

MANHATTAN EYE, EAR AND THROAT HOSPITAL

150 YEARS OF VISIONARY HISTORY

DR. PAUL N. ORLOFF & DR. RICHARD P. GIBRALTER

WITH LAWRENCE A. ARMOUR



*We dedicate this book with great appreciation to our wives, Donna and Susan,
whose support, understanding, patience and endurance made it all possible.*

— PAUL AND RICK

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THE MANHATTAN EYE FOUNDATION

Our hope in writing this book is to restore and preserve those precious memories of a unique time in our lives which might otherwise have been lost to the fog of the past.

— DR. PAUL ORLOFF AND DR. RICHARD GIBRALTER

Mission Statement

The primary mission of the Foundation shall be to support those activities which seek to enrich the medical education of ophthalmology residents, fellows and attending physicians alike. The Foundation was created and sustained from the efforts of those attending ophthalmologists who dedicated their time and energy to supporting the ophthalmology teaching program at the Manhattan Eye, Ear and Throat Hospital.

The primary Foundation goal will be to provide support for educational activities in all the subspecialty fields of ophthalmology. The Foundation will consider applications for funding grants, educational stipends, and purchasing specialty equipment that is within the scope of the Foundation's activities.

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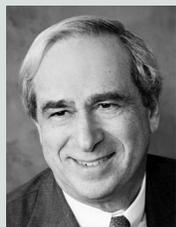
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Preface

This is the remarkable history of an institution founded by a small group of civic-minded individuals, just four years after the American Civil War. They were joined by a group of compassionate physicians who donated their skills and services to restore the sight and hearing of indigent patients who were unable to afford the health care they desperately needed.

As MEETH celebrates its 150th anniversary, this book recounts the story of a hospital that continuously achieved its goals and became a national center of excellence in the areas of patient care, education, research and innovation. After a period of rapid growth and relocation, the hospital found its permanent home at 210 East 64th St., where it has remained for over one hundred years.

MEETH became a national center of excellence . . . The inventions and innovations developed by the faculty changed the face of ophthalmology worldwide.

Significant changes took place in the last fifty years of the twentieth century. The number of inpatient hospital beds decreased as surgery became more ambulatory. State of the art operating rooms were built. A highly prestigious residency program in ophthalmology and ENT was mentored by a superb voluntary clinical staff. The institution created the finest subspecialty clinics in the field. Medical education was enhanced by comprehensive grand rounds, a robust lecture series and visiting professorship presentations.

The inventions and innovations developed by the faculty changed the face of ophthalmology worldwide. These revolutionary developments included adaptation of the operating microscope, small incision phacoemulsification cataract surgery, fluorescein angiography and ophthalmic ultrasound imaging. The use of lasers to treat retinal disease as well as glaucoma and the development of new surgical procedures were popularized and refined as well. The first Eye-Bank to provide corneal tissue for transplants was housed on the tenth floor at MEETH. Noteworthy accomplishments also were occurring in the specialties of otolaryngology and plastic surgery.

Members of the board of the Manhattan Eye Foundation were residents and fellows at MEETH. They continued to serve as medical educators for the next generation of ophthalmologists. It is their wish that the story of this unique hospital and its residency training program be told and preserved. Their thoughts and memories of training experiences are presented along with a profile of other legendary doctors who practiced and taught here. The hospital's journey from glory to near extinction is a fascinating tale. There is optimism for its future resurgence as a leader in patient care and medical education in ophthalmology.

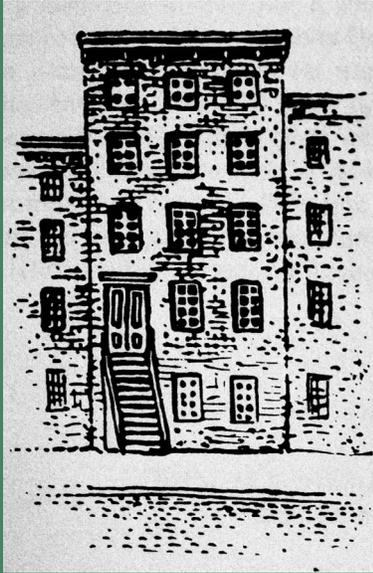
DR. RICHARD P. GIBRALTER

DR. PAUL N. ORLOFF

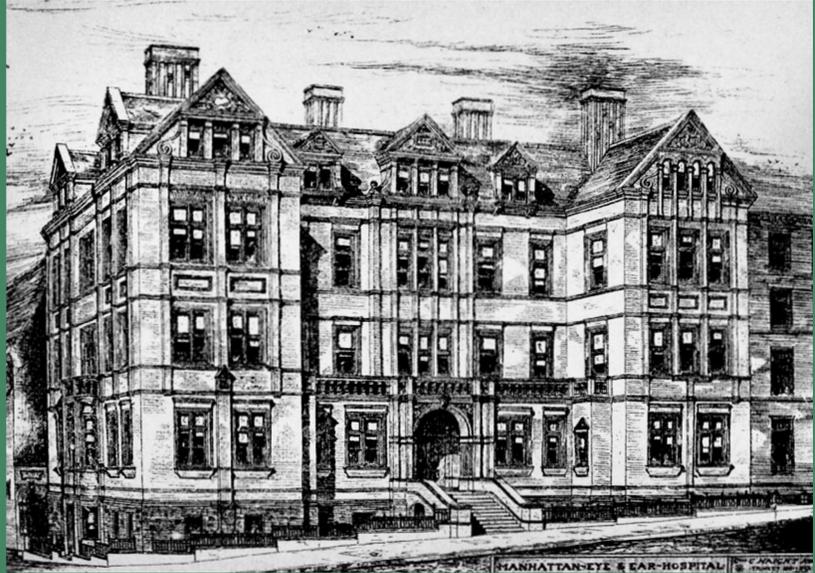
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Edward Steichen. *The Clinic Stairs* (publicity photograph for New York Eye, Ear and Throat Hospital) [for Vanity Fair, December 1931].
Credit: Harvard Art Museums/Fogg Museum, Bequest of Edward Steichen by direction of Joanna T. Steichen and the George Eastman House
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Photo: President and Fellows of Harvard College



The first home of Manhattan Eye, Ear and Throat Hospital, 233 East 34th Street. October 15, 1869 to October 2, 1881.



103 Park Avenue; Manhattan Eye, Ear and Throat Hospital's second building. October 3, 1881 to October 30, 1906.



Manhattan Eye, Ear and Throat Hospital at 210 East 64th Street opened November 1, 1906.



Manhattan Eye, Ear and Throat Hospital, 1975.

PART 1

The Story of MEETH

In 1869, a group of seventeen altruistic men established a small specialized hospital to care for patients in need. This is how that hospital became a vanguard of innovation and excellence in the fields of ophthalmology and otolaryngology.

The Beginning

One hundred and fifty years ago, a group of 17 prominent New Yorkers decided that their city needed a hospital to care for poor people who were in danger of losing their vision or hearing. The hospital they founded, eventually known as Manhattan Eye, Ear and Throat Hospital, fulfilled their goal of helping millions of people. It also became a fortress of medical excellence and a place where generations of skilled physicians were trained and passed on their knowledge to the next in line. It was also a setting where techniques and equipment were invented, introduced and improved and a locus of genius, passion, generosity and hard work that resulted in significant advancements in their respective fields.

Three of those 17 civic-minded, influential, wealthy men were ophthalmologists and 14 were businessmen. They knew each other from social circles and some were related by marriage. Their names were, and still are, the best-known among the New York upper crust, such as Roosevelt, Lanier, Harriman, Dodge, and others.

They often met at the Union League Club, an impressive building on the corner of 37th Street and Park Avenue. At around the same time that MEETH was being discussed, The Metropolitan Museum of Art and The American Red Cross got their start at the club. Union League Club members were also instrumental in bringing down the Tweed Ring.

By all accounts, the members of the club were compassionate, convivial and family-oriented. It has been said that the warm, personal atmosphere that permeated MEETH started with its founders and never dissipated. These men were serious about doing good because of religious conviction and awareness of the misery around them.

In the 1860s, in New York City and across the country, the medical needs of the poor were addressed by people like these. The local, state, federal government did not intervene nor accept any responsibility. There was no health insurance at all until the 1920s, when a small group of hospitals in Texas formed Blue Cross to help their patients afford their services. A few years later, doctors in California



Dr. Cornelius Rea Agnew



Dr. Daniel Bennett St. John Roosa

founded Blue Shield so that they, instead of hospitals, could be in charge. But in New York in 1869, when those 17 individuals were talking about founding a hospital, people who were sick or injured had to pay for their own care. If they were too poor to pay, they had to find a charitable institution or a doctor willing to work without fees, or just suffer, sometimes go blind or deaf or die.

At the time that MEETH came into being, many New Yorkers fell into the “too poor” category. Several waves of immigrants had arrived recently and jobs were scarce. Veterans had returned from the Civil War, many of them injured and unable to work. Working families were housed in crowded, poorly-ventilated tenements, mostly below 14th Street. Diseases such as cholera, tuberculosis and dysentery had not yet been tamed, so seriously ill, and contagious people often lived among the still-healthy ones. There were already several public hospitals in the city. Bellevue, then called City Hospital, the oldest public hospital in the United States, opened in 1736 and New York Eye and Ear Infirmary was founded in 1822 but conditions were less than stellar. Before mid-century, when the benefits of a sterile environment were discovered, hospitals were used mostly by poor people who could not afford home care and the institutions were geared to those who had no choice. Sometimes they were worse than the diseases.

The three ophthalmologists who founded Manhattan Eye and Ear Hospital were experienced and respected.

Dr. Cornelius Rea Agnew, a native of New York City, graduated from Columbia University College of Physicians and Surgeons. He had served as surgeon-general of New York State and medical director of New York Volunteer Hospital, which had provided care for Union soldiers. A year before he created MEETH, he was responsible for the establishment of the Brooklyn Eye and Ear Hospital, which closed in 1976.

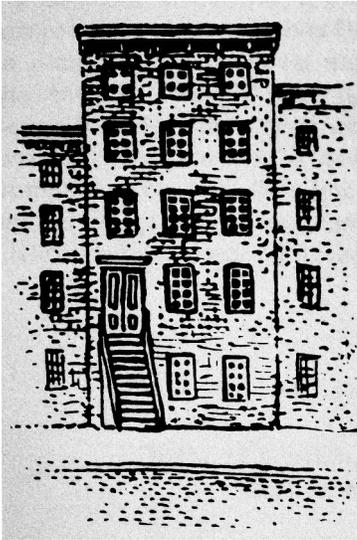
Daniel Bennett St. John Roosa was born in Bethel, New York and graduated from New York University’s Medical College in 1860. He worked with Dr. Agnew at the New York Volunteer Hospital and held professorships at NYU, the University of Vermont, and New York Post-Graduate Medical School.

The third physician, Dr. Edward G. Loring, was born in Boston and studied medicine in Europe and at Harvard. He joined Dr. Agnew at Brooklyn Eye and Ear and later became Dr. Agnew’s partner in his New York practice. Dr. Loring was the inventor of the Loring ophthalmoscope, which had 15 rotating lenses. The three ophthalmologists ran successful medical practices in the city and donated time and money to Manhattan Eye and Ear for many years after it opened. The doctors and their business associates had a clear purpose, which they stated in their first annual report: “the alleviation of the sufferings of the poor, the prevention of pauperism, and the cultivation and diffusion of sound knowledge of all that relates to diseases of the eye and ear.”

Once the decision was made to start the hospital, they acted quickly. They applied for a charter from New York State and received it on May 5, 1869. Because they did not need money from the government, the charter was granted quickly and within a few months the board was actively engaged in setting up shop.

... the alleviation of the sufferings of the poor, the prevention of pauperism, and the cultivation and diffusion of sound knowledge of all that relates to diseases of the eye and ear.

—MISSION OF MANHATTAN EYE AND EAR HOSPITAL, FROM ITS FIRST ANNUAL REPORT



The first home of Manhattan Eye, Ear and Throat Hospital, 233 East 34th Street. October 15, 1869 to October 2, 1881.

The first order of business was finding a site. They chose and rented a four-story brownstone at 233 East 34th Street, part of a row of tenements. The buildings had been erected in the early nineteenth century on the former farm of Jacobus Hendrickson Kip, a Dutch settler. It was a good place for a hospital, near enough to the downtown area where their intended patients lived but close to the doctor's practices and residences. Dr. Roosa had an office on Lexington Avenue and 30th Street and Dr. Agnew lived on Madison and 39th.

The building was four stories tall and had just 13 beds. The hospital opened its doors on October 15, 1869, accepting in-patients 24 hours a day, seven days a week. It held out-patient clinics from 9 am to 2 pm every day except Sunday. Word spread, and the hospital quickly filled with patients, all of whom were treated for free. Services and private rooms for those who could afford to pay were added later. During its inaugural year, as reported in the first annual report, seven doctors, including Drs. Agnew, Roosa and Loring, treated 1,717 eye and ear patients and performed 294 operations.

In the first years of the hospital, there were just two clinics, one for eye, one for ear. In 1872, a throat clinic was added when the doctors realized that "experience shows that many diseases of the ear arise directly from those of the throat." In 1876, another clinic was added for nervous disorders which the doctors noted were sometimes caused by or the cause of physical symptoms, but it closed in 1896. The medical staff grew from seven doctors in 1869 to 14 in 1876 to 22 in 1879. In addition, medical personnel from all over the city recognized it as a resource. Records show that in 1872 alone, 364 physicians and medical students used the hospital.

Even without the instant media of the twentieth century, it didn't take long for word to spread that there was a small building in New York City that would provide effective healing free of charge. The second annual report tells the story of a blind man who came to the hospital all the way from Texas, begging for charity to make the journey. Surgery restored his vision to "sufficient for reading the finest print."

The hospital's clearly-stated mission was to provide care for those who could not pay, but not for those who could pay and did not want to. After encountering some deceitful people who were looking for a free ride, they developed a policy which they recorded in their second annual report: ". . . inquiry is gently but firmly made before registering the names of new applicants for admission whether they are entitled to partial or entire gratuitous care. If neither, they are informed that they are not entitled to benefits of the hospital." Payments by those who could afford them were put into a fund that paid for medicines for those who were totally destitute. The physicians continued to work without compensation.

Although the original board continued to make donations to maintain the hospital, they found that they needed outside funding as well. Their annual reports solicited sympathy and cash by telling heartbreaking stories of unfortunate people who could be helped by their donations, such as ". . . a poor man who was a widower, and his four small children came into the hospital with ophthalmia contracted in their over-crowded tenement . . . They formed a piteous group and were in immediate danger of blindness. They were ragged and unclean; special arrangements were made to cleanse, clothe and treat them . . . they were all saved from blindness."

The hospital received a steady flow of contributions as it grew, at least until the Depression of 1873, which was known as the Great Depression until it was eclipsed by the Depression of the early 1930s. Throughout Europe and North America, the economy fell apart and philanthropy declined. Many of the board members reduced their annual contributions to a small fraction of what they donated previously, though some provided products in lieu of cash. Paton & Company donated firewood, John J. Sperry gave a ton of coal, Mrs. Roosa handed over some used linen, Mrs. Fulton brought in eight old rocking chairs. But Dr. Cornelius Rea Agnew doubled his donations to \$800, a very large sum in those days, while other founders reduced theirs to \$50 or \$100.

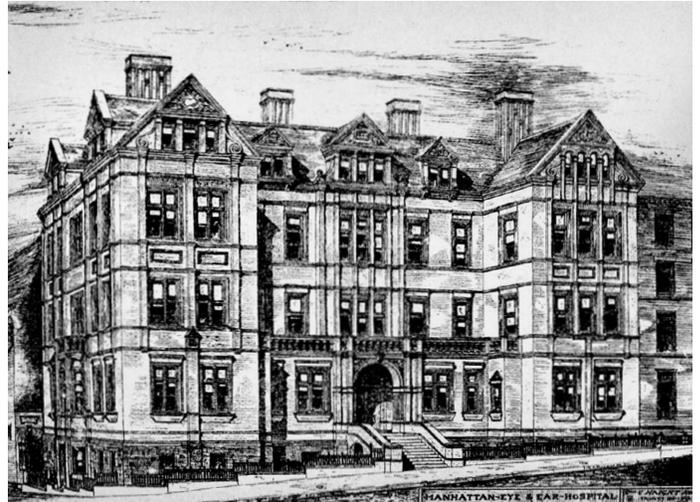
Though the contributions dwindled through the depression, patients continued to arrive in droves. By 1879, the hospital's tenth anniversary, close to 40,000 people had been treated in the hospital's eye, ear, throat and the later-discontinued nervous conditions divisions and 4,000 operations had been performed. Clearly, the tiny brownstone on East 34th Street couldn't handle the volume of traffic.

The astute businessmen on the board had concluded that they'd need a bigger building much earlier. They had started searching for a new site in 1871, just two years after the hospital opened its doors. These were railroad and coal barons and they knew that the city was about to change dramatically because of a major new train depot that was being built in the East 40s. And even though real estate prices were already rising near the new facility, they decided to invest \$50,000 in a plot on the corner of 40th Street and Park Avenue, a block from what is now Grand Central Station, in 1872.

Plans to construct a new building were derailed by the Depression. The Board could not borrow money because of the debt they'd incurred by purchasing the plot and donations had dried up. The Board had trouble raising enough money for maintenance of the existing hospital, building a new one was out of the question. So they survived and made do in the little brownstone until 1879. They were able to rent out the lot on 40th Street to help pay expenses. In 1879, two events cleared the way for a move to a bigger, better facility. The Depression lifted and the Board received a donation of \$25,000 from Edwin D. Morgan, a former governor of New York State.

103 Park Avenue

Plans were completed for a new facility and ground was broken on April 19, 1880. The building opened on October 3, 1881. It was an imposing edifice, built of brick trimmed with red sandstone on four 20 x 100-foot plots. There were 75 beds for surgical cases, clinics for outpatients, and a pharmacy. It included residences for doctors and nurses. Every room had its own fireplace and Turkish baths were installed because many people who came to the hospital needed washing.



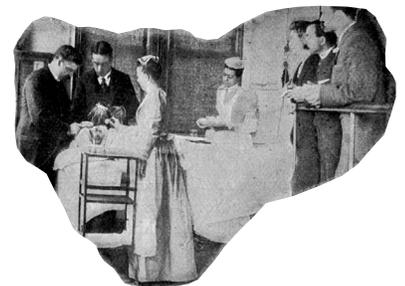
103 Park Avenue; Manhattan Eye, Ear and Throat Hospital's second building. October 3, 1881 to October 30, 1906.



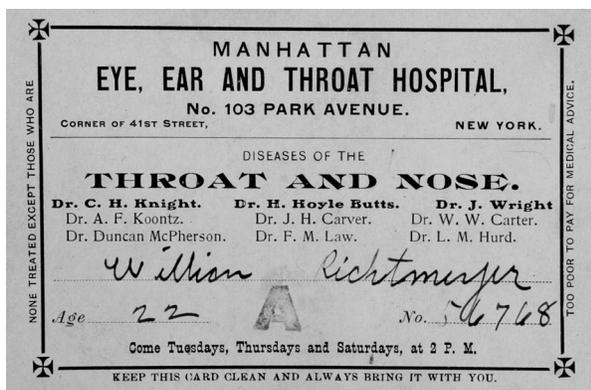
The baby's ward at 103 Park Avenue.



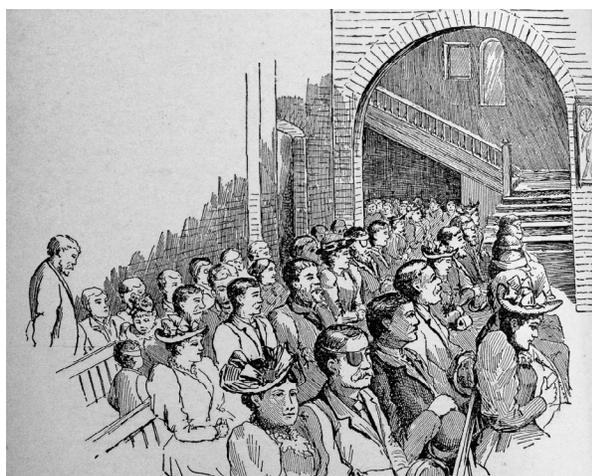
A visit to the ear clinic.



Surgeons, nurses and students in the operating room.



A clinic card used in the 103 Park Avenue building.



A few of the hundreds of people waiting for help.

The Board worked hard to create the best possible building and they thought it would last forever. By 1903, they would be searching for space again.

Manhattan Eye and Ear was already known for superior doctors and innovative medical practices; their reputation continued in the new building. At an 1885 meeting of The American Ophthalmological Society, Dr. Agnew reported a new method of removing a lens dislocated in the vitreous of a blind, but not disfigured, eye using a double needle. Dr. Roosa was the author of many articles and books and President of the New York Academy of Medicine. Dr. Edward Thomas Ely, who tragically died at age 35, first came to prominence in 1881 when he developed a new method for corrected the protruding ears of a young boy who complained that his schoolmates ridiculed him. In his short life, Dr. Ely also completed research on the medical effects of tobacco on the upper respiratory systems, refraction on newborn babies' eyes, and treatment of complications from mastoid abscesses.

In 1887, the hospital ended its policy of free treatment for all and accepted its first private patients. Those who could afford it paid seven to ten dollars weekly for private rooms. At the same time, contributors began endowing beds for \$5,000 each. This practice continued through the twentieth century and filled the hospital's coffers so that impoverished

patients could be treated gratis. Plastic surgery was another lucrative area. Several entropion and canthoplasty operations were performed in the very first year that the hospital opened, and these continued in the new building.

