Association of University Professors of Ophthalmology

Members, Associate Members and Administrators

News & Views

September 2007

PRESIDENT'S COLUMN

By Mark S. Blumenkranz, MD

I thank you for the great privilege of serving as the president of the AUPO for the next 12 months. As a specialty, the future of ophthalmology has never seemed brighter, in terms of our prospects for scientific discovery that will lead to new treatments for many common forms of blindness, as well as the promising cadre of medical students, residents, and fellows that we will train as the caregivers and medical leaders of tomorrow. Nonetheless, we face serious challenges that deserve our full attention and effort. These include the general challenges to all of academic medicine, including declining reimbursements stressing our financial systems, more bureaucratic paperwork, and a shrinking base of physicians interested in academic careers because of the inherent stresses associated with it.

We also face a series of problems specific to ophthalmology, including a system-wide devaluation of the importance of ophthalmology to both the mission and the margin of academic medical centers and real decreases in ophthalmic work effort as reflected in RVUs compared with other major surgical subspecialties, which are seeing positive re-adjustments in RVUs. Nonetheless, ophthalmology remains one of the most rewarding surgical subspecialties, in my mind, and it is our challenge and obligation to convey our sense of the vitality of the field to future generations of ophthalmologists, with whose training we are charged.

Some of the areas that we will address in this column and through our efforts in the future include new and more effective ways of teaching both the art and the science of ophthalmology to medical students, residents, and fellows. We will also examine ways in which we can more effectively interact with the other leadership organizations in our specialty, including the American Academy of Ophthalmology, the American Board of Ophthalmology, the Association for Research in Vision and Ophthalmology, and related subspecialty societies. We will explore methods to advance the research mission of ophthalmology as it relates to both vision science in its most pure and abstract form, as well as the practicalities of disease management that place an increasing premium on cost effectiveness and outcomes as metrics. Finally, we will continue to examine some of the less glamorous aspects of our jobs as the stewards of our specialty, including the field of management science: how we can effect organizational change within our departments and streamline methods by which we render care, teach, and perform research.

In that regard, let me reflect back on the recent symposium at the annual AUPO meeting on February 1, 2007, in Indian Wells, where we examined trends in physician compensation, including presentation of some of the data relating to the physician compensation survey conducted by the AUPO in the past year. Tim Cotter, principal of Sullivan Cotter & Associates, presented data and some general guidance regarding this important area. Mr. Cotter drew attention to a recent study suggesting that there would be a 40% increase in the demand for ophthalmologists in the years 2001 to 2020. In contrast, from 1995-2004, ophthalmology experienced the largest percentage decrease in first year medical residents and fellows of all specialties, ap-

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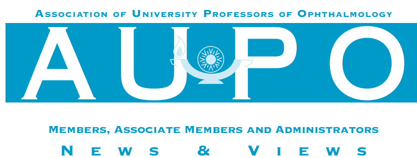

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Send feature articles and correspondence to:
Bartly J. Mondino, MD
Department of Ophthalmology
Jules Stein Eye Institute
100 Stein Plaza, UCLA
Los Angeles, CA 90095-7000
Ph: 310.825.5053 | Fax: 310.206.7488
E-mail: mondino@jsei.ucla.edu

Associate Editor
Jonathan Smith, MBA, MS, COE
Department of Ophthalmology
Jules Stein Eye Institute
100 Stein Plaza, UCLA
Los Angeles, CA 90095-7000
Ph: 310.206.6641
E-mail: smith@jsei.ucla.edu

Send announcements, association news, and address changes to:
AUPO Administration Office
P.O. Box 420369
San Francisco, CA 94142-0369
Ph: 415.561.8548 | Fax: 415.561-8531
E-mail: aupo@aao.org

Production
Drew Seaman
AUPO Administration Office
E-mail: amstemp@aao.org

proximately a 20% decline, pointing the way towards an eventual crisis in the availability of qualified providers of care, assuming these trends were to continue. During that period, total compensation levels for ophthalmologists increased by approximately 28% in private practice, but only 14% in academia, while work RVUs and collections remained relatively flat, necessitating that the ratios of total compensation to collections as well as pay rates per RVU were required to rise by 22% and 15% respectively, a change that is probably not sustainable, given the rate of practice cost increases. Mean total compensation of ophthalmologists remains below that of other surgical subspecialties as a whole, a ratio of approximately 0.8. This places ophthalmology in the general range of ENT, Urology, and Vascular Surgery, a little higher than Ob-Gyn, and considerably below Orthopedic and Neurological surgery. Both collections and median work RVUs for ophthalmology are also below comparable medians for surgical subspecialties as a whole. Somewhat surprisingly, the ratio of mean total compensation to median RVU productivity for ophthalmology is well below that for the rest of surgery suggesting that we face challenges as a profession, convincing patients and third party payers that our work should be as highly valued as other specialties, a fact that is not lost on hospitals and medical school administrations when determining allocation of the scarce resources of manpower, space, and equipment in the annual budgeting cycle. Finally, issues related to changing trends and physician compensation in the future were discussed, including the fact that 18% of physician employers were now decreasing total compensation as a means of dealing with fiscal shortfalls, while as many as 40% of physician employers were now employing either hiring bonuses, or 16% educational loan repayments as recruitment tools in a shrinking workforce required to provide ever increasing levels of care. Other issues that are likely to become important in the future include whether or not to provide additional incentive pay for on-call to selected physicians.

Clearly moving forward, performance based compensation will become an increasingly common methodology, much as it has already become in the private sector. Academic institutions, in addition to competing with each other for the services of the most highly skilled and productive physicians, will need to recognize that the competitive landscape includes not only fellow academic institutions in neighboring States or nationally, but also local and regional private practices that increasingly offer many of the advantages and fewer of the disadvantages associated with fulltime staff model academic departments. One corollary will be the requirement for physicians and departmental chairs to develop appropriate and fiscally sound compensation models that incentivize performance most consonant with academic values and also the strategic mission of the department, while also recognizing that no compensation model is capable of replacing strong physician leadership and the clear articulation of the culture and values of an institution that transcend simple compensation formulas, work hours, or other benefits. Hopefully, we as an organization can both incubate and articulate that strong leadership to our colleagues as a means of continually strengthening our profession and the institutions and organizations associated with its health and vitality.

