

Richard P. Wilson, MD

Dr. Wilson
contemplates the
glaucoma
subspecialty, its
practitioners,
and the role of
the AGS.



1. What will be the nature of glaucoma surgery in 20 years?

As a glaucoma specialist, I envy the continual advances in cataract and retinal surgery. During the past 35 years, progress in our field has consisted of releasable and “laserable” sutures, antifibrotic regimens, and minor technical refinements. The aqueous shunts we use now are only slightly more effective than the single-plate implant (Molteno Ophthalmic Limited, Dunedin, New Zealand) introduced in 1973. This glacial progress is about to change.

Because the majority of resistance to aqueous outflow from the eye resides at the level of the juxtacanalicular apparatus, multiple investigators are attempting to overcome this obstacle. Devices to shunt aqueous from the anterior chamber into Schlemm’s canal have been developed for both the transanterior-chamber and the ab externo approaches. Additionally, researchers are success-

fully using the excimer laser to open passages into Schlemm’s canal.

Admonitions from Peng Khaw, PhD, FRCS, FRCOphth, of London that filtering surgery should be performed with fornix-based conjunctival flaps and a wide application of mitomycin have greatly reduced but not eliminated the long-term complications of this antifibrotic. Investigators seek (1) more benign antifibrotic agents that can be delivered locally in a time-released fashion throughout the postoperative period and (2) adjustable sutures that can both release tension on the trabeculectomy flap to increase outflow postoperatively and increase tension if the outflow was misjudged. Cambridge Antibody Technology’s (Cambridge, England) development of an antibody to neutralize transforming growth factor beta 2, although inadequate for limiting postoperative fibrosis, was an excellent idea that is sure to be followed by others.

For intractable cases, I look forward to a more rapid evolution of the aqueous shunt. Expected developments include less bulky plates impregnated with a time-release antifibrotic compound and more effective valves that can be flushed free of debris with digital ocular compression.

2. How did your tenure as President of the AGS change your perspective on glaucoma practitioners?

The most important attributes of a president are his ability to convey his vision for the organization persuasively and his diplomatic ability to enlist others to work as a team to fulfill this vision. Although I had consider-

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FAST FACTS

- Attending Surgeon for the Glaucoma Service (1988 to present) and Co-Director of the Glaucoma Service (2004 to present) as well as Director of the Glaucoma e-Medicine Program (1998 to present) at Wills Eye Hospital in Philadelphia
- Professor of Ophthalmology at the Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1999 to present
- Immediate Past President of the AGS, 2003 to 2005
- Board Member of EyeCare America Glaucoma Program, AAO Foundation, 2000 to present
- Chair of the Committee on Glaucoma Society Organization, Association of International Glaucoma Societies, 2003 to present
- Editor of *Yearbook of Ophthalmology*, 1997 to 2002
- Recipient of the Golden Apple Award from Wills Eye Hospital (1985 to 1986) and of the AAO’s Senior Honor Award (2000)

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able room for improvement, I had the distinct advantage of working with and for glaucoma specialists. We are continually humbled by the disease we treat and emerge better people for it. When cataract surgeons get together, they discuss their last 10,000 cases, done with the latest technique in 8 minutes per eye with only two minor complications. Retina surgeons talk about how they were able—with exceptional skill and daring, of course—to transplant retinal tissue from outside the arcades into the macula and improve so-so hand-motion vision to excellent hand-motion vision. When together, glaucoma specialists discuss their last three hemorrhagic choroidals, flat chambers, shunt erosions, etc. The ensuing commiseration adds immeasurably to our esprit de corps. With low reimbursement levels and increasing costs for malpractice insurance, glaucoma specialists are happy for anyone trying to better their lot and that of their patients. Consequently, working with glaucoma specialists was the highlight of my presidency.

3. What is the most important role of the AGS?

Its most important role continues to be educating glaucoma specialists so that we provide the best possible care to our patients. Recently, we have found it necessary to work with the AAO to educate federal and state legislators as well as third-party payers, regulatory agencies, and other healthcare policy makers about the needs of glaucoma patients. These efforts included the creation of the Medicare glaucoma screening benefit and the acceptance of computerized imaging of the posterior pole by third-party payers.

4. What is the greatest challenge for a teacher of ophthalmology?

The milieu in which we work makes it difficult to train residents and fellows. That decreasing reimbursement coupled with increasing liability-insurance costs drive overheads ever higher forces us to see more patients to stay solvent. Better training of residents and increasing numbers of glaucoma specialists in the community increase the average complexity of cases referred to tertiary centers such as Wills Eye Hospital in Philadelphia. These more challenging glaucoma patients combined with a more litigious society amplify the spasm of all one's visceral smooth muscle when passing on surgical cases. The most difficult aspect of being in an active training program is to call the fellow in when a teaching opportunity arises but one is 2 hours behind in a 60-patient day. It is the widening of fellows' eyes when they see something they have never seen before that reinforces the need to take that time. Teaching, like public

health, allows one to multiply manyfold the number of patients helped.

5. Why did you become active in policy-making as regards coding?

Richard Simmons, MD, then President of the AGS, asked me to become the representative for glaucoma specialists in this arena, because he knew of my work with ab interno laser sclerostomy and other new technologies. Although the importance of coding and terminology may not be readily apparent to everyone, each diagnostic test and therapeutic procedure must have a code, or it will not be reimbursed by any third party. To obtain a new code or change an old one, the AGS must provide a detailed description of the test or procedure, including its advantages and possible abuses, suggest a reimbursement level, and take it to the AAO. If the AAO agrees, together, we present the proposed code to the Relative Value Scale Update Committee (RUC) of the AMA.

In this challenging process, the presenter faces representatives of each specialty in medicine who, while trying to be fair, are there to protect their own reimbursement levels. Because under Medicare there is a set amount of money for patient care, accepting a new technology for ophthalmology means less money for all other specialties. Clearly, the discussions are intense, and often the approval of a new code for a more complicated technique means a reduction in the established but less complicated code's relative value units. We are lucky to have the AAO's William Rich, MD, who is now the Chairman of the RUC, advising us on these matters.

I take pride in having reshaped the ICD-9 and CPT books on glaucoma, but the task was often stressful. My hardest decision was when to bring the code for computerized scanning of the posterior pole to the RUC. Bring a code too soon without enough supporting literature, and the RUC will shoot it down and not reconsider it for several years. Bring it too late, and the development of a promising technology will be retarded, because no one will buy it without being able to charge a fee for its use. I also worried about the potential for abuse (eg, MDs and ODs buying the technology as a profitable test without understanding how it should be incorporated into practice to enhance patient care).

Although under considerable pressure from developers and advocates of the technology, I waited until I felt it was better than a practitioner who only occasionally looked at an optic nerve or took a CME course. Jeffrey Liebmman, MD, helped me introduce the code to the RUC. It passed, but the resistance of Aetna and other insurers to accepting and paying for the technology even years later shows how delicate that decision was. □