology or NEOS. Do you have a preference?

DR. PARKE: It makes no difference to me. The American Association of Ophthalmology was founded to become involved in advocacy problems. We knew back in the early 60s that there was an effort being made by optometry to expand its scope of practice and to become more medically involved in optometric practices. And so the AAO was started at that time.

DR. GARCIA: I think the American Association of Ophthalmology was formed because of frustration with the Academy, particularly because at that time the Academy, being a 501c3, was a tax-exempt educational organization, and could not participate in socioeconomic issues because they would lose their tax exempt status.

DR. PARKE: And that's right, and also at that time we were the American Academy of Ophthalmology and Otolaryngology.

DR. GARCIA: Yes.

DR. PARKE: And so there were different interests in medical economics between ophthalmologists and otolaryngologists.

DR. GARCIA: I think that the Academy, at that time, was principally run and administered by academicians because it was primarily an education institution, dealing in post-graduate education. It made sense that the people who were most involved were the people who ran the departments of ophthalmology who were prepared to deal with these issues.

DR. PARKE: And I think those people also believed very, very clearly, that no responsible Congressperson or legislator would ever give medical licensure or medical privilege to people who were not medically trained.

DR. GARCIA: True, very true.

DR. PARKE: And so they sort of did not realize at the beginning that there was a great force out there with which to become involved.

DR. GARCIA: It's kind of interesting. The way that I got involved in all of these activities was that in Massachusetts, and in the New England area, the New England Ophthalmological Society was similar to the Academy in terms of the role that it played, but it also dealt a little bit with some of the

issues that existed at a socioeconomic level in the various New England states. After the government passed Medicare and Medicaid in 1966 or '67, I believe it was, there became a need to have individual state organizations, because the parties responsible for reimbursements and other issues only wanted to deal with the ophthalmologists in their states. So we formed what was at that time the Massachusetts Ophthalmological Society. We also did one in Maine, Connecticut, Vermont and New Hampshire—everybody developed a state society. As a result we were looking for some information on these issues. We needed education. We weren't used to doing these things, and the only national organization that existed at the time that dealt with socioeconomic issues was the Association. So a couple of us decided that we should go to an Association meeting and find out what it was all about. And I think that might have been where I first met you.

DR. PARKE: I'm not sure, actually, where we first met. Actually, I became involved in the political and medical social aspects of ophthalmology quite early on. In 1959, I was appointed the ophthalmology representative to what was called CMS, which was Connecticut Medical Services—it had nothing to do with present day CMS—and it was the precursor of Blue Shield. And I was only in practice for two or three years when I was appointed by what is now the Connecticut Society of Eye Physicians to represent ophthalmology on that committee. And what we were dealing with, primarily, in those days, was usual, customary and reasonable fee schedules. Doctors, up until that time, had independent relationship with their patients with regard to charges and so forth. And the development of Connecticut Medical Services and later Connecticut Blue Shield, was the real advent of a third-party payer system, and was probably the real beginner in a so-called healthcare system. Up until that time, patients dealt solely with the physician on a financial basis. Now we have, with a few exceptions, an intervener and this changed the whole thing.

And then, actually, the Social Security Act was amended in 1965 to develop Medicare, and they... as you say, it became a state-by-state phenomenon. In Connecticut, Connecticut General Insurance Company, which later became Cigna, was the fiscal intermediary for Medicare, and they then appointed me as the ophthalmologist on the committee for Medicare in Connecticut, and that's how I got involved in Medicare.

DR. GARCIA: I think it was a combination of those economic issues and the fact that optometry was starting to become very aggressive with regard to expanding their scope of practice. They were becoming very aggressive with regards to approaching state legislators to expand the scope of practice through legislation rather than by education, lengthening their period of training and changing or altering the kind of training that they received. The Academy couldn't deal with any of those issues at that time because of the tax laws.

The experience that I had when I first went to the Association was that this was a very concerned and a hardworking group of people, but they were underrepresented, they were underfunded, and it was really just a very small group of people who were involved. When I went home what I reported back to my state society was that we needed a national level of representation, but we either had to improve this organization or find another organization to help us to do that effectively.

DR. PARKE: I think you're very right, and Larry Zupan... do you remember Larry?

DR. GARCIA: Oh, very well.

DR. PARKE: Larry was the person who was in charge of the Association, and he complained to me that oftentimes his voice went unheard among the leadership in the Academy. And as you say, this is what generated statewide interest, because we were involved in early legislative activity by the optometrists. My first involvement was in 1962, which was rather early, I think, and we had a bill brought before the Connecticut State Legislature in which optometrists asked for the right to use atropine, Neo-Synephrine, and topical anesthesia. The argument they used with the legislators was that this better enabled them to recognize departures from normal so they could then refer patients to ophthalmologists for better care. And it was very obvious that this was a sort of thinly veiled attempt to expand their scope of practice.

DR. GARCIA: I think I have a unique perspective on that, because I was an optometrist. I graduated from UC Berkeley School of Optometry, and subsequently went to medical school to become an ophthalmologist and to expand the scope of my practice, because I felt that that was what I needed to do at the time. I think I was probably even a little more aware than a lot

of people of how inappropriate this attempt to expand scope of practice through legislation was.

DR. PARKE: Well, my father was an optometrist, so I also had some background relationship with what optometric practice was. My father actually became an optometrist without ever having gone to optometry school.

My father was born in Ireland and he went to Trinity College in Dublin, where he became a pharmaceutical chemist, and part of being a pharmaceutical chemist or a pharmacist, as we know them here, was dispensing glasses, and they used an old skiascopic rack, and people ran... you ran it up and down in front of them to select the power lens they wanted.

DR. GARCIA: It was like going to the store and trying the glasses on until you could read the small print.

DR. PARKE: Which makes you see better. And he also became a licentiate of the Royal College of Physicians, and that was done purely through a program where he apprenticed himself to a physician in Ireland, and it took him about eight years to pass and become a licentiate. Because of personal problems he immigrated to this country in 1920, and the Flexner Report had just changed the rulings with regard to who could practice medicine in the United States, and he was not accepted with his licentiateship, and he became an optician in a department store. And then it wasn't until 1922, I believe, two years after he started, that they actually had a State Board of Optometric Examiners, and he was grandfathered. So literally he became an optometrist in that regard.