ADMINISTRATOR'S UPDATE

By Jonathan D. Smith, MBA, MS

Medicare and Quality Care Reporting

As this article is being prepared, Medicare has rolled out the first phase of the Physician Quality Reporting Initiative (PQRI), also known as "pay-for-reporting." This program was included in the Tax Relief and Health Care Act of 2006 (TRHCA), which is the first significant step by Centers for Medicare & Medicaid Services (CMS) to measure outpatient quality of care, and subsequently tie reimbursement to it by using specified measures of performance for patient care delivered. This significant step, as part of a pay-for-performance plan, is being implemented by providing participating organizations up to 1.5% of the Medicare Fee Schedule as an incentive in the form of a "lump-sum" bonus during the initial phase from July 1, 2007 to December 31, 2007.

As the situation currently stands, it is important that academic departments of ophthalmology begin participating in this program as soon as possible. In a recent internal review of specialties within the UCLA community, it was revealed that ophthalmology ranked first as being the specialty that would stand to benefit the most by implementing and participating in the 2007 PQRI program. This is due to the high percentage of Medicare patients within ophthalmology practices, as well as the nature of ophthalmology based services.

The process of implementing this program can be time consuming in the beginning as encounter forms (a.k.a. "super bills") are revised to include the list of measures, service "quality-data codes," and valid modifiers. However, these steps will need to be taken to be eligible for the incentive based reimbursement. According to the CMS website for the PQRI program, at least two 2008 PQRI measures must be included in accordance with the TRHCA. However, apparently there is legislation pending that could change these measures. Each specialty and sub-specialty encounter form will need to be revised to include these quality-data codes, which will be used to calculate the professional's performance rate for each measure during the designated reporting period. In addition, there are also potential structural requirements, such as the use of electronic medical records (EMR) that could be included in the measures to qualify for pay-for-performance bonuses.

There are a number of measures that may be selected by a department; however, these measures should be based on current patient panels and types of services rendered by a particular specialty. Currently, the bonus is calculated for each individual provider via UPIN identifiers. Should one member of the faculty not participate, it does not affect payment for other faculty in the same practice group or division. It is anticipated that the bonus will be paid as a lump-sum to the tax ID number, and hopefully will include identifiers for each participating physician.

It must be noted, once again, that this is the initial phase. There is a possibility that the incentive rates could change based on legislative actions. Even though this is currently being presented as a bonus, it is likely that the bonus will eventually become merely a percentage of the Medicare allowable, thereby resulting in a decrease of the normally expected reimbursement if measures are not met. This is when meeting PQRI quality measures become critically important to the financial welfare of the department.

As for departments who have yet to begin the process of implementing PQRI, it may be beneficial to appoint a skilled clinical faculty member who has a sincere interest in helping establish the necessary elements, and the ability to encourage cooperation among other faculty members. However, it will be important that he or she has a good understanding of the specifics of what is required. This process will need to be well coordinated, and cooperation among the various divisions within department is necessary. The CMS website has an abundance of information regarding the PQRI program at www.cms.hhs.gov/pqri.

Although this is another reimbursement challenge for departments to wrestle with, it is also an opportunity for ophthalmology programs to lead the way in our respective organizations. Even though the initial phase is incentive driven, the goal of PQRI is to eventually become a pay-for-performance system by linking payment of services to quality of care, which could have a negative impact on reimbursement if measures are not being met. Needless to say, the current specifics of the 2008 PQRI program may depend on potential legislation that could be passed during the current calendar year, and history has demonstrated that changes in this arena can indeed occur.

AUPO Program Director's Council—President's Report

By Karl C. Golnik, MD

The Program Director's Council (PDC) strives to improve the PD's educational abilities and enhance effective residency program management. The PDC consists of seven members for 2007-2008: the Immediate Past President (Anthony C. Arnold, MD), President (Karl C. Golnik, MD), President-Elect (Maria M. Aaron, MD), and four at-large members (Steven J. Gedde, MD, Mark S. Juzych, MD, Richard A. Harper, MD, and Andreas K. Lauer, MD). The Past President rotates off the council each year and a new member is elected in the fall. PDC members must have at least two years experience as a PD and be ready to serve seven years on the Council. Nominations for membership will be solicited in October/November via email. If you are not on the PD listserve (Eyepdnet@aao.org), contact the AUPO office at aupo@aao.org.

Two new task forces have been formed to address resident optics education and practice management. The **Optics Resident Education Task Force** is Chaired by Tom Hejkal, MD. This task force is charged with assessing the relevance of the Optics portion of the Basic and Clinical Science Course (BCSC) and the practicing ophthalmologists curriculum (POC) to resident/clinician education. The **Practice Management Task Force** is chaired by Leslie Jones, MD. This task force is charged with: 1) Forming opinion on the program's role in this area, 2) Assessing existing best practices/resources available, and 3) Suggesting a plan by which programs might improve training in this area. Reports from each task force will be given at the PD Forum the Thursday afternoon of the AUPO meeting.

Upcoming PDC sponsored educational events include (in chronological order):

1. The annual AUPO-sponsored **Teaching and Learning in Ophthalmology (TLO) Symposium**, "Preparing the Ophthalmology Resident for Live Ophthalmic Surgery," will occur at the AAO meeting in New Orleans on Sunday, November 11, 2008 from 2:00-3:30 p.m. in Hall D1. It will be chaired by Anthony Arnold, MD and Mark Blumenkranz, MD. This symposium focuses on the components of a structured program for resident instruction in ophthalmic surgery prior to participation in live surgery. Methods for the development of a knowledge base and of cognitive and technical skills will be discussed. At the completion of this symposium, the audience should be able to improve resident preparation for live ophthalmic surgery by: 1) Developing a surgical curriculum, 2) Applying new technology and practical tips to update wet lab experience, 3) Utilizing cognitive and technical skills testing to ensure resident preparation, and 4) Integrating virtual and simulated surgical training instruction. JP Dunn, MD will conclude the symposium with the Straatsma Lecture. Next year's TLO symposium must be submitted prior to this year's AAO meeting. Topic suggestions should be submitted to Karl Golnik, MD at kgolnik@fuse.net.
2. **Educating the Educators (EE) 5** will take place on Wednesday, January 30, 2008 immediately preceding the annual AUPO meeting. Nicholas Volpe, MD and Tara Uhler, MD have developed an excellent program focusing on Resident Selection and Systems-based Practice. In addition, a free paper session will allow program directors to share their best current practices and models for resident education. Please note the deadline for abstract submissions for this meeting has been extended to October 1, 2007. Please submit your medical education research abstracts (introduction, methods, results, and conclusions, maximum 300 words) to meded@willseye.org.
3. The **AUPO Residency Program Symposium** (Thursday, January 31, 2008) is under construction; forward topic suggestions to kgolnik@fuse.net.

