Jack M. Dodick, MD

Dr. Dodick discusses how emerging research and technologies have influenced his pursuit of advancements in the field.

What are the most urgent issues that ophthalmologists currently face? Unfortunately, they are not medically related but legally and financially driven. Serious problems with regard to malpractice litigation, decreasing reimbursement, and encroachment by optometrists are challenging ophthalmologists. For example, decreasing reimbursements have resulted in many physicians' opting out of therapeutic procedures such as cataract surgery. They feel that their livelihoods depend upon patient-reimbursed elective procedures such as cosmetic or refractive surgery. With improvements in surgical techniques, patients' expectations have risen, creating a smaller permissable margin of error for surgeons and increasing malpractice rates. It is sad and telling to see the children of ophthalmologists pursuing careers outside of ophthalmology for these reasons.

Who influenced you along the road to becoming a surgeon? I was blessed with the opportunity to fulfill my training at the Manhattan Eye, Ear, and Throat Hospital, a facility that has seen an unusual number of masters in the subspecialties. I trained with the reknowned Byron Smith, MD, in ophthalmic plastic surgery. My early publications were in this field and included the discovery of the frequent occurrence of medial wall fractures with blowout fractures of the orbit. I would have pursued this discipline, but, from the moment IOLs emerged on the scene, I was captivated by the entire sphere of anterior segment surgery. Tremendous surgeons, including Richard Troutman, MD, and Sigmund Schutz, MD, guided me in this field. In addition, I witnessed Charles Kelman, MD, perform the first ultrasound phacoemulsification. I developed a lifelong friendship with Charlie, whom I credit with inspiring me to think outside the box. I traveled to Gronigen, the Netherlands, in 1972 and was motivated by Jan Worst, MD, and his work with IOLs. Shortly thereafter, I launched my career in cataract and implant surgery. In 1982, I visited Danièle Aron Rosa, MD, in Paris. It was her work in YAG laser posterior capsulotomy that made me consider lasers as a viable way to remove cataracts. As a result, I began research in this field.

What are the latest developments in Dodick Laser Photolysis? My colleagues and I continue to improve this technology as a means of removing the cataractous and clear lens without generating heat, making the modality safer than ultrasound-based procedures. We have made great strides in improving the system's efficiency by enabling it to remove 80% of lenses in a timeframe equal to that required for ultrasound phacoemulsification. Dodick Laser Photolysis will continue to evolve, as did ultrasound during its period of development. We are currently embarking on a six-center clinical trial to ablate the germinal epithelium within the capsular bag after cataract surgery. We hope that this study will aid in preventing future cases of PCO and open the door to preservation of the bag and injectable lens technology. The preliminary results are very encouraging.

What do you believe is the most challenging aspect of your profession? The most challenging aspect of ophthalmology is dealing with the visually devastating effects of age-related macular degeneration and proliferative diabetic retinopathy. Both of these conditions can cause severe visual loss. The patient's ability to work, ambulate, and remain independent may be limited, with significant financial, social, and psychological implications. Although there are many promising treatments on the horizon, much work remains in the battle to eradicate the catastrophic visual loss these diseases can cause.

What has been your most memorable surgical case? During my senior residency, an elderly woman presented with bilateral angle-closure glaucoma secondary to intumescent lenses and counts fingers vision. Unable to break the attack medically, we decided that surgical iridectomy was the only option (the YAG laser had not yet been introduced). Our plan, as laid out by my resident instructor, was to perform bilateral iridectomies with redraping between both procedures. He further indicated that bilateral intracapsular lens removal was the proper course of action, provided that the iridectomies went smoothly, which they did. The surgery commenced at midnight and ended at 2 a.m. The next morning, our patient was reading large print with a pair of aphakic spectacles. I have never forgotten that case. ■