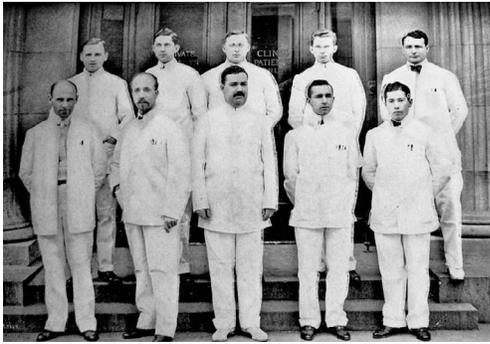
By 1901, the Park Avenue building was bursting at its seams. The hospital's excellent reputation was only part of the reason why it was so busy. Another was the city's population explosion. Between 1869 and 1903, the city grew from 950,000 to 4 million people and its area expanded from 19.68 to 308 square miles. So, it was not surprising that, after treating 1,717 patients in 1869, their records report 28,478 visits in 1903. That is when the search for an even bigger building began.

210 East 64th Street

The investment that the Board of Directors had made in their Park Avenue lot had paid off. Prices in the area were now sky-high and by moving to a low-rent neighborhood they could vastly improve their facility. They chose a massive plot on the Upper East Side, which was practically deserted in 1900. Farms and marshland still covered much of the area, though some wealthy families had already settled on Fifth Avenue and others had country homes in the sixties and seventies. The Directors bought a tract of land that stretched from 63rd Street all the way



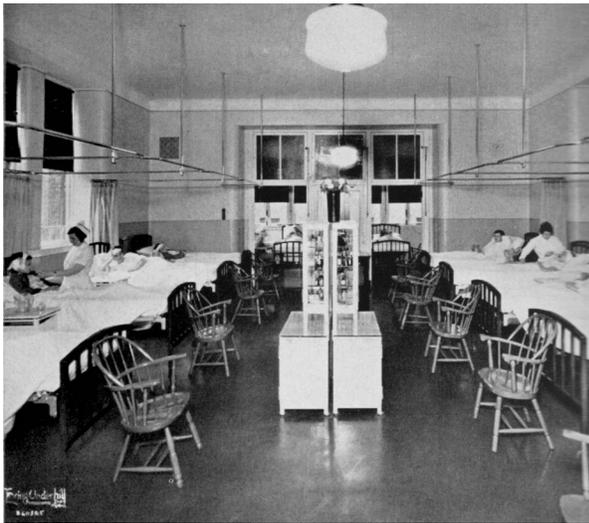
Sketch of the proposed building at 210 East 64th Street.



The house staff at MEETH in 1910



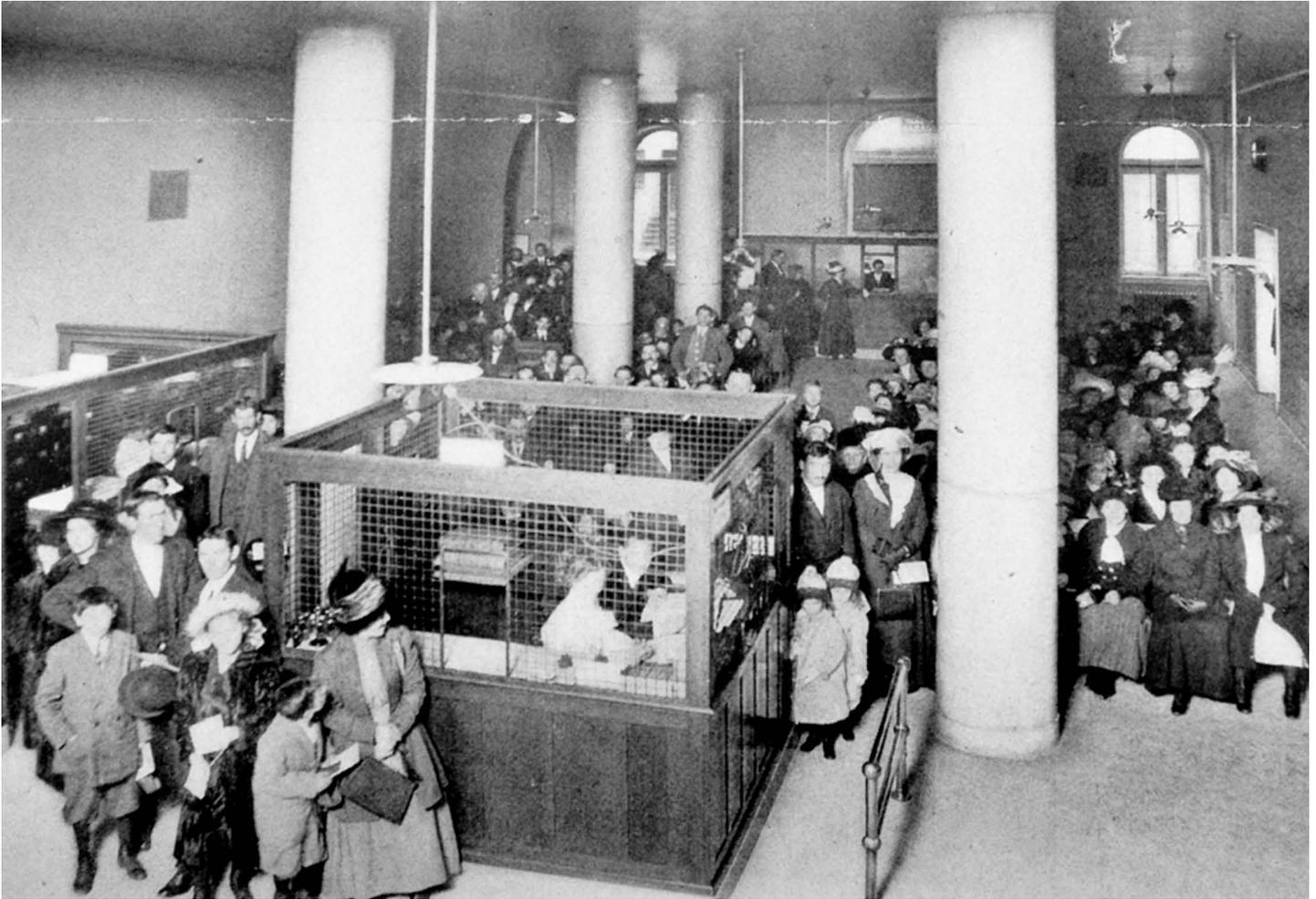
Manhattan Eye, Ear and Throat Hospital. Opened November 1, 1906.



A public ward.



A private room.



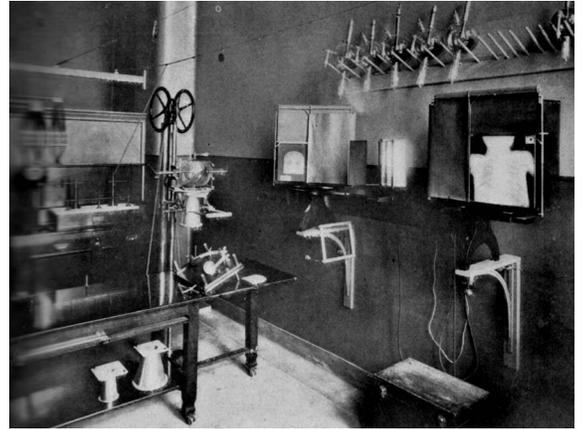
The reception and waiting room at 210 East 64th Street.

through to 64th. There was room for a huge reception area, enlarged clinics, 125 free beds, 35 private rooms, and plenty of examining rooms and offices. Once again, they thought they were set, but they found they needed more space in a little over a decade. In 1917, they built an annex which contained, among other things, a nurse's residence. In 1925 they added three more stories.

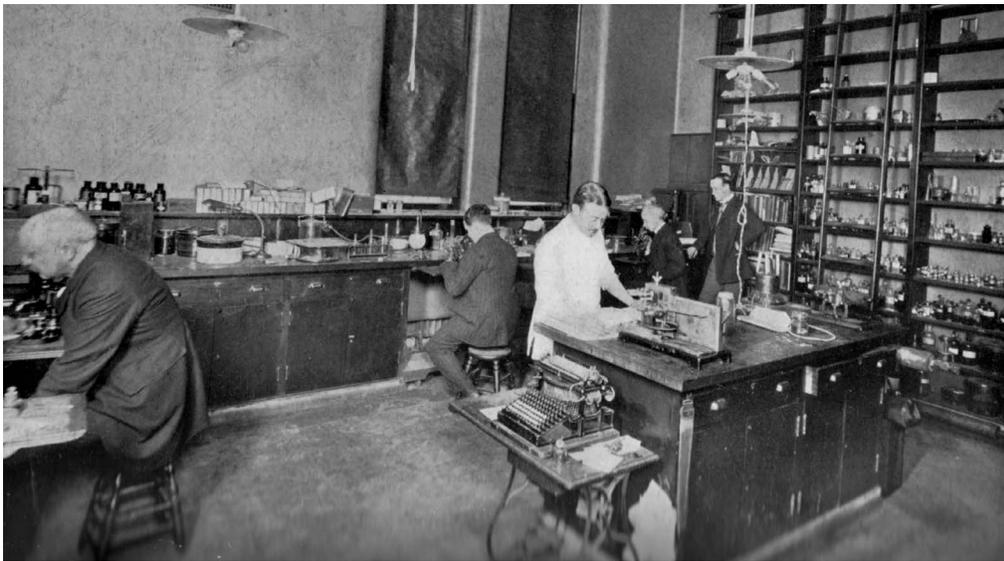
Around the turn of the century, the hospital had installed a pathology lab in the Park Avenue building and hired its first pathologist, who used the facility to analyze removed tissues and to examine blood for traces of malaria and tuberculosis. This lab was greatly expanded in the new building and updated with what was then cutting-edge equipment. An X-ray room was also set up. Although X-ray machines had been invented several decades prior, they were still rare at the time when 210 East 64th was built.

In 1904, The Board of Directors had added the word "Throat" to their name. The full name, Manhattan Eye, Ear and Throat Hospital, was, and still is, chiseled into the building's façade. At 210 East 64th, the ENT clinic was greatly expanded under the supervision of Dr. Walter Chappell, a professor of clinical laryngology who counted the Rockefellers among his patients. An allergy clinic, one of the first in the U.S. was included.

From its inception, Manhattan Eye and Ear had provided instruction to new doctors. In 1901, it formalized its educational curriculum by establishing a post-graduate school of ophthalmology, otology and laryngology, offering extensive lectures and autopsy classes as well as bedside and clinic experience. The school was discontinued in 1928, but other residency programs followed. In 1934, the Board of Directors created full-time, paid positions for a resident ophthalmologist and a resident otolaryngologist. These hired physicians were expected to instruct all members of the house staff. Their teaching was supplemented by visiting professionals in all specialties. The hospital also provided extensive training for nurses through a



ABOVE: Early X-ray apparatus.
LEFT: Manhattan Eye and Ear's first pathology lab.



Children awaiting tonsil and adenoid surgery in MEETH's ear clinic.



Children being fitted for glasses. Many of them would not have been able to improve their vision if not for the doctors at MEETH. A sign in the clinic read: "For Those Who Cannot Afford to Pay a Doctor."

Coming from a society where each day's struggle is to get as much as possible from their fellow human beings, and to give as little as they can in return, these patients learn the spirit of a society in which it is better to give than to receive.

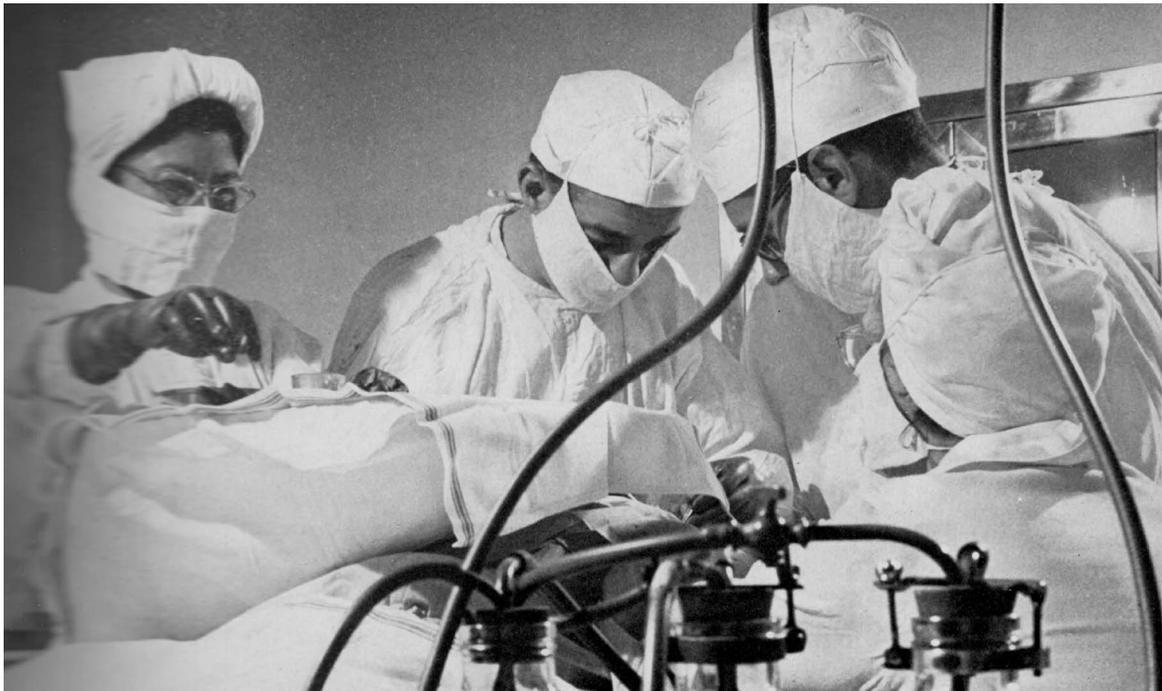
—FROM "THE SPIRIT OF THE HOSPITAL,"
a MEETH publicity brochure circa 1910

formal post-graduate program. In their 1914 Annual Report, they summarized the success of their educational programs:

"The widespread knowledge of our ability to give special post-graduate instruction in diseases of the eye, ear, nose and throat has resulted in a demand for clinic instruction which we have not felt we could disregard."

One thing did not change as Manhattan Eye, Ear and Throat Hospital expanded and treated more and more patients: the friendly and warm atmosphere that was cultivated. They spoke of it in a publicity brochure called "The Spirit of the Hospital" that probably dates to 1910, though the date is not clear on surviving copies: "In this Hospital there seems to be less institutional rigueur, so productive of coldness of heart than is often seen where services are well paid. Physicians and nurses, instead of losing sympathy, grow with each year more humanly and personally interested. The Golden Rule, so often seen print and so seldom observed, is more than a maxim of mutual helpfulness in the ward. It has been inculcated into the daily life there."

By the early 1930s, the hospital was treating over 42,000 patients a year. A Social Work department was installed to help with non-medical problems.



Highly-trained doctors and nurses perform a delicate eye operation in the 1940s.

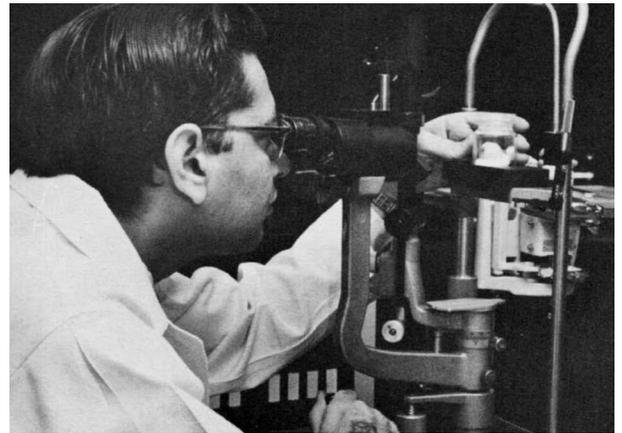
World War II and Beyond

Perhaps it is because the records and memories are more recent, but MEETH seemed to soar even higher in the middle part of the twentieth century, paving the way for the era that some people called “Camelot” in the last decades of the millennium. The MEETH building housed almost 200 private and public rooms, spacious clinics and meeting rooms, plus residences for staff. The resident program was thriving. Each year, a group of the brightest candidates learned from an illustrious faculty. The number of patients treated continued to rise; by the middle of the 1960s, they treated up to 80,000 patients annually.

This stellar period in MEETH’s history was accompanied by and caused by an influx of supremely talented and influential faculty, world-class ophthalmologists who developed and pioneered innovative equipment and treatments.

Dr. R. Townley Paton was on the staff of MEETH from 1933 until 1959, rising to the post of Surgeon Director and Chairman. Dr. Paton performed the first corneal transplants in the United States and in 1944, he created the Eye-Bank for Sight Restoration, making corneal tissue available for the vision-saving surgery. Established in one small room of the hospital annex, the Eye-Bank eventually occupied the entire top floor and several laboratories throughout the building.

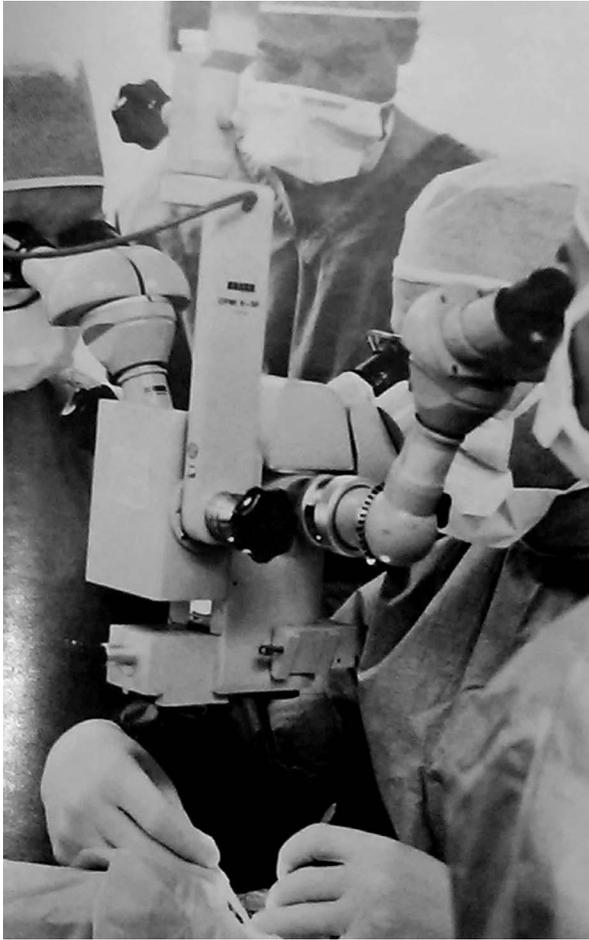
In the pre- and post-war era, Jewish and other minority professionals had trouble finding places at many teaching hospitals in the United States, but MEETH developed a policy of welcoming the most qualified people without regard to their race or religion. Their even-handed policies brought them new faculty members who had fled Nazi Germany, such as Dr. Adolph Posner, who started the first glaucoma clinic in the United States at MEETH and Dr. Arthur Linksz, who wrote a seminal book on the physiology of the eye.



Examining corneal tissue at the Eye-Bank for Sight Restoration.

Timeline of MEETH Firsts and Significant Developments

- 1942** Opens one of the country’s first treatment clinics for glaucoma
- 1944** World’s first eye bank established at MEETH
- 1955** Develops a clinic devoted to ophthalmic plastic surgery
- 1966** Uses the first B-Scan ultrasound to detect retinal problems
- 1967** Surgeons perform first cataract removal using phacoemulsification
- 1967** First cochlear implant center
- 1972** Develops krypton laser photocoagulation to treat retinal disorders
- 1990** Conducts first excimer laser vision correction trials
- 1993** Performs first laser procedure for cataract removal

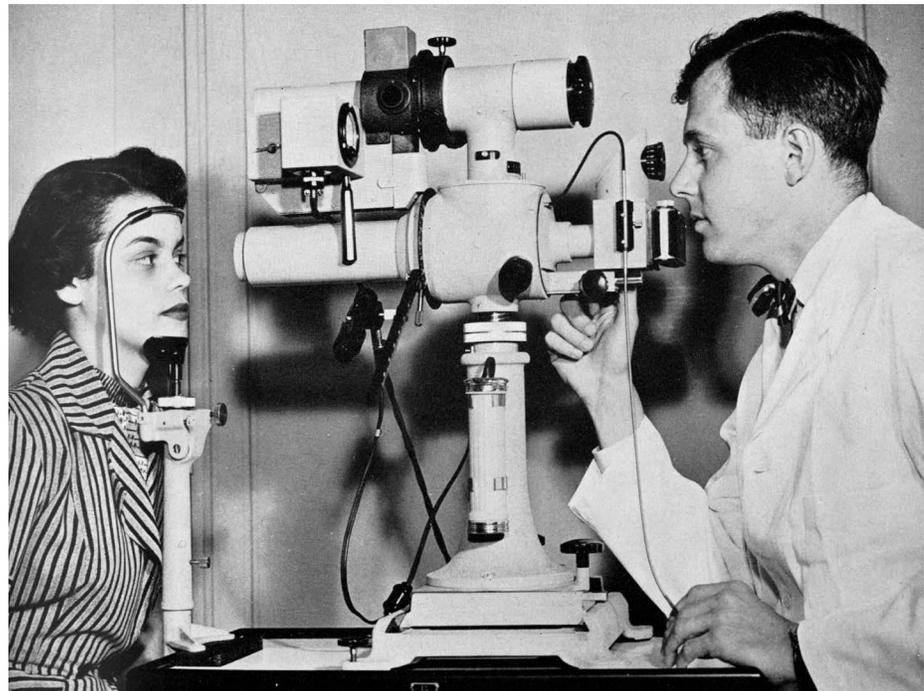


Soon after the war, Dr. Byron Smith joined the staff at MEETH. He had served in Europe during World War II, treating patients who had suffered traumatic injuries to their eyes. In battlefield hospitals, he developed techniques for fixing horrific damage. When he returned to the United States, he, along with Dr. Frank Converse, another pioneering expert in the field, pooled together their knowledge and innovative ingenuity to create the subspecialty of ocular plastic surgery. MEETH became the center of that field and over the next fifty years, generations of the best oculoplastic specialists trained and practiced at MEETH.