In other related news, the most recent Program Directors Medical Education Group (PDMERG) research project, "Video Vignettes for Teaching and Assessing Professionalism & Communication Skills in Ophthalmology Residency Training Programs," has been accepted for presentation (PO365) at the annual AAO meeting in New Orleans (Monday/Tuesday). Additionally, most PDs (87) responded to a listserve survey regarding the ACGME competencies; these results will be presented as a poster (PO364), "Program Director Survey to Assess the Shift to Competency-Based Education," at the AAO meeting (Monday/Tuesday).

The PDC was formed to help and improve the PD's existence. If you have questions or concerns related to your role as PD, please feel free to contact me at the email address listed above.

The View from RPB

By Matthew Levine

Forty-seven years ago, Research to Prevent Blindness (RPB) was conceived as a catalyst between the ophthalmological researcher and all available sources of financial support. In broad strokes, the organization's founder, Jules Stein, and the early Board of Directors saw RPB expanding the capacity of the vision research community to bring hope and care to those suffering from loss of vision.

"The range and impact of the scientific endeavors we have supported over the years," says RPB Chairman David F. Weeks, "are the direct result of the wisdom of the founders' initial conception and their foresight in creating RPB's unique grants program."

For starters, the stipulation that, in order to receive RPB unrestricted support, a department of ophthalmology be just that—a separate department—created an incentive for medical schools across the country to establish many of the outstanding departments of ophthalmology now in existence.

Quickly, RPB initiated a comprehensive nationwide survey of the personnel, laboratory space, equipment and money available for ophthalmic investigations, as well as projected needs going forward. The survey exposed a shocking lack of laboratory space and a severe shortage of scientific personnel. Only 15 ophthalmologists and 37 basic scientists in the entire country were engaged in vision research. Fewer than half of U.S. medical schools provided space for eye research. Their equipment was antiquated and space was cramped.

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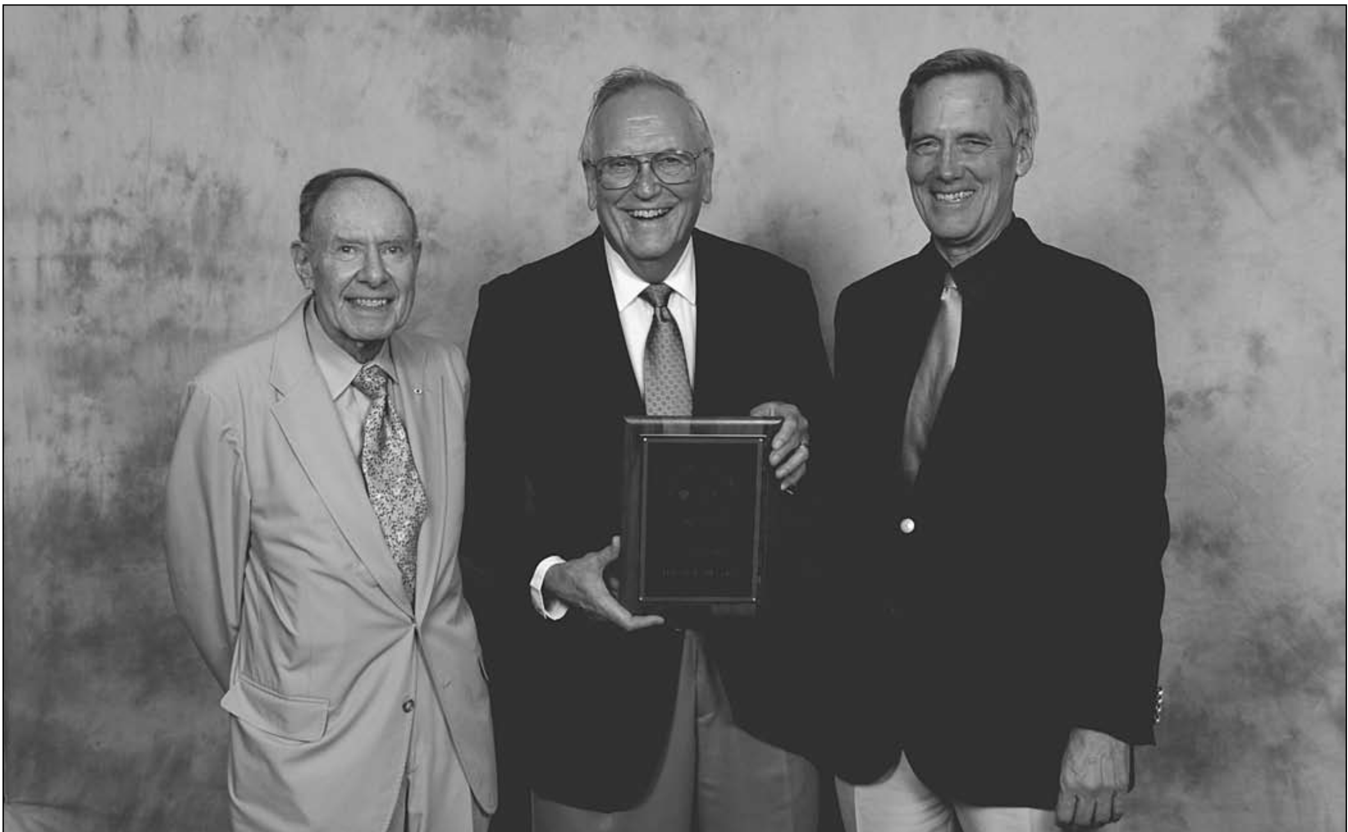

On May 6, 2007, RPB Chairman, David F. Weeks, received the Kupfer Service Award, named for the founding Director of the NEI. The Award acknowledges RPB's national leadership role in advancing ophthalmic science. In their introductory remarks, Drs. Kupfer *(left)* and Stephen Ryan *(right)* made note of Weeks' instrumental role in establishing the NEI as well as AUPO, and his 46 years of leadership at RPB. Weeks holds honorary memberships in both ARVO and AUPO. He has also been accorded an honorary doctorate degree from the University of Louisville.