And so I watched the evolution of my father as first D.W. Parke, Optometrist, and then in 1934 the American Optometric Association decided that they could call themselves doctors, and so he became Dr. D. W. Parke, and there was no OD, as I understand it, until 1952.

DR. GARCIA: When I graduated from UC Berkeley you got a Master of Optometry degree, but there was no academic doctorate that was conferred upon you. The Board of Optometry after you took the exam and passed issued the Doctor of Optometry.

But to get on with the story about the Association, we were working hard trying to do what we could, starting to gather more information, increasing membership and so forth. Then the tax laws changed. The Academy was able to alter its tax status so that in addition to educational activities it could also deal with socioeconomic issues. I think the perspective of most people at the time, and your comments will be important in this regard, too, was that it made a lot more sense to have... it was a lot more efficient to have one organization deal with all of these issues. The Academy had enormous representation and was in much better financial shape. I was the president of the Association when we merged with the Academy in 1980.

One of the interesting things about that merger was that the Academy also took over our program for patient pamphlets, instructional pamphlets and all of those sorts of things. That became a part of the new organization.

DR. PARKE: At that time, 1980, was a pivotal year in the whole ophthalmology/optometry relationship. In 1978, an optometrist by the name of Robert Whittaker from Kansas, who was a member of Congress, approached Robert Dole, who was the Senator from Kansas, and was, at that time, the Chairman of the Senate Finance Committee. Whittaker, knowing as an optometrist that he could not really introduce legislation on behalf of optometry, asked Dole to establish a committee to see why optometrists could not be reimbursed under Medicare, because in 1965, when Medicare was established, there was Part A and B, just Part A for hospital reimbursement and B for physician reimbursement. As early as 1967, just two years later, optometry tried for the first time to become included as recipients under Medicare, and they did this three other times, along with other organizations, tried to become included. And in 1978, when Whittaker approached Robert Dole, Dole formed a committee illegally. There is a Federal Advisory Committee Act that really specifies how an investigatory committee has to be established, and Dole ignored that, and the first investigatory committee was made up of the four immediate past presidents of the American Optometric Association, four ophthalmologists and four public members.

The odd part about it was medicine and the Academy were never asked to participate in the selection of the ophthalmology members, and it turned out that the American Optometric Association presidents chose the four ophthalmologists, and they were all men who had some association in

teaching in optometry schools. And the four public members of the group were all either related to optometrists, or in some way business-wise connected to optometry, so it was a loaded committee. And to top it off they chose a man from the Bureau of Health Manpower, who was an optometrist, to chair or to guide this group through the legislative arena. And they went to a number of organizations, including Health Education and Welfare, the Health Care Finance Administration (HCFA), Bureau of Health Manpower, the Bureau of Budget and Management at that time, and so forth, and they all voted against the inclusion of optometrists in Medicare reimbursement, but not surprisingly, the Bureau of Health Manpower was pushed by the optometric member to endorse it, and it was the only committee that did endorse it.

DR. GARCIA: Well, I think it's a reflection of how naïve ophthalmology was about the legislative process. You know, God bless them, ophthalmologists were interested in taking care of patients, doing eye surgery and practicing medicine. Most of them, many of them, felt that it was kind of beneath them to get involved in politics. Optometrists, on the other hand, had advocated that optometrists get to know their local politicians, support them, give them money, take people to the polls, and distribute literature for them. They were very effective, far more effective than we were, at that time, in the legislative arena, and we got blindsided plenty of times.

DR. PARKE: Well, Dr. James Allen, who was the Professor and Chair in New Orleans, at the Oxnard Clinic,... was one of the first people, he and Dr. Roger Hyatt, the professor and chairman at University of Tennessee, were very aware of the danger of some of the optometric legislation, and they became aware of this Committee and activity on the part of this committee that Senator Dole had established, and so they got a group of us, who they knew were involved in this issue... I was involved in Connecticut as you were in Massachusetts... but they asked a few of us if we would support a challenge in the federal court to the bill... to the activities of this reimbursement committee. And we did take our cry to the federal court, and the federal court stated, without any respect to the constitutionality of the development of the Advisory Committee, that we were assuming that the report from this committee would cause Congress to enact legislation, and therefore they turned down our plea that the Committee's report be rejected.

We took our case to the appellate court, but the appellate court didn't hear our case for over a year, and during that period of time the chiropractors and the podiatrists joined the optometrists and a bill was passed, which allowed chiropractors and optometrists and podiatrists to be covered under Medicare, and it became known as the COPs Legislation because of the chiropractors, optometrists and podiatrists. And by that time the Court of Appeals said that we were right, that the Advisory Committee as set up by Senator Dole had been illegal, but now that there was legislation the only thing we could do was to try to have the bill repealed, and you know it's a fat chance to get a federal bill repealed.

And therefore in 1980 the Budget Reconciliation Act then officially included chiropractors, optometrists and podiatrists. And the wording of the bill was that those three, the chiropractors, optometrists and podiatrists, should be considered physicians for purposes of reimbursement as allowed by state law, and could be reimbursed for things that physicians could do if allowed by state law. This gave great impetus, then, to the great number of scope of practice legislative initiatives.

DR. GARCIA: Well, I remember there was a big move in optometry to call themselves The Eye Physicians.

All of these things were certainly stimulating, to say the least. As far as the Academy's involvement, we eventually, over many, many years, were able to build a more effective advocacy group, with a suitable representation in Washington with knowledgeable, effective people, and state organizations that were more effective. The battle still goes on, nothing's been resolved. I think this is pretty typical of politics. They keep slugging it out and nobody wins, they just keep going on and on, and the lobbyists make a fortune.

DR. PARKE: Well, the Academy developed the State Affairs Committee in 1982, I believe that was the year it was developed, and Hunter Stokes was the first chairman of the State Affairs Committee, and I was appointed to the State Affairs Committee shortly after its development, and we worked diligently for five years to try to enact... or to get state societies interested in the whole problem of advocacy, and Hunter did a tremendously good job in getting this thing started. And we then had marvelous opportunities to get the states involved, but again, as the old saying goes, until it hits people in the pocketbook they oftentimes don't really come up to the plate.

