

ASSOCIATION OF UNIVERSITY PROFESSORS OF OPHTHALMOLOGY



MEMBERS, ASSOCIATE MEMBERS AND ADMINISTRATORS
NEWS & VIEWS

JUNE 2006

PRESIDENT'S PERSPECTIVE

BY MARCO ZARBIN, MD PHD



I trust that this editorial finds you, your families, and the members of your department well. Below I have summarized developments in three areas in which AUPO members have been active during the past year.

Resident Training

Can you name the seven competencies? If not, please keep reading this paragraph. The AUPO Program Directors Council is a group of seven resident program directors elected from among and by the program directors of all accredited ophthalmology resident training programs represented in the AUPO. The Council has taken a leadership role in developing methods and technologies to permit assessment of resident performance in each of the seven competencies (i.e., patient care, medical knowledge, surgery, systems-based practice, practice-based learning, interpersonal and communication skills, and professionalism). This process must continue to evolve if the tools we use are to remain meaningful and practical. The American Academy of Ophthalmology (AAO) has provided staff and funding to support the creation of educational manuals and also supports an educational forum ("Teaching and Learning in Ophthalmology Symposium") at the annual AAO meeting. (The next time you see Dunbar Hoskins, you might thank him for his leadership in this regard.)

Please encourage members of your clinical faculty to attend the Teaching and Learning Symposium. Although most individuals in attendance are program directors, the target audience is actually everyone on the faculty involved in resident training. Despite the

many years we have spent in classrooms and in conferences, many of us know little of the science of teaching and learning. Attending the symposium is an easy way to learn from the experience of other teachers and to make your program (i.e., your residents) stronger.

The commitment of our program directors is impressive. I suspect that they are the unsung heroes of many departments.

Fellowship Training

Thanks to the leadership of Stuart Fine, John Keltner, the AUPO Board of Trustees, and a group of committed and resourceful fellowship directors, the AUPO has taken the lead in establishing criteria by which quality of ophthalmology fellowship programs can be assessed. The functioning of the AUPO Fellowship Compliance Committee (AUPO FCC) is described in detail by John Keltner in a previous article. As noted by Dr. Keltner, the AUPO Task Force and representatives of each subspecialty society have established guidelines defining the properties of fellowship training programs that are "in compliance." Compliance with the educational standards is entirely voluntary. In addition, this process will be entirely self-supporting financially. For the AUPO FCC process to be successful, it is essential that department chairs and program directors notify any residents seeking applications for an Ophthalmology Subspecialty Fellowship on the AUPO SF Match Web site (www.sfmatch.org) that the resident should look for the AUPO FCC "In Compliance" logo, which indicates that the fellowship program is in AUPO FCC Compliance and thus meets the educa-

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tional standards developed by that subspecialty and approved by the AUPO FCC. In addition, programs in AUPO FCC compliance will be listed on the AUPO FCC Web site www.aupofcc.org. We expect that by July 2007, all cornea, refractive surgery, and external disease; glaucoma; neuro-ophthalmology; ophthalmic pathology; pediatric ophthalmology and strabismus; retina; and uveitis fellowship training programs in full compliance will be identified as "In Compliance," should their directors seek that status and they are found "In Compliance" by the AUPO FCC.

AUPO Annual Meeting

What would happen to your department if the faculty members did not attend business meetings or if managers did not attend management meetings regularly? In my case, I suspect that the organization could survive reasonably well until there was a significant new challenge to confront, in which case our response would be disorganized, ineffective, and would result, ultimately, in regulatory noncompliance, patient dissatisfaction, net revenue loss, or some combination of these outcomes. Since significant challenges arise at least annually, we probably would be under new management within five years or we would become a subdivision of the department of surgery. Academic ophthalmology cannot prosper without the ongoing, creative involvement of its leadership, broadly defined to include chairs, directors of training programs, administrators, and research directors.

Please make every effort to attend the annual meeting and encourage your program directors, departmental administrators, and research directors to do so also! The AUPO meeting facilitates identification and discussion of problems we must confront in academic ophthalmology. In principle, the meeting also provides an opportunity to develop solutions to these problems. The AUPO meeting is unique because the program is focused on the management of ophthalmic education, research, and clinical practice operations. (Development of philanthropic programs is also a frequent topic of discussion.) To ensure that we use this time together wisely, members of the AUPO Board of Trustees consider carefully the venue, the representation of ophthalmology department members, and the syllabus of the meeting. The AUPO membership's recent decision to include research directors in the meeting is a manifestation of this deliberation. Do you think the AUPO meeting is a waste of time? Is there a session that we should add to or remove from the program? Please let the AUPO Board of Trustees know by completing the meeting survey or simply by calling or e-mailing one of us. Many of the workshops and symposia at the AUPO meeting are the direct result of suggestions that you have made (although it may have taken several years to actualize these suggestions!). In this regard, it is very helpful for us to fill out the questionnaire at the end of each AUPO meeting. The AUPO Board of Trustees reviews the survey and makes plans for future meetings based on our responses.