In 1961, RPB launched a laboratory construction program that led to the coast-to-coast development of modern eye institutes serving millions of Americans. Soon after, capital campaigns directed by RPB helped schools across the country build much-needed laboratory space. In 1967, RPB played a substantial role in developing the Association of Professors of Ophthalmology (AUPO). RPB then led the movement to create the National Eye Institute (NEI) within the National Institutes of Health (NIH).

Today, having nurtured a flourishing vision research community, RPB provides major funding to more than 50 leading scientific institutions in the U.S. and supports the work of hundreds of talented vision scientists engaged in a diverse range of research. RPB's clinical and basic research grants are designated on a highly competitive basis to scientists at virtually every stage in their career—from medical school fellowships through mid-career and senior scientific investigator awards.

In fact, for the last 10 years, RPB has given out an average of 242 grants a year (including both unrestricted grant support to departments of ophthalmology and individual eye researchers). In that same time, a yearly average of more than 800 published studies in peer-reviewed journals have cited support from RPB.

There is another interesting gauge of RPB's grants program. RPB awards provide leverage for researchers seeking NEI grants by allowing them the leeway to pursue new ideas. And scientists working under NEI grants can use RPB support for offshoot areas of inquiry beyond the scope of their government awards. Last year alone, in the *Archives of Ophthalmology,* RPB and NEI support was cited in the same paper on 45 occasions and, in Investigative Ophthalmology and Visual Science (IOVS), in more than 120 papers.

"I want to thank the Chairs of all of our grantee institutions for seeing to it that we receive notification of published studies citing RPB support," said Weeks. "It's an important indicator of our success. I also want to thank grantee and non-grantee chairs who have helped us maintain and expand the ranks of our ophthalmological membership. We take those membership dollars and turn them directly around into research grants."

On June 5, 2007, AUPO Executive Vice President, Bartly J. Mondino, recognized RPB for its continued commitment and service to AUPO and academic ophthalmology. Pictured, left to right: Bartly Mondino, Diane Swift, and David Weeks.

View from the NEI

By Paul A. Sieving, MD, PhD, Director, National Eye Institute

NEI Budget Update

Negotiations continue on FY 2008 appropriations. The President's original FY 2008 budget for the National Eye Institute (NEI) was $667.8 million. In June, the House Appropriations Committee for LHHS recommended a $677 million appropriation for NEI, representing a 1.5% increase over FY 2007. The Senate Committee on Appropriations recommended an appropriation of $681.9 million; this represents a 2.2% increase over the FY 2007 enacted level of $667.1 million. The final appropriation will be decided when the bills go to conference this fall. Alternatively, the National Institutes of Health (NIH) funding could come through a multi-agency, omnibus spending bill.

Ocular Epidemiology Strategic Plan

Fueled in part by advances in genomics, exposure detection tools, bioinformatics, and molecular biology, the field of epidemiology is becoming an ever more powerful discipline in the effort to understand and treat eye disease.

To ensure that it fully leverages the field, the National Eye Institute developed a strategic plan to guide grant making decisions. The process began with an Ocular Epidemiology Symposium in Sarasota in January 2007, and in March, I appointed a planning panel to develop a forward-looking consensus report that would incorporate a broad range of views of those working in the discipline. Sheila West chaired the esteemed panel consisting of Stanley P. Azen, Julie E. Buring, Jonathan L. Haines, Jonathan M. Holmes, Douglas A. Jabs, Paul P. Lee, Lance Liotta, Jerome I. Rotter, Rohit Varma, Daniel E. Weeks, and Karla Zadnik.

The panel has been diligent in reaching its goals to issue a strategic plan. It considered past accomplishments, current NEI grants, emerging opportunities and expertise to create a broad set of goals for the future. Through a series of teleconferences and meetings, a draft of the plan was developed and circulated to the members for additional comment by May 31. This draft was then presented to the NEI Advisory Council on June 6 for comment by June 22. Currently, the panel is creating the final version of the report. The report will be posted to the NEI Web site for public comment sometime in late summer/early fall.

Strategic planning is a challenging process. On behalf of the NEI, I extend my gratitude to the panel members for their perseverance in achieving consensus. I also thank everyone in the field of ocular epidemiology for your interest and help in assisting NEI to perform appropriate due diligence in planning for the public's investment in vision research.

NEI to Continue Institutional Clinician Scientist Development Award Program (K12)

Well-trained clinician investigators provide a critical bridge between laboratory and clinical vision research. The NEI Institutional Clinician Scientist Development Program (K12) was initiated in 2003 to provide clinicians with the fundamental skills needed to engage in the many facets of modern clinical and patient-oriented vision research. Awarded to institutions, the K12 program provides for mentored, career development opportunities, ranging from two to five years depending on an individual candidate's level of previous research experience. Program graduates are expected to transition successfully into positions as independent investigators. Following a review of this program that included discussions with the National Eye Advisory Council, NEI has determined that, with several modifications, the K12 program will continue. Due to budget constraints, the K12 program will be scaled back to help stabilize support for the individual clinician scientist development award programs (K08, K23). The new K12 announcement will be published soon in the NIH Guide for Grants and Contracts. For further information please contact:

Chyren Hunter, Ph.D.
Research Training Officer
Division of Extramural Research
National Eye Institute
Suite 1300, 5635 Fishers Lane
Bethesda, MD 20892-9300
301-451-2020
clh@nei.nih.gov

Development Symposium

By Gary Abrams, MD

One of the highlights of the 2007 AUPO Annual Meeting was the Development Symposium: "Can Chairs Afford Not to Fundraise?" The symposium featured Walt Edwards from Advancement Resources, LLC, Cedar Rapids, Iowa who wove together didactic points in fundraising, anecdotes from donors and fundraisers, and showed compelling videos of donors, medical and institutional leaders, and fundraising professionals that emphasized his points. Following Mr. Edwards' presentation, a panel of chairs that have had success in fundraising addressed some practical issues facing department chairs in fundraising.