DR. GARCIA: And there was some division within the ranks. There were people who took advantage of the situation to line their pockets.

DR. PARKE: Oh, absolutely. That was one of the tremendous results on this Reconciliation Act, when the number of x-rays ordered by chiropractors and podiatrists exceeded all of the x-rays done by radiologists in the United States, and of course then the government started reigning in some of the parameters for which they allowed them to do x-rays.

DR. GARCIA: Did you have any final comments you wanted to make on the...?

DR. PARKE: Well, only that the State Affairs Committee has evolved into one of the most important committees in the Academy.

DR. GARCIA: As witnessed by statements made at the opening session this morning.

DR. PARKE: Absolutely. And... an interesting thing is that at least six of our presidents since 1990 have been former members of the State Affairs Committee, and I think that's significant.

DR. GARCIA: Interesting. Well, you trained at Wilmer.

DR. PARKE: Yes.

DR. GARCIA: And Wilmer was a great place. It was almost as good as the Massachusetts Eye and Ear Infirmary!

DR. PARKE: Well, you know...

DR. GARCIA: Obviously stated in a way because that's where I trained.

DR. PARKE: That's sort of like, you know, Yale versus Harvard.

DR. GARCIA: Yeah. We were both very fortunate.

DR. PARKE: I was tremendously fortunate to be at Wilmer, and that was quite by accident. I don't know whether it's of interest as to how I got involved in that. I had applied for a residency in ophthalmology at Columbia Presbyterian with Dr. Dunnington. And they had a peculiar program at the time where they took a new resident every three months, and I had been selected among the four that they selected for a year, but I wasn't to start for six months. And I appealed to Dr. Dunnington, you know, that I just really had to get going, I had a young family and I just needed to go, and he called me the very next day and said, 'Would you be interested in going to Wilmer? They have had a resident who has backed out of their VHA affiliation and I've just talked with the officials at Wilmer, and if you are interested they will talk to you tomorrow in Baltimore.' So I went down for an interview and had my interview and that's how I got into Wilmer and their associated VHA program.

DR. GARCIA: You know it's really interesting; everything is so organized now with matching programs. Everybody hears on the same day. They go on the interview circuit, make the rounds and it's very well organized, which is a nice thing. My experience was not unlike yours in the sense that having been an optometrist I was pretty sure that I wanted to go into ophthalmology, although I almost went into internal medicine because we had tremendous role models in medical school in internal medicine where I went to Boston University. One of the reasons I had come to the East Coast was with the hope that I could get into the Eye and Ear Infirmary, because my wife, whom I'd married when I was in the service, was from Massachusetts. We had the opportunity to take an elective in our senior year in medical school, and I wanted to do an elective with the Eye and Ear Infirmary. So I called Dr. Dunfey's office, he was the chairman of the department at the time, and Dr. Dunfey had the kind of secretary that everybody wishes that they had in their life. She was knowledgeable, she was informed, and she was very gracious, interested in the process type of person. When I called to get an application for the elective she said, 'Why are you interested?' And I told her a little bit about my background, and she said, 'Well, I'm going to send you an application for the residency also.' I laughed and I said, 'You don't understand.' I said, 'I'm just a... junior in medical school, starting my senior year. And she said, 'Young man, I know what I'm doing and I'm going to send you an application. Fill it out and send it in,' which I did. I got the elective, and it was a very impressive place. They had a stellar group of people who were at the infirmary. The

infirmary had the same program that you had at the time. They started people every three months. Some people would wait a year, a year-and-a-half, two years, to start their residency because they got picked after they got out of their internship or something. It was difficult. They had to take jobs, and I had a family to support. I had a child. But I got my residency on the Friday before we got our internship assignments, so that I knew before I started my internship that I was going to be starting at the Eye and Ear Infirmary, which was pretty amazing, and for which I was very grateful.

But it was really an interesting way to go through, training, don't you think, every three months?

DR. PARKE: Well, not having experienced...

DR. GARCIA: Inefficient, but...

DR. PARKE: Yeah, of course...

DR. GARCIA: I mean, as far as your personal life.

DR. PARKE: And thank God it no longer exists, although it probably gave me an opportunity to learn from my peers in a different way than residents do now.

DR. GARCIA: That's what I was referring to. You developed skills as you went along and they added on, and you assumed more responsibility, and in that sense it kind of fit. It felt good that you developed the necessary skills as you advanced. I think we also both benefited from the kind of role models that we had at our institutions.

DR. PARKE: And, interestingly, the number of full-time faculty... I don't know about at Mass Eye and Ear, but certainly at Wilmer there were not many full-time faculty members at that time.

DR. GARCIA: It was interesting at the Eye and Ear Infirmary, in order to get on the staff at that time you had to agree for the first five years to work in the clinic twice a week. That was two half-days a week working in the clinic. You also did a surgical rotation for each one of those clinics, roughly every six to eight weeks. At the end of five years, for the rest of your

professional life, you were expected to spend one half-day a week in the clinic and do a surgical rotation. So we had enormous exposure to over a hundred different ophthalmologists.

DR. PARKER: Yes, that was the way it was at Wilmer. We had, I believe, five full-time people, and the full-time people were just marvelous. We had Jack Gyton... I don't know if you knew Jack...

DR. GARCIA: Oh yeah, sure.

DR. PARKE: Jack was a tremendously hyperactive, but tremendously knowledgeable person, and we made rounds every morning, and we learned much from Jack Guyton. He had sort of a photographic memory and he could tell you... we'd be discussing a particular case, he would say, 'Well, in the October 1938 issue of *AJO* on Page 34 on the upper right-hand corner, you will find this.' And it wasn't anything that he was prepared to bring up, and we'd go to the library and check on him, and he was always right.