Dr. Richard Troutman, another physician who burnished the reputation of Manhattan Eye, Ear and Throat Hospital, introduced, promoted and improved ophthalmic operating microscopes and initiated the field of microsurgery in North America. Working with European manufacturers, he made the microscopes more effective and available. He invented several improved tools and created a curriculum for teaching microsurgery to residents.

Dr. Brian Curtin's Myopia Clinic was another area where MEETH provided unique leadership. Dr. Curtin's research resulted in his comprehensive textbook, *The Myopias*, in which he brought attention to

ABOVE: Using an ophthalmic operating microscope.
 RIGHT: The most modern apparatus was always available at MEETH, not only for the benefit of its patients but also for instruction in the residency training program. In this 1950 photograph, a fundus camera is used to photograph the retina in color.



pathological myopia, a common but little-understood disease. Dr. Curtin, and later Dr. David Sudarksy, were early specialists in retinal disease, a subspecialty to which MEETH later became a significant contributor when Dr. Lawrence Yannuzzi and Dr. Yale Fisher pioneered the use of diagnostic and treatment options such as fluorescein angiography and argon and krypton lasers.

At the same time, Dr. Abraham Schlossman was expanding the Eye Muscle Clinic with Dr. Suzanne Véronneau-Troutman and Dr. Richard Raskind. Dr. Charles Kelman was conducting experiments that would lead to his invention of the phacoemulsification technique for cataract removal, a giant step forward that has improved vision for tens of millions of people and is still used today.

In 1947, MEETH became one of 63 institutions where candidates for the Aviation branch of the military could receive physical examinations. During the year, more than 4,000 candidates for the Air Force were examined at MEETH and instructions in performing X-rays were given to more than 400 Army surgeons.

By the middle of the 1960s, the hospital was treating up to 55,000 patients a year.

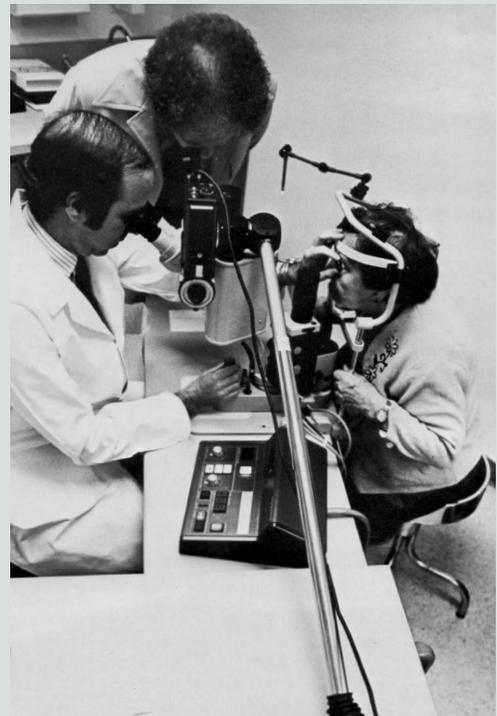


A clinic visit in 1965; over 55,000 patients were seen every year at MEETH in the 1960s.

Some of MEETH's Contributions to Ophthalmology

Manhattan Eye, Ear and Throat was one of the first hospitals to perform epikeratoplasty, keratomileusis, YAG Laser capsulotomy and radial keratotomy. Over the years, it also played a leading role in the development of:

- Phacoemulsification, to remove cataracts, developed by Charlie Kelman
- The use of the microscope in eye surgery
- The first use of image-guided surgery in New York
- First use of micro-fiber endoscopy on the East Coast
- The treatment of regular and pathological myopia
- The diagnosis and treatment of retinal disorders
- The treatment of ocular allergy and infection
- Corneal transplants and refractive surgery
- Facial plastic surgery
- Middle ear stapedectomy



Dr. Jerome Levy treated a patient with a newly acquired YAG laser.

The Centennial

In 1968, MEETH proudly reported that it had treated more than five million patients since its founding 100 years before. Operating income for the year exceeded \$4.5 million, slightly more than expenses, and the balance sheet showed assets of nearly \$7 million.

The Centennial Year began on May 6, 1968 with the cutting of a huge birthday cake. The ceremony was attended by hundreds of the hospital's staff and friends and a group of nurses dressed in nurses' uniforms from the Florence Nightingale era participated. The main entrance was decorated with birthday bunting for an entire year. The celebration ended with a Gala Ball in May, 1969.

The highlight of 1968 came midway through the year. In honor of its centennial, MEETH sponsored an international symposium that brought together more than 600 doctors from the U.S. and 26 other countries. They discussed the changes that had taken place, and were continuing to take place, in ophthalmology, otolaryngology and plastic surgery. This meeting provided a first-hand reinforcement for the attendees of MEETH's standards of excellence and the changes that the hospital inspired and encouraged.

Dr. Donald M. Shafer, President of the Board of Surgeon Directors, reviewed MEETH'S accomplishments. "Many of the new eye techniques and procedure in ultrasonics, cryosurgery and microsurgery introduced here have had wide acceptance and discussion throughout the medical world." Similar advances, he added, were being made on a regular basis for the relief of everything from inner ear disorders, Meniere's disease and cleft lip deformities.

During its 100 years of service to the community, the hospital has treated more than five million patients and trained thousands of surgeons who have carried the specialty techniques and procedures learned here to every part of the world. As it enters its second century, the hospital is proud of its rich accumulation of experience and its outstanding medical staff, renewed through five generations.

—DR. BLAIR O. ROGERS
MEETH plastic surgeon, writer and historian

The Centennial Year started with the cutting of a huge cake. Surgeon Director Dr. R. Townley Paton cut the cake in a ceremony attended by nurses dressed in uniforms from the time of Florence Nightingale.



The Centennial Year in Review

Dr. Byron Smith, chairman of the department of ophthalmology, underscored the fact that the previous year was the most active year in the hospital's 100-year history. Nearly 5,000 patients received surgical treatment during the year and a total of 55,645 patients visited MEETH clinics.

- Each week the Ophthalmic Plastic Clinic attracted an average of at least five fully trained ophthalmologists, who traveled to New York from various parts of the country and from abroad. They came to observe, learn and exchange medical knowledge. Many went on to establish similar clinics in other medical centers.
- The three-year-old Ultrasound Clinic continued to grow, thanks to a new technique that used a beam of sound in place of light to examine eyes for tumors, retinal detachments and other diseases in instances where optical instruments could not be used for direct observation.
- The Eye-Bank for Sight Restoration, the first organization ever established to supply tissue for reconstructive surgery and corneal transplantation, marked its 25th anniversary with strong growth, helped by the increasing awareness of transplant possibilities.
- Dr. Charles D. Kelman continued to make progress with his revolutionary ultrasound technique of cataract removal through a small incision. A special operating room was designated for the development of his technique, called phacoemulsification.
- The Eye Muscle Clinic, which dealt with eyes that cross or diverge, marked the completion of its first year in new quarters with a significant increase in patient volume. Dr. Richard H. Raskind, project director of the muscle clinic's ocular mobility unit, reported steady progress in the two-year-old electromyopathy clinic, which recorded the electrical activity of eye muscles.
- The Fluorescein Angiography Clinic, directed by Dr. R. David Sudarsky and Dr. Lawrence A. Yannuzzi, showed a dramatic increase in both patients and in the number of eye conditions studied by this novel method using an injected dye, fluorescein, to create detailed photographs of the retinal and choroidal circulation. A research team headed by Dr. Yannuzzi was also exploring the possibility of treating degenerative and vascular diseases of the fundus with light coagulation under the guidance of fluorescein.



Over 600 ophthalmologists attended MEETH's Centennial Symposium,

Dr. Yale L. Fisher conducts the second annual course in ophthalmic ultrasound at MEETH in 1976. Ophthalmologists from many parts of the country came to learn this advanced diagnostic technique.



1970s, 1980s, 1990s

Now in its second century, MEETH was firmly established in its three areas of expertise: ophthalmology, otolaryngology and plastic surgery. MEETH was on every top-five list for eye care and for residency programs. Its research departments were creating, testing and improving the latest advances in its specialties and subspecialties. Its clinics, 16 in ophthalmology, 10 in ENT, were providing patients with state-of-the-art treatment as they trained residents and fellows in the procedures. Ophthalmology clinics included Cataract, Contact Lens, Cornea, Electoretinography, External Diseases and Infections, Eye Muscle, Fluorescein Angiography, Glaucoma, Microsurgery, Myopia, Neuro-Ophthalmology, Oculoplastic, Photocoagulation/Laser, Retina, Ultrasound, Uveitis. Otolaryngology clinics included Allergy and Immunology, Dermatology, Endoscopy, Head and Neck, Hearing and Speech, Neurology and Neuro-psychiatry, Nose and Throat, Otology, Otoneurology and Pediatric Nose and Throat.

There was a blip in the otherwise stellar history of the Manhattan Eye, Ear and Throat Hospital which occurred in the winter of 1975. The New York State Health Department attempted to close a dozen or so New York City hospitals, citing an oversupply of hospital beds. Hospital staff and residents who were about to begin training opened the newspaper and found out that their careers were in jeopardy. However, the disappointment was short-lived because a court case convinced the city that MEETH should remain open.

Although MEETH was considered a center of excellence in almost all subspecialties, it lacked a university affiliation, and this made it harder to acquire research grants. In the late seventies, a complicated merger with Weill-Cornell hospital was negotiated. Although many doctors and administrators at both hospitals saw advantages in combining the two programs, and the deal came close

1975: A Snapshot of a Year at MEETH

Perhaps the best way to understand the depth and quality of MEETH in the last quarter of the twentieth century is to look at a single year:

RESEARCH

- Dr. Charles D. Kelman was exploring the feasibility of introducing an intraocular lens through a small incision. The procedure was designed to complement his phacoemulsification procedure for the removal of cataracts; today, that process is used in the majority of cataract operations.
- Dr. Richard C. Troutman led the search for new techniques to prevent and control astigmatism, either pre-existing or resulting from cataract surgery. Data was developed to better quantify the clinical use of the operating microscope keratometer, which was designed by Dr. Troutman, who also was involved in work on the development of new instrumentation for anterior segment surgery related to the cornea.
- Dr. Herbert M. Katzin investigated the use of videotapes as part of a surgical teaching program to improve the methods of instruction for resident training.
- Dr. Frederick H. Theodore studied diseases of the conjunctiva and cornea that cause filamentary keratitis.
- Dr. Abraham Schlossman, together with Dr. Brian J. Curtin, studied the problems of myopic patients who suffered various types of strabismus. Dr. Schlossman recently had completed a study on the treatment of amblyopia in patients with high myopia that affects only one eye.
- Dr. Suzanne Véronneau worked on a study to discover if the use of prisms has a beneficial effect in the treatment of primary exotropia.
- Dr. Lawrence A. Yannuzzi continued to study the long-term benefits of laser treatment on several diseases. Dr. Yannuzzi researched cystoid macular edema, one of the most significant complicating factors that can follow cataract surgery.
- Dr. R. David Sudarsky and members of the Laser II Clinic researched the ideal shape for silicone implants used in the treatment of retinal detachments.

EDUCATION

The residency training program was directed by Dr. Sigmund Schutz and Dr. Yale L. Fisher in 1975.

- The program accepted six residents each year from a field of 150 or more well-qualified applicants. It provided an outstanding clinical and surgical education in the various aspects of ophthalmology. Members of the volunteer attending staff participated in the teaching and guidance of the residents.
- New residents spent most of the first year working with patients in the Eye Diagnostic Clinic and assisting in surgery.
- In the second year, residents rotated through the subspecialty clinics, became involved in research projects and began to develop their surgical skills by performing extraocular muscle surgery. During their last year of training, they acquired the skill and facility to perform not only intraocular surgery, but nearly every type of ophthalmic operation.

Life at MEETH

Although training at MEETH was a rigorous and exhausting process, time was set aside for social activity. There were annual softball games, frequent dinners and parties. At some of these parties, senior staff members were lightly but hilariously roasted. Some of the residents could mimic their voices and mannerisms to great effect. Through it all, lifelong friendships were formed, alliances that made life at MEETH richer and continue until today.



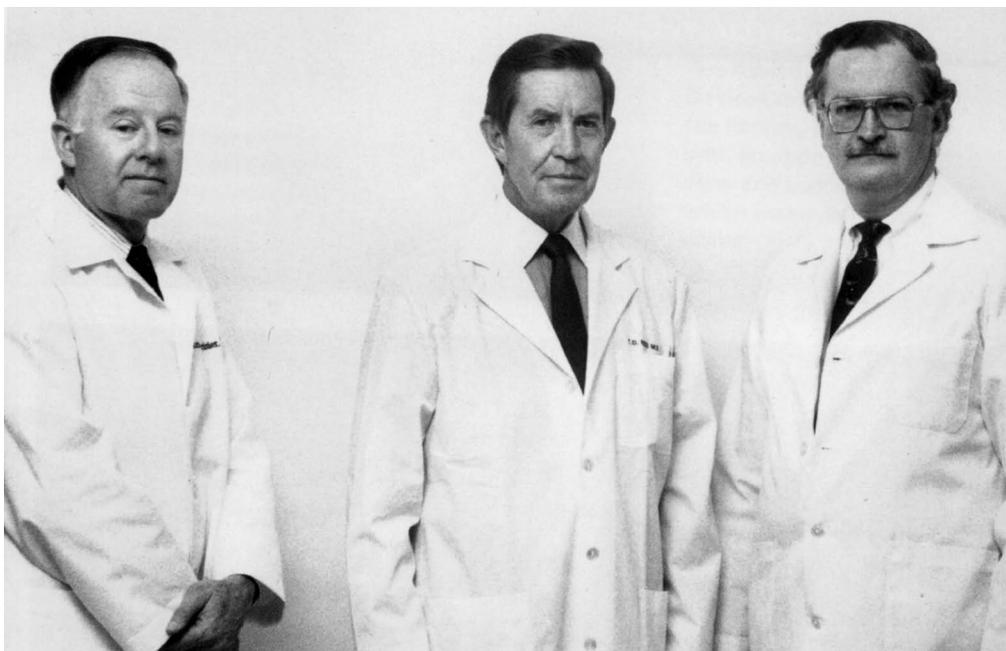
Dr. Vincent Giovinazzo, Dr. Kenneth Wald and Dr. Jack Dodick at the annual MEETH softball game.

to completion, it fell through at the last minute, mostly due to personality conflicts. MEETH would remain independent.

After, and partially a result of, the failed merger, leadership of MEETH consolidated under three strong leaders. Dr. Thomas Rees headed plastic surgery, where a group of talented and renowned surgeons made the hospital a mecca for the entertainment industry and the wealthy. In the otolaryngology department, Dr. Simon Parisier oversaw state-of-the-art clinics and perfected the cochlear implant program that was initiated in 1973. The ophthalmology department reached new heights under the leadership of Dr. Frederick Jakobiec.

Dr. Jakobiec arrived at MEETH in the early 1980s and, with his analytical mind and organizational skills, figured out exactly what was needed to round out the program and then effected the needed changes. He started a pediatric fellowship, appointing Dr. Norman Medow to head it. In addition, he expanded the series of lectures and symposia that brought together experts from across the country, deepening the educational experience of the MEETH residents and burnishing its reputation by attracting standing-room only audiences. The MEETH ophthalmology residency program, one of the crown jewels of the hospital became even more prestigious. Dr. Jakobiec created a 30-page curriculum which comprised a comprehensive educational plan that was unmatched in other residency programs. When Dr. Jakobiec left the hospital in the early 1990s, he turned the reins over to Dr. Jack Dodick, who retained the extraordinary level of organization and quality.

From left to right: Dr. Simon Parisier, Dr. Thomas Rees and Dr. Frederick Jakobiec were legendary leaders of the plastic surgery, otolaryngology, and ophthalmology departments, respectively, at MEETH in the 1980s.



The Meeth Residency Program

Education was part of the original mission of MEETH, discussed in the 1869 charter of the hospital. In later years, the strength of the program was derived from several sources. First, the large volume of inpatient surgery and outpatient visits ensured that each resident had vast and varied clinical experience. In addition, the hospital had a very large staff of practicing ophthalmologists, including subspecialists in most fields, all of whom were deeply committed to resident training. The members of the attending staff were not only willing but eager to share their knowledge and experience in the clinics, the operating room or the lecture hall. In addition, they volunteered their services and gave their time freely in all aspects of resident education.

The residency program was run by a director. Over the years, this post was held by prominent doctors including Drs. Richard Troutman, Sigmund Schutz, Frank Constantine and Lawrence Yannuzzi. In addition, a resident instructor provided personal instruction to each group. Drs. Richard Raskin, Yale Fisher, James Schutz, Lawrence Yannuzzi and Richard Gibraltar served as resident instructors.

One feature of the teaching program at MEETH were symposia that were scheduled throughout the year where experts presented their latest findings and instructed their audiences on new techniques and equipment. There were often up to a dozen seminars a month. Such meetings are standard at teaching hospitals, but the ones at MEETH were exceptional. They covered topics such as the use of ultrasound or krypton lasers and sometimes gathered the most prominent specialists from several institutions. They played to packed rooms, often in MEETH's main auditorium, Corwin Hall. Scientists came from all over the country and the world to participate. They often taped the proceedings to bring back to their own universities. Among the most eagerly anticipated lectures were the "Masters of Ophthalmic Plastic Surgery" courses held annually in the 1980s and 1990s.

The residency program was in full swing through the end of the 1990s. It was one of most sought-after "matches" in ophthalmology and MEETH was always able to attract its top choices who were among the brightest stars in the field of incoming residents. No one could have possibly imagined that this was about to end.



Attending surgeon Dr. Philip H. Zweifach, right, teaches a group of eye residents on the neuro-ophthalmology service.



MEETH's classes of residents became more diverse as years passed. ABOVE TOP: MEETH Ophthalmology residents, class of 1964. From left to right: Drs. Earl Braunlin, Richard Hulquist, Richard Ziter, Stuart Fay and Welbourne White.

ABOVE: MEETH Ophthalmology residents, class of 1997. Standing: Dr. Suresh Mandava, Dr. James Kelly, Dr. Daniel Litwicki. Seated: Dr. Tara Sweeney, Dr. Belinda Shirkey, Dr. Jack Dodick, department chairman, and Dr. Dawn Jackson.

Surviving the Closing

By Steven E. Fochios, President of the Board of Surgeon Directors
and Chief of Internal Medicine at MEETH

On a Saturday morning in April of 1999, I was casually reading *The New York Times* and, to my surprise, I came across an article that said the Board of Directors of Manhattan Eye, Ear and Throat Hospital was planning to sell MEETH's real estate to Memorial Sloan Kettering Cancer Center for \$41 million. What made this particularly stunning was the fact that, at the time, I was President of the MEETH Board of Surgeon Directors and had no prior knowledge of the decision. The chairmen of our prestigious residency and fellowship programs in ophthalmology, otolaryngology and plastic surgery had not been informed, nor had they any prior knowledge of the proposed sale. The national and international residents and fellows also did not know, despite the fact that all of them were planning to start work at MEETH in July of that year as they continued with absolutely essential training for their careers.

This was an outrageous situation that had to be addressed immediately. The physician executive committee did just that, demanding a meeting with the chairman of the Board of Directors and the executive director of the hospital. Much to our surprise, we were told that the financial standing of the institution had deteriorated to the point where continuing as a hospital would be impossible. We were also told that the transaction would go through as announced and that the decision was irreversible.

As members of the MEETH board, none of whom were doctors, saw it, in a changing health care environment with many hospital closures, MEETH's mission could best be preserved by using the money from the sale of the real estate to establish satellite clinics involving the three specialties in under-served areas of the city. All this was distressing because the physicians at

MEETH were at odds with the administration since there had been no strategic planning to market the institution's reputation and maintain or even grow the volume of surgical cases. We also discovered that the hospital's \$30- to \$40-million endowment no longer existed.

To fight back, the MEETH doctors, led by Jack Dodick, Sherrell Aston, Richard Lisman, Abe Schlossman, Larry Yannuzzi, Norman Medow, David Edelstein and myself, held a series of meetings with the chairman of the board. When it became clear that the board had no intention of changing its mind, we hired an attorney, George Bunn whose law firm represented the interests of MEETH as well as many members of the lay board.

After we brought Mr. Bunn up to speed, he held multiple meetings with the board but was unsuccessful in getting the members to listen to his arguments, or even consider changing their minds.

At that point, the entire Board of Surgeon Directors insisted on having a meeting with the entire lay board, at which the physicians eloquently spoke of the importance of maintaining MEETH's mission and its prestigious residency and fellowship programs. This too fell on deaf ears, and it was subsequently discovered that the minutes of this long and protected meeting were sanitized and did not accurately portray what happened.

The physicians' outrage grew and the law firm of Stillman and Friedman was hired to block the sale of MEETH. The physicians raised close to a million dollars to fund the legal action. In addition, we met with Eliot Spitzer, who was Attorney General of the State of New York at that time. Spitzer was sympathetic to our plight and directed us to his lead attorney in the Charities Bureau, William Josephson.

Josephson was moved by the dedication the physicians had towards MEETH and quickly came to understand the importance of preserving its mission. It was also clear to him that the lay board of MEETH had no interest in preserving the hospital's mission. The Charities Bureau, supported by our attorneys, launched a lawsuit against the lay board.

Bernard Fried, a distinguished judge who went on to serve on the New York County Supreme Court, presided over a two-week trial. After the trial was over, Justice Fried wrote a brilliant brief as to why the mission of MEETH needed to be preserved. The trial piqued the interest of many of the other hospitals in New York City, which led to a bidding war. Mt. Sinai, New York University, the Continuum system (which included New York Eye & Ear Infirmary) and Lenox Hill hospital all expressed interest in taking over MEETH.

For a variety of reasons, it became a choice of either Continuum or Lenox Hill. There were many advantages to joining with Continuum because of its relationship to New York Eye & Ear Infirmary. Many of the MEETH physicians were already on staff at NYEEI and since, after the public announcement that MEETH was going to close, a number of surgeons had moved to NYEEI to operate on their patients. However, the chairman of Continuum made it clear that MEETH would no longer be able to remain independent. Also, the Continuum system was hemorrhaging money and its survival was in peril.