Advancement Resources is the leading provider of research-based training workshops for the development field. They serve many of North America's premier universities and medical centers, but even more important than that, they work with clients to help them develop the processes, knowledge, and skills to raise the resources that will transform society—the very society that our children and their children will inherit.

The topic of Mr. Edwards' talk was: "Myths and Truths of Major Gift Fundraising." In his introduction, he emphasized the importance of individual philanthropic giving in America. In 2005, individuals gave more than 200 billion dollars in individual gifts and bequests, accounting for over 80% of all philanthropic gifts that year. The 80% figure for individual giving is actually understated. Foundation giving accounted for another 30 billion dollars, and many foundations are instruments for individual or family giving. Individual giving accounted for 37% of medical giving in 2005, while foundations and corporations accounted for 33% and 16% respectively. Fourteen percent came from other institutions. He categorized giving into three categories: 1. Regular (annual) gifts that come from income, 2. Major gifts that derive from assets, and 3. Ultimate gifts that are given from estates. He emphasized that a successful program has all three types of gifts.

Mr. Edwards dispelled the myth that fundraising is best left to development professionals. The emphasis for fundraising should come from the top and every person that is committed to the mission of the organization should play an important role in the work of development, but people play different roles. He gave this quote from a successful university president: "I insist that advancement be highly integrated with the whole of the institution. Everybody here is responsible for raising money: the provost, the dean, the professors. I am the chief fundraiser for the university. I model the behavior. Everybody knows it. And Advancement reports directly to me." Mr. Edwards noted that medical leadership must articulate the vision of success; the vision should be big and important and leadership should explain the vision everywhere and champion it to everyone. He stressed that donors scale their gifts to the size of the overall goal: the bigger the goal, the bigger the potential gift. He suggested the following points for articulating a vision:

- the vision should be results oriented, set at a future time point and be about people;
- one should help the donor "see" the vision;
- be concise with points, be able to count them on your fingers;
- the vision is more compelling when it crosses institutional and/or societal lines;
- it is okay for the vision to be unusual or a little "quirky";
- lack of enthusiasm for the vision is not okay.

While being able to articulate a compelling vision is important, it is often just as important to understand and care for a donor's passions. He emphasized the need to listen to the donor and that "development magic" happens when the donor's personal story connects to an organizational initiative.

The second myth that Mr. Edwards dispelled is: "It's about prying money from the reluctant." Donors are not reluctant if several key elements are present. The first element is that people are motivated to give for their own reasons and those reasons are not always obvious. It is important to ask the donor what is important to him or her. A second key element is that the primary motivator of donor giving is a deeply-held yearning to make a difference. He emphasized that people with money are looking for additional meaning in life. They are served when they can be helped to invest their money into something in which they have an emotional stake. When donors give because they have an emotional stake

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in the mission of the organization, it is called "philanthropic passion." He pointed out two types of major gifts: loyalty gifts and passion gifts. Loyalty gifts are about helping organizations achieve their goals. Passion gifts are about helping donors achieve their goals.

Mr. Edwards discussed institutional vs. donor perspective on major gifts. While an institution may look at a major gift as an amount given to realize a specific program or project with a set dollar amount, the donor may look at a major gift differently. From the donor's perspective, a major gift is any donation of money or assets to an organization that requires the donor to take time to consider whether or not to make the gift, get other family members involved, and/or seek advice from outside professionals. From the donor's perspective, a major gift is not defined by the criteria of the organization, but by the value placed on the gift by the donor. Another important area was "stretch gifts." A stretch gift is any donation of money or assets that stretches the donor to the limits of his or her giving capacity. This type of gift is often accompanied by a powerful feeling sometimes described as a spiritual joy. The size of a stretch gift is relative to each donor's giving capacity. He emphasizes that donors deserve to be asked for stretch gifts.

An important area discussed by Mr. Edwards was return on investment. Donors, as successful individuals, expect to see positive return on their investments. It is an opportunity for the fundraiser to help donors realize how high the returns will be on their investments with an organization.

For medical institutions and departments of ophthalmology, there is an opportunity to benefit from donations from grateful patients. He noted the importance of linking the donation to a recent medical event and that "grateful tears dry quickly." It is important for the institution or department to have a program in place to identify such patients and work with them soon after the medical problem has occurred. He related that joy and anger are passions and that people with money understand that giving is a way to express joy and gratitude. They also understand that money is a powerful weapon to fight disease.

Mr. Edwards summarized his presentation with a restatement of the myth about fundraising: "It's about prying money from the reluctant." He said the key truth is: "It's about providing donors the opportunity to experience joy they can experience no other way."

A panel discussion followed Mr. Edwards' presentation. The goal of the panel was to have chairs of a diverse group of successful fundraising departments of ophthalmology comment on practical issues in fundraising. Participating were John Shock, Bartly Mondino, Randall Olson, Hilel Lewis, Ronald Smith, Paul Lichter, and Walt Edwards. All participants had a fundraising infrastructure that included full-time development personnel. The structure varied according to the institution with which they were affiliated, but all felt it important that the fundraising personnel report to the chair. In most of the departments, the fundraising personnel had some affiliation with the hospital or the university but worked exclusively for the department of ophthalmology. One issue pointed out is the potential for conflict with the university or hospital over control of donor databases and who has access to specific donors. Most have an understanding with their university or hospital that ophthalmology has ready access to donors with a clear relationship with the department. The chairs were asked if HIPPA regulations created problems in maintaining a donor database and identifying potential donors. Most felt that there were no problems as long as private health information was not divulged. Most did maintain a donor database, some within the department and some in conjunction with the university or hospital.

The chairs were asked if they had a program to enhance the experience of donors during medical visits. Some had development personnel escort the patient during medical visits and all felt that it was important to enhance the donor's visit to the department. Most of the departments have a fundraising board with the role of the board to support departmental fundraising efforts. The Board is composed of donors and others that can enhance the fundraising effort.

