The American Ophthalmological Society

Established 1864

Frederick H. Verhoeff Lecture

2026

Council Introductory & Editorial Comments

2026 FREDERICK H. VERHOEFF LECTURE

Introductory Comments

AOS Council

In planning the Symposia for the AOS 2026 meeting, we knew there were policy and program changes either underway or planned for many of the federal programs that are central to the care of patients with eye disease, vision research, and education of future ophthalmologists. M. Roy Wilson, AOS Program Committee Chair, organized and led the AOS Saturday Symposium "Impact of Changes in Washington: A New Reality for Ophthalmology", that included four topics:

1. **Medicaid Funding Cuts: Impact on Vision Care of Vulnerable Populations**
2. **Ophthalmic Drugs and Devices: Will FDA Regulatory Changes Affect Eye Health**
3. **Is Eye Research in Peril: What's Happening at the NIH and NEI**
4. **GME Funding at Risk: Strategies to Maintain our Commitment to the Next Generation of Ophthalmologists**

We were fortunate to have expert speakers for each of these topics:

- **Medicaid Funding** – Carla Siegfried, MD, Vice Chair for Strategic Initiatives, Washington University in St. Louis, Chair, AAO Ethics Committee
- **Ophthalmic Drugs and Devices** – Jayne S. Weiss, MD, Chair, FDA Ophthalmic Devices Panel, 2002–2004 and 2014–2018
- **Eye Research** – Shefa Gordon, PhD, Former NEI Director of Science Policy and Legislation
- **GME Funding** – Terri Young, MD, MBA, Immediate Past-President, AUPO

These are complex and, in some cases, highly technical issues involving policy, regulation, and government spending. All have a direct impact on patient care and how we deliver it. Therefore, it is critical that we have access to accurate information about these policy and program changes, so we can understand, anticipate, and evaluate the effects on the profession of ophthalmology and our patients.

We hope you will **review the presentations**, all but one of which are available on the AOS Website. Each of the presentations contains well-researched factual information. As with any presentation, the speaker will bring an individual perspective, and we recognize that the interpretation of these facts may differ from one observer to another. Nevertheless, the goal is to provide information and forge a better understanding of how these important changes can affect the health of individual patients and populations, vision research, and ophthalmology trainees.

An important challenge is how best to leverage the many policy and program changes. We were very fortunate to have David J. Skorton, MD, President and CEO of the AAMC, present the Verhoeff Lecture titled: "**Impact of Changes in Washington on the Health of Our Nation**." The text of Dr. Skorton's excellent presentation is on the **AOS Website**. Dr. Skorton emphasized four key areas on which we can all agree: Nutrition Education, Rural Health, Medical Research, and Physician Payment. Most of all, he stressed that physicians need to be open to change. Although not part of his presentation, we feel that developing care systems that employ the richly informative imaging that is becoming so prevalent in ophthalmology is one change that could improve access to care in underserved rural and urban areas, particularly if coupled with advances in artificial intelligence. Many other suggestions are included in the individual presentations.

We hope you will review the materials from this Symposium. We are confident they will keep you informed and help all of us adapt to future developments, whether you specialize in patient care, research, or education.

2026 FREDERICK H. VERHOEFF LECTURE

Impact of Changes in Washington on the Health of Our Nation

David J. Skorton, MD
President and CEO, AAMC

Thank you, Roy. That was great. I just want to say a couple of things about Roy Wilson, in case you don't know him well. Not only is he a highly accomplished ophthalmologist and scientist, but he's a real Renaissance man in the true sense of the word.

A very successful president of Wayne State University, a master athlete, and author and memoirist. If you haven't read "The Plum Tree Blossoms Even in Winter," get it on your reading list. It is a fabulous memoir of his life. Now, Roy, we're friends, and you might be wondering why I'm buttering you up so much.

Well, it turns out that after years of avoiding my ophthalmologist, I'm going to get my cataracts fixed up this summer, and I need some advice. I mean, I'm a cardiologist. Things are simple. There are four valves, four chambers, and a couple of arteries here and there. I don't know what a premium IOL is.

And they're asking me about femto something, lasers. Very, very confusing. So, during the Q&A later, don't worry too much about Washington. I am changing the title of this speech to "What's Happening in Washington Relevant to David's Cataracts."

All joking aside, you are part of an amazing organization. My family and I have had many vision challenges, including saving my vision in one eye and a lot of other things.

I've followed this society for a while. The AAMC is celebrating our 150th anniversary this year. That was 1876. You all were founded in 1864. As far as I know, this and the New York Ophthalmological Society were the first two specialty societies in this country's history, and you have a very distinguished legacy of leadership.