DR. GARCIA: It was also interesting, too, because we were both trained, prior to Medicare, and one of the motivations, I think, for passing Medicare, as I recall, was to establish a single standard of care for everyone. What that did is it totally altered the clinic milieu that we both, I think, experienced. We had a clinic every morning at the Eye and Ear Infirmary where we would see somewhere between 125 to 150 patients on average. There would be two or three residents and a half a dozen staff people seeing all these patients. A lot of consultation went on amongst the people who were attending at the time. The patients who were going to be admitted for surgery would be admitted on that day. We would work them up that afternoon, go over them with whoever the attending surgeon was for the next day. At the end of the day we would call the attending surgeon and tell them what our findings were and our plan for surgery. We both got a chance to see the patients when they were admitted in the clinic, and then the next day we would operate on those patients. So we had two clinics, two surgeries every week, and then the other two days we were either in glaucoma, retina or some of the other specialty clinics.

DR. PARKE: Well, we used to admit patients the night before surgery, and we had a routine that we had to follow. And of course at that time Wilmer's Dr. Alan Woods made it the uveitis capital of the world, I think, and so we

worked up everybody and regardless of what their problem was, we also worked them up for uveitis.

DR. GARCIA: Fortunately we didn't have to do that.

DR. PARKE: But it was a great thing to get to know your patients through your own history and physical [examination], and I think that's one of the things that residents today miss very much.

DR. GARCIA: The other interesting thing at the Eye and Ear Infirmary, as far as training was concerned, was that the residents were never required to work up the attending's patients or to do the "scut work" and so forth. They really served us more than we served them. Now we did a lot of things in terms of taking care of patients and handling emergencies and doing all sorts of things with regard to their patients when they were required and so forth, but the program was really built to educate House Officers and support the residency program, which was very nice.

DR. PARKE: It was a nice opportunity, also, to become personally involved with some of the attendings, I think much more so than may be true today. There was a great man at Wilmer, M. Elliott Randolph, who became sort of my mentor, and we became very close friends. He and his wife were great to my wife and me throughout the residency program, and he was just a marvelous man, a superb surgeon, and just a great friend. Frank Walsh and Jonas Friedenwald were also great.

DR. GARCIA: Which is nice. You don't get that kind of relationship very often nowadays.

DR. PARKE: You're right.

DR. GARCIA: You know, we only have a few minutes left, and we have been asked to cover a number of subjects here. One thing that I think we should spend a little bit of time on, because it's so relevant to what's going on today, is the whole subject of international ophthalmology. Through most of our professional lives the Academy just dealt with American ophthalmology, and that certainly has changed a lot.

DR. PARKE: Well, this is now one big world, and the problems internationally in this regard to ophthalmology are rather different elsewhere than they are in this country. The causes of visual impairment are different on an international basis than here. I heard Al Sommers give a talk just last year in which he used the figure, and I remember it very clearly, 131 million people are blind from cataracts in this world, and that is a...

DR. GARCIA: Treatable disease.

DR. PARKE: ...A treatable disease. And then he talked about the number of physicians per population, and in this country there is one physician for every 10,000 people, and in India there's one for every 100,000 people. In Sub-Saharan African there's one for every million people.

DR. GARCIA: Part of the solution to that, I think, is what motivated me. When you're the President-elect of the Academy you have an opportunity to make a suggestion to pursue a program. One of the solutions to that international problem is to educate ophthalmologists and make them more effective in the communities that they're in. I was impressed that this was really lacking in many parts of the world, and not necessarily just in deepest, darkest Africa or in the boondocks of India, and so forth. Much of Eastern Europe was far behind in a lot of technology that we were doing because they were using textbooks that were 15, 20 years old. We couldn't really provide them efficiently with a lot of textbook-type of education because they're bulky, they're expensive, you have to ship them and distribute them, all of which is difficult. So we created a committee for International Ophthalmology. I think what they've done has just been enormously effective in bridging the gap, spreading information throughout the world. And now with the internet availability, it's just so much easier.

DR. PARKE: Well, when you start to think about today 30% of the Academy members are international members. And we are sending people more and more to underserved countries to teach and to actually do surgery. And the JCAHPO group is very, very active in training people to be assistants in surgery on an international basis, and I think that's a very interesting thing.

DR. GARCIA: Okay. Well, it looks as though we're at the end of our allotted time here, David. Do you have any other comments that you want to make to kind of wrap things up?

DR. PARKE: No, I just hope that ophthalmologists will heed what little we have been able to say today and really support OPHTHPAC, and the Surgical Scope Fund. I think it is tremendously important that we maintain the integrity of ophthalmology and have patients' interests at heart, and make sure that we strive for the best outcomes.

DR. GARCIA: My thing is, number one, I feel so lucky and so blessed to have had an opportunity to be an ophthalmologist because it is a very satisfying profession, and specialty. I frequently thank God for the Academy, because it's a brotherhood. We've made wonderful friends and it's been so effective and useful in our professional lives. I'm really, really proud of the American Academy of Ophthalmology and what it's accomplished.

DR. PARKE: I second that very much, and people say to me, 'At your age why are you so concerned?' As you know, my son is an ophthalmologist, I have a grandson who's a resident in ophthalmology, and I have another grandson who's going to medical school and may become an ophthalmologist, so, you know, I really am concerned about the future and I think we have a bright future if we all work hard and contribute.

[END PART I]

DR. PARKE: I'm David William Parke. I'm 87 years old. Today's date is October 25th, 2009. We are at the American Academy of Ophthalmology annual meeting in San Francisco. And my partner today is just a long-time friend in ophthalmology, and we're not related.

DR. GARCIA: And I'm George Edward Garcia, 79 years old. Today's date is October the 25th, 2009. We're in San Francisco, California at the American Academy of Ophthalmology annual meeting. David Parke Sr. and I have known one another for about 30 years, both because we were in New England together and through the Academy, have many opportunities to share experiences.

DR. PARKE: And George has been very active in all Academy and New England Ophthalmological Society affairs. He was a past president of the Academy, but he was also very involved in the New England Ophthalmological Society, which is a premiere society, a regional society, but has a great reputation nationally, and George might like to talk a little bit about that.