The panel members were asked if their departments host fundraising social events. The attitudes varied on the value of such events in raising money, but most felt the events were useful in focusing donor attention on the department and creating good will.

The fundraising symposium was highly rated by the members, and there are plans for a follow-up symposium at the 2008 AUPO meeting.

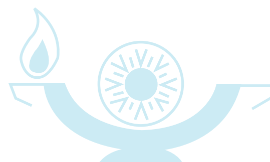
Twelve Helpful Attitudes When Raising Money

John P. Shock, MD

At the recent AUPO meeting, I was very impressed with the presentation, "Myths and Truths of Major Gift Fundraising," by Walt Edwards of Advancement Resources. I think all would agree that fundraising is a very important topic for chairs of academic ophthalmology departments. Gary Abrams, MD, who organized the symposium, had asked a few of us to participate in a panel discussion following the formal presentation, but this discussion was limited due to time constraints. Prior to the meeting, I had prepared a list of helpful attitudes when raising money and had planned to share them during the panel discussion. When that did not occur, Bart Mondino, MD, asked if he could publish them in News and Views to which I readily agreed. For those AUPO chairs who are experienced fundraisers, I am sure you can add many more points to the list.

1. As the department chair, you need to be very involved in raising money no matter the personal sacrifice of time and effort.
2. You must be appropriately persistent, but be prepared for rejection and not take it personally.
3. Never give up on a good prospect who shows interest in your program. Continue to maintain a relationship until your time comes.
4. Do not become discouraged by failure to obtain a gift from a prospect. There are plenty of people who will believe in your dream if you believe in your dream.
5. Always express your gratitude more than once for gifts and help.
6. Remember the relationship is not about you. It is always about the donor and the charity you represent. Learn about the interests of the donor.
7. Be humble and do not seek the limelight. If your efforts are successful, you will get plenty of credit.
8. Be mindful that there is fierce competition for donors. Never, never get the donor involved in your disappointments. If you lose, move on, and wait for another day.
9. A very big factor is relationships. The stronger the relationships, the more difficult it becomes for someone to direct the donor elsewhere.
10. Your relationships should remain strong long after the last gift, if not forever. It shows your gratitude and respect, not only to the donor, but to the donor's family and friends.
11. Long-term relationships are vital. Many become life-time relationships, which provide multiple gifts and good will.
12. Read, attend workshops, and team with an experienced fundraiser, at least, when you are beginning.

Obviously, this is not an all inclusive list, but hopefully, will serve as a reference when dealing with donors or potential donors.



Council of Academic Societies—Spring Meeting

Robert E. Kalina, MD

The Council of Academic Societies (CAS) of the Association of American Medical Colleges (AAMC) met in Long Beach, California on March 15-17, 2007. The focus of the meeting was "The Role of Research in Training the Next Generation of Physicians."

Although Johns Hopkins envisioned itself part of a university with a research mission in the late 19th century, most other schools were slow to follow suit. Flexner (1910) believed that every medical school should incorporate research, but only with the National Institutes of Health (NIH) expansion following WWII did this become a reality. The Medicare windfall led to further support for research through cross subsidization from clinical income. Research became the dominant value of medical schools. Deans gave endowed positions to scientists, not teachers, and research training for medical students became institutionalized in nearly all schools. Residency review committees established requirements for research by faculty members and research training for trainees in nearly all specialties.

Today, there often is little connection between the research program of a science faculty member and his/her teaching assignment. The clinician faculty member is pressured to see more and more patients with an erosive effect on both research and teaching (Flexner believed that patient care by faculty was important only insofar as it made them better teachers and investigators). With the current drive to increase US medical student enrollment by 30%, the value of research training for medical students is being questioned. Competing curricular elements are legion and include not only science but also items such as empathy expression, coping with ambiguity, self-reflection, etc. Those who fund medical education are asking for evidence that research training makes a student a better doctor and that research makes a faculty member a better teacher. The value of research training in graduate medical education similarly is being questioned. Data are lacking except for pass rates on board exams and perhaps maintenance of certification results in the future. Academic societies are encouraged to conduct studies to support the value of research in their training programs or it is likely that research requirements will be dropped for both faculty and trainees.

The AAMC has an on-going Faculty Satisfaction Assessment project that will result in a management tool for Deans and Chairs expected to be rolled out later this year. Focus groups at five institutions have described expected sources of dissatisfaction with clinician educators being perhaps the most disaffected. A common source of discontent is failure of "expectation management," wherein the newly recruited faculty member expects to be scholarly (or thinks that is what he/she heard) while the chair expects a clinical engine.

Tenure now includes a financial guarantee at only 50% of medical schools and only in 5% is the guarantee for full salary. At least eight years of probationary status is allowed before a tenure decision at 43% of schools with options for stopping the clock at 69% and for part time tenure at 30%. The percentage of tenured MD faculty has shown a steady and continuing decline over the past 20 or more years. Emerging tenure issues include recognition of interdisciplinary team science and expanded definition of scholarship (discovery, integration, application, education). Post-tenure reviews are becoming popular to help non-productive faculty find new opportunities.

The Organization of Resident Representatives (ORR) met with the CAS, and two ophthalmology residents were present. The ORR was integrated into the CAS plenary sessions and had their own program that included a session on principles of interaction with industry. The ORR may grow future academic leaders.

Darrell Kirch, MD, former Dean at Penn State and the new President of the AAMC, has launched a strategic thinking and positioning process that will review all aspects of the AAMC. I have suggested that the CAS dues structure be modified to be less prohibitive for large organizations such as the Association for Research in Vision and Ophthalmology (ARVO).