I wish you all a terrific summer and thank you for the privilege of serving you.

ADMINISTRATORS UPDATE

By Jonathan Smith, MBA, MS

LEGACY OF LEADERSHIP

Time has a way of testing legacies. U.S. presidents often desire to establish a legacy by making policies, enacting laws, creating programs, and capitalizing on current events. How successfully these items are addressed will add or detract from a legacy, but there are two factors that seem to soar above all of these: character and courage.

In a Wall Street Journal poll of scholars conducted in 2000, there were only three presidents that were categorized as “great.” They were George Washington, Abraham Lincoln, and Franklin Roosevelt. These men shared a common struggle: they were wartime presidents. Their wars were such that, if the outcomes had been different, the course of history in America would have been drastically altered.

Although we are not normally faced with life and death decisions in academic ophthalmology, we are faced with unknowns and issues beyond our control. We maintain a constant awareness of Medicare reimbursement levels, as well as debated legislation that can significantly influence our operations. These challenges require strong leadership to remain competitive and advance the organization.

George Washington is often remembered for his extraordinary leadership during the Revolutionary War. He was not highly educated nor was he considered a tactical genius prior to the war. However, there were two characteristics that he displayed time and again that his peers in the Continental Congress uniformly recognized. These traits were unquestioned character and courage. A study regarding the public life of both Lincoln and Roosevelt also manifested these same characteristics.

Additionally, Washington embodied a unique talent that is not often highlighted. He had the ability to identify character and courage in others, regardless of their experience. He chose some to be members of his staff

who had limited or no experience on the battlefield. Most notable were Nathaniel Green and Henry Knox as military leaders, and Alexander Hamilton as an invaluable aid.

Washington, through his highly esteemed character traits, not only had the ability to inspire those under his command; he was also able to recognize opportunity. Washington’s crossing of the Delaware and subsequent battle is considered one of the most important turning points of the war. Washington achieved this critical victory, which reinvigorated a tired and tattered remnant army, as well as lifted the morale of a country struggling for freedom.

As leaders we should also consider identifying and developing staff members throughout the organization who possess valuable leadership traits, and not just those in a few select positions. Quality attributes concerning character can provide much greater returns than solely considering educational endeavors and related work experience. Some may believe that leaving a legacy requires building a new edifice, or some other tangible item that can be readily recognized. Structures are important for the expansion and development of programs, but a successful tenure of inclusive leadership can provide significant tangible and intangible benefits. The legacy of our leadership offers an opportunity for a long-lasting, positive impact on the future welfare of the organization. These efforts can establish a solid foundation, thereby preparing us for the challenges ahead.

The outcome of these challenges may rely on whether or not we have assembled and invested in a team of capable leaders, those who can assist in leading the organization through difficult times. The legacy we establish will be determined by these defining moments, and time will be the measure of success.

BUSINESS MANAGEMENT SYMPOSIUM

By Mark S. Blumenkranz, MD

Enterprise Management: The influence of conceptual models of decision-making and cost-effectiveness on the success of academic departments of ophthalmology

Healthcare costs are rapidly escalating in the United States with nearly \$1.3 billion spent on healthcare annually, of which nearly half or \$519 billion was spent by Medicare and Medicaid on 83 million beneficiaries in 2004. This amounts to in excess of \$5,000 yearly per capita on healthcare expenditures or 14% of gross domestic product (GDP) of the United States. This has naturally led to considerable effort by the United States government to contain costs, which are projected to rise more than 2.5% annually over the next five years, potentially increasing the percentage of GDP spending on healthcare from 14% to 17%. All of this has in turn affected hospitals, and particularly academic medical centers where decreasing clinical revenues, combined with reduced funding through the NIH and NEI, have resulted in extreme financial pressures. Furthermore, what appears to be a generalized trend nationally towards the deprioritization of ophthalmology by hospitals and medical schools represents a serious challenge to chairs of departments of ophthalmology today.