DR. GARCIA: The New England Ophthalmological Society, I believe, is the oldest American ophthalmological society, certainly regional society. It goes back over a hundred years. I think their 125th anniversary was this year or last year. Anyway, it's been around for a long time, and it's been a prestigious society because there have been many prominent ophthalmologists over the years who were associated with the Massachusetts Eye and Ear Infirmary in Boston, who provided some of the leadership, and there's been a lot of participation by ophthalmologists in Maine, New Hampshire, Vermont, Connecticut and Massachusetts over the years. It's served a very valuable function in post graduate education. We were able to attract a lot of prominent speakers from all over the country. They currently, I believe, have six meetings a year. At one time we actually had more than that. We also had one meeting a year that was held in conjunction with the Eye and Ear Infirmary Alumni, which was fairly extensive.

The meetings were structured so that, usually, two prominent ophthalmologists from some other part of the country were invited to make a presentation in their field of expertise. They were invited to Boston and their expenses were paid, plus an honorarium. There was a meeting of the Executive Committee the night before the meeting, which was generally very pleasant and something that people looked forward to and remembered long after. Boston is a very visual... it's like San Francisco in a way. It's a very pretty city and people liked coming there, many of them had friends or family in Boston that they could visit with, so it was easy to attract a lot of good people.

We would fill out the program by having various members of NEOS who had an interest in whatever specialty the program featured present free papers. We also had a format where there was an opportunity to discuss papers that were presented, panels to review cases and so forth. The meetings were structured so that there was usually a cataract session every

year. Then we had sessions on cornea, retina, uveitis, neuro ophthalmology, plastics and more recently we introduced a session on ethics, so that it was quite varied. Over the period of a year there was a cycling of subjects.

One of the reasons that I think it was effective is that they had a very good Executive Committee. They worked hard, and they really stressed the quality of the programs. The Program Committee consisted of about a dozen people. They were assigned individual sectors of meetings to prepare and to pick the speaker. There was a lot of organization to make sure that the meetings ran efficiently. It was very much like the Academy. When the Academy structured their programs a lot of that structure became incorporated into the way we ran the New England meetings.

DR. PARKE: Well, I became a member of the New England Ophthalmological Society early on in practice. But I disagree with you on one point, George, and that is that I always get lost in Boston. The traffic flow there is one way, one way, or one way, and I never got...

DR. GARCIA: Well, the other thing about Boston that's terrible is most of the streets in downtown Boston were determined by where cattle roamed. They don't go in any particular direction, they circle around, they intersect at odd angles and so forth, so it is confusing.

DR. PARKE: And if we changed the meeting location at the New England Ophthalmological Society, it took me until the end of the year to get to a meeting on time. But they were great meetings and they had, as you say, some really eminent scholars in ophthalmology from all over the country come and speak to us.

One of my personal interests in Boston was beyond the New England Ophthalmological Society, and that is that when I first started in practice I spent a half day a week with Dr. Cogan in his clinic, and we became fast friends. And David Cogan was a unique person, one of the brightest men I ever knew, and a very giving man. He was very good with his patients.

And one of the things for which I really feel very indebted to Dr. Cogan was at the time that President Eisenhower was in office he established a program in the Pan American area called Operation Bootstraps. I don't know if you remember that, George, but he brought people from all scientific disciplines

or had them go to South America and so forth, and to Mexico, to try to encourage the Pan American people, who were very bright, and a lot of them had good educations but they were not involved much in a global effort, and so that even way back then, at the time of President Eisenhower, he wanted to make the scientific community in the Pan American area shine. And so there was a group of ophthalmologists that was established to go to several places to discuss the general practice of ophthalmology, and David Cogan and Conrad Berens and I were the three people who went to represent American ophthalmology. And it was a great experience and I've never forgotten how grateful I am to David Cogan for having afforded me that opportunity.

DR. GARCIA: And I think one of Dr. Cogan's strengths—he was a great scientist and he was wonderful in the lab. All of his contributions to the literature attest to that. But he was the director of the Howe Laboratories after Freddie Verhoeff, and Dr. Cogan had the ability to bring people together, to bring the best out of them. One of the things that I remember when I was in training was... at that time there was a program where you could be a public health service fellow and participate in some research at the Howe Laboratories and get some experience in the lab. Dr. Cogan used to have brown bag lunches every day right outside of his office. We had a conference room, and all of the staff, anybody who wanted to could come. All of the scientists who worked in the lab and all of the fellows who were working in the lab, used to get together, and there was an open discussion. Sometimes it would be directed. There would be a particular subject that Dr. Cogan maybe had on his mind when he walked in that day, and that would lead off the discussion or somebody had a project that they were working on in their lab that they wanted to discuss. One of the things that Dr. Cogan used to make us do is if we were going to be presenting a paper on something or we were preparing a paper for publication, we had to present it to the group first for critique and for a little editorialization and comment. That was very stimulating and very inspirational for young people who were starting off their careers. Whether you continued in a laboratory environment or whether you chose to be a clinician, you learned to evaluate data, you learned to be critical, and he fostered that. He had the kind of people in there who were just wonderful for that environment.

DR. PARKE: Another thing that he fostered was an appreciation for the history of ophthalmology, and oftentimes we would be discussing an

individual problem, and he would then spend 5- or 10 minutes just discussing the history of people who had tackled these problems early on, and he ... greatly appreciated the work of his forbearers in ophthalmology. And that probably was the genesis of what we now call the Cogan Society, which is devoted to the history of ophthalmology.

DR. GARCIA: I think another interesting example of the kind of environment that they created there was the relationship between Paul Chandler and Dr. Grant. For those who are unacquainted with Dr. Chandler, he was one of the preeminent ophthalmologists in Boston and was also very involved in the Academy. He was a cataract surgeon and had a big interest in glaucoma, and probably the most prominent glaucoma surgeon in New England. Dr. Grant was a kind of an introverted, very quiet laboratory scientist who was very thorough, and they developed this unique relationship. Dr. Chandler actually created like a... it wasn't called a foundation then, but he used to lend a lot of financial support to the relationship. He always operated with Dr. Grant so that they collaborated in the operating room, also, in terms of evolving new techniques for dealing with glaucoma. That was a relationship that was very fruitful and everybody benefited from it.

One of the things I always remember about my training in glaucoma is that when we were assigned to the glaucoma clinic, we had a direct line to Dr. Grant's office. A resident could call Dr. Grant at any time to come down ... he was there in five minutes... to see a patient and go over a patient with you. Boy, did you learn from those sessions!