Association of University Professors of Ophthalmology
2008 Annual Meeting—January 31–February 2
The Ritz-Carlton
Sarasota, Florida

Wednesday, January 30

8:00a–5:00p	Educating the Educators

Thursday, January 31

8:00a–8:15a	Welcome
8:15a–9:30a	Management Symposium
9:30a–9:45a	***BREAK***
9:45a–11:15a	Management Symposium (continued)
11:15a–11:30a	Resident Applicant Survey Results
11:30a–12:00p	Straatsma Award Presentation and Lecture
12:00p–1:30p	***LUNCH (On your Own)***
1:30p–4:30p	Residency Program Symposium
6:00p–8:00p	Members & Guests Buffet Reception

Friday, February 1

7:00a–8:00a	AUPO/RPB New Chairs Breakfast (by invitation only)
8:00a–9:30a	Symposium: Underrepresented Subspecialties
9:30a–9:45a	***BREAK***
9:45a–10:45a	Symposium: AUPO/RPB Resident and Fellow Research Forum
10:45a–11:30p	Business Meeting
11:45p–1:15p	Workshops and Discussion Groups 1. RRC/Program Directors: Key Accreditation Issues 2. Research Workshop 3. New Chairs Workshop
6:30p–10:00p	Reception and Banquet for Members, Administrators and Registered Guests

Saturday, February 2

8:00a–9:30a	Symposium: Development
9:30a–9:45a	***BREAK***
9:45a–10:45a	Symposium: Electronic Medical Records
10:45a–12:15p	Organization Reports 1. American Academy of Ophthalmology 2. American Board of Ophthalmology 3. Research to Prevent Blindness 4. National Eye Institute 5. Association for Research and Vision in Ophthalmology 6. Alliance for Eye and Vision Research/National Alliance for Eye and Vision Research 7. San Francisco Match 8. Foundation Fighting Blindness 9. Fight for Sight 10. Fellowship Compliance Committee 11. Heed Foundation Resident Program
12:15p	***Meeting Adjourns***

Administrator's Preliminary Program
Sarasota, FL 2008

Wednesday, January 30, 2008

7:30 pm Welcome Cocktail Reception

Thursday, January 31, 2008

7:00 am Registration and Continental Breakfast
8:00 am Management Symposium
11:15 am Resident Applicant Survey
11:30 am Straatsma Award Presentation and Lecture
12:00 am Listserv Live

1:30 pm Lunch (On Your Own)

3:15 pm Administrators' Evening Out

Friday, February 01, 2008

7:00 am Registration and Continental Breakfast
8:00 am Practice Assessment and Clinic Efficiency

10:00 am Break

10:15 am Harvest the Wins
11:45 pm What's Happening in My Backyard

1:15 pm Lunch (On Your Own)

6:30 pm Reception and Banquet

Saturday, February 02, 2008

7:00 am Registration and Continental Breakfast
8:00 am Symposium: Development

9:30 am Break

9:45 am Symposium: EMR
11:00 am Business Meeting

11:30 am Meeting Adjournment

Educating The Educators Preliminary Program
Wednesday January 30, 2008

Session I: Systems Based Practice: Learning and Quality Improvement

Goal: To provide background, framework, and existing data on systems based practice models that have been used for teaching and assessing this residency competency

Topics:

- Systems Based Practice Overview
- The Task Force and RRC/ACGME Perspective
- Systems Based Practice Models: Lessons Learned in Hospital Systems
- Systems Based Practice and Quality Improvement
- Web Based Teaching and Assessment of Systems Based Practice
- Implementation of Effective Methods for Teaching and Assessing Ophthalmology Residents "Practice in the System"
- Small Group Discussion
- Consensus and Overview

Session II: Resident Selection Process

Goal: To provide background and reach consensus on how we currently select residents and how this process should be modified to enhance the process for both the applicant and the program

Topics:

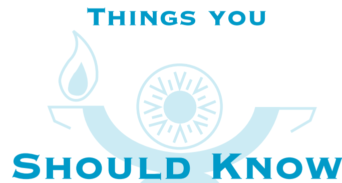
- Review of Current Statistics—OMP
- Ophthalmology Resident Selection: What Do other Programs Do? Results of a National Survey
- Small Group Panel Discussions
- Resident Selection: Best Practice and Methods from other Specialties
- Reengineering the Resident Selection Process

Session III: Free Papers Section

Goal: to provide the educator with updated information concerning current areas of research in ophthalmic education

Topics:

- Selection of Resident Education Related Free Papers Submitted by the Membership and Discussed by a Panel

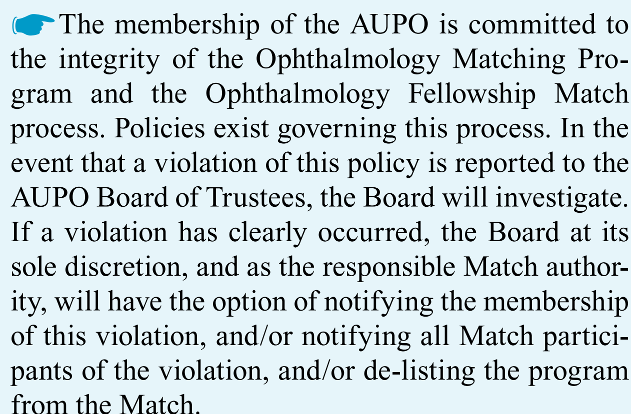


2007 Straatsma Award Recipient
J. P. Dunn

AUPO wishes to congratulate J.P. Dunn, MD, as the recipient of the 2007 Straatsma Award for Excellence in Resident Education. Dr. Dunn is currently the Residency Education Director at the Wilmer Institute, Johns Hopkins University. He is also Associate Professor of Ophthalmology and Director of the Division of Ocular Immunology at Johns Hopkins University. This award is sponsored by the American Academy of Ophthalmology and AUPO, and J.P. Dunn will make presentations at both annual meetings.

Annual Business Meeting

- The membership is invited to submit agenda items to the Executive Vice President for consideration at the Annual Business Meeting. Submissions of items of business in advance will allow full discussion of issues of concern by all AUPO members.
- ***Future Annual Meeting Dates***
  January 29–31, 2009
  Renaissance Esmeralda Resort & Spa—
  Indian Wells, California
  January 28–30, 2010
  Ritz Carlton—Sarasota, Florida



AUPO Policy Statement
Match Violations

☛ The membership of the AUPO is committed to the integrity of the Ophthalmology Matching Program and the Ophthalmology Fellowship Match process. Policies exist governing this process. In the event that a violation of this policy is reported to the AUPO Board of Trustees, the Board will investigate. If a violation has clearly occurred, the Board at its sole discretion, and as the responsible Match authority, will have the option of notifying the membership of this violation, and/or notifying all Match participants of the violation, and/or de-listing the program from the Match.