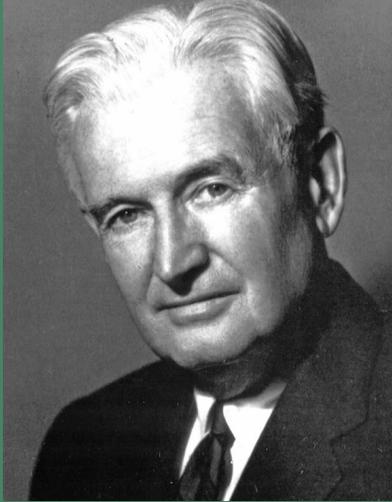
Lenox Hill insisted on MEETH's independence. It also was in a much healthier financial position. As a result, Lenox Hill was chosen to enter into a sponsorship agreement with MEETH. After the Charities Bureau and Justice Fried blessed the union, the old MEETH board resigned and Lenox Hill took over. However, within a very short time, and after a sizable departure of surgical cases, it became clear that Lenox Hill would be unable and/or unwilling to invest in MEETH. In retrospect, Lenox Hill was in trouble at the time but hid it well. Lenox Hill also saw MEETH



as a real estate asset and it eventually sold one of MEETH's buildings, the Annex, for \$33 million to offset its own financial losses.

The physicians at MEETH ultimately signed a vote of no confidence to a continued relationship with Lenox Hill and once again appealed to Eliot Spitzer. He was involved in a race for governor of New York, however, and could not help. Lenox Hill, with its own dire financial circumstances, finally admitted defeat and was acquired by the Northwell Health System.

MEETH is now a multispecialty ambulatory surgery center with no residencies, no clinics, no ER and no laboratories. Its three prestigious residency programs no longer exist, and the hospital is quite different from the former glory days. However, the attempt to tear it down was unsuccessful. MEETH still stands, functions and has a potential future thanks to the hard work of its physician members and the emergence of a full-time faculty of ophthalmologists involved in teaching and patient care. ♦



Dr. R. Townley Paton



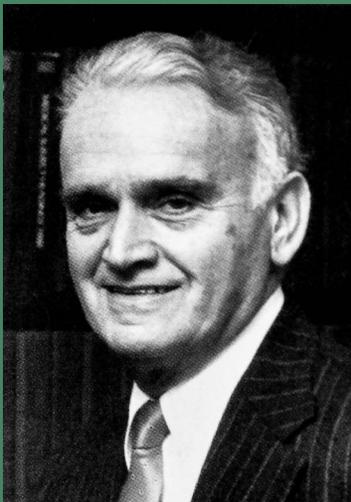
Dr. Brian J. Curtin



Dr. Byron C. Smith



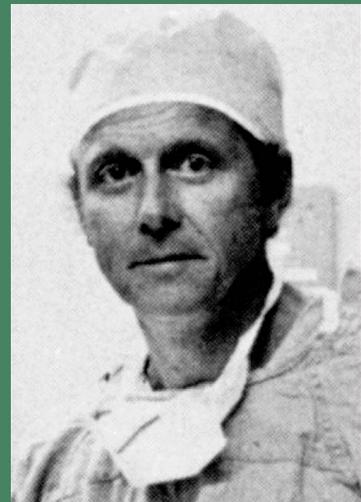
Dr. Charles D. Kelman



Dr. R. David Sudarsky



Dr. Abraham Schlossman



Dr. Richard C. Troutman

Dr. Byron C. Smith

*“I never do the same thing twice—
that way nobody steals my secrets.”*



*Everybody remembers Byron.
His word was God.*

—DR. RICHARD LISMAN

Born on a ranch in Tonganoxie, Kansas in 1908, Byron Capleese Smith’s education began at the nearby Smith School, named in honor of Fountain Smith, one of its founders and Byron’s paternal grandfather. During his childhood and youth, Byron became proficient in riding, animal husbandry, agriculture endeavors and other activities related to rural life.

After completing college and medical school at the University of Kansas in his early twenties, Byron interned in psychiatry for two years. At age 24, he was honored with an appointment to the Kansas-Missouri Neuropsychiatric Association by Dr. Karl Menninger. Although he eventually decided he was better suited to surgery, he always believed that the experiences he had during his psychiatric training played a significant role in his medical, surgical and personal development.

Dr. Smith, an ophthalmic plastic surgeon, traveled the world, led a full, active life and made huge contributions to medicine. Among other things, he published five major textbooks during the course of his life. He also served in the Army Medical Corps during World War II and, in the early 1980s, was awarded the Howe Gold Medal from the State University at Buffalo School of Medicine.

Forty years earlier, Dr. Smith and Dr. John Converse had founded an ophthalmological training program at New York University-Bellevue Medical Center, one of the world’s first.

It was followed in 1946 by a second training program at Manhattan Eye, Ear and Throat Hospital. Dr. Smith, who had joined MEETH that year, became Chairman of the Ophthalmology Department in 1963.

As part of his training, Byron participated in an orthopedic and general surgical residency at the Yale-New Haven Medical Center. During this time, he was temporarily assigned to the ophthalmological service under the direction of Dr. Eugene Blake, Dr. Francis Guida and Dr. Arthur Yudkin. Dr. Clement Clarke, a recent graduate from the service of Dr. John Wheeler, was another member of the team who helped convince him that ophthalmology would become his future career.

At the outset of World War II, Byron took matters a step further and decided to specialize in ophthalmic plastic surgery, a specialty area in its infancy and which he

helped to create, primarily as the result of his war experiences. Through the influence and interests of Dr. Wheeler, Byron had been appointed a resident at the New York Eye and Ear Infirmary. After completing his residency, he began a fellowship in ophthalmic plastic surgery under the tutelage of Wendell Hughes. His involvement in World War II confirmed Byron's belief that his training in ophthalmology and plastic surgery would be an asset to the U.S. Armed Forces.

He had the perfect background. Byron was of Anglo-Saxon descent. His predecessors engaged in military activity during the Revolutionary War, the War of 1812 and the Civil War. On his paternal side, he was related to General Robert E. Lee. This strong family history of service in the military stimulated Byron and his brother to actively engage in the Armed Forces during World War II. His interest and devotion to ophthalmic plastic surgery was nurtured during this time. He served as chairman of the department of ophthalmology, as well as plastic surgery, for the first general American army hospital during World War II.

During the height of the action in the war, Byron replaced the late Colonel Derrick Vail as senior consultant in ophthalmology for the U.S. military forces in Europe. Throughout his life he retained his interest in the Armed Forces, serving as a civilian consultant. He regularly asserted that he was physically fit and emotionally ready for any demands the government might make of him.

General Elliott Cutler, Professor of Surgery at Harvard, was elated when Byron located and removed an episcleral shell fragment from the eye of his son, Elliott, Jr., under biomicroscopic surgery during the Battle of the Bulge in 1944. Byron had discovered that biomicroscopic surgery of the anterior segment was invaluable in the removal of Plexiglas, which was a common problem resulting from shattered aircraft windshields. He, as well as a number of other surgeons at that time, realized that Plexiglas was well tolerated as both a corneal and an intraocular foreign body. Shortly after Dr. Harold Ridley designed and performed



A giant in his field, Dr. Byron Smith is considered to be the father of the specialty of ophthalmic plastic surgery.

Dr. Byron Smith, with his good friend and ardent supporter General George Patton.



Dr. Smith, consulting in the ophthalmic plastic surgery clinic.

the early intraocular lens implants, Byron followed by performing the first intraocular lens implant ever done at the Manhattan Eye, Ear and Throat Hospital.

One of the high points of Dr. Smith's military career was a surgical procedure he performed on General George Patton. General Patton became interested in the problems and achievements in ophthalmic plastic surgery at the First General Hospital in Europe, and after his operation he became an ardent supporter of Byron's practices.

Byron's close affiliation with the major surgeons of that era provided much impetus for his surgical innovations. His good friend Dr. Ramon Castroviejo

designed and perfected the mucotome in the early 1950s. This device made it possible for Dr. Smith to perfect total eyelid reconstruction by use of large midline glabellar or temporal transposition flaps, as well as socket reconstruction. The technique of suturing mucous membrane to a midline glabellar forehead flap and leaving it in its bed to take prior to first stage eyelid reconstruction three to four weeks later, are documented in Converse's multivolume text, *Plastic and Reconstructive Surgery*. All of the major sections pertaining to the eyelids and orbits were written by Dr. Smith. They were initially published in 1950.

Byron had met Dr. Converse in Paris during the winter of 1944. Both realized that their future contributions to the field would be enhanced if they combined

their surgical skills and experiences in a common effort. In 1946, bolstered by the encouragement of Dr. R. Townley Paton, they established the Society for Rehabilitation of the Facially Disfigured in New York. Dr. Paton, who had started the first corneal bank at the Manhattan Eye, Ear and Throat Hospital, encouraged Drs. Converse and Smith to establish the first Oculoplastic Clinic at MEETH. Dr. Converse had previously organized facial plastic surgery clinics at Bellevue Hospital and MEETH. The Clinic at the Manhattan Eye and Ear Hospital was believed to be the largest volume clinic of its kind in the country.

Byron held the position of Chairman of the Department of Ophthalmology at Manhattan Eye and Ear Hospital between 1950 and 1960, as well as the title of Surgeon Director beginning in 1948. He trained over 150 residents in ophthalmology at Manhattan Eye and Ear alone. Byron's fellows worked throughout the U.S. and in many foreign countries. Approximately 20 percent of his fellows did not become ophthalmologists, choosing instead to become board-certified plastic surgeons who extended their training into ophthalmic plastic surgery. In 1968, Byron expanded his ophthalmic plastic surgery fellowship to include the New York Eye and Ear Infirmary, as well as the Manhattan Eye and Ear Hospital. His fellows had the experience of learning from him at both institutions, as well as at the Institute for Plastic and Reconstructive Surgery at the New York University Medical Center.

In 1958, five of Byron's former fellows—Dr. Charles Beyer, Dr. Margaret O'Bear, Dr. Robert Wilkins, Dr. George Buerger and Dr. Thomas Cherubini—conceived the idea of forming and chartering the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). A similar European society followed the ASOPRS format. At the same time, John Converse went on to initiate and develop a major plastic surgical division at the New York University Medical Center.

Byron's published works are extensive, including articles, chapters in various books, major texts on ophthalmic plastic surgery and research projects. Two of his articles in psychiatric literature date from his training with Dr. Karl Menninger. He covered many topics, ranging from a paper on retinal detachments to one outlining treatment of hand injuries. Byron had operated in the burn center at the first general hospital in Europe during World War II, and one of his greatest



Dr. Smith's contributions to medicine included many new surgical techniques.

Byron was born in Kansas. Incredibly, he trained in psychiatry, surgery, orthopedics, ophthalmology and plastic surgery. Who trains in all those fields these days? The point is this medical giant was a renaissance physician, renowned in his field, not just because of the way he ran Manhattan Eye and Ear but because of the heritage he left behind.

—DR. RICHARD LISMAN

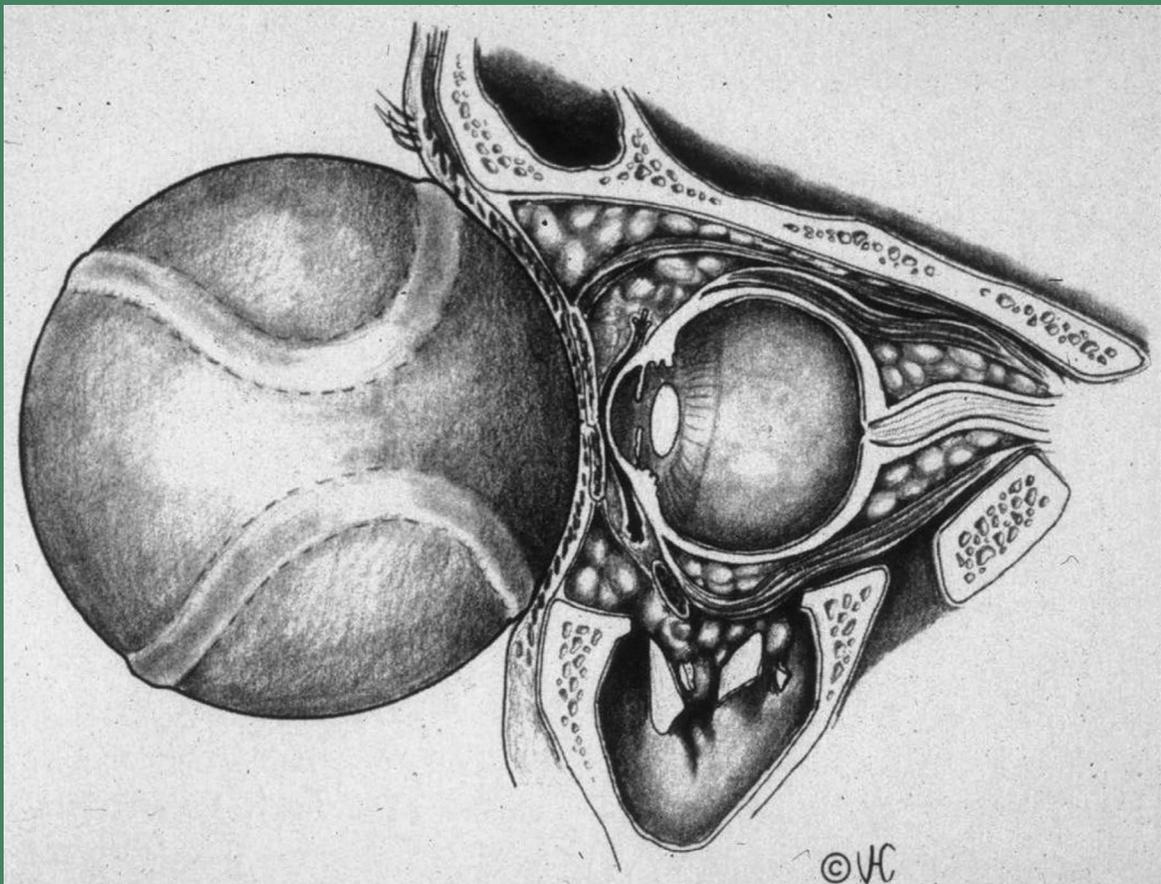
Dr. William F. Regan



Dr. William F. Regan

In December 1957, Dr. Smith and Dr. William F. Regan published “Blow-Out Fractures of the Orbit,” in *The American Journal of Ophthalmology*; this ground-breaking article described the mechanism of post-traumatic internal orbital fracture.

Dr. Regan, who trained in ophthalmology at Manhattan Eye, Ear and Throat Hospital, Stanford University and the Wilmer Institute at Johns Hopkins University, was an early specialist in retinal diseases and the use of ultrasonography for diagnosis. He was a founder of the retina service at MEETH.



Regan and Smith’s significant, innovative laboratory experiments and research were triggered by a patient who sustained a hurling ball injury to the orbit and typified the post-traumatic syndrome they described as a blow-out fracture.

accomplishments at that time was the management, treatment and rehabilitation of burned hands.

In addition to articles on ophthalmic plastic surgery, Byron's major contribution to this field included the recognition and treatment of fractures of the orbit. In 1957, Byron and his resident, Dr. William Regan, coined the term "blowout fracture." Their significant laboratory experiments and research were triggered by a patient who sustained a hurling ball injury to the orbit and typified the post-traumatic syndrome they originally described as a blow-out fracture. Although internal orbital fractures had previously been mentioned in the literature, its recognition and specific manifestations were not popularized prior to the publications of Smith and Regan in 1957 in the *American Journal of Ophthalmology*.

Another contribution to ophthalmic plastic surgery, the dermis-fat graft, had much to do with Byron's close friendship with Dr. Ignacio Barraquer of Barcelona. Byron was well aware that dermis-fat grafts were used by Dr. Converse and other plastic surgeons without much success. He knew that most soft-tissue deformities throughout the body did not have the vascular bed to supply a free composite fat graft without significant atrophy. He was also aware that Dr. Barraquer had performed fat grafts to the socket. Byron followed one of these patients who had undergone a fat graft to the socket at the Yale-New Haven Hospital. He believed that fat grafts have a significant place in the reconstruction of the soft tissue socket since the socket's vascular supply is unusually rich, unlike other soft-tissue deformities. The paper was published in 1976 with Dr. Richard Petrelli.

Along with his presidencies at numerous professional societies, Byron was endowed with professorships and faculty appointments at various academic institutions. Two that meant a great deal to him were his position on the Board of Surgeon Directors at the Manhattan Eye and Ear Hospital and his chairmanship of the MEETH Department of Ophthalmology. Other awards—including those bestowed on him by the American Academy of Ophthalmology, his memberships in the American Ophthalmological Society and the New York Ophthalmological Society, his academic appointments as professor at the New York Medical College, his past professorship at the New York University School of Medicine and his appointment as a lecturer at the Scheie Eye Institute—were also cherished by him. His Bronze Star from World War II and the Howe Gold Medal from the University of Buffalo significantly expanded his collection of professional awards and diplomas.

"Positive consistent thinking aiming toward a goal in life, honesty, diligence, generosity and persistent maturation towards maximum achievement at all times," is a quote that appears in Byron's biographical sketch in *Who's Who in America*. Another quote he would often share with his fellows: "I never do the same thing twice—that way nobody steals my secrets."

Dr. Smith died in December 1990. He was 82. ♦

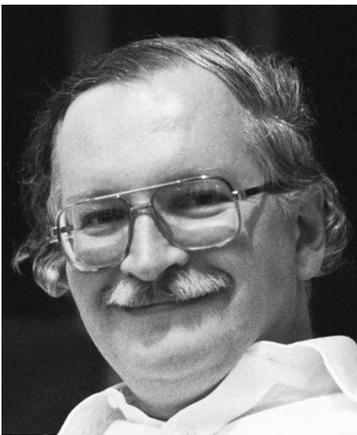


Dr. Smith was a world adventurer, avid fisherman, and member of The Explorers Club.

The majority of the material in this article originally appeared in a 1985 study on ophthalmic plastic and reconstructive surgery written by Dr. Richard Lisman.

Frederick A. Jakobiec, M.D., D.Sc.

My Recollections of an Eventful Decade (1979–1989) at Manhattan Eye, Ear and Throat Hospital (MEETH)



My reactions and responses to the experiences I had at MEETH were formed by my personal, religious, educational and institutional backgrounds. There is an informal and conversational tone to this brief memoir because it was derived from an edited, taped interview, which is reflected in its non-rigorous and somewhat meandering narrative flow. My recall and reconstruction of events after 30 years are, perforce, compressed and partial. My reminiscences, furthermore, do not completely convey the fine texture and granularity of situations, despite my best efforts to be fair and balanced.

I was born in Manchester, New Hampshire in 1942. My mother was of Irish descent and my father was of Polish descent. My mother's cousin, John W. King, was elected governor of the state of New Hampshire and subsequently became Chief Justice of the Supreme Court. He was the most prominent person in our extended family's history. The public high schools in Manchester were very good and produced many prominent people. Grace Metalious, who wrote the notorious and then-pornographic *Peyton Place*, was a Manchester grammar school teacher. I attended local Catholic schools. The all-Catholic high school faculty was comprised of highly educated men; one teacher had a PhD in history from the Sorbonne and he influenced me a great deal. I very much enjoyed my religious education, particularly ecclesiastical history and the study of ethics. The pastor of my local church was a highly cultured man who introduced me to many intellectual treats such as the fine arts and classical music. I graduated valedictorian of my high school class. In high school, however, I began to see contradictions in organized religion, eventually leading me to become a skeptic with a sense of private spirituality and deeply felt values stemming from my background and observation of life.

Accepted by Yale, Dartmouth and Harvard, I chose Harvard because it was closest to my home. My parents, neither of whom had gone to college, revered Harvard as the first among equals. At Harvard, I had the time of my life, especially since Manchester was not exactly a cultural oasis. Back then the city was populated by French Canadians, and was also heavily Irish, Greek and Italian. The church and parochial schools played a huge role. At Harvard, I learned that



Dr. Frederick Jakobiec in 2019.

I was far from the smartest in my class—a lesson in humility I attempted to compensate for with hard work.

In 1964, I graduated from Harvard College magna cum laude. Harvard led me to experience my moment of true adult liberation, further establishing my values, reinforcing my instinctual modesty and shyness and leaving me with a proportionate degree of pride and self-respect. My senior honor's thesis, which was awarded a summa cum laude grade, was written in the History Department, History of Science Division. The subject was the foundation of the French Royal Academy of Sciences (1668). One of my history professors used to say that history is an excuse to study everything. I regard the subject of history as an exploration of human psychology and behavior writ large. It has disciplined my mind and created the framework for much of my outlook on life and scholarly activities. I took the MCAT, a qualifying aptitude test for medical school, and got a very high score. I was admitted to Harvard Medical School for the years of 1964–1968. Harvard Medical School inculcated in me the desire to excel. I began to think of four areas of academic specialization—psychiatry, dermatology, ophthalmology and neurology. I decided that ophthalmology was the best fit for my interests and my personality. My brother had been blind from birth from retinopathy of prematurity, which subliminally influenced my attraction to ophthalmology.

In my era, medical school required one to decide on a specialty before even applying for an internship. I was offered eye residencies by Columbia, John Hopkins and Washington University in St. Louis, which were all very high quality programs. I wound up at Columbia/Harkness Eye Institute, which I enjoyed along with living in New York City. After my residency in ophthalmology, I decided I wanted to do a residency in pathology, so I matriculated into the pathology program at Columbia Presbyterian to become double boarded in both ophthalmology and pathology. I earned a D Med Sc degree while at Columbia; this degree required a thesis, which was written on the ultrastructure of orbital tumors, and was successfully defended before the Thesis Committee.