DR. PARKE: I can well imagine. Dr. Chandler was a very interesting person, as you've mentioned, and there's a story that I remember from years ago, when the librarian at the Mass Eye and Ear was a man who had high myopia...

DR. GARCIA: Oh yeah, Charles Snyder.

DR. PARKE: Snyder, and he became impressed with a concept of pressing your eyes, palming your eyes to alleviate myopia...

DR. GARCIA: Oh sure...

DR. PARKE: There was a group in New York, a couple of optometrists in New York, who were sure that they could cure or reduce myopia by palming and whatever other methods they had. And so Snyder went to Dr. Chandler, as I understand it, and had his eyes examined, and used that as a baseline, and then he went to New York and went through this program of exercises and palming and whatever. But at any rate ... what he realized was that they were getting him to appreciate the 20/40 'E' or something like that, and convince him that he could actually see it a little bit better, simply because they were putting this knowledge into his head that that was an 'E'. This is called brain washing. When he went back to see Dr. Chandler a year or so later, actually his vision was poorer than it had been at the original examination. And he wrote a charming article called *Bates, Huxley and Me*, and you say his name was Snyder...

DR. GARCIA: Charles Snyder.

DR. PARKE: ...Charles Snyder, and I'd love to be able to get a hold of that article.

DR. GARCIA: Well, one of the things that gave credence to that theory at the time was Huxley's involvement, because he was a noted scientist, and he was a very vocal advocate of this system, which had been investigated and proved to be ineffective as far as affecting progression in myopia or regression of myopia.

Paul Chandler was really a marvelous teacher and also kind of... here's a guy who was, I mean, world renowned, and who had this very active practice. And, again, one of the benefits, and I'm sure you had the same thing at Wilmer, at the Eye and Ear Infirmary was access to the staff. There was a surgeon's lounge where everybody used to go in and get ready to do their surgery... and if you were in there and Paul was in there, if you were having a problem with one of the clinic patients, he'd put his arm around your shoulder and say, 'Let's go take a look.' He would go see the patient with you, free consultation, and he'd spend a few minutes with you telling you what the problem was and how to address it. He'd always finish stuff by saying, 'Boy, you're lucky to have this guy as your doctor.' But it was good teaching and we really enjoyed it. I'm sure you had people like that at the Wilmer, too.

DR. PARKE: Well, we did. We had marvelous people with whom to work. Angus McLean was the strabismus expert when I was a resident, and Angus was... God forgive me for saying this... was a terribly poor surgeon, but he had great knowledge of strabismus, and he knew what should be done, and so the residents often did the surgery but he would be right there...

DR. GARCIA: Telling you what to do.

DR. PARKE: ...telling you what to do, and it was just a marvelous experience.

And we also had the opportunity at Wilmer, as you did at Mass Eye and Ear, to have world-renowned experts come and talk to us. And Sir Stewart Duke-Elder came to spend some time at Wilmer when I was a resident, and of course he was the preeminent editor of *Ophthalmologic Knowledge* up until that time.

DR. GARCIA: Eight volumes.

DR. PARKE: Yeah, tremendous. And he actually was a man who had a tremendous memory and read avidly, and his writings were just marvelous, but he also was a rather poor clinician, and he was sort of the first to admit it, because he had such great knowledge that sometimes he had difficulty focusing on one individual problem, and he also admitted that he wasn't a very good surgeon. And he was given the opportunity to do surgery at Wilmer, ... and it really ended up that a resident would be doing surgery with Sir Stewart Duke-Elder.

DR. GARCIA: And he was a consultant to the Royal Family.

DR. PARKE: Yes, and really an amazing man. And a number of years later when I was in practice, I received a letter from Sir Stewart Duke-Elder which just absolutely blew me away that he even remembered my name, and he referred a patient to me who had had a retinal detachment, and he had treated this person at Moorefield's, and the person was from Connecticut. And so he knew that I was in Connecticut and referred the patient to me. And I've kept that letter of referral, I just treasure it because it came from Duke-Elder, and I'm sure he didn't send him because I was that knowledgeable.

One of the great... you mentioned another person earlier, Dr. Verhoeff...

DR. GARCIA: Oh, yeah.

DR. PARKE: At Wilmer we had annual meetings, resident meetings, and the alumni and people from all over the East Coast used to come to our annual meetings at Wilmer. And they... originally, when I was there we were in a hall that probably held 200 or 300 people, but it has now become a huge affair today. But we had to, as residents, present original research and would give our papers at the Wilmer meeting. And I had spent some time with Helenor Campbell Wilder at the Armed Forces Institute of Pathology, and we were trying to develop a rapid way to stain acid-fast bacilli. And so I had worked on this for approximately a year and had gone through what I thought was all of the literature and so forth, and came up with a method for staining acid-fast bacilli and presented it at the Wilmer meeting. And after the presentation Dr. Verhoeff, who always sat right in the front row, said, 'I wrote about that in 1915.'

DR. GARCIA: It was usually in a fairly loud voice.

DR. PARKE: And I was completely blown away. And I had not gone back as far as the 1915 literature, and he was absolutely right.

DR. GARCIA: Well, he wasn't wrong very often. Speaking about the New England Society, that was one of the things that our visitors used to have to put up with, and our local people, too. Freddie [Verhoeff] always sat in the front row and had this squeaky high-pitched voice, and he always had a comment to make and it usually wasn't favorable.

DR. PARKE: This was not favorable. I was destroyed.

DR. GARCIA: In fact, every Monday afternoon when I was a resident we used to have a pathology conference at the Eye and Ear Infirmary. He was fairly elderly at the time, but when he came he used to give Dr. Cogan what-for about some of the reading of the slides. I remember one particular incident where there was a discussion about whether a corneal section was edematous or a hypertrophied, and he got up and he said, 'You know, David, what's the matter with you? I wrote about that and it's 64 layers in the

cornea and you should know that. And if it's edema, you know, there's interstitial fluid.' I mean, right in front of everybody. Poor David, Professor of Ophthalmology is getting what-for.

DR. PARKE: Well, maybe that's enough reason why I like David Cogan so much. But it was unknown to me.