The symposium was organized to address the important dual and interrelated areas of metrics for decision analysis and cost-effectiveness, both as they relate to rendering of medical care to patients and in the strategic planning and management of academic ophthalmology enterprises.

The symposium was divided into two parts. The first was a series of three lectures. The first two lectures were delivered by Milton Weinstein, Henry J. Kaiser Professor of Health Policy and Management in the Harvard School of Public Health, a seminal contributor to the field of medical decision analysis and one of the originators of the concept of cost-effectiveness analysis as a healthcare policy tool.

Dr. Weinstein's first lecture was entitled "Decision Analysis: Weighing Risk and Benefits," which focused on the conceptual and practical framework with which medical decisions could be made. During his lecture, Dr. Weinstein discussed the rationale for

an analytic tool for circumstances under which (1) a decision must be made under conditions of uncertainty, (2) the consequences of the action are uncertain, and (3) when objectives may conflict. He gave several examples of areas under which this rubric might be applied in ophthalmology, including the decision whether or not to perform cultures first or empirically treat for a serious eye infection, how to sequence intraocular pressure lowering treatments for patients with primary glaucoma, or whether to treat one versus two eyes in patients with age-related macular degeneration. Dr. Weinstein also gave an illustrative example of a hypothetical patient with giant cell arteritis in which the risks and benefits of obtaining a biopsy first and waiting to treat with steroids depending upon the outcome were compared with initiating treatment right away with or without a biopsy. This took into account both the potential negative consequences of steroid therapy in the elderly, the potential risk of the biopsy itself as well as both the sensitivity and specificity of a biopsy and how that might affect the process. He introduced the concept of a decision tree, which takes into account each possible decision, and its potential outcome as well as the relative probabilities assigned to each. He discussed how imperfections in testing methods such as biopsy affect both positive and negative predictive values as well as the concept of sensitivity analysis in which the impact of variable results influences choices. Dr. Weinstein explored the concept of how a Markov model, constructed to weigh the impact of these factors, is employed in modern decision analysis using computerized methods. Finally, he discussed the use of threshold analysis for imperfect tests, which permits the determination of a value that allows a clinician to make a rational decision between test and do not test or treat and do not treat for given populations based upon the prevalence of the condition in those populations. While much of this is theoretical and best understood by practitioners in the area of health outcomes research, it also has important consequences on the teaching of clinical care to residents in ophthalmology that will practice in a new era of evidence-based medicine.

Dr. Weinstein's second lecture was entitled "Cost-Effectiveness Analysis: Getting Value for Money in Healthcare." In the lecture Dr. Weinstein introduced the proposition that Americans are not willing to pay what it would cost to provide all the beneficial health services available. With costs rapidly rising due to the introduction of new technologies, it has become increasingly important to measure value for money. Dr. Weinstein provided a lucid discussion of the metrics for such decisions, with money defined as the net resources consumed in providing interventions and value defined as improvement in health outcomes. He then went on to explain in more detail some of the specific metrics related to these two variables. Health outcomes may be measured as either disease-specific outcomes such as days of intraocular pressure control, months of visual acuity greater than 20/20, or 20/200 in the case of ophthalmology, or cases of cancer detected or days of asthma controlled for other general health conditions. Health outcomes can also be measured in terms of quality-adjusted life years, or QALY. Dr. Weinstein went on to explain the concept of QALY in greater detail since it is a critical and recently developed metric in health outcomes research as well as cost-effectiveness determinations. Quality adjusted life years represent not only absolute increases in life expectancy, but also improvement in the quality of life over a constant life span. Thus, for areas such as ophthalmology, although treatments for elevated intraocular pressure or age-related macular degeneration may not increase absolute life expectancy, they nonetheless produce increased QALY through their contribution to improvements in the quality of life. Calculation of a QALY represents the product of years of life remaining (either increased or decreased by the intervention), multiplied by an index of health, ranging from zero to one, with one being perfect health and zero being death. Dr. Weinstein went on to explain that the calculation of the numerical multiplier based upon quality of health is able to be calculated with some degree of precision through psychometric and statistical methods employing community preferences through the use of two different techniques—time trade-off and the standard gamble. Using this type of analysis, it is possible to compare the health benefit as measured in QALY between different procedures for the same disease state such as age-related macular degeneration, or to compare health improvement outcomes for different intervention in different disease states and disciplines

such as cardiology and nephrology.