By 1978–1979, I had written and edited a book while I was still a resident, entitled *Diseases of the Orbit*, with one of the senior orbital surgeons at the Columbia/Harkness Eye Institute, Dr. Ira Jones, who opened his clinical files to me. He was listed the first author but it was a wonderful mind-expanding experience for me. The text was incorporated into a systematic series generated from the Wills Eye Hospital in Philadelphia called *Duane's Looseleaf Ophthalmology Textbook*. It included six volumes and I wrote or edited two sections: the Orbit, and the Anatomy, Embryology and Teratology volumes, each of which was excerpted as a hard cover book and sold separately. These books were published by Harper & Row. I subsequently became the director of the Algernon B. Reese Eye Pathology Lab at Columbia/Harkness Eye Institute after an eye pathology fellowship at the AFIP in Washington, DC.

At around the same time, Jack Coleman, a superstar in ultrasonography at Columbia, had been offered the chairmanship at Cornell-New York Hospital after turning down a similar position at the Wilmer Institute of Johns Hopkins Medical Center. He was then an associate professor at Columbia's College of Physicians and Surgeons and a member of the Columbia Eye staff. Even before Jack had contemplated the offer, an affiliation agreement had been negotiated between Cornell and Manhattan Eye and Ear. Jack was sorely tempted to go off to a new vista, a new horizon without having to leave the greater New York area and his collaborators, a position advocated strongly by his wife as well. At the time, I was being contacted by Tom Duane, the eye chief at Wills Eye Hospital who had invited me to be its eye pathologist. When Coleman got wind of this, he asked me to join him at Cornell and Manhattan Eye and Ear. I asked, what am I going to

do? I'm an eye pathologist. He said he would introduce me to people at Manhattan Eye and Ear, so I made the rounds, visiting several of the prominent and powerful eye doctors at the hospital. They interviewed me to decide whether I would size up or not, and, ultimately, they agreed that I could be their eye pathologist.

The three people who interviewed me were Arnold Turtz, Herb Katzin and Brian Curtin. Curtin was a cataract surgeon and a scholarly man who had written a definitive text on myopia. He was a solid and disciplined physician with a deep

Credentials

CURRENTLY

Director of the David G. Cogan Laboratory of Ophthalmic Pathology; Chief Emeritus of Ophthalmology, Massachusetts Eye and Ear Infirmary; Henry Willard Williams Professor Emeritus of Ophthalmology; Professor Emeritus of Pathology, and Chairman Emeritus, Department of Ophthalmology, Harvard Medical School.

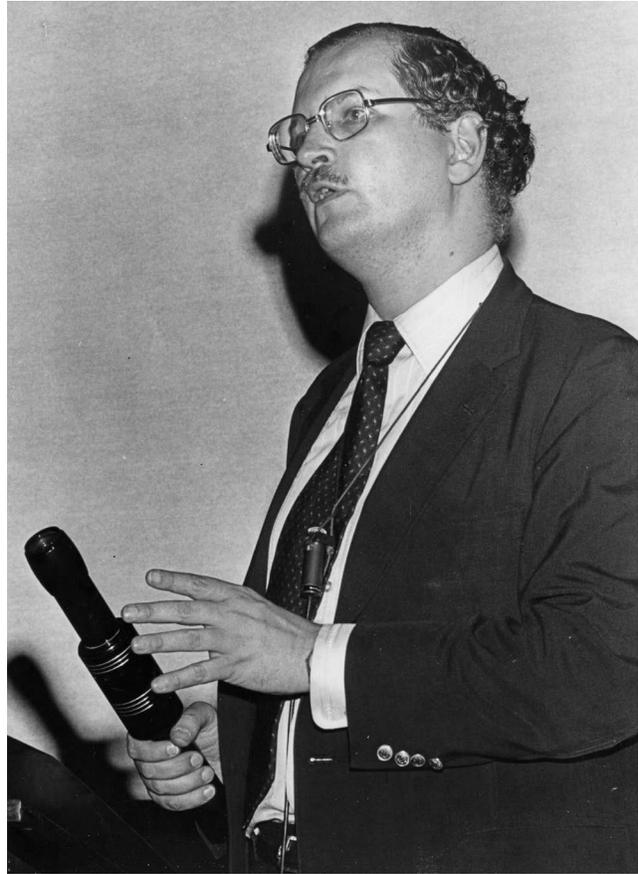
FORMERLY

Professor of Clinical Ophthalmology, Columbia University College of Physicians and Surgeons and Director of The Algernon B. Reese Eye Pathology Laboratory, Edward Harkness Eye Institute Columbia-Presbyterian Medical Center; Professor of Ophthalmology and Pathology and Vice Chairman of Ophthalmology, New York Hospital and Cornell University Medical School; Chairman of Ophthalmology and Chief of Pathology, Manhattan Eye, Ear and Throat Hospital.

devotion to Manhattan Eye and Ear. The three of them were la crème de la crème at the hospital. Katzin went to Harvard College and bragged that he was the most junior person ever to get a degree from Harvard University. I think he was 15 or 16. He was a little eccentric but brilliant. He and I formed a fast friendship. Arnold Turtz was a classy and serious man who was an accomplished cataract surgeon and totally devoted to MEETH. I liked all the MEETH leaders whom I met. I still wondered whether MEETH would be a good fit for me, a good job. There had to be something for my growth at Cornell as well as at Manhattan Eye and Ear. Coleman could provide research opportunities at the Cornell end. The Manhattan Eye and Ear could provide me with a large volume of pathology. I decided that the ingredients for my growth existed at MEETH and Cornell, and I accepted Coleman's offer to join him in achieving his academic aspirations.

Coleman established his base of operations at Cornell-New York Hospital. He inherited a staff there of people of substance but without the combined weight of the staff at Manhattan Eye and Ear. Everyone at both institutions was waiting for a chief. A recently negotiated affiliation agreement proposed that the chief at Cornell would also serve as the chief at Manhattan Eye and Ear. The earliest implementation and functioning of the affiliation began in July 1979. On a warm summer afternoon, the people at Manhattan Eye and Ear assembled in their stuffy auditorium with no air-conditioning to meet Dr. Coleman, who had just formally accepted the job at Cornell. They all knew about the affiliation agreement with MEETH and wanted to hear how it would develop and what it would mean for them at Manhattan Eye and Ear. Three of us—Bob Ellsworth (a retinoblastoma expert), Jack Coleman and I—crowded into a limousine to go downtown to MEETH, where we arrived late due to heavy traffic. The audience was uncomfortable and restless.

This was Coleman's debut. He came onto the stage, a man of modesty, grace and generosity, but uncharacteristically he adopted what was interpreted by the MEETH staff as a pompous and supercilious style, very unlike him from my experience. I interpreted his manner as a reflection of his passion and commitment to his new and unique undertaking. I had known Jack for over a decade and had never detected a trace of any negative personal attributes. Essentially, he delivered a message of what he was going to do for Manhattan Eye and Ear, and how he and his colleagues from Columbia were going to bring an elevated standing and academic respectability to Manhattan Eye and Ear through his affiliation with Cornell New York Hospital. Understandably, this did not go over very well. A



At a 1981 lecture, Dr. Jakobiec described new diagnostic methods and the use of cryotherapy in managing cancerous growth.

number of senior people at Manhattan Eye and Ear stood up at the end of his talk and said, “Dr. Coleman, before we ever heard of you, we had our own reputations. We don’t need you to burnish our reputations.” Other prominent people stood up and called him out on this. This was a most unfortunate introduction for Coleman and the MEETH-Cornell project.

Donald Shafer was the man who had driven the affiliation from the Cornell end. He practiced retinal surgery at both Cornell and Manhattan Eye Ear, and was the acting chair at Cornell. He was well-liked by all sides, certainly not a venal politician in terms of his own self-interest or pushing one component of ophthalmologists over another. He was a well-intentioned man. He had helped draft the affiliation document, which was needed to enhance MEETH as conceded by all sides. Although Manhattan Eye and Ear had grown without an academic umbrella, its prospects were uncertain at the time and would be firmed up by a good and workable academic relationship with an infusion of resources for research. I know the Cornell dean liked the idea of the affiliation. Schaffer liked the idea and I think the doctors were amenable at Manhattan Eye and Ear. Coleman’s inaugural speech stated that he and his recruits were coming to work with MEETH to enhance its reputation. This created an aura that clouded the beginning of the affiliation.

I was given a position at Manhattan Eye and Ear as Director of Eye and ENT Pathology and served as Vice Chairman for the combined MEETH-Cornell department, but I was obviously Coleman’s man. He brought me down from Columbia, introduced me to everyone, so I was considered, if you’ll pardon the fancy expression, a xenograft. In case you don’t know what a xenograft is, it’s the imposition of a body part of one species onto that of another species. Thus, I was regarded a little suspiciously as a partisan and Coleman’s man. I was essentially an alien graft onto MEETH, so the doctors were somewhat leery of me,

My own personal teaching was an important feature of the life of the department. I was a very good teacher and invested heavily in it.

—DR. FREDERICK JAKOBIEC

understandably, but they were not unkind. Still, they wondered how much they could trust Jakobiec—is he going to tell Coleman everything we think and do at MEETH? In fact, my primary loyalty was to Coleman’s vision and plans, which I thought would be good for both institutions.

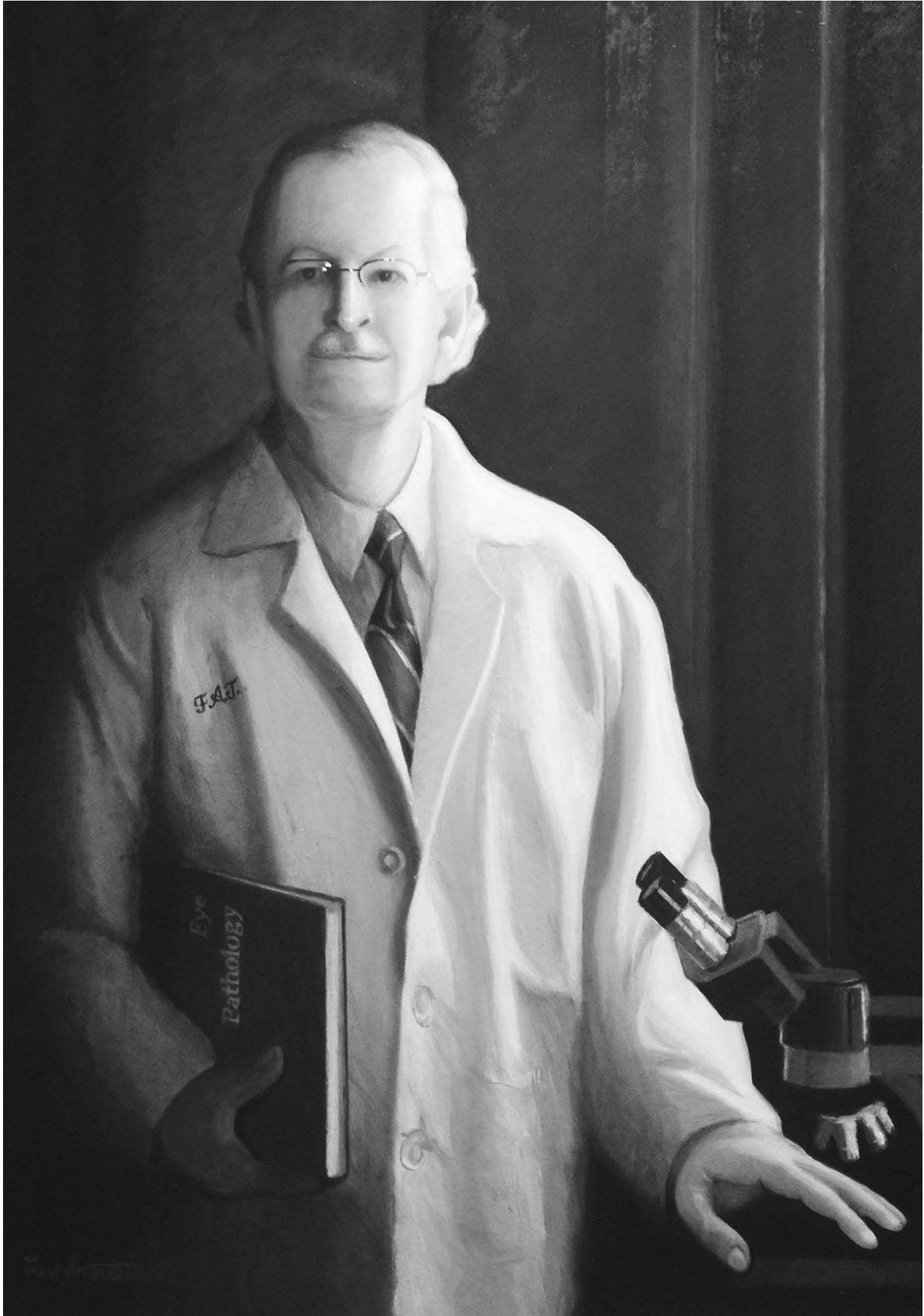
I spent most of my time during these early days of the affiliation at Manhattan Eye and Ear because that is where the pathology was. I had developed a clinical oncologic practice at Cornell, where I saw tumor patients. Coleman was totally supportive. I had an office for pathology and administration at Manhattan Eye and Ear, but I was not in charge of the residency. I was a pathologist and teacher. I devised some special teaching events that were popular, and I got along well with the doctors and residents. I tried to give them the best service I could. I was not only an eye pathologist, but because I’m a board-certified general pathologist, I also did ENT pathology, so I served both departments as well as plastic surgery. The pathology and patient referral volume at MEETH fed me many fascinating cases. I’d go over to Cornell about once a week to look at eyeballs microscopically that had been enucleated or orbital tumors that had been removed



from the socket, but the volume wasn't great. There may have been 10 surgically active doctors at Cornell vs. 150 at Manhattan Eye and Ear. The difference and the disproportion were enormous.

During my time at Manhattan Eye and Ear, I saw that the affiliation process was not working well and that Coleman was getting more and more frustrated. For him, obtaining the chairmanship at Manhattan Eye and Ear was non-negotiable. He had to have it as a good faith part of the deal or it wasn't the deal he had agreed to. He needed the position to coordinate the best features of the two institutions. Those at Manhattan Eye and Ear said to themselves, what's he going to do with the MEETH chairmanship? I tried to be honorable toward Coleman and to serve him well, but I had to serve the doctors at Manhattan Eye and Ear fairly as well. On a limited, non-political basis, I was their pathologist and teacher of the residents. With heightening anxiety, I saw the academic political thunderclouds gathering on the horizon and threatening the greatest experiment in twentieth-century New York institutional ophthalmology which began to flounder. I tried to warn Coleman. Although I was not calling the shots, I cautioned Jack that gradualism rather than the quick imposition of a new structure was preferable. I continued to support Jack's academic vision and our shared ideal that we would create a great clinical and research center composed of the two institutions. I refused to offer Jack any Polonius-like false political wisdom or misguided advice. I feared he was receiving nefarious advice from others. I told him only my unvarnished, situational observations and characterized the *dramatis personae*. My fundamental belief was that a subtle blending of the values and resources of two disparate institutional cultures over time would yield a unique

Dr. Frederick Jakobiec, Director of Laboratories and Dr. Winston Harrison, Associate Pathologist, examine a tissue section with visiting physician Linda Mottow. This microscope is invaluable in teaching and research since doctors can view the same slide simultaneously.



evolutionary creation for American ophthalmology that would be highly effective in the long run. This would lead to achieving Coleman's goals, which would become the envy of competing institutions and eye departments. In 1981 or 1982, Jack Coleman was getting ready to sue for a divorce that would rupture the affiliation. I understood his frustrations and sense of betrayal. Jack seemed indifferent to the inevitable need for gradualism in effecting a workable marriage between two institutions. This would require a generational span to build and fully achieve.

The powers at MEETH were intransigent before the affiliation rupture occurred. In retrospect, it seems to me that a trial period of Coleman's chairmanship at MEETH would have been advisable. If this were successful, Jack would continue as chairman; if it led to untoward consequences for MEETH, the position could be withdrawn. Neither side advanced such a proposal, and this, I believe, was a fatal decision with profound and seismic implications, to put it mildly. The failure to consummate a durable affiliation can be blamed on both sides. Despite this setback, I continue to have a deep admiration for Jack Coleman and his vision. I also had respect for the risk-averse medical leadership at MEETH. For me, Jack Coleman remains an exemplary person with an abiding interest in, and support of his faculty. I am eternally indebted to him for his kindness and his positive impact on my professional development.

I didn't know at the time how the contemporary explosive situation was going to reach its ultimate denouement, so I developed some backup plans of my own. I feared that an affiliation dissolution may be impending. Coleman triggered the end of the affiliation in 1982. I was at that moment an attractive, young and promising academic figure who had been publishing a great deal. I was already a professor at Cornell and many chairmanships had openings across the country. The University of Chicago took interest in me, which became known to the Manhattan Eye and Ear people. They'd gotten familiar with me and they didn't want to lose me. What would it take to keep me? Well, since I was looking at chairmanships, the MEETH people thought that maybe they should make me chairman there. If I went to another city, I would have to build a following, but here in New York people know me. I would also have to forego my research collaborations. I also thought that since they are willing to offer me the chairmanship at MEETH, they must trust me at least to some degree, so I took the job in New York. I was very sensitive to the needs of doctors in private practice at Manhattan Eye and Ear. I thought that dimension should exist and be preserved in juxtaposition to the full-time group practice at Cornell, who were under the control of the chairman at Cornell. The MEETH faculty could supplement the faculty at Cornell with its research interest and resident rotations between the two institutions.

An academic environment is the type where a monarch, as it were, sits on the top of a hierarchy, but he or she may be changed every ten or so years. Then the chief steps down. It's a very powerful position and individual faculty members give up their independence, which is a difficult challenge and decision for a life-long private practitioner. Academic chiefs control promotions, salaries, office

... (M)y decade at MEETH was one of the most rewarding of my life. I learned the elusive lessons of leadership and found that my greatest personal rewards were in having a positive impact on the lives of others through responsible and generous decisions and disciplined actions.

—DR. FREDERICK JAKOBIEC

OPPOSITE: Formal portrait of Dr. Frederick Jakobiec, Chief Emeritus of Ophthalmology, Massachusetts Eye and Ear Infirmary; Henry Willard Williams Professor Emeritus of Ophthalmology; Professor Emeritus of Pathology, and Chairman Emeritus, Department of Ophthalmology, Harvard Medical School.

space, support staff, OR access and time allocations, research space, etc. The people at Manhattan Eye and Ear had spent their lives building up their private practices. They weren't about to give up a lifetime of toil to somebody else with a foreign philosophy whom they didn't know or trust. I understood that because I had been in a Park Avenue private practice while at Columbia, for several years, so I indicated I had no desire to impose a group practice on them. For me to become chairman, I needed a new structure. I needed to put a local person in charge of the clinical activities at MEETH, somebody they trusted. Consequently, I appointed Jack Dodick, an innovative and expert cataract surgeon, as ophthalmologist-in-chief and gave him considerable authority in the clinical realm. Actually, Jack had to step down to vacate the chairmanship for me—a most unusual, generous and enlightened move on his part, done for the anticipated good of the hospital. The doctors trusted Jack. He was one of them. He had risen through the ranks and had completed his residency at MEETH. He knew all the powers that be and the staff ophthalmologists, and he was a wonderful and flexible person to work with. That settled my problems with the staff, if I was ever going to have any. Essentially, I said, “Jack, do whatever you think is advisable for the staff because they know you and you can act as an intermediary between me and them for the good of all.”

Manhattan Eye and Ear had about 150 active doctors. They went to the hospital to perform their surgeries and to attend the hospital's clinics a half day a week to teach residents and responsibly supervise resident surgical cases. In addition to the general clinics, there were around six or seven subspecialty clinics and senior MEETH staff in charge of them. The clinic chiefs were all very experienced, accomplished and prominent individuals. You just don't push people like that aside, so I kept all them in place and in charge. As openings occurred, I'd consult with Jack Dodick and key members of the staff before appointing someone we thought was the best person to assume the position.

Norman Medow, who became a very dear friend of mine, was an exemplar of this approach. He was a highly active participant in the life of the staff. The old nurses' residence that was attached to the main Manhattan Eye and Ear hospital building was being partially renovated for new clinical facilities and activities. Therefore, we had an opportunity to develop a new pediatric ophthalmology center. With Jack Dodick's and the staff's approval, I appointed Norman to be chief of the new Pediatric Eye Service due to his organizational skills, devotion to the hospital and skills as a pediatric cataract surgeon. Norman has become an internationally recognized pediatric ophthalmologist over the years. He's a buoyant, ebullient man, who is optimistic and happy. He loves ophthalmology and notably the history of ophthalmology almost as much as cataract surgery. His devotion to Manhattan Eye and Ear was total.

One of the things I really enjoyed about Manhattan Eye and Ear was that I liked everybody I met. Incidentally, MEETH was a very Jewish hospital and throughout my adult and professional life my closest associates and friends have been predominantly Jewish. I find that many Jews are very intellectual, supporters of culture and philanthropy, and doctors at the top of their fields. Manhattan Eye and Ear had a super-abundance of these accomplished people, including some fascinating emigres from Europe who fled the Nazi era.

A varied gamut of people came to the Manhattan Eye and Ear because it was a welcoming environment for Jews. People like Arthur Linksz and Adolf Posner exemplified such European personalities. Abe Schlossman was born in this country. In 1948 he and Posner were responsible for identifying a rare, recurrent and typically unilateral inflammatory ocular hypertensive disease that has been called the Posner-Schlossman syndrome. These were names I had learned while in residency. Linksz was an optical man, very famous in his field, gave courses at Dartmouth in the summer. An American born super-specialist in external ocular disease was Fred Theodore, after whom superior limbic kerato-conjunctivitis was named. All of these physicians were excellent practitioners and fun people.