Dues News

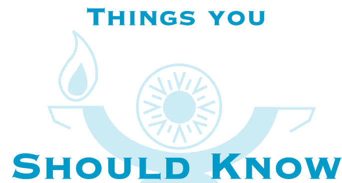
- Renew your dues online! Renewing members may now pay their dues online using either a Visa or MasterCard. The link for renewing online is located in the Membership Section on the AUPO web site. Please note that new members must contact the AUPO office and may not join online.
- Research Directors may now join AUPO as Associate Members. A membership application is located on the AUPO web site in the Membership section.
- If your 2007-2008 dues are still outstanding, Members and Associate Members will not be able to register for the Annual Meeting and Administrators will need to register as nonmembers. Contact the San Francisco office at 415.561.8548 or aupo@aao.org if you have questions regarding your Member or Associate Member dues status. Contact Thelma de Souza at 415.502.1127 about your Administrator dues status.

The Heed Foundation
Merit Award Fellowship Program

The Heed Ophthalmic Foundation designates the Heed Fellowship as a Merit Award of $12,000. This annual Award is granted to individuals pursuing postgraduate studies in ophthalmology or the related visual sciences. Applicants for the Award must be citizens of the United States, graduates of either accredited medical schools or schools of osteopathic medicine and the postgraduate studies must be conducted in the United States. Deadline for receipt of applications is January 15th for fellowships beginning in the same year. For information, please contact:

Froncie A. Gutman, MD
The Heed Foundation
Cleveland Clinic Foundation
9500 Euclid Avenue, Desk i-32
Cleveland, OH 44195
www.heed.org
Phone: 216-445-8145 | Fax: 216-444-8968

Things you



Should Know

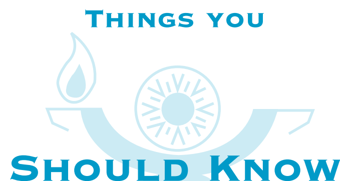
AUPO Board Meeting Highlights July 2007

The AUPO Board of Trustees met in San Francisco on Saturday, July 21, 2007. Following are some of the highlights of the meeting:

- Reviewed the draft 2008 Annual Meeting schedule and confirmed times, titles, format, speakers, and coordinators for all Annual Meeting activities.
- Discussed plans for a new breakfast at the Annual Meeting with Research to Prevent Blindness (RPB), for new Chairs.
- Established a process for AUPO's committees and activities to improve continuity and historical perspective.
- Approved a budget for a meeting of Medical Student Educators in November during the AAO Annual Meeting.
- Developed a policy allowing the Board to approve reciprocal links on the AUPO web site with academic organizations, subspecialty societies, and supporting organizations.
- Approved development of a symposium on generational differences and diversity for the 2009 annual meeting.
- Accepted the Straatsma Award Committee's recommendation of Dr. J. P. Dunn as the 2007 recipient of the AUPO/AAO Straatsma Award.
- Approved a membership application and dues of $300 for Research Directors to join as Associate Members of the AUPO.
- Approved an increase to $300 annually for Associate Member dues for Program Directors beginning with the 2008-2009 dues period.
- Accepted the audit for fiscal year ended 2006.
- Approved a five-year budget for the AUPO Fellowship Compliance Committee.
- Established a policy allowing only academic positions to be posted on the AUPO web site.
- Held preliminary discussions about an Emeritus membership category.

AUPO Policy Statement
Opthalmology Matching Program Policy Reminders

- ☛ All applicants participating in the Ophthalmology Matching Program (OMP) must use the Universal Application form and the Central Application Service (CAS) to apply to all programs in the match.
- ☛ Programs wishing additional information (photographs, hand-written materials, etc.) prior to interviews or prior to signing contracts may request it from applicants in accordance with institutional guidelines.
- ☛ So called "Audition Electives" by medical students at institutions other than their own are discouraged.
- ☛ Residency programs participating in the Ophthalmology Matching Program are not to distribute additional application material prior to July 1 each year.
- ☛ Residency programs are not to initiate contact with applicants after the interview until the match has been completed. This policy has been promulgated in the ophthalmology matching program directory in order that candidates will know if this policy is violated by programs.
- ☛ Fellowships should not be required to begin prior to July 7 in order that residents may complete training on June 30.
- ☛ The AUPO discourages its members from charging applicants fees for applying to residency training programs.
- ☛ AUPO policy strongly discourages any representative of a residency program from entering into discussions with a resident from or matched to another program prior to consultation with that resident's residency program director.
- ☛ The AUPO and its member departments recognize the costs and logistical difficulties borne by applicants in the fellowship interview process. Departments will endeavor to select interview dates which will mitigate these difficulties without negatively impacting the quality of the process.



Faculty Positions Available September 2007

For the most complete, up-to-date listing of faculty positions, with full descriptions, please visit the "Faculty Positions" section of www.aupo.org.

Emory University, Atlanta

Glaucoma Specialist

Medical College of Georgia, Augusta

Oculoplastics Specialist

Medical College of Wisconsin, Milwaukee

Comprehensive Ophthalmology
Pediatric Ophthalmologist

Saint Louis University School of Medicine

Pediatric Ophthalmologist

Tulane University Health Sciences Center, New Orleans

Vitreoretinal Disease and Surgery

University of California, San Francisco

Orbit, Oculoplastic and Reconstructive Surgery
Pediatric Ophthalmologist

University of Iowa, Iowa City

Cornea and External Diseases
Medical/Surgical Retina
Pediatric Ophthalmology and Strabismus

University of Kansas Medical Center, Kansas City

Glaucoma Specialist

University of Pittsburgh School of Medicine

Oculoplastic Surgery
Pediatric Ophthalmology and Strabismus
Vitreoretinal Surgery
Medical Retina Specialist
Glaucoma Specialist

University of Texas Health Science Center at San Antonio

Comprehensive Ophthalmologist/Medical Director
Pediatric Ophthalmologist
Comprehensive Ophthalmologist
Academic Glaucoma Specialist

Weill Cornell Medical College, New York

Comprehensive Ophthalmologist
Glaucoma Specialist
Orbit, Oculoplastic and Reconstructive Surgery Specialist
Uveitis Specialist
Vitreoretinal Specialist