Dr. Weinstein then went on to describe the metrics related to the second pillar of cost-effectiveness analysis, cost itself. Cost includes the various components of the traditional healthcare bill including provider services, drugs, technical services provided by the hospital, in addition to softer and more indirect costs such as loss of earnings potential related to disability following an intervention. The ratio between net increases in healthcare costs divided by net gain in health outcomes as measured by QALY represents the incremental cost-effectiveness ratio. As new technologies, drugs, or procedures are introduced into the medical armamentarium, the incremental or differential costs and benefits associated with these advances as compared with existing therapies has been termed the incremental cost-effectiveness ratio and has represented one rational tool by which health policy decision-makers adopt new therapies. Dr. Weinstein then provided a hypothetical cost-effectiveness analysis used to make a decision between two different forms of therapy.

Dr. Weinstein concluded by discussing the important impact these analytical decision-making tools have on society and the future practice of medicine, including government, managed care organizations, hospitals, and specialty organizations such as the AUPO and the American Academy of Ophthalmology (AAO).

Dr. Hilel Lewis, Director of the Cole Eye Institute, delivered a lecture on a related topic geared more toward the management of a clinical operation rather than the teaching of residents in medical decision-making, and the development of public health policies related to cost-effectiveness within ophthalmology. Dr. Lewis's lecture was entitled "Cost Management: An Analytical Framework for Success." Dr. Lewis stressed that all costs should be analyzed, that managers should establish targets and analyze historical trends, evaluate all variances to budget, and seek best practice costs standards. He then went on to define management processes to evaluate, analyze, and implement cost management initiatives, as well as to continuously seek cost management ideas and new analytic frameworks. Dr. Lewis presented data from the Cole Eye Institute indicating a breakdown in costs, including physician salaries of approximately 35%, ancillary salaries of 27%, benefits of 13%, medical expenses of 13%, and non-medical expenses of 12%. He discussed cost challenges in the management of the enterprise including

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the current crisis of skilled labor shortage, lower Medicare reimbursement, increasing volumes of uninsured and Medicaid patients, increasing capital funding costs, the management of accounts receivable, payor arbitrage, and increasing compliance and regulatory costs. Dr. Lewis presented examples of standard reports and controls employed at the Cleveland Clinic. These included profit and loss statements, contribution factor analysis, non-labor expense variance analysis, surgical costs per case, productivity, and production volume analysis. He went on to discuss manpower-planning, use of RVUs as a measure of physician productivity, the capital procurement approval process, and supply chain management. He emphasized how these processes could best be managed in a cost-controlled environment. Drug management in an era of increasing cost and decreasing reimbursement was also discussed. Dr. Lewis concluded with the admonition that deficiencies can become significant opportunities for improvement, provided that staff and ancillary personnel participate in achieving best practice performance. He emphasized the role of delegation of responsibilities, the use of best practice metrics, and innovation to redirect institutions towards a culture of excellence.

The second component of the symposium consisted of a panel discussion that centered on practical implementation of these concepts of decision analysis and cost-effectiveness analysis for academic departments of ophthalmology based upon the experiences of fellow chairs and members of the AUPO.

The session was moderated by Mark Blumenkranz, MD of Stanford University, and in addition to Dr. Milton Weinstein included, Dr. Hilel Lewis, Dr. David Epstein of the Duke Eye Center, Dr. Carmen Puliafito of Bascom Palmer Eye Institute, and Dr. Joe Robertson of the Casey Eye Institute of Oregon Health Sciences University. Dr. David Epstein led off with a thoughtful discussion of the impact of increasing cost pressures and their associated management on academic departments and particularly the research enterprise. Dr. Epstein proposed that the greatest threat to ophthalmology departments of the future is the systematic deprioritization of ophthalmology by medical schools. He suggested that the ultimate cost-effective strategy was to have a cohesive faculty program with all oars pulling in the same direction integrated into and valued

by the school of medicine and health system. He recommended chairs be good university citizens and perform university services, including integration with other departments and schools within the universities as a means of increasing influence and prioritization. He stressed the importance of understanding and analyzing chairs, deans, and other reporting relationships as a means of improving influence and outcomes and concluded by stating that strategic planning was an essential component of cost effectiveness.

Dr. Joe Robertson, who recently transitioned from chair of ophthalmology to dean, concurred with these recommendations and further stressed the need for constructive collaboration between departments of ophthalmology and schools of medicine as a means of improving influence and deemphasizing the general trend towards deprioritization. The causes for deprioritization were discussed amongst the panel members, including the perception by healthcare administration that ophthalmology departments, as a general rule, contribute less to the overall financial well-being and profitability of medical centers than other departments, such as neurosurgery or cardiac surgery, that are more resource-intensive and make better use of the operating rooms and intensive care units.