I was one of a handful of people at Manhattan Eye and Ear who thought deeply about it as a collective entity. I've had varied experiences—private practice at Columbia and academic full-time practice at Cornell. I am an academic person by nature and instinct. I have an admiration for learning, scholarship and subject mastery, which I have tried to pursue myself. When I became chairman at MEETH, my goal was to strengthen the institutional structures undergirding progressive academic growth for the benefit of trainees and staff, particularly through courses that they would organize and teach by themselves to benefit other regional professionals. We developed a curriculum with a brochure of over 30 pages that advertised the courses to be given throughout the year. This electrified American ophthalmologists to whom it was mailed. No one had ever seen such a comprehensive educational plan. In fact, the chairman of ophthalmology at John Hopkins was interviewing one of our residents while glancing through our brochure. The resident said he was “salivating.” He wanted to do the same thing at Johns Hopkins. People from all over New York City would come to our lectures. We would charge a minor tuition fee and give them an early evening meal and syllabus. There were 22 residency programs in New York and its boroughs and hundreds of residents would show up. This was the first time an encompassing New York City-wide educational program had been instituted for the scattered ophthalmology residency programs.

Many people would attend grand rounds or one or more of the courses. Private doctors would attend to update themselves in neuro-ophthalmology and eye pathology together with more surgically oriented courses. The cycle of programs expanded even further after I left New York. The template, however, had been laid down. All kinds of people began to have the experience of being part of something bigger than they were used to. Young people and senior people were both involved in these courses, an amalgamation of the generations.

My own personal teaching was an important feature of the life of the department. I was a very good teacher and invested heavily in it. At my conferences I would have unknowns presented to me and I'd analyze them with no foreknowledge

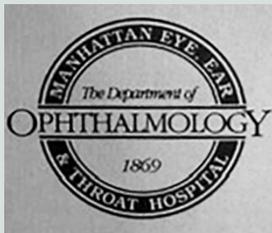


Dr. Jakobiec described himself as a symphony conductor who identified talent and brought out the best in everyone.

of what the diagnosis was. This exercise was considered a tour de force. It was a give-and-take session with the attendees. All these educational programs brought different institutions together in ophthalmology. New York was at that time stratified—uptown, midtown, downtown and the boroughs. No one had ever thought of creating an educational core of academic opportunities that would radiate outwards towards other departments. I tried to do that with Manhattan Eye and Ear serving as the hub.

We had 17 operating rooms at MEETH, and they were incredibly efficient. The anesthesiologists were really on the ball. They didn't stall between cases because they functioned on a fee for service basis and the anesthesiologists realized they could generate a decent income for themselves by running very efficient ORs. Some academic centers have an hour's delay between cases. That's intolerable. At MEETH the flow of cases was lickety-split, and you're off to the next case with as little delay as possible. The physicians, residents and administrators were all very happy with this arrangement. The surgical attendings were also all on the ball. They came in on time because they valued the anesthesia services they were getting and the time allotments they received. The operating rooms ran smoothly. I never had to intervene. Most of the doctors were very competent or outstanding and Dodick oversaw quality control. We had a tissue review committee chaired by Dr. Paul Orloff to make sure surgeries being performed were appropriate. Occasionally, we would have to ask a surgeon to explain why he did

The International Fellows Program



Dr. Jakobiec founded the International Fellowship Program in 1993; it continued until 2005. Dr. Rene Rodriguez-Sains, a MEETH resident and Dr. Jakobiec's

fellow was appointed director. The program was a period of specialized instruction in a wide range of subspecialties, including cataracts and phacoemulsification, glaucoma, vitreo-retinal diseases, pediatric ophthalmology, strabismus, and ocular plastics.

Each fellow was assigned a preceptor who coordinated daily lectures, seminars with residents, fellows and staff, complemented by observation in operating rooms and clinics. In all, 15 fellows graduated from the International Fellows Program.



Dr. Jakobiec with Dr. Rene Rodriguez-Sains.

something unusual and the inquiry was generally enough to make him/her trim sails a bit. I also had a surgical practice of my own while I functioned as the chief eye academic officer. Between my academic salaries as chairman of ophthalmology, my pathology salary, and my practice income, the institution rewarded me generously for my services—a genuine two-way street.

Other MEETH ocular luminaries were included. Richard Troutman, one of our top surgeons, was a gifted man. He had written books on the design of surgical instruments and their adaptation for microsurgery. He was one of the first ophthalmologists to use the operating microscope for cataract surgery. He was the eye chief at Downstate but an absentee chief. He did most of his clinical work at Manhattan Eye and Ear, where he was the chief for a while. His wife, Suzanne Véronneau-Troutman, had a practice in pediatric ophthalmology. She was an accomplished lady. She did very important work with prisms applied to spectacles to help people with persistently misaligned eyes after strabismus surgery. She was a very credible, elegant and a highly regarded person in her area of expertise. Charlie Kelman was the epitome of a New Yorker. He did cataract surgery, research and invented a revolutionary ultrasound technique that scared the reactionary old-timers. They couldn't imagine his new technique becoming ascendant because it would make them obsolete, leading to a decline in their gigantic practices. They tried to demolish Kelman, but he survived. He was a tough and resourceful guy but a very nice man. I enjoyed having lunch with him once a month. He just wanted to do his thing. Today, most cataracts are removed using his technique, phacoemulsification.

David Sudarsky was one of the smartest people I've ever met; I admired him and we became close friends. He was always a strong supporter of me. After graduating from Yale, he trained at Harvard and Massachusetts Eye and Ear Infirmary for his residency and did his fellowship in Boston and the Infirmary with Charles Schepens, an internationally famous retinal surgeon who midwifed modern retinal detachment surgery. After studying with Schepens, David went to New York and brought the new surgical techniques he had learned in Boston to MEETH. He had a head start that gave him a commanding presence and a large practice for 15 years in New York, since locally nobody else had ever trained like him. David also invented a battery-powered cryoprobe, which can be used in third world countries that don't have electricity. You just place it on the cataract, which adheres to the probe, allowing a gentle removal of the cataract. It has been widely used in Europe, Canada, Australia and third world countries.

The organization of Manhattan Eye and Ear had a surmounting governing Board of Directors who represented the ultimate authority. A new hospital administrator had been appointed who was the board's intermediary ("eyes and ears"). Senior clinicians constituted the Board of Surgeon Directors. My administrative departmental "kitchen cabinet" at MEETH was made up of creative and generous younger people, whom I liked and respected; Sudarsky was the most senior among them and Dodick was another experienced staff member in our circle. The younger staff upon whom I relied included Richard Lisman, Norman Medow, James Schutz, Richard Gibraltar, Paul Orloff and Rene Rodriguez-Sains. These were spirited people of mixed talents and temperaments. They were not stuck on

themselves, but instead had open minds, progressive attitudes, were willing to grow, had a good sense of humor and healthy understanding of new directions that might be advantageous for the Manhattan Eye and Ear.

But then, in 1982–1983, we confronted a terrible problem—a human impediment and scourge of MEETH’s continuing collective academic and professional advancement. A recently-appointed administrator had an entirely different approach. I believe he was intelligent but also a calculating, manipulative and secretive man. His main objective was power and control of the lay board’s thinking and their overarching attitude toward the doctors. Throughout his tenure at Manhattan Eye and Ear, he showed an adversarial attitude toward the doctors. He gratuitously and negatively intruded on medical staff and residency matters, for which he had no apparent competency. Due to decisions taken by the lay board that he constantly and maliciously misinformed, gradually MEETH was driven into the ground, culminating in the legal contretemps described elsewhere in this volume.

Equally valuable were the close friendships I made with selected staff at MEETH which fortunately remain intact and vibrant to this day.

—DR. FREDERICK JAKOBIEC

Such aggressive interventions are a modern, venomous administrative phenomenon that has taken full bloom across the country. Hospitals are now run by administrators, not by doctors, which is a shame. A guiding insight of my career has been that a hospital’s reputation is based on the excellence of its medical staff and leadership and its surpassing excellence of patient care. If you put an administrator in charge who is power-hungry, who isn’t enlightened or particularly humanitarian and isn’t educated in the medical sciences, you’re going to find yourself in terrible trouble eventually. He’ll capture the board of directors because he has the most access to them. The physicians at MEETH mounted a counter-campaign and went to the Board. They indicated that the administrator was standing in the way of progress, but the Board wouldn’t hear it. After many entreaties, the Board of Directors finally took a vote of no-confidence in the administrator, but the chairman of the Board backed him and the other Board members withdrew their motion.

The administrator stayed on. I left in 1989 to go to Boston as chairman at Harvard and chief at The Massachusetts Eye and Ear Infirmary. The administrator and his authoritarian style had three or four more years to play out. He got bolder and bolder and MEETH faltered. My position wherever I’ve been is that I want influence, a major role but not raw power, or total authoritarian control. I never dealt in threats or political revenge. I believe that over time the sway of persuasion engaged with logical receptive minds will win out. This is a form of meliorism. You don’t have to clobber people with vulgar threats to make advancements happen. The administrator dealt in a kind of unconstrained power and other bullying and manipulative techniques. The impression he wanted to give to others was that he alone had the wisdom to know what to do.

You have to understand what a pleasant place Manhattan Eye and Ear had been before the administrative “troubles” erupted. It was a wonderful environment for the doctors. When I was chairman, I didn’t change things as much as add new things. The administrator, however, was persuaded that I was a troublemaker, so I saw an unpleasant and possibly catastrophic future unfolding for

myself and the institution. Both Columbia and Harvard had offered me chairman positions. They were very prestigious chairmanships, two of the most desirable in the country. Many individuals were in competition for them. After being offered the two jobs, I elected to go to Boston to be closer to my family. I was sad when I departed MEETH because I was leaving a comfortable and supportive professional constituency and a hospital milieu that I loved.

A few final reminiscences will round out my insider/outsider perspective on Manhattan Eye and Ear. Let me relate an interesting story. There were two ophthalmological societies comprised of the upper echelons of ophthalmologists in New York. One was the New York Ophthalmological Society. It is the oldest continually operating society of ophthalmology of any kind in America. It was established back in the late 1700s. Historically, it was very Anglo-Saxon and Christian. If you were Jewish, you could not get into that society or you had to change your name and camouflage your Jewish identity. So Jewish people set up a comparable society, the Manhattan Ophthalmological Society. You got admitted into one or the other of these societies by invitation. There may be 2000–3000 ophthalmologists in greater New York, but only 30 colleagues belonged to each society.

While I am of Irish and Polish descent and a Catholic by upbringing, I nonetheless relished being invited to become a member of Manhattan Ophthalmological by the people I got to know at Manhattan Eye and Ear. The Manhattan Ophthalmological would meet at the Plaza Hotel four times a year in a marvelous dining room overlooking Central Park. We'd have a scientific presentation, a social hour with a few cocktails, and a memorable meal. I cherished these get-togethers. Then, I got a call from somebody at Columbia: He said "Fred, we've decided it's time to invite you to join the New York Ophthalmological Society." I said, "thank you so much." "But Fred," the conversation went on, "you will have to resign from the



LEFT TO RIGHT: Dr. Rene Rodriguez-Sans; Dr. Frederick Jakobiec; Dr. Jack Dodick; and Dr. Norman Medow at a Thanksgiving celebration in 2017.

Manhattan Ophthalmological Society.” I told them I could not do that. “These are my friends; they invited me into their society. I’d be happy to join both but I’m not going to give up one society to join the other.” Six months later, I received a call back. “Okay,” the speaker said, “we’ll allow you to be a member of both societies.” I was the first person ever to belong to both, but this is nonsense. I have always felt that the two societies should meld. I’m proud of the position I took in this matter. For me science and medicine are non-ideological and non-political and should not be tainted by religious or any other extraneous considerations. Commitment and service to humanity, coupled with compassion, honesty and tolerance are among the highest and most enabling attributes of our species and of well-rounded medical professional life. They should be the prime goals of a truly liberal education and profession. Breaking out of conventional straightjackets and not surrendering to unreflective orthodoxies are gifts of the liberal imagination.

To return to the people of MEETH, David Sudarsky was synonymous with Manhattan Eye and Ear. He became an arch-promoter of young, talented people there. Renée Richards and I were never close friends, but I always had the sense that if I needed her support she would be there. Her presence at the hospital was emblematic of its open-mindedness. Renée was in the private practice of pediatric ophthalmology, but the dichotomy between academics and private practice can be misleading and artificial. Academics simply means that you practice in a large medical center where there are resources for you if you want to do research. You pay a price in independence because you serve under a chief, as I’ve already explained. I have always believed that a hybrid arrangement is probably the best solution for maximizing ophthalmic academic and clinical productivity. Renée exemplified such a synthesis.

Abe Schlossman also needs a deepened portrait. He was a colorful man at Manhattan Eye and Ear, yet surprisingly very sophisticated, politically aware and nuanced. He was a man of academic accomplishments and always in pursuit of solutions for ophthalmic challenges. He didn’t publish a great deal, but most of his papers were significant and useful. He was a great teacher, but you’d have to listen closely for the message because of the noise that surrounded Abe’s monologues and riffs. He was all over the place. The positive way he treated people was the main ingredient that made him stand out. He wanted to be friends with everybody. He was a kibitzer and a kvetcher—indeed he kvetched all the time. He had lots of *shpilkes* (ants in the pants) mixed with *sechel* (street smarts).

The final people I would like to celebrate at MEETH include Sigmund and his son James Schutz. The former was the father of my dear friend and supporter, Jimmy. “Siggie” the elder was the epitome of Manhattan Eye and Ear—always available for a consult, day or night, willing to bail out a colleague, generous to a flaw in teaching residents, and an overall master of ophthalmic surgery. He was a sweet and decent man. His friendliness was real and immediate. He was never remote or superior in action or attitude. His son, Jimmy, embodied his father’s finest virtues—honesty, directness, generosity, and reliable friendship. Jim had received a pedigree education—Yale College, Harvard Medical School, Massachusetts General Hospital surgical internship and Manhattan Eye and Ear ophthalmology training. I nominated him to be director of the residency program when I became

Dr. Sigmund Schutz

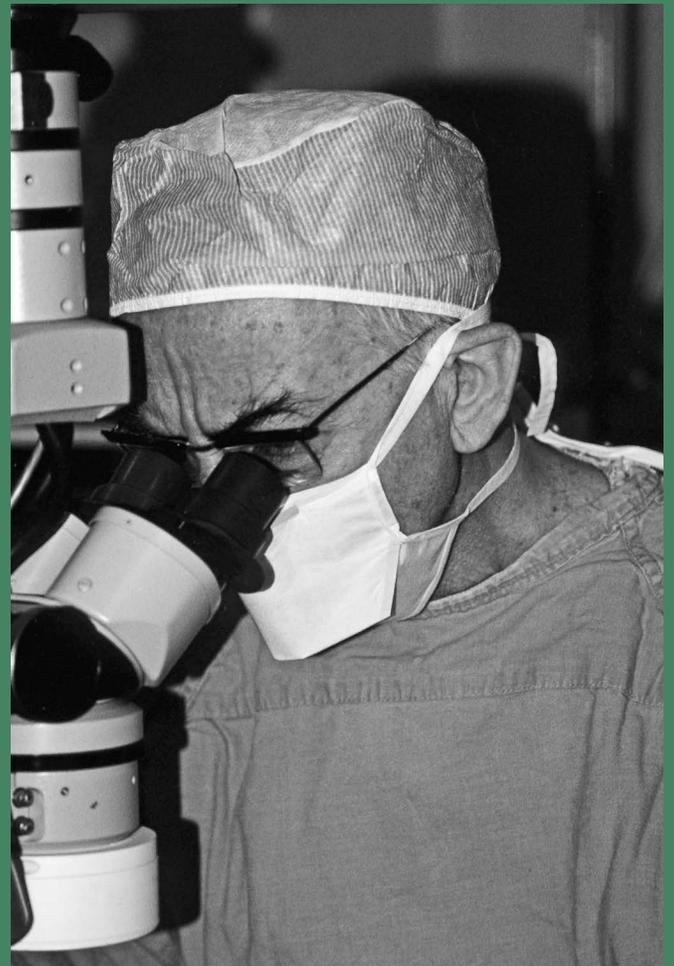
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—DR. FREDERICK JAKOBIEC

He taught you. He spent time with you. You don’t get this today. Senior physicians like Dr. Schutz, who had 30 to 40 years of experience, knew how to teach and loved to teach.

He offered the kind of knowledge you can’t get from anybody except a person who has been around a long time.

—DR. MELVIN ROTHBERGER





Dr. Frederick Jakobiec speaking at event at which he was honored after a record-setting philanthropic donation to Mass Eye and Ear Infirmary in July, 2019.

chairman. Jimmy was always sensitive to the academic life of teaching and scientific writing. He gave a retinal conference at Cornell during and after the disaffiliation fiasco. In his last professional years, he moved to Switzerland with his Swiss wife and took up teaching at the University Hospital in Geneva. There he was idolized and lionized by his students who had not encountered his like among their European teachers. Jimmy continues to publish scientific articles in his seventies and periodically returns to Geneva to give courses to the trainees.

Having returned to work in Boston after temporarily retiring from my Chairmanship due to two serious back-to-back illnesses from 2000–2006, over the last 13 years I've had a rebirth in my passion for pathology. My illnesses had forced me to step down in 2002 as Harvard Chairman and Chief of Ophthalmology at Massachusetts Eye and Ear after 12 years in these positions. I am satisfied with my record as Harvard and MEEI Chairman—for example, eleven

chairpersons nationally have been selected from among the faculty and trainees during my tenure. I was allowed to return to Harvard to serve as its chief of eye pathology in 2006 under a new chairperson, Dr. Joan Miller, one of the staff whom I had promoted to a full professorship. Together with faculty, fellows and residents, I have published around 250 articles during this period of return. From the beginning of my career, I have published 12 books and over 500 scientific articles. One of these publications was put together with the entire Department of Ophthalmology at Harvard as an underlying and unifying theme of my initial phase of chairmanship. Initially, a six-volume textbook resulted from our efforts, *Principles and Practice of Ophthalmology* (Saunders 1992). It has gone through three revised editions and a fourth is now in preparation under the direction of Joan Miller at Harvard. It has become the standard textbook in ophthalmology used by residents, fellows and practitioners in all subspecialties around the world. None of the Harvard period of my career accomplishments would have been possible without my rich experiences at MEETH.

In closing, I must state that my decade at MEETH was one of the most rewarding times of my life. I learned the elusive lessons of leadership and found that my greatest personal rewards were in having a positive impact on the lives of others through responsible and generous decisions and disciplined actions. Equally valuable were the close friendships I made with selected staff at MEETH, which fortunately remain intact and vibrant to this day. My rendition of my experiences may read like a disingenuous and fulsome paean to MEETH, but I am very realistic about the frequent defects of hospital life and medical staff behaviors. On balance MEETH's distinctive virtues outstripped any imperfections. My period at MEETH has indelibly influenced me in so many ways and has left a profound and enduring imprint on others. It has left a legacy for the future and will continue to inspire excellence and creativity through memories of the hospital's life at its apogee. ♦

Comments of Dr. Norman Medow

What you have just read are some of the recollections of Fred Jakobiec, Chief of Pathology and Chairman of Ophthalmology at Manhattan Eye, Ear and Throat Hospital (MEETH) from 1979–1989, how he arrived and how he left. Richly written in the Jakobiec style, it gives the reader a smidgen of insight into the mind of one of the giants of modern day ophthalmology. He embodies the quartet of academics, education, patient care, and research. While he writes of the hospital, its physicians and their achievements he mostly glosses over the role he played in accomplishing these.

As Fred said, the doctors at MEETH were smart, well educated, caring, experienced and clinically capable. Many had achieved consultant status and many of them had large lucrative practices. What was lacking was a sense of belonging and a feeling of not having achieved their maximum goals. It was this that Fred fostered, developed, encouraged and strengthened. Some of it occurred unknowingly, covertly, as Fred was developing into an acclaimed pathologist/oncologist. As he grew in stature, so did his hospital. As he published books and book chapters, as he published more articles, as he lectured in far lands, the name Jakobiec, Chief of Ophthalmology at MEETH, also grew in stature. *The U.S. News and World Report* placed MEETH among the ten best eye departments in America.

During his ten-year tenure, the following occurred: Approximately 15 books were written by the faculty including books on myopia, cornea, ophthalmic plastics, pathology, prisms, ophthalmic history, retina amongst others. Many hundreds of lectures were presented by MEETH physicians as

were hundreds of papers published. Fred was responsible for beginning the fellowship program in pediatric ophthalmology and refractive surgery and expanding the program in ophthalmic pathology and in cornea and cataract surgery.

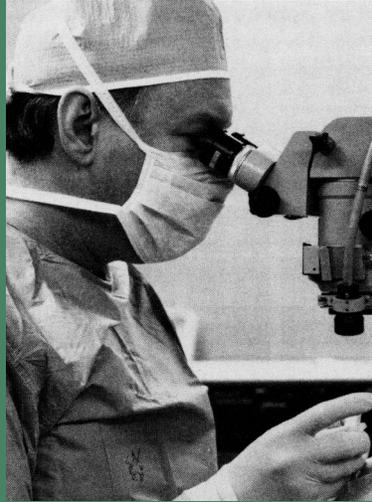
During his 10 years at MEETH, surgical innovations and advances at MEETH included myopia surgery, keratomileusis, RK, pediatric cataract implants and the continued advancement in phacoemulsification. All of these occurred with the strong support of and often with the innovational initiative of Fred.

The MEETH doctors not only achieved professionally, they also did so socially. Our annual holiday parties were a must for all to attend, held at Maxwell's Plum or Tavern on the Green. A ticket was important to gain for any ophthalmologist in NYC. Our residency selection days were joyous, as under Fred's chairmanship, the best and brightest sought to gain a position as one of the six residents at MEETH. The fact that you were asked to interview at MEETH was a goal even if not selected as one of the six. As Fred recalled, he was not asked to interview at MEETH when he applied for a residency. But, unlike Giuseppe Verdi (who, when asked to sit on the board of the Famous Milan Academy of Music in Italy, the school that turned him down as a candidate for training said "You would not have me then, you shall not have me now"), when Fred was asked to be chair at MEETH he did not turn down the job. Look at how fortunate MEETH was. Those under his leadership thrived and so did all who knew him then and still know him now.