In 1864, when you were founded, local anesthesia had not yet been introduced. Imagine this, in the middle of the Civil War. And more recently, I've witnessed amazing advances in my own field. In the year that I was born in 1949, over 80% of babies born with congenital heart disease passed away before reaching adulthood.

Only 20% reached adulthood.[1] Today, a baby born with congenital heart disease has a 90% chance of reaching adulthood, You have made similar changes in the outlook of illnesses that affect so many people in your field. How do these kinds of things happen? Advances like these have required not just the rigorous pursuit of scientific knowledge, which of course is enormously important, but also steady voices and advocates guiding the practice of medicine itself.

Looking back on the AOS's history, this organization has been one of those prominent voices. Being founded during such a tumultuous time in the country, and of course, we're having a time of challenge now, too. But that time during the Civil War was also uncertain, and the goal of the society was, in part, to establish both ethical and scientific standards for the field of ophthalmology. Reading about the history of the AOS was very uplifting.

To be that trusted and comprehensive national voice during a time when so much was shifting is very, very important. That remit, of course, holds true now amid the rapid pace of change that we're seeing everywhere, but today I'm here to talk about Washington. You are the ethical and scientific lifeblood of an incredibly important specialty, one that I hold in high regard.

From my vantage point at the AAMC, my colleagues and I are seeing that the current period of significant transition and rapid policy change in Washington and in state capitals with impacts felt everywhere is both a time of unsettling uncertainty and this is the bottom line of my talk, a moment of opportunity to reimagine the future of our nation's health.

This opportunity must not be wasted, and we need to get on with it. Our charge is to lead by adapting and seeking opportunities to improve what we do, while adhering steadfastly to data and evidence. I want to say it again. Our charge is to lead by adapting and seeking opportunities to improve what we do, while adhering steadfastly and courageously to data and evidence.

To make the most of this moment, we collectively must adapt and be open to continual improvement. Last year, I delivered a commencement address at the University of Rochester School of Medicine and Dentistry, home to the renowned Flaum Eye Institute. I'm sure you know about that. I was struck by the school's motto of "Meliora," Latin for "ever better."

It's a reminder that all of us can and should be continually on the lookout for ways we can improve the important work we do. It isn't always easy to face up to this, but we in medicine have, of course, not always gotten everything right, despite our best intentions and efforts. Nothing is truer than in my own field of cardiology.

The many discussions in Washington on topics like access to care, cost, and delivery of care make it clear we, of course, have a lot of work to do despite our many successes and breakthrough advances. That doesn't mean we shouldn't celebrate areas where we have made progress. It does mean that rather than continuing with the status quo, we can, and we must, embrace change where it makes sense to do so.

Identifying what needs to change, that's the hard part. It must start with humility and open-mindedness. It requires us to listen actively to those who have different views on the challenges and potential solutions, and that is not always easy. It requires us to ask questions with honest curiosity to better understand the perspectives of those with whom we disagree, and sometimes very strongly.

That type of listening requires discipline. But I'm here to say it can work, even amid what can be at times a politically incredibly divisive environment in the national discourse and even within our own communities. Our collective challenge, at the AAMC and the AOS and across American medicine, is to maintain what the Zen Buddhist monk Shunryu Suzuki called a beginner's mind.

That means being open to all possibilities and flexible to change. The quote from Suzuki is that "In the beginner's mind, there are many possibilities. In the expert's mind, there are few." So, we need to be open to possibilities, while at the same time upholding and honoring the ethical and scientific standards that our respective organizations were founded upon roughly a century and a half ago.

Following evidence fearlessly, we can and must do that. We also must acknowledge that data and evidence are continually evolving. However, we can and must speak with confidence in areas where data and evidence have indeed provided us with a clear path to follow, and we cannot wander from that path.

That's especially crucial today. We must maintain a firm commitment to following the evidence, even as we work to find common ground across differing perspectives. Well, that may seem like a tall order and something someone says in a speech, but I believe we can achieve that balance just as our organizations have sought to do throughout our recent history.

Today I'm going to try to demonstrate very briefly through the lens --guess I shouldn't have used that "lens" business – through the lens of four issues that have been quite topical in Washington over the last few months. These are in no special order, but I'm going to jump right in with the first one: nutrition education in medical education.