Dr. Puliafito and Dr. Epstein both emphasized that while many of the highly objective metrics delineated by Dr. Lewis and Dr. Weinstein were important, some of the more subjective measures of why faculty choose to practice in academic medical centers rather than private practices or group practices were critical to maintaining the vitality of academic departments. These included the ability to teach and perform research, as well as the bonhomie associated with academic departments historically, which should be valued and maintained.

The symposium concluded with a general agreement by the panel that the use of metrics would become more important and in fact indispensable for academic departments going forward. This will include not only their use for managing enterprises in a cost-effective and fiscally responsible way, but also in the teaching of cost-effective medicine to residents and fellows who will be under increasing pressure to understand and employ these techniques in the practice of medicine in the mid and later portions of the twenty-first century.

BURNOUT IN CHAIRS OF OPHTHALMOLOGY: RECOGNITION, DIAGNOSIS, AND PREVENTION

By Oscar A. Cruz, MD

Burnout in physicians and other healthcare providers has become an important national concern. Burnout is a syndrome characterized by emotional exhaustion, depersonalization in relationships with co-workers, and a sense of inadequacy or reduced personal accomplishment. Burnout occurs most often among individuals who work closely with people including healthcare professionals. The likelihood of burnout increases when there is significant, prolonged occupational stress, such as work overload, and inadequate resources in meeting these stressors. Burnout has been associated with impaired job performance, poor health, and deterioration in relationships with family and friends.

Department chairs are experiencing significant stressors, including increased oversight and bureaucracy associated with patient care, teaching, and research, decreased reimbursement for patient care services, and a reduction in time available for teaching and research. Steven Gabbe, MD, Dean, Vanderbilt University School of Medicine presented a symposium at the 2005 AUPO meeting highlighting burnout in chairs of obstetrics and gynecology. His study showed that burnout in chairs of obstetrics and gynecology is characterized by a high level of emotional exhaustion, moderate to high depersonalization, and high personal accomplishment. He concluded that the psychological well-being of the chairs of academic departments of obstetrics and gynecology affected the quality of leadership they could provide in teaching, research, patient care, and administration.

With the approval of the AUPO Board of Trustees, a cross-sectional questionnaire-based study of chairs of ophthalmology was performed. The study included questions devoted to demographics information, mod-

ified Maslach-Burnout Inventory – Human Services Survey, and questions identifying patient stressors.

We performed the cross-sectional study of 131 chairs. Questionnaires were returned from 101 chairs for a response rate of 77%. The average age of chairs was 56.7 years with 70% of chairs between the ages of 51 and 65. The average length of time as chair was 9.4 years, but 33% of the chairs had served less than four years. The most significant stressors were faculty retention and recruitment, departmental budgets and deficits, and RRC/ACGME issues. Ten chairs had all three risk characteristics (increased emotional exhaustion, increased depersonalization, and decreased personal accomplishment). Burnout in chairs of ophthalmology was characterized by moderate to high emotional exhaustion, low depersonalization and low personal accomplishment. The high scores for emotional exhaustion and low scores for personal accomplishment are significant risk factors for burnout. The risk for burnout can be decreased by controlling the number of hours worked per week, spending time with a spouse/partner and family, having a mentor, and utilizing individual approaches to reducing stress.

The AUPO has been proactive with programs that reduce the risk of burnout. The annual meeting provides a forum for the chairs, and participation and attendance should be encouraged. The summer management/advanced leadership course should also be encouraged. New chairs should be advised to participate in the mentoring program and senior established chairs should be solicited to serve as mentors.

In addition to the toll that burnout has on the individual chair, the consequences to the schools of medicine with increased job turnover and instability contribute to the high cost of burnout.

AUPO MEMBERS LEAD CAPITOL HILL ADVOCACY FOR RESEARCH FUNDING

By James Jorkasky, Executive Director, NAEVR/AEVR

AUPO members have played a leading role in contacting their members of Congress to support vision research funding in the Fiscal Year (FY) 2007 federal budget and appropriations process. This has been especially critical in this funding cycle, as the president's FY2007 budget has proposed to flat-fund the National Institutes of Health (NIH) at the FY2006 funding level of \$28.6 billion and to decrease National Eye Institute (NEI) funding by 0.8% (or \$5.3 million) to \$661 million.