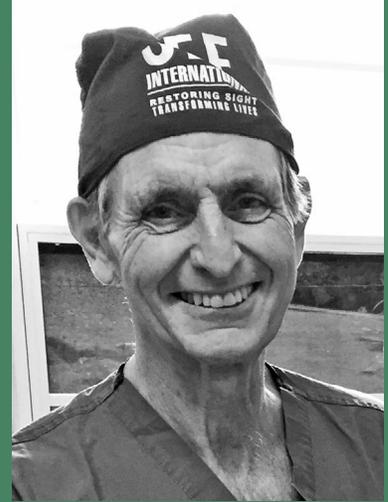
Thank you, Fred, for all you did. Please keep up the good work!



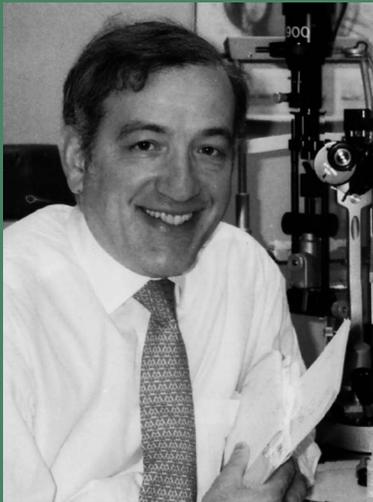
Dr. Jack M. Dodick



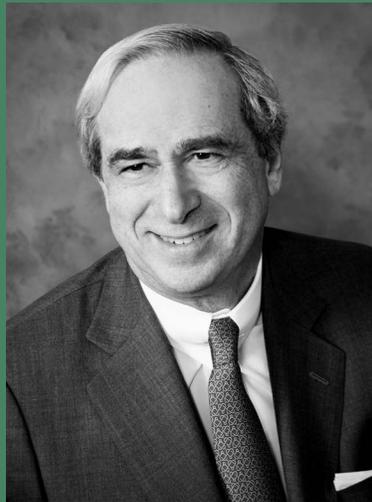
Dr. Robert H. Brown



Dr. Anthony M. Pisacano



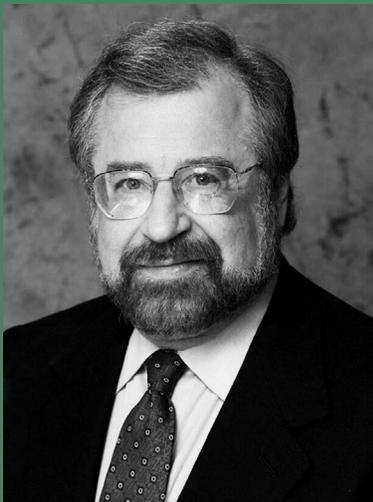
Dr. Melvin Rothberger



Dr. Richard D. Lisman



Dr. Richard P. Gibraltar



Dr. Paul N. Orloff



Dr. David H. Haight



Dr. Kenneth J. Wald

Dr. Jack M. Dodick, MEETH '67

**“My complete ophthalmology career has been at MEETH,
and I have truly enjoyed every second of it.”**



I finished my internship at the Philadelphia General Hospital in 1964. I really didn't know I wanted to be an ophthalmologist until 1963, when I was midway through the internship. I applied to and was accepted at Manhattan Eye and Ear and started on July 1, 1964. I would describe my years as a resident as magical. Here we were, a group of six residents, a band of brothers, in a residency program for three years. All six of us felt thrilled to be there. We knew we were in the best place on the planet, certainly the best place in New York, and the people we met made our lives exciting every day.

One of the first people I worked with was the chief of ophthalmic plastic surgery, a man by the name of Byron Smith. The guy was bigger than life. We knew that he was the inventor or credited with being the inventor nationally of contemporary ophthalmic plastic surgery. The field really didn't exist as a specialty before his time, but he made it into a subspecialty.

Byron was fun to work with. He created his own language, referring to things in the operating room that still stand to this day. For example, when the typical surgeon gets to suturing up certain wounds, the stitches are put in place and then tied over a pledget, a flat piece of cotton that is put on the wound. In Byron's case, the pledget would be rolled out of cotton by the resident into a circular cigarette configuration. He would call for a certain size and the resident would know exactly what he wanted. If it was a small wound, Byron would say, "Doc, get me a cigarette for a mouse." If it was a big wound, and he had a lot of sutures to place and tie over the pledget, he'd say, "Doc, get me a cigarette for an elephant." We always knew what he was referring to.

Byron was bigger than life and he's credited with a lot of innovations in ophthalmology. I believe he was the first to describe a condition known as 'blowout fracture' of the orbit, which involves a blunt trauma to the orbit and the orbital floor along with the ethmoid sinus, where the walls of the orbit would hydraulically break. I published a couple of papers with Byron and I thought at one time that I was going to be an ophthalmic plastic surgeon because he impressed me that much.

There were many other luminaries at Manhattan Eye and Ear during my residency years. We had a man by the name of Richard Troutman, who was a skilled surgeon. He just was a natural. He was able to do magical things that other

people couldn't do, and he also did many things for Manhattan Eye and Ear. These were the days before the internet, faxes and video, so how did people get information? By getting up, going out, and finding it.

A lot of innovations in ophthalmology were occurring at that time in Europe, so Troutman would hop on an airplane and travel ten hours to Europe. He would always be going to Spain or Germany, where the seat of innovation really was. Germany was his favorite. He had a friend there by the name of Professor Harms. One trip he came back with a concept for finer sutures. In those days, we would grade sutures as 6-O, 7-O, 8-O, 9-O or 10-O, with 6-O being thickest, 10-O being thinnest. We were generally using 8-O white silk sutures that we would stain with methylene blue. Troutman saw a surgeon in Europe using 9-O and 10-O black silk sutures. He bought the concept back to the United States, and the suture companies started making them for the American market.

During my training, everyone operated, not with an operating microscope that would magnify things 10 or 15 times, but with loupes much like jewelers' loupes that you'd wear over your eyes. The system worked, but while he was in Europe Troutman saw that the Germans, in conjunction with Zeiss, had developed an operating microscope. He bought the concept to the U.S., and he got an American company to create one of the first American-built ophthalmic microscopes. It was called the Weck Operating Microscope. Troutman is one of the first American ophthalmologists credited with popularizing microsurgery in the United States.

Troutman traveled to Spain where he had a good friend, Joaquin Barraquer, a fifth-generation ophthalmologist, who was using a chemical called alphachymotrypsin. What was this chemical? In the old days, we would remove the cataract by creating a very large wound, about 8 to 10 mm, and remove the lens entirely in the capsular bag with forceps. When we would take it out, sometimes the capsular bag would break and then it would become a messy cleanup operation. Barraquer began using a chemical that dissolved the puppet strings, or zonules as they were called, that held the lens in place. When they were removed, the occurrence of capsular rupture decreased immensely.

Troutman was credited with bringing back a lot of new innovations to Manhattan Eye and Ear. We had another superb surgeon, also very magical with his hands, named Herbert Katzin. Both he and Troutman were chairmen of the department for a while. Katzin was not as well known internationally but he was a superb surgeon and we learned a lot of surgical skills scrubbing with him.



Dr. Jack Dodick was Chairman of the Departments of Ophthalmology at MEETH and NYU School of Medicine and has served as President of the American Society of Cataract and Refractive Surgeons.

In addition to surgical ophthalmologists, we had a lot of luminaries in other subspecialties of ophthalmology. For example, Frederick Theodore was a specialist in inflammation and infection of the eye. He published a book on the subject. What do I remember about him? That he was totally accessible to the residents. We could hardly believe that someone of his stature would be so available. We would be on call every sixth night. All sorts of emergencies would come in. On occasion, we might have an eye with a bad infection, and it was important to identify the microbe that was involved so that we could select the appropriate antibiotic to treat it. A resident would think nothing of calling Fred Theodore at home on a Saturday at eight in the morning and saying, Dr. Theodore, we have an eye that we think is infected but we are not quite sure what to do. His response would be, I'll be right over. And he would come over and would work with us, creating gram-stained slides of the microbes so that we could identify it and treat the infection appropriately.

What made MEETH so great was that these luminaries were very friendly to us. We had others that we interfaced with. One was Abraham Schlossman. He was originally at New York Eye and Ear, downtown, which was our competitor but nowhere near us in stature. They didn't treat him well, so he moved up to the Manhattan Eye and Ear. He was a specialist in strabismus or pediatric ophthalmology, in which children who were cross-eyed or wall-eyed had operations to tighten or straighten their eyes by operating on their muscles.

There were other great people, not internationally known, like Sigmund Schutz, Adolph Posner and George Gorin. These were people who had emigrated from Eastern Europe, who were very talented and who really helped us as residents. They were the luminaries of the older set. MEETH also had a younger subset of attendings who were very helpful, always there and willing to assist us on a voluntary

basis. They didn't get paid for what they did.

A few stand out in my mind. Renée Richards, for example, who was known then as Richard Raskind. When I arrived at Manhattan Eye and Ear, Richard was our resident instructor. He was an attending who had recently graduated and was responsible for the conduct of the residency training program. He was always around, 24/7 by phone. If we had problems, we'd call him.

One story comes to mind. It was late in the evening, about 8 o'clock at night, and an elderly woman came into the emergency room. I was on first call. She had a very rare condition called bilateral intumescent lenses, which caused an acute bilateral glaucoma with high pressure in the eye. The treatment for that procedure was to remove the offending intumescent, or over-ripe, cataract. But this lady had it in both eyes and we never ever did two eyes at the same sitting. To this day we do not do two eyes at the same time because of one complication that we are still concerned about—that one in 5,000 might get a postoperative infection. We didn't want to subject both eyes to the same probability of infection.

I called Richard Raskind, who immediately came over and said, "Jack, we're going to operate," which meant I was going to operate and he was going to be my

What made MEETH so great was that these luminaries were very friendly to us.

—DR. JACK DODICK



attending. We got the evening emergency crew in, the OR nurses in, and we got set up to do the first eye at 11:30 in the evening. We draped the eye. Richard was at my side. I successfully removed the lens, sutured up the eye and he said, "What do you think we should do now?" I said, "I don't know, what about the other eye?" He responded, "Yes, we're going to do it." I said, "But we never do both eyes at the same time." He said, "this is different, this is an emergency." So, we basically undraped the first eye, re-prepped and then did the second eye.

It was amazing. We kept all patients in the hospital at that time for seven to nine days, depending upon their progress, and we made rounds on them every morning with Richard. At 7:30 the next morning, this woman was sitting in bed with a pair of thick post-cataract glasses reading the New York Times. It was one of the most exciting events I can remember as a resident. Had we not treated it, the pressure in the eye would have destroyed the optic nerve and the patient would've sustained irrecoverable blindness. It was a true emergency. We had to lower the pressure by removing the over-ripe cataracts.

To this day, I marvel at that. I still do cataract surgery and I've made my own contributions. I've evolved to modern contemporary cataract surgery. How we did cataract surgery 50 years ago is very different compared to how we do it today. The surgery I described earlier was intra-capsular. We would make a 10 to 12 mm wound, compared to a 2.4 mm wound today. The blades we had then were not

Dr. Harold Waldman, Dr. Jack Dodick and Dr. Abraham Schlossman.



“Everyone likes to talk about Charles Kelman. I do too,” says Dr. Jack Dodick. They are shown together here.

surgical/manufactured blades. We used Gillette razor blue blades. We would break off shards of the blades. They were extremely sharp, made great wounds and were great surgical instruments. You laugh, but that was the gold standard of that era. Shards of Gillette blue blades to make the wounds.

Before Troutman brought the microscope to the U.S., we would operate with loupes. We would close the eye with multiple stitches, as many as 9. As I mentioned, we’d keep the patient in the hospital for seven to nine days. Today, patients are not hospitalized. They stay for a few hours and often go out to lunch or dinner at a restaurant following the procedure. Even in great hands, the procedure, from beginning to end, skin to skin, would take 40 to 60 minutes. That’s compared to an operation today that takes four to five minutes, done through a wound of 2.4 mm, so small that it requires no stitches to close it because the wounds are self-sealing. In place of Gillette blue blades, we’re using surgical instruments like diamond blades and other disposable metal blades that are very sharp. You can see the truly amazing progress compared to what we were doing then. I lived through it, experienced it and was even a small part of the remarkable evolution in cataract surgery.

Everyone likes to talk about Charles Kelman. I do too. I started my residency in 1964. Charlie had finished his residency at the Wills Eye Hospital in 1960. He had moved to New York to establish his practice in ophthalmology in an office across the street from the Manhattan Eye and Ear, and he was already in New York for about four years while I was doing my residency. He was very personable, but he was so engrossed in his own thing and trying to find a better way of doing cataract surgery that during the early years the residents really didn't have close contact with his teachings.

Charlie was building a practice in ophthalmology, but he couldn't get adequate operating time at Manhattan Eye and Ear. It was reserved, or block time, for the upper echelon—the Troutmans, the Katzins, the people who were more senior in status—so he started taking some of his patients to St. Barnabas Hospital in Livingston, New Jersey where he would get ample time to operate. His patients went there by car or limo, but Charlie flew over in his helicopter, which he kept at a helipad on the East Side. While he was at St. Barnabas, he met a very interesting person—a world-renowned neurosurgeon named Irving Cooper. Cooper was doing very innovative things not done anywhere else in the country. He was operating on brain tumors but rather than excising them with a scalpel, he was using a freezing instrument to create an ice ball around the tumor, and he'd then extract it like a lollipop. It was a very effective way to remove tumors of the brain.

That's when Charlie had his first "aha" moment. Remember, we were removing cataracts at that time through a 10 mm wound with forceps that would often break the capsular bag. Charlie said, what if I create a probe that creates an ice ball on a lens, freeze it and then pull the lens out? He developed it in 1963 or '64. It was called the cryoprobe. It immediately took off like a rocket because it reduced the chance of adverse consequences of a ruptured capsule and became very popular. But those were the days when information didn't travel quickly between this part of the world and the other side because there was no fax, internet, Google and so forth. It later became known that Charlie's first "aha" moment had been thought of and published by another ophthalmologist named Thadius Krawitz in Poland in the British Journal of Ophthalmology in 1961, three years before Charlie had developed it.

However, Charlie did get credit for it because he popularized it, so it became known as the Kelman Cryoprobe. It was his first major innovation, but he didn't stop there. I got to know him well and got to chat with him frequently. He told me he had a vision of trying to remove a cataract through a smaller incision so that we wouldn't have to open the eye and close it with six or eight stitches. In other words, he was trying to figure out a way to remove unwanted tissue inside the eye through a small opening. To get the necessary funds, he applied for and received a \$250,000 Huntington Hartford grant in 1964. The Huntington Hartfords were the A&P Supermarket people, and what was \$250,000 in 1964 would probably be \$2 million dollars today. It was a large grant.

You can see the truly amazing progress that phaco made compared to what we were doing previously. I lived through it, experienced it and was even a small part of the remarkable evolution in cataract surgery.

—DR. JACK DODICK

Most people have heard this story, but I like to tell it because I was there. Charlie immediately went to work trying to develop a device to remove cataracts through a small opening. How he managed to do it, I don't know. He was essentially persona non grata at the hospital because the elders were jealous of him, but somehow there was space on the tenth floor of the hospital that had a vivarium where Charlie kept cats in a cage. He would work on developing devices and performing the trial surgery in this vivarium.

A vivarium is a place where you keep animals for surgical experimental use. I was on call one night and was in the hospital seeing patients. The private rooms were on floors eight and nine, and the vivarium was on 10. Someone left the cat cages on the tenth floor open one night, and I got a call from the nurses that cats were wandering around in the patients' private rooms. If you ever heard people talk about "how difficult it is to herd cats," I had that experience.

Charlie continued to do his work for well over a year and a half, and we became close friends during that time. He was so engrossed in his work, he never went home till late at night. His marriage was on the rocks. He grew a beard. He hadn't visited his dentist. He just didn't take care of himself. He was deeply engrossed in making this happen. He was a very determined physician.

But, as he confided to me, his grant was about to run out and he was ready to give up—not actually ready, but he was thinking about it because he had created 30 to 40 devices to do the surgery, and none of them worked. Just as he decided to pack it in, he had his second "aha" moment. He decided to get a haircut, a shave, and visit his dentist on Long Island. His dentist, Larry Kuhn, was one of the first dentists in the country to get a new technology that used ultrasound to clean tartar on teeth, and he used it on Charlie. And Charlie said, "What is this?" Larry explained what it was, and Charlie said, "Aha, I got it." That was the birth of Charlie's ultrasound.

He went back to his lab, developed a prototype and then the day came that he was going to try it on his first patient. I was there. I was a third-year resident. It was late spring, I was going to graduate on July 1 and I was on call that day. The procedure was done in total secrecy because if the elders found out what he was doing, there'd be hell to pay. There was no FDA or Institutional Review Board at that time. It was what the patient and the doctor agreed to.

Charlie decided to do the case on a Saturday morning. He was good friends with the Chief of Anesthesia, Shamus Lynch. Everyone was paranoid about what was about to happen. His assistant, Cheryl, stayed with the machine Friday night, slept in the same room to make sure that nobody tampered with it. I was on call, but it was verboten for anybody to go into the operating room. I knew something was about to happen, but I didn't know exactly what. So, I went up to OR seven and tried to look in the room through the little peekaboo window in the door. It was shuttered. There was a sign on the door, "INFECTION, DO NOT ENTER," sort of like a skull and cross-bones on a bottle.

The procedure, Charlie's first case, took about four hours. It involved a man who had been scheduled to have an eye removed for a malignant melanoma. The eye was going to be enucleated. So, Charlie said to the patient, "Would you like to help advance science by having this procedure done prior to enucleation?" The

Orbis Flying Eye Hospital

Since 1982, the Orbis Flying Eye Hospital has been working to eliminate avoidable blindness around the world. With a network of partners, they mentor, train and inspire local teams so that they can save sight in their communities. Orbis was founded by Dr. David Paton, son of Dr. R. Townley Paton, Surgeon Director at MEETH who established the Eye-Bank for Sight Restoration.

In the five-year period from 2013–2017, Orbis completed almost 175,000 trainings by doctors, nurses and other community workers. They have performed over 15 million screenings and eye exams, conducted about 385,000 surgeries and laser procedures, and provided over 28 million medical and optical treatments.

Several MEETH doctors have boarded the Orbis plane and flown to distant countries to teach local personnel how to save vision. In 1985, Dr. Jack Dodick flew to China and performed a corneal transplant; Dr. Kenneth Wald joined Orbis missions to Uganda in 2006 and Mongolia in 2011.



ABOVE: Orbis' newest DC-10, packed with millions of dollars' worth of equipment.
LEFT: Surgery aboard the DC-8.

patient agreed and that's how the first procedure took place. The case ended up with a fulminating infection and the eye was enucleated, but no harm was done because it was going to be removed anyway.

The procedure was not accepted immediately. The first case was in 1967 but it never took off until the early 1980s, and there's a reason why. Charlie had decided to take things into his own hands. He was opposed by the hierarchy of all the university professors, who thought it was a dangerous thing. He was swimming up river, trying to promote it. He hired a publicist and appeared on many TV talk shows. He could do this in part because he was a terrific musician. I remember the Jack Parr show, where he talked about his innovation and then played the saxophone. He was a good saxophonist.

During its initial phases, the phacoemulsification procedure was technically difficult and had a high propensity for complication.

Dr. Dodick and others like him fought through those early challenges, bringing the technique up to its current extremely safe level.

—DR. KENNETH WALD

Along the way he started to give courses to doctors who would come from all around the country, and some from other parts of the world, to learn the new technology. The doctors felt they had to learn it and some felt they had to buy it even though they weren't sold on the idea, because if a patient asked them, "Do you do the small-incision surgery?" they could say, yes, because they had the machine, even though in most instances the machine was tucked away in a closet and never really used.

That was the birth of ultrasound phacoemulsification. Charlie would give these courses. I attended some and they were very interesting. He would do live surgery. He would have a didactic course and in

the evening the participants were treated to dinner. Charlie would invite many of his patients who had the procedure done to the dinners, and he would entertain by playing the saxophone and singing. He was a good vocalist, and he'd put his own words to some of the famous Frank Sinatra tunes like My Way.

It was a very exciting time. It was also a great time to be at Manhattan Eye and Ear. The architecture of our training was very interesting. It was a three-year program, and during the first year the residents were responsible for manning the clinics. We wouldn't do surgical procedures, but we would see patients who came in with problems and treat them medically.

There were two major clinics, the East Eye Clinic and the West Eye Clinic, which was a receiving clinic. If you were a patient who came in with a general problem—say, for example, your eye was irritated but the problem was a cinder in your eye—we would take it out and you'd be discharged. But you also may have come in with poor vision and, in the receiving clinic, you may have been diagnosed with having glaucoma. You would then be given an appointment for the Glaucoma Clinic, which occurred in the East Eye Clinic on certain days of the week. Or you may have been diagnosed with having a cataract. In that case you were sent to the Cataract Clinic, which was also in the East Eye Clinic on certain days.

The East Eye Clinic was ruled with an iron fist by a nurse named Charlotte Goshorn. She was strong. She knew the clinic was hers. She always appeared for work punctually in her crisp white uniform, with her crisp white nurse's hat, and



God help the residents if they were ever late for clinic. She would get on the horn, get hold of the chief resident, who would get hold of the resident who was supposed to be there and chide them. That was the East Eye Clinic.

There was also emergency room duty. The official work day may have finished but we also had a 24/7 emergency clinic. At 6 o'clock at night, if someone came in with an irritated eye, the resident would be called, and he would treat the patient. The common complaint was a foreign body sensation. Often it was a cinder or maybe an infection in the eye. The thing I remember best about the emergency room bench, as we called it, was that we met the most fascinating people. We were on the Upper East Side in a silk glove area. We met people of every socio-economic class: rich, famous, not-so-rich, not-so-famous.