It's been a recent focus in Washington, and my colleagues and I have discussed this set of issues with several members of the current administration. Over the past decade, the AAMC's member medical schools, many of your schools, have helped catalyze a national shift toward integrated competency-based nutrition education in med school, huge changes, and we're committed to embedding it across medical education. In a lot of our contacts with Health and Human Services Secretary Kennedy, he has shown great enthusiasm for this work.

Just last November, we, the AAMC, issued a **call to action** for U.S. medical schools and academic health systems to further strengthen nutrition education, including by sharing their individual local models across all stages of medical education.[2] That's a very important point to make. At the AAMC, we don't take care of patients. We don't do research. We don't deliver patient care. We represent you, those who do.

I think that the progress you're making in your schools in this area, as well, is important to share across the country. We hosted a Teaching Kitchen Collaborative (that's an organization) **event** this past April, where we continued the conversation about nutrition, education, policy, and working with our communities.

This is an example of how we're continuing to evolve what we do, always following the evidence, always maintaining the focus on local control of curricula in conjunction with an increased policy focus on this important topic, where we are finding some common ground.

The second issue is rural health. This is a second area in which there have been increasing policy discussions at the federal and, of course, state level about access to care in rural areas.

I spent more time in Iowa than anywhere else in my career or my life, and that's a state without any big cities, many rural areas. And many of our states not only have rural areas but have areas of population density so thin they don't even qualify as rural. They're called frontier areas.

I've been particularly interested in this topic. I'm a member of the Aspen Health Strategy Group, and we released a **report** entitled "Meeting the Health Needs of Rural America." You might take a look at it. You can find it on the Aspen Health Strategy Group website.[3] But among other findings, this report on rural America noted that rural residents experience multiple barriers to accessing care wherever they are in the country, including those related to affordability, of course, the availability of services and facilities, and workforce shortages.

It is hard to fill those positions in rural or frontier America. According to a survey we did in 2022,[4] nearly 15 percent of patients in rural areas are not always able to receive care. I know you're aware of this problem, and to underscore something that may be obvious, a 2025 **study** in JAMA Ophthalmology[5] confirmed the much larger workforce density of ophthalmologists in metropolitan and non-metropolitan counties compared with those counties that actually qualify as rural or frontier.

We know that limited access to eye care leads to worse outcomes for our patients in rural America. A separate challenge is that while eye disease has the potential to touch us all, it disproportionately impacts African American, Latino, and Native American communities wherever they are living.[6] We, as the medical community, have to ask ourselves a difficult question: How can all of our neighbors truly have access to excellent care, eye care, and otherwise, and have the best chance of reaching their health goals regardless of where they live and regardless of what their background is?

One solution that has been tried in various ways for decades may be to recruit and train more individuals from rural areas to serve in the medical profession. As you know, **studies** have shown again and again that physicians, for example, who come from rural backgrounds are much more likely to practice in rural communities, either where they came from or elsewhere.[7]

There is **evidence** from the for-profit business literature[8] suggesting that teams with members from a variety of backgrounds and perspectives can improve creativity and innovation. We need everyone's creativity and innovation to ensure that our physician workforce can best serve all patients and all communities, developing and testing new models to reduce barriers to care.

That includes, among many other examples, more physicians from rural areas, physicians who were the first in their families to go to college, and those with other perspectives. That brings me to my questions for you:

- Are there new ways that together we can imagine providing care to rural patients who may not be able to get to urban centers for care?
- Are there opportunities we collectively have not yet tried to bolster the ophthalmology workforce in rural areas of the country?
- Are there new ideas to recruit and train physicians from a wider variety of backgrounds to enhance creativity and innovation, based on that business literature, to help us better solve some of our biggest, thorniest, and most persistent challenges, including addressing health and healthcare inequities?

I'm very anxious to hear some of the other speakers this morning, and I'll be taking notes and trying to learn from you as you come up. The AAMC continues to pursue **strategies** to address access barriers faced by rural populations and others through policy efforts, including aiming to increase long-term federal investment in the rural health infrastructure.

We sponsored a **congressional briefing on rural health** on Capitol Hill last February, facilitated by the National Hispanic Health Foundation. That event shared an overview of the newly established Rural Health Transformation Program or Rural Health Transformation Fund, highlighting how states plan to leverage these funds to ensure or improve access to care in rural and underserved communities.

However, the program to this day is only funded for five years, so we have more work to do. Our ongoing discussions in Washington will continue to evolve as we collectively learn from each other and from you about how to deliver this important care, and as we collect and analyze more data shedding light on differing population needs.