In advocacy campaigns coordinated by the National Alliance for Eye and Vision Research (NAEVR), of which the AUPO is a founding organization, AUPO members were represented in the thousands of letters sent to both the Senate and House supporting a \$7 billion increase (more than what was proposed in the president's budget), for health and education programs in the budget resolutions passed by each chamber. The additional \$7 billion would enable allocations within the Labor, Health and Human Services and Education (LHHS) appropriations bill to be increased. In the case of NIH, this would mean \$2 billion more than in the FY2006 budget.

NAEVR's campaigns, held in conjunction with coalition partner organizations from the health and education communities, resulted in the March 16 Senate and May 18 House passage, respectively, of budget resolutions that included the additional \$7 billion. At press time, House and Senate appropriations leaders were negotiating as to how this increase would be reflected in allocations to specific programs in the LHHS spending bill, including NIH and its individual Institutes, such as NEI.

On May 19, AUPO member Dr. Peter McDonnell (Wilmer Eye Institute) testified on behalf of NAEVR at the Senate LHHS Appropriations Subcommittee hearing, urging increased funding for eye and vision research greater than that proposed in the president's budget. Dr. McDonnell's testimony focused on NEI's extensive research in age-related macular degeneration (AMD), the leading cause of blindness in the United



States, and identified follow-up research that would
Dr. McDonnell (third from right) during panel testimony.

FY2007. Dr. McDonnell's testimony can be found on NAEVR's Web site at <http://www.eyersearch.org/pdf/mcdonnellstatement.pdf>.

AUPO members have also been instrumental in contacting Congress to support the continued eligibility in FY2007 of eye and vision research for competitive, peer-reviewed grants available within the Department of Defense's (DOD) Congressionally-directed Medical Research Program (CDMRP). Eye and vision research was initially made eligible in FY2006 DOD funding. AUPO members from New York and Texas have contacted, respectively, House Military Quality of Life and Veterans Affairs Appropriations Subcommittee chair Congressman James Walsh (R-NY) and Senate Defense Appropriations Subcommittee member Kay Bailey Hutchison (R-TX), who are serving as champions for the continued eligibility of this alternative funding source. NAEVR's FY2007 DOD/CDMRP funding justification can be found at http://www.eyersearch.org/naevr_action/cdmrp07.html.

UCLA/AUPO INTRODUCTORY COURSE ON CLINICAL RESEARCH FOR OPHTHALMOLOGY RESIDENTS, FELLOWS, AND FACULTY SEPTEMBER 15 – 17, 2006

By Gary N. Holland, MD

One of three major objectives of the Association of University Professors of Ophthalmology (AUPO) is the promotion of research in ophthalmology; the AUPO Board of Trustees believes strongly that skills learned by participation in research are invaluable components of the education of an ophthalmologist. While the AUPO Resident and Fellow Research Forum provides an opportunity for selected residents to interact with chairs and program directors, the AUPO recognizes that only a few residents are impacted by this program each year. As an additional means of promoting research training among a larger group of residents, the AUPO is co-sponsoring, with the UCLA Jules Stein Eye Institute (JSEI), a course entitled "Introduction to Clinical Research." The course, which will be conducted on the UCLA campus, has also been endorsed by ARVO.

The course will address the need for comprehensive, entry-level instruction for beginning researchers and for those without training in the interpretation of research reports, but will be applicable to those already involved in clinical investigation as well. It will be open to residents at all levels of training, to clinical fellows, and to faculty. It will be particularly relevant for residents early in their training programs, prior to beginning research projects of their own. For faculty attending the course, it will cover material that can later be incorporated into training programs at their own institutions.

The course will emphasize practical information that is directly applicable to resident and clinical fellow research activities, and will assume that attendees do not have extensive experience with patient-based research. It will also highlight the value of research data for clinicians, whether or not they eventually participate in research or pursue academic careers. The course will deal with research methods and with related issues, such as regulations that affect research and scientific publication. Concepts will be emphasized; with respect to statistics, for example, the uses and interpretation of various statistical measures will be

presented, to help residents and clinical fellows avoid inappropriate use of statistics, but the course will not specifically train attendees to perform statistical tests.

The course will focus on the types of studies performed most commonly by residents (e.g., case series, laboratory data from patient cohorts, and cross-sectional studies). The course will help residents to design studies, analyze data, and prepare publications, but it will also improve their abilities to read the medical literature critically, which is a requisite for the practice of evidence-based medicine.