One story stands out in my mind. It was 1965 and a new restaurant had opened on 65th Street. It was called Sign of the Dove. I knew the gentleman, a dentist, who opened it, and it became the hottest restaurant in New York. One night he was home cooking a steak in his gas oven but when he tried to ignite it, the flame burst out of the oven and singed his eyelashes and his cornea. So, he showed up at the Eye Clinic. We got to chatting, became friends and I tended to his eye and saw him on a couple of follow-up visits. He subsequently invited me and my girlfriend at the time to dinner at the Sign of the Dove. I could never afford to go to the Sign of the Dove in those days, and there, three tables away, was Jacqueline Kennedy. It never would've happened had I not been on the emergency bench.

The video behind Dr. Dodick allowed visitors to observe his advanced surgical technique.

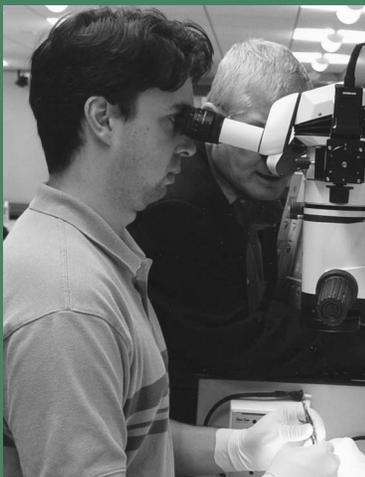
Microsurgery Lab

The advanced microsurgery lab allowed residents and fellows to train under the watchful eyes of experienced surgical instructors. They were able to perfect microsurgical skills in preparation for administering care to their own patients in the operating room.

Each practice area was equipped with an operating microscope and the same instruments used during surgery, reproducing the experience of being in the operating room.



The microsurgery lab at MEETH.



A standard setup for residents in the microsurgery lab.



The Eye-Bank for Sight Restoration generously supported this educational experience by providing donor eyes for the program. These were corneas deemed unsuitable for transplants.

The operating rooms were ruled by another lady with an iron fist. Her name was Julie Quigley. She controlled the schedule and she had her favorites. Sometimes, if you had an add-on case, she would make room for you if you were nice to her, but she ran things very, very efficiently.

After I finished my residency, I left MEETH to do a two-year fellowship, but I immediately came back and have spent my entire professional life, close to 50 or so years, at MEETH, ultimately becoming chairman of the department, which I served for over 20 years except for a four- or five-year stint. At that point we brought in a full-time chairman, Fred Jakobiec, who was there for 10 years but then he left for Boston and I became chairman again. My complete ophthalmology career has been at MEETH, and I have truly enjoyed every second of it.

The leadership structure at MEETH was interesting. We had what was called a Board of Surgeon Directors. It was a group of doctors who comprised the chairmen of the three major departments—ophthalmology, otolaryngology and plastic surgery—plus the chief of medicine and two members who were elected at large every two to four years to serve on the board. We would have meetings at least once a month, sometimes more, to run the medical conduct of the institution. In addition, the chairs of the three major departments, along with the executive director, would meet as an executive committee for things that had to be tended to at that moment.

Our residency training program without a doubt enjoyed an extremely high reputation and ranking for many years. We were in the top five in the country. If you wanted to train in ophthalmology, there were five great programs you could go to, and we were one of them. Our only competition for residents came from Massachusetts Eye and Ear, Wills Eye Hospital, The Wilmer Institute at Johns Hopkins and maybe one other for people who wanted to train on the West Coast. New York Eye and Ear was a great institution, but we were the big dog in town.

Each year, from July to December, we would receive applications from people who wanted to be residents at MEETH, and we generally would have several hundred applications. They would be reviewed by members of our staff. We would cull out 25 to 30 that were the best of the best, and we would issue invitations to them to come for an interview in late or mid-December. We would then submit our rankings to a national ranking facility in San Francisco. We would always get our top six picks. In other words, we rarely had to go down to number nine or ten. If we would lose out, it would always be to one of the institutions I mentioned earlier.

MEETH was a place of many firsts. By far the single most important was the small incision cataract surgery developed by Charlie Kelman. It is deemed by most surgeons throughout the world as the most important innovation in cataract surgery in the past century. When you think of the significance of what he accomplished, it is overwhelming. He was the first surgeon to prove that you could remove unwanted tissue through a small opening rather than filleting someone open and sewing them up. So de facto he became the father of small incision surgery in the eye.

But soon after it started in the eye, small incision surgery was taken up by other disciplines. The next to follow was neurosurgery, which adapted the ultrasound phaco to emulsify tumors. They would de-bulk the tumors with ultrasound, so

they could remove it through a smaller opening. Now we had minimally invasive surgery in the brain. Orthopods caught on and said, wow, why can't we devise ways of doing minimally invasive procedures through small incisions for arthroscopic surgery, laparoscopic surgery and so forth. Although Kelman was the father of small incision surgery in the eye, in my mind he's the grandfather of all least-invasive surgery in the human body. That's how important his contribution was. He was nominated and posthumously received the Lasker Award. Many Lasker people are nominated for and some win the Nobel Prize. Had he lived longer, who knows what could have happened.

There are other MEETH firsts I've talked about, like the microscope that Troutman brought over from Europe. Ultrasound, which was a technology used to see into the eye through opaque media, was not invented at MEETH, but it was pioneered at MEETH by a man named Nat Bronson. One of his younger disciples, a resident named Yale Fisher, took it up and made significant contributions in the use of ultrasound.

Larry Yannuzzi was very important in that he pioneered the use of fluorescein and indocyanine green, which are dyes that would be injected into the vein of an arm, and then pictures would be taken to see whether there were leaks in the blood vessels in the eye. I myself traveled to Europe in the early stages of YAG-laser capsulotomy, and I brought the very first Switched YAG lasers in North America to Manhattan Eye and Ear. I proceeded to give about 40 courses to doctors who came in from all around the country in the use of the YAG laser. I also went to Europe and brought back modern intraocular lens implants and became the second person in New York to start doing implants. I was also responsible for training a lot of surgeons at the Manhattan Eye and Ear.

Those were the good years at MEETH. Sadly, they were followed by the dark years. I was chairman at the time. In January of 1999, we held our interviews and accepted our class of six residents to start in July of 2000. We already had residents accepted for July of 1999. We had commitments to two classes of residents that were yet unfilled. In February, one month after accepting our residents, the three chairmen were told by the administration that Manhattan Eye and Ear was about to close as a hospital. We would have to end our residency program immediately and we would have to cancel all obligations we had made to residents for the coming years because what was a successful and famous hospital was about to close after 130 years because the board felt the real estate was more valuable than the work we performed.

It was a tumultuous time at Manhattan Eye and Ear. There was a lot of anger, many people were very upset and there was a very big flurry of concern. The leadership rose to the occasion. Our first concern was what was going to happen to these young lives who were currently in training and would have to leave the hospital and possibly never finish their training. What would happen to the six residents coming into ophthalmology in July of that year? We would have to tell them, sorry, you can't come. What would happen to the six residents that we committed to for July of 2000? We had to tell them, sorry, something has come up and there is no place for you any longer.

But we all got together and many of us knew people throughout the country and somehow, somehow, we managed to place our current in-house residents that we had committed to for July 1999 and July 2000 in other programs. It helped that our residents were the cream of the crop and of the highest quality. So that was settled. But then there was a directive to close the hospital, and many of the attendings flew the coop. Most of them went down to New York Eye and Ear, where they secured operating time, maybe not at the most favorable slots, but at least they had a place to operate. There was no one left to keep the lights on at Manhattan Eye and Ear except for a few stalwarts, a handful of us who said, we're not leaving.

To close a hospital, there's a process that you go through. Firstly, you must make application to the state. The state needs to make sure that no patients would be harmed. What were the plans for the clinics? How would they be closed? What were the plans for ongoing surgeries at the hospital? How would they be taken care of? In particular, there were three of us that I can remember: myself, Sherrell Aston in plastic surgery, and Nicolas Tabbal also in plastic surgery, who simply refused to leave and who continued to keep the lights on and book our cases.

The hospital was obligated to keep the operating rooms open because they had not gotten a closure plan approved by the State of New York. But the directors were submitting a closure plan and it ultimately would have come to the point where we would be told, okay, the plan was approved, you have to leave now. We were trying to delay that as long as we could by just staying there. Had all of us left, they could've made an application to the state, saying that nobody is operating at MEETH anymore, and it would've closed two days later or however long the bureaucracy took.

Most left but a few of us stayed on and we got together as a band of brothers. The people who come to mind are David Edelstein in ENT, myself in ophthalmology, Richard Lisman in ophthalmology, Sherrell Aston in plastic surgery, and Steve Fochios in medicine. We got together and said, we've got to do something. We've got to fight the hospital's application to close shop. We couldn't do it ourselves by appealing to the Department of Health in Albany, so we hired a lawyer, George Bunn, who was a friend of Richard Lisman. He came from the Bunn coffee family. Each of us kicked in about \$10,000, so we had the nucleus of a retainer to pay George Bunn to forestall the rapid closing of Manhattan Eye and Ear. We had a lawyer in place, which meant the hospital wasn't going to close as quickly.

Then we made appeals to others. Even though they had left, many started giving some money and contributing to the kitty. It became clear that George Bunn, who was a good guy and helped us quite a bit, didn't have the infrastructure of a large firm nor the background to deal with the Health Department. So, we ventured out and retained a Park Avenue firm named Stillman and Friedman. They wanted a good amount of money as a retainer, and we went back to the well again and got some money and retained them and they were extremely helpful. They continued to work along with us without requiring us to pay their bills until the time would come when we could afford to do so. They were probably

*Three of us refused to leave.
We kept the lights on and continued
to book cases.*

—DR. JACK DODICK

operating under the premise that eventually someone, whether it be the Health Department or the attorney general's office, would adopt a closure plan and order all outstanding bills to be paid before closure could occur. So, they were giving us their services on good faith.

Somewhere along the way Sherell Aston, David Edelstein and I went to the attorney general's office and met with Eliot Spitzer. He was impressed by our story and he turned us over to the charities and trust division that was run by Bill Josephson. He became very interested in the case and said, "No way the hospital can be shut down. What do you doctors want to happen?" We said we wanted the hospital to live. The administration wanted to close it, sell it, and have high-rise condominiums put up on it. He said, "If you want the hospital to continue, how are we going to do that?" And we said, if we have a friendly takeover by another institution, maybe we would live for another day.

At that point, Eliot Spitzer, the 800-pound gorilla in the story, got into the fight and he was on our side. What followed was a prolonged court hearing in which a group of doctors sued the board of directors of the hospital with the help of the attorney general. We were successful in dismissing the board and, we were told, it was the first time in the legal history that something like this had happened. We were courted by New York Eye and Ear, Lenox Hill and others, and ultimately Lenox Hill took us over. That sort of worked for a while and then Northwell took over Lenox Hill and we arrived at where we are today.

Today, we are part of Northwell. We have a building but no beds, no clinics, no emergency rooms and

no laboratories. We do have 18 operating rooms that are used by physicians who book them to do their surgery. What will we look like ten years from now? It's hard to say because it's a different structure today. MEETH is fundamentally an ambulatory surgery center with 18 ORs that are filled by ophthalmology, ENT, plastic surgery and orthopedics. Any discipline that does ambulatory surgery may become a user of the facility depending on how busy the ORs are.

Before all the turmoil, MEETH was an institution where doctors in the community would come and book their cases and go back to their offices. But medicine has changed. After MEETH was taken over by Northwell, Northwell brought in their own faculty doctors who are paid employees of Northwell and who used the facilities to see patients. Voluntary doctors can still use it, so it's a hybrid. If I had my guess, it will probably morph into a faculty group practice serving the community doctors, but that's fading anyway, the way medicine is going.

Back in the day, two groups of patients were treated at MEETH. We had large clinics with patients and then there were the private patients that doctors would bring into the operating room. The clinic patients were operated on by the residents who were supervised by voluntary attendings. Many of these patients had some form of insurance, so a surgical fee would accrue to the surgeon who assisted the resident. Using income derived from the resident cases, we started a fund called MEETH Associates. Money was put into that fund with the goal

We knew we were in the best place on the planet, certainly the best place in New York, and the people we came into contact with made our lives exciting every day.

—DR. JACK DODICK



of supporting resident education, and initially a very minimal distribution was given to the surgeon who assisted. Following the demise of the residency, and after much discussion, the name was changed to the Manhattan Eye Foundation, which still lives today with a goal of supporting education and research in the entire downstate area with a corpus of about \$2 million.

Over the years many well-known people came to MEETH. During its heyday, the Plastic Surgery Department was populated by the *crème de la crème* in New York. It was a closed shop run by the chair Tom Rees, and it was very hard to get privileges. Rees was an icon in the field, and they had a small group of luminaries that were the most powerful in the city, nationally and internationally. The New York Post would always write stories with “tummy tuck” and “facelift” in the headlines, but that didn’t diminish the work the Plastic Surgery Department did or the reputation it developed.

In its heyday, MEETH had 150 beds. That figure was subject to attrition because cataract surgery, which was once a hospital-based procedure, became an outpatient procedure. We simply did not need all those beds. We only needed beds for people who needed to stay in the hospital for a protracted time—two or three days, say, for a retinal detachment—but that changed too because even detachments started to be done on an outpatient basis. At that point, the MEETH beds became basically used for plastic surgery cases because the department would keep their facelifts there for one or two days. Bit by bit, the beds went from 150, to 70, to 50, to none, as the trend to outpatient surgery became the norm for the disciplines operating at MEETH. ♦

The resident selection committee, included, among others: Dr. Lawrence Yannuzzi, Dr. Henry Spitz, Dr. Jack Dodick, Dr. Jason Slakter, Dr. Susan Hahn, Dr. Julia Hsu, Dr. Norman Medow and Dr. David Guyer.

The Future of MEETH

By Kevin Beiner and Dr. Richard E. Braunstein



Dr. Richard E. Braunstein

The introduction of Northwell Health (formerly known as North Shore LIJ Health System) into the Manhattan health care market in 2011 was centered mainly on the acquisition of Lenox Hill Hospital. The merger of a tertiary facility into the network consumed significant resources and attention. Anticipated growth and expansion, as well as future plans in ambulatory clinical and surgical areas, were established from the outset. Throughout the early stages of integration, it became clear that MEETH would play more than an ancillary role in the health system's expansion. With its past national and international reputation as a premier specialty hospital, it was clear that the opportunity to reinvigorate the facility would be a high priority. The benefit of being associated with the MEETH brand could not be ignored.

The buildings at 210 and 222 East 64th Street were in a state of neglect. They had not been well maintained, the academic programming for which MEETH was famous had become almost nonexistent and the value of the MEETH name and reputation had slipped considerably. The immediate impression of a visitor was of a tired building which was cobranded as Lenox Hill Hospital along with Manhattan Eye Ear and Throat Institute. The lobby was crowded and poorly configured and the famous central great hall was being used as a registration office for patients. The first-floor clinics were dated, though functioning. In addition, as the result of the almost complete shift of Ophthalmology, ENT and Plastics to ambulatory surgery, there were numerous empty, former inpatient units on the upper floors. Furthermore, the operating rooms, while efficient, were not optimized for 21st century patient care. As Northwell Health assessed the facility, it was clear that MEETH was being used as a place to send ambulatory surgery cases by Lenox Hill. LHH was, at that time, experiencing its own financial challenges and needed to prioritize which procedures could be done most cost efficiently at its new outpatient location.

As the Northwell Health leadership made plans for the MEETH transition, an unmistakable culture among the staff in the building emerged. Rather than attempting to conceal the challenges that they faced, loyal employees were eager to acknowledge, describe and highlight their issues as well as propose solutions. Patient care, research and educational opportunities were paramount to those closest to the front line. There was also a unique desire by the staff to articulate and advocate for a future strategy. In addition, and much to its advantage, Northwell Health was welcomed and encouraged to tap into the knowledge and experience of the stakeholders who had spent their entire professional lives at MEETH and who could provide a much needed perspective.

Shortly after the health system's acquisition of LHH and MEETH, a meeting was held at MEETH with Dr. Larry Smith, Dean of the Hofstra Medical School and Physician in Chief at NS/LIJ, speaking on the future of the hospital. I attended that meeting, as did many others, eager to hear of plans for the institution. The strategy for MEETH had not yet been determined, and Dr. Smith focused on the health system, its growth across the region and its expansion into NYC. After the meeting, I contacted Dr. Ira Udell, chair of Ophthalmology at Northwell Health and asked if the health system would be interested in establishing a full-time ophthalmology faculty practice at MEETH. Within a few weeks, a group of us were meeting with Dr. Smith and Michael Dowling, President and CEO of Northwell Health, to discuss MEETH's strengths and weaknesses and how to reestablish it as a Center of Excellence.

At that time, ophthalmology had a diminished role at MEETH. The West Eye Clinic, the general ophthalmology clinic where patients were first seen, was still operational with devoted MEETH staff and residents from NYU rotating through the clinic and ORs. The residents were under the direction of Dr. Laurence Sperber, the residency program director, and Dr. Jack Dodick, chair of ophthalmology at NYU. Dr. Stephen Obstbaum, Chair at LHH/MEETH, maintained the balance between NYU's program, MEETH's outpatient clinic, and the Lenox Hill Hospital ambulatory ophthalmic surgical program. Ophthalmology at MEETH was kept alive through the extraordinary efforts of residents and faculty, determined to keep the mission, dating back to 1869, afloat. The operating rooms were active and ophthalmology dominated the surgical mix with a number of loyal physicians utilizing them although many surgeons had dispersed to other facilities over the years.

Early in 2012, shortly after becoming involved with Lenox Hill/MEETH, Northwell Health began a major effort at MEETH to provide a safe, up-to-date environment where quality patient care could be delivered. Millions of dollars were



MEETH in 2019.

In its first decade as a member of Northwell Health, MEETH has proudly moved forward and has reclaimed its place at the lead of innovating health care.



invested to hire staff and to purchase critical equipment. In addition, essential safety upgrades were made to the facility. Dramatic and extensive expert resources were provided, to bring the hospital into regulatory compliance. Over the course of the first 24 months of integration, MEETH was given its own local administrative team and the reputation of the legendary name began to be restored. MEETH was on the road to recovery.

As these new and significant changes were unfolding, Northwell Health established a strategy to build upon the hospital's cornerstone departments with ophthalmology as a central theme. Working with Northwell Health leadership, we shaped a vision to re-establish MEETH as a destination center for ophthalmic care. To start, a small group of us would join Northwell Health and create a new eye center at MEETH, where we would hope to attract patients and build a faculty practice, something that had never existed before at the hospital. We had great appreciation for MEETH's storied past and the world class faculty whom we hoped to involve in working to rebuild the institution. Our group of four physicians—Dr. Gaetano Barile, Dr. Amilia Schrier, Dr. William Schiff and myself—moved to MEETH in July of 2012. We were completely supported by the MEETH administration, led by Kevin Beiner, and eventually Gail Greenwood, assistant vice president at NS/LIJ, whose background in ophthalmology proved to be an enormous asset.

Many of MEETH's loyal faculty, who still considered the institution home, were incredibly responsive to our arrival. Drs. Yannuzzi, Lisman, Dodick and Orloff were immediately involved and asked to help us in achieving our mission.

It was as if we had joined something far bigger than we could appreciate. Our goals were simply to start and develop our program to once again make MEETH a site for high quality patient care. Our hope was that if we indeed delivered the type of care that we anticipated, the MEETH reputation as a destination for superior eye care would be restored.

We built our practice on the seventh floor of the new building, initially with 12 examination lanes and multiple additional offices which could be converted to lanes if practice demand grew. We worked in temporary space utilizing the historic retina clinic exam rooms which we outfitted with state-of-the-art equipment. Our new office opened in the fall of 2012 and the faculty program was off and running. The fellowship programs followed us and we established a cornea fellowship and an additional rotation in the combined Retina fellowship at MEETH. Academic education and training of the highest order was making a comeback at MEETH.

Our faculty practice grew quickly with the addition of Dr. Obstbaum, several optometrists, and Dr. Jamie Mitchell, a neuro-ophthalmologist, recruited from Cornell to help support the new neurosurgical program at LHH. A new Chair search was initiated to help lead ophthalmology's resurgence and Dr. Celso Tello, an internationally recognized glaucoma specialist, was recruited to join MEETH and spearhead our program's path.

Dr. Tello developed a glaucoma center at MEETH with a new glaucoma fellowship, additional faculty recruits and a robust glaucoma research program. Dr. Sean Park, director of glaucoma research, stepped up to launch an aggressive path to becoming a leading center in glaucoma research. Research fellows, students, and additional research support people were engaged to complete the transformation.

With the addition of Dr. Michael Samson, director of uveitis at the New York Eye and Ear Infirmary, Dr. Steven Odrich, former director of glaucoma at Harkness Eye Institute, Dr. Naomi Goldberg, medical retina and uveitis, and Dr. Jules Winokur, cornea faculty and program director of the Northwell Health residency, we had 16 full time faculty practicing at MEETH by 2019. At this time we are well on our way to achieving the goal that we set out in 2012 . . . that MEETH's reputation would once again be on national and international maps.

In 2014, I became Executive Director of MEETH, in addition to my role as the administrative leader for ophthalmology across the Northwell Health system. I have had the incredible opportunity and responsibility to participate very broadly in the rebranding and growth of MEETH. The expansion of ENT, plastics and orthopedics programs have begun in the facility and marquee practices are being brought back to East 64th Street. The effort to renovate each floor of the hospital continues. Buildings that were built more than 100 years ago have been refit for service in the 21st century and continue the legacy of caring. Throughout this first decade as a member of Northwell Health MEETH is proudly moving forward and has reclaimed its place at the lead of innovating health care.

These are indeed exciting, productive and energetic times. With a superb entrenched and growing faculty practice, a facility that has been renovated both clinically and surgically, and a strong re-emphasis on an academic program, the future of MEETH is bright and moving in a positive direction that will allow it to fully reclaim its historic past. ♦