DR. GARCIA: One of the other interesting things that you reminded me of is when I was a house officer at the Eye and Ear Infirmary, the senior staff used to operate without gloves. The only time they wore gloves is when they did what they called dirty cases. And their feeling was that, they were scrubbed and washed all the time, and the gloves that were available at that time were kind of thick so that they reduced your tactile sensation. They felt that it was an impediment to some of the surgery that they were trying to do. They were allowed to do that. Obviously things changed and when we were in training all the younger surgeons were required to wear gloves, but they were still exempt. They could continue to operate without gloves, and had had a very good record of no infections.

DR. PARKE: I know that Dr. Chandler, when he did cataract surgery, right up until the end, I believe he used a Graefe section.

DR. GARCIA: Oh yeah.

DR. PARKE: Yeah, I know one resident who chose Dr. Chandler to be his assistant, if you will, at his first cataract case, and he was going to use a keratome and scissors, and Dr. Chandler said, 'If you ask me to assist you, you do it my way.' And the resident said that was his first and last Graefe section.

DR. GARCIA: That was pretty hairy, you know, just taking a narrow, sharp blade and running it all across the anterior chamber and slicing your way out, but it worked.

DR. PARKE: Well, I never used a Graefe, but we did, of course, originally do all of our cataract surgery as intracapsular, and we made about 160-degree incision, we used a keratome and then corneal scissors...

DR. GARCIA: The incision extended with scissors.

DR. PARKE: Extended it with scissors, and we used the so-called J. McLean-type sutures, too, through the conjunctival flap and then through the limbal incision, and it was a... to me it was the way to do cataract surgery.

DR. GARCIA: What size sutures were you using?

DR. PARKE: 6-0 black silk, which, you know, by today's standards...

DR. GARCIA: Looked like ropes.

DR. PARKE: ...using rope and... and, of course, that's why we had to keep people's eyes patched, because they were... the stitches, themselves, were so irritating. And although at Wilmer we never kept people in bed in sandbags, I know that was still prevalent in many places in the country.

DR. GARCIA: Not when I was at the Eye and Ear. There was none of that.

DR. PARKE: And then when I went into practice, and my first orders on my first cataract patient that I sent to the floor were 'up to bathroom with help, elevate head 35 degrees, and out of bed tomorrow.' And the nurses refused to honor my instructions because the other ophthalmologists in the city in which I practiced kept them in bed with sandbags with private duty nurses.

DR. GARCIA: Oh, my gosh.

DR. PARKE: And the incidence of paralytic ileus... and people actually died from cataract surgery from having paralytic ileus. So they had to call Wilmer. I asked them, at my expense, to call Wilmer and have them assured that what I was doing was not outlandish, and from then on it was standard procedure.

DR. GARCIA: One of the things that I often think about, and I'm so glad that it's no longer an issue, is we used to load patients up with atropine after surgery to keep their pupils dilated, and we were the urology's department best friend over at the Mass General, because we used to transfer probably two or three a week, at least, over to the Mass General for urinary obstruction.

DR. PARKE: Yeah, and, you know, we see this today... if you listen to the infomercials on television, so many of them will say, particularly things that are related to benign prostatic hypertrophy or to urinary frequency, one of the complications may be eye complications, and what we're doing is we're atropinizing them in some respects, and they get dry mouth and so forth, and you hear that in the infomercials. Some urologist drugs do produce "floppy iris syndrome" which alters cataract surgery.

DR. GARCIA: One of the other interesting things that we enjoyed at the Eye and Ear Infirmary was the diversity of surgeons, as I said, and one of them was Dr. Trygve Gundersen. Trygve Gundersen was also a very renowned surgeon, and he was an excellent cataract... he was an excellent surgeon, to begin with, much better than Paul Chandler was, as far as technique and so forth. But Trygve became very intrigued with doing extracapsular cataract surgery, and so we used to really enjoy helping him and learning to do extracaps at the time. But it was a much different and much more difficult procedure than what we're doing now. You really basically got out as much of the cortex as you could, you left whatever else was there to get absorbed, and then later you'd wind up doing an incision on the scarred posterior capsule. They all wound up with vitreous in the anterior chamber. But it did have its benefits, particularly in young patients at that time, as opposed to an intracapsular.

DR. PARKE: Well, going back into the intracapsular, I became very interested in intraocular lenses. I had gone to a meeting in Los Angeles, and I'm really not sure why I went or what the actual meeting was, but it was in 1971, and I met Dr. Jan Wurst .

DR. GARCIA: Oh, from...

DR. PARKE: ...from the University of Groningen in Holland, and I was so intrigued by his using intraocular lenses that I asked him if it would be possible to visit with him in Groningen, and he graciously invited me, and I went over there and spent about three weeks with him in Groningen. And he was a master technician in that he made his own lenses, and he had a little laboratory up over his garage, where we would spend the evening grinding lenses and different powers and so forth, and we didn't have the ultrasound and the capabilities of really determining power that we use today. But he

was a very interesting man, and he oftentimes did not really evaluate his patients well before surgery. They could be sent to him from someplace in Western Europe, and he would look at the person with a Finoff light and say, 'We'll do your surgery tomorrow.' And... but it was very interesting. He was... technically, he was very good, and we did intracapsular cataract extractions and then put his Wurst implants in there, W-u-r-s-t, which later turned out to be the w-o-r-s-t implants.

But I came back to this country and Dan Taylor in New Britain had also taken a course in intraocular lens implants in Philadelphia, so we both got permission, and I don't remember the federal agency for which we had to work, but we had to make sure that the federal government was aware of everything we were doing...

DR. GARCIA: Oh yeah.

DR. PARKE: ... and all the paperwork was tremendous. So Dan Taylor and I, in the same week, did the first intracapsular cataracts with intraocular lenses in Connecticut that I know of, and I was roundly criticized at the time by people for inserting a foreign body into the eye and all of this thing. And literally, once it became an accepted procedure, some of the people who were the most vocal in condemning Dan Taylor and me for having done this, became the real cataract cowboys and did it in volumes.