Representative topics for Discussion

- I. IRB/HIPAA Regulations (as they relate to patient-based research)
 - A. Waivers
 - B. Exemptions
 - C. Informed consent
- II. Ethical Issues in Research and Publication
 - A. Authorship
 - B. Conflicts of interest
- III. Study Design
 - A. Case series, cohort studies, case control studies, randomized clinical trials; value and limitations of each study type
 - B. Creation of appropriate control groups
 - C. Issue of differential follow-up
 - D. Outcome measures
 - E. Data quality, and dealing with problem data
- IV. Statistical Issues and Concepts
 - A. Type 1 errors, Type 2 errors
 - B. Statistical significance vs. clinical relevance
 - C. Understanding odds ratios, relative risk values, positive and negative predictive values
- V. Manuscript Preparation
 - A. Organization of a research paper
 - B. Techniques of data presentation
 - C. Common problems that reduce quality of a manuscript
 - D. Examples of "good" and "bad" articles, discussed in an interactive format

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The course will be organized by Gary N. Holland, MD and Bartly J. Mondino, MD through the JSEI Clinical Research Center. Course faculty will include individuals from the David Geffen School of Medicine at UCLA, the UCLA School of Public Health, and invited guest speakers, representing a broad spectrum of expertise related to research activities. Included will be representatives from the UCLA Institutional Review Board (IRB) and individuals with expertise in scientific writing, editing, and publishing. Sessions will be informal, with close interaction between attendees and course faculty.

The course will begin Friday evening, September 15, 2006, to allow participants from the East Coast to travel that morning. The course will conclude with lunch on Sunday, September 17, 2006, allowing

participants sufficient travel time to return home on the same day, thereby minimizing time away from their training programs.

Registration Contact Information

Residents and clinical fellows must be selected by their departments for participation, but there is no limit on the number of registrants. Programs interested in the course should contact Ms. Debbie Sato of the Academic Programs Office, Jules Stein Eye Institute (telephone: 310.825.4617; e-mail: sato@jsei.ucla.edu). Course attendees or the programs they represent will be responsible for travel and lodging expenses, but there will be no registration fee for the course. The deadline for registration will be Tuesday, August 1, 2006.

AUPO CHAIR MENTORING PROGRAM

AUPO invites you to become part of our Chair Mentoring program, detailed in the September 2005 issue of *News & Views*. If you are a new or about-to-be new chair, consider having a mentor to provide guidance and perspective during the initial phase of service as chair. For information regarding how to obtain an AUPO mentor, please call Melania Vartanian at 310.825.3381. A mentor will be assigned and a notification will be sent to the mentor. The mentee can then make the initial contact.

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 post-graduate 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:

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Future Annual Meeting Dates

February 1-3, 2007
Renaissance Esmeralda Resort & Spa ~ Indian Wells, California

January 31-February 2, 2008
The Ritz-Carlton ~ Sarasota, Florida

January 29-31, 2009
Renaissance Esmeralda Resort & Spa ~ Indian Wells, California

THINGS YOU



SHOULD KNOW

FACULTY POSITIONS AVAILABLE JUNE 2006

The faculty positions section lists positions available within the AUPO Member Departments of Ophthalmology. If your institution is interested in advertising ophthalmology positions (at no charge), type your advertisement for publishing and submit it to the AUPO San Francisco office.

THE DEAN A. MCGEE EYE INSTITUTE GLAUCOMA SUBSPECIALIST

The Dean A. McGee Eye Institute (DMEI) is seeking a talented glaucoma subspecialist who would join Dr. Gregory L. Skuta and nearly 30 other ophthalmologists, immediately assume a busy clinical and surgical glaucoma, cataract, and anterior segment practice, and have the opportunity to flourish personally and professionally in a unique and rewarding environment. The DMEI will soon break ground for a \$30 million expansion, utilizes an ambulatory surgery center fully owned by the Eye Institute, ranks eighth nationally in NEI funding, and provides outstanding residency and glaucoma fellowship training programs. Oklahoma City has a population of approximately 500,000 (and a metropolitan area of over 1 million), currently is experiencing a major downtown renaissance, and boasts numerous cultural and recreational opportunities as well as wonderful people. Additional information is available on the AUPO Web site. Potential candidates should contact:

Gregory L. Skuta, MD
James P. Luton Clinical Professor
Dean A. McGee Eye Institute
608 Stanton L. Young Blvd.
Oklahoma City, Oklahoma 73104 405.271.7806
Phone 405.271.6088
Fax greg-skuta@dmei.org

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER ASSISTANT PROFESSOR OF OPHTHALMOLOGY (RETINA)

Texas Tech University Health Sciences Center is seeking an Assistant Professor of Ophthalmology (Retina) to work in Lubbock, Texas. Candidate must have a Doctor of Medicine degree, Texas Medical License or eligibility and one year experience in job offered or one year related experience as Ophthalmology Retina Fellow. Fax resume to Janet Coquelin at 806.743.2882. Put job code 030334 on resume.

CASEY EYE INSTITUTE DIRECTOR, PEDIATRIC OPHTHALMOLOGY SERVICE

Casey Eye Institute, the Department of Ophthalmology at Oregon Health & Science University, is seeking a full-time pediatric ophthalmologist to direct the Elks Children's Eye Clinic. This service has been highly successful in clinical care and research and has great potential for growth. It includes a fellowship training program and adult strabismus service. Casey Eye Institute has 28 full-time clinical faculty and eight full-time PhDs.

The longtime support of the Oregon State Elks Association will permit us to expand the current Children's Eye Clinic from 3,000 to 7,500 square feet beginning in late 2006. A state-of-the-art research laboratory in OHSU's new Biomedical Research Building is available, with Elks support for operations. Dedicated surgery suites are also available.

Qualifications include board certification and eligibility for licensure in the state of Oregon. Salary and academic rank based on qualifications and experience.

Interested candidates should forward CV and cover letters by June 30, 2006, to:

David J. Wilson, MD
Thiele-Petti Chair, Casey Eye Institute
3375 SW Terwilliger Blvd.
Portland, OR 97239-4197

THINGS YOU



**UNIVERSITY OF TEXAS
HEALTH SCIENCES CENTER – SAN ANTONIO
PROFESSOR AND CHAIR,
DEPARTMENT OF OPHTHALMOLOGY**

The University of Texas Health Science Center at San Antonio, TX seeks a chair of the Department of Ophthalmology. The Department provides services in the University Health System, South Texas Veterans Health Care System, University Eye Consultants (private clinic), and Texas Diabetes Institute. The Department maintains busy clinical and research services and is ripe for growth. The fully accredited residency program has 12 residents and one to three fellows. The successful candidate will have overall responsibility for clinical programs, medical education programs, and maintenance of a substantial research program, and will have demonstrated leadership in some or all of the areas. San Antonio is one of the most attractive and livable cities in America. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer. All faculty appointments are designated as security-sensitive positions. Review of applications begins April 1 and will continue until the position is filled. Send cover letter and CV to:

Randal A. Otto, MD
Professor and Chairman, Folbre Endowed Chair
Department of Otolaryngology – Head and Neck Surgery
University of Texas Health Sciences Center at San Antonio
7703 Floyd Curl Drive, MS 7777
San Antonio, TX 78229-3900

**DEPARTMENT OF OPHTHALMOLOGY,
MEDICAL COLLEGE OF GEORGIA
GLAUCOMA SPECIALIST**

The Department of Ophthalmology at the Medical College of Georgia in Augusta GA is seeking a full-time tenure track clinician/scientist at the Assistant/Associate Professor level. Responsibilities include patient care, teaching and research. This is an excellent opportunity to join a well established and expanding academic health system.

- Must be Board Certified or Board Eligible
- Must be able to become licensed in Georgia
- Must have completed an approved ophthalmology residency program as well as fellowship training in glaucoma
- Academic rank and salary will be commensurate with credentials and experience
- Work in an academic environment with 10 full-time faculty (including 3 PhDs), 2 part-time faculty, 9 residents, and 2 research fellows
- Strong commitment to clinical and surgical excellence as well as resident teaching is required
- Protected time for laboratory and clinical research (approximately 65% effort)

The Augusta, GA area has a population of 500,000 persons (second largest metropolitan area in Georgia) and offers a location with easy access to major cities, beaches and mountains, a low-cost of living, relaxed lifestyle, year-round outdoor recreational activities, including world renowned golf and a family-oriented environment.

The position will remain open until a suitable candidate is identified. Please send curriculum vitae and a list of at least three references including addresses and telephone numbers. Applications and supporting documents should be sent to:

Julian J. Nussbaum, MD
Chairman, Search Committee
c/o Brenda Sheppard
Department of Ophthalmology, BA 2701
Medical College of Georgia
Augusta GA 30912-3400
706.721.1148 Phone
706.721.1158 Fax