DR. GARCIA: You know, it was really an interesting time, and you and I both went through the experience of dealing with aphakia, removing the lens and trying to fit patients with cataract spectacles post operatively, with all their limitations. The only recourse that you had at that time was to try to fit the patient with a contact lens in order to normalize their vision, and if you had a monocular cataract patient and you did monocular surgery, if you didn't wear a contact lens that was it. I mean, you'd use one eye or you'd use the other, but you didn't use them both. And my interest at that time was the aphakic contact lenses and extended wear and, oh, boy, I tell you, it was so time-consuming. You were limited in terms of the patients that you could apply it to because they had to have certain skills in order to handle a contact lens, or they had to have someone who lived with them who could help them manage the lens. When implants came along, obviously there was a lot of desirability in going in that direction, but there were so many

problems at the time. I remember the Maltese lens, which was basically a lens that was shaped like a cross, a Maltese Cross...

DR. PARKE: That's what Dan Taylor used, the Maltese. The worst lens was like a hard contact with platinum iridium loops...

DR. GARCIA: Those heavy metal loops, the lens that sank into the anterior chamber...

DR. PARKE: ... you put two behind the iris and two in front of the iris, sort of as a paperclip phenomenon, although they were at 90 degrees from one another. And so one of our greatest problems was dislocation of those lenses, and actually the...

DR. GARCIA: Well, and you could never dilate these patients afterwards.

DR. PARKE: Yeah, and... well, that's an interesting phenomenon. We began to realize, and this is over a period of time, that men dislocated their lenses more frequently than women. Did you know that? And one of the reasons was because, in orgasm their pupils would dilate and they'd dislocate their implants, and...

DR. GARCIA: Yeah, there were a lot of horror stories at the time. I remember... I can't remember the name of the surgeon in Spain who did 400 implants, and shortly after... within a few months they started coming back with all kinds of problems. He called them all back and explanted them all because they were so troublesome.

DR. PARKE: And one of the problems with that is then you increase the incidence of bullous keratopathy and we didn't have good control with corneal treatment at that time in dealing with...

DR. GARCIA: And there was no helon, there was nothing to protect the cornea.

DR. PARKE: And so, you know, in a way it was great to be somewhat of a pioneer, and...

DR. GARCIA: I can still remember the first patient that I did an intraocular lens implant on. I did a Binkhorst 4 loop, which had crossed polyethylene loops. But, number one, the experience of removing the lens—everything is perfect, you've got a perfectly good eye, and now you're going to start messing around with it—holding that thing in place while you constricted the pupil to get the posterior loops in place and capture them, was unreal! The surgery went well, and I can still recall, I could pick this lady out of a crowd today, I swear, she had 20/20 vision the day post surgery, which was wonderful. Unfortunately, six months later she needed a corneal transplant.

DR. PARKE: Well, it was great... the next thing that came along, of course, was the development of extracapsular surgery and the ability to do phacoemulsification, and this was a great step in my life in which to become involved in.

DR. GARCIA: That was interesting, too, because Charlie Kelman was one of the people invited to the New England Society. He was not very well received initially, because phaco at that time was not the phaco that people are doing today, obviously. I remember seeing some of Charlie's patients post operatively who were in trouble. Obviously, his was a very busy practice, and it was not geared to deal with complications. It was geared to deal with surgeries that went well. That was a troublesome time, but you're absolutely right. One of the things that I think is extraordinary now that the technique has been refined, now that intraocular implants have been refined, the benefits to the world... you were talking about these 130 million people with cataracts in other parts of the world... one of the problems of dealing with that has always been, 'What do you do post operatively?' You remove the lens, many of them can't get glasses, they lose their glasses, their glasses get scratched, they can't replace them, and all of those issues. All of these problems you used to have to deal with are non-existent, and it's a safe procedure.

DR. PARKE: Well, when I was a resident we went to Algiers and did cataract surgery on the Nomads who came in from the desert, and we always gave them a pair of plus-11 lenses. Of course, we were doing intracaps at that time, and never saw them again, they went off into the desert with their plus-11s and we never knew what kind of outcome they had.

DR. GARCIA: Which kinds of brings us full circle to international ophthalmology again. We've made a tour.

DR. PARKE: And one of the things that... we talk about international ophthalmology... is the number of women who are going into ophthalmology in this country and abroad. And I have an interesting story about the Manhattan Eye and Ear. The first woman resident there was Eleanor Faye.

DR. GARCIA: Oh, I remember her.

DR. PARKE: And Eleanor is really the grand dame of low vision, and still is very active. But she was refused a residency at Manhattan Eye and Ear because they had no facilities for a woman to dress or undress for surgery. And she said, 'Well, why can't I use the nurses' locker room?' And that's how she was accepted. And that was many, many years ago, but she was the first woman who ever was a resident at Manhattan Eye and Ear. And now at Yale about... 50% of our residents are women, and they're just great, bright and very exciting to be engaged with and to teach. I learn more from my residents than I teach them, I'm sure.

DR. GARCIA: Okay. Well, it's been a trip, David. I think you and I have had an opportunity to live through interesting times. That's an old Chinese curse, but in our case I don't think it was a curse, I think it was a blessing. We've lived through an evolution of eye care advocacy, all of these improvements, and we've had a great time doing it.

DR. PARKE: We have, and I just envy those who are in training now because they're going to learn so much more than we ever had an opportunity to learn, and I just think the future of ophthalmology is just great.

DR. GARCIA: You know, when I was in medical school genetics was a half-a-day, and it was basically Mendelian and sex-linked inheritance and that was about it. Who knew about DNA... nobody... I mean, they knew it was there but nobody knew what it was or what it did. Immunology was really pretty much non-existent. It's really a changed world.

DR. PARKE: And the world, what we're doing now with macular degeneration and vascular endothelial growth factor is just changing the world for so many people. There are great things being done for people that we never believed could be done.

DR. GARCIA: Well, the only thing we used to offer these people were some kind of lipid extracts, whatever. There was... the theory was that they might be beneficial. And it was so frustrating to be faced with a condition that you couldn't really do anything about, and have to tell a patient 'there's nothing more that I can do for you.' I mean, those are words that you just don't like to say and people don't like to hear. Don't have to say that anymore.

DR. PARKE: That's right. There's always help and hope.

DR. GARCIA: Thank God!

[END PART II]