That's issue number two. Number three, medical research. This is a crucial aspect of the practice of ophthalmology, deeply affected by changes in Washington in biomedical research. Later this morning, we'll be hearing from Dr. Gordon discussing National Institutes of Health funding for eye health research, another one of the talks I'm looking forward to hearing.

This research is immensely important and valuable, and you no doubt experience the results throughout your practice in the innovations that enable you to perform delicate eye surgery with enormous and unprecedented precision, restore vision in minutes, and even apply bioengineering to treat disease.

Funding NIH has traditionally earned bipartisan support, but as you know, there is currently great disagreement on the total need and how funds are to be distributed. My colleagues and I at the AAMC have had the privilege of interacting a lot with Dr. Jay Bhattacharya, director of the NIH. We hope to continue those discussions.

I want to take a moment to recognize one of you who is doing enormously important work, Dr. Mike Chiang, director of the National Eye Institute. He's here today, and I want to tell you he's doing very important work for all of us, and I want to recognize Dr. Chiang.

Mike and his crew are teaching us at the AAMC some important things, and we're working together. Now broadly, the AAMC has **joined** nearly 600 organizations, not people, 600 organizations representing patients, clinicians, scientists, and other collaborators, which collectively make up the Ad Hoc Group on Medical Research, to recommend an appropriation of at least 51.3 billion dollars for the NIH's fiscal year 2027 foundational work.[9]

Our patients are counting on more than just our current clinical skills, as impressive as they are. They're counting on continued discovery. That is why robust NIH funding is so crucial, and we welcome your voices, should you be so inclined, to advocate for research that can ultimately lead to even better outcomes.

Finally, the fourth area I want to touch on is physician payments.

The issue of physician payment models, particularly for specialties like ophthalmology, continues to evolve rapidly. Federal legislation, as you know, includes nearly 1 trillion dollars in Medicaid cuts over the next decade, starting later this year. I don't have to tell you about the risks these cuts present in limiting access to care to those who may need it most.

Depending on the type of facility in which you practice, I know you're aware that other policy changes may and will affect how payment for crucial eye care works. The recent physician fee schedule rule is shifting physician payments in a budget-neutral fashion, so to speak, toward more office-based payments, reducing payments for procedures conducted in hospital settings, including cataract surgery.

Of course, while only a subset of ophthalmologists practice in academic medical centers and hospitals, this change brings about new financial burdens to consider, and we're spending time working on these areas, trying to represent you as well. It's important to look at how we can adapt to changes with the patient's needs and evidence-based policy at the center of everything we do.

At the national level, the AAMC is doing just that. My colleagues and I have personally met with administration officials and members of Congress advocating to maintain crucial support for Medicaid and working on many of these physician payment details. We're continuing those conversations to make our concerns heard.

Our dedicated advocacy efforts include urging adequate financial support for facilities that care for the most complex and the most vulnerable patients as a matter of health for the nation. I would love to hear your ideas during the Q&A today or the "meet the speakers" portion of our agenda. I welcome learning if there are ways we can improve what we are doing on your behalf and align our advocacy work together with you to amplify our collective message.

All of us, as physicians who have taken an oath to make the health and well-being of our patients our first consideration, must work together in support of our shared values. In times of rapid change, in times of unpredictable change, in times of uncertainty, we learn much through building relationships with each other, listening and learning from other viewpoints, while remaining committed to data-driven, evidence-based approaches.

All four of these issues I touched on briefly today –nutrition in medical education, the care of patients in rural America, our nation's biomedical research infrastructure, and the payment models affecting our work – each and all are significant. I would be remiss not to mention the toll that navigating such important topics amid existing daily pressures in a rapidly changing landscape, the toll this can take on all of us.

None of us is immune to burnout or even more serious consequences. We must take care of ourselves and our own mental well-being as we navigate these unpredictable times. Let's be kind to ourselves as well as each other. And at the same time, let's remember our collective strength, too, as a community of clinicians.

Supporting each other while improving the health of people everywhere is what we do. While the founders of the AOS in 1864 might not have been able to predict today's exact challenges and opportunities, much less how our world would be transformed through unforeseen changes like AI, the AOS remains the same powerful force it was more than 150 years ago.

It's worth looking back to how Dr. Frederick Verhoeff, for whom this lecture is named, approached his work. In a 1969 eulogy, Dr. David Cogan of Harvard Medical School...spoke directly to Verhoeff in a poignant letter as if he was writing it to him.

"Dear Freddie," he **wrote**, "When I asked you what led you into ophthalmology, you gave me a direct and simple answer. Your father gave you a camera for your 12th birthday. That gift of a camera marked the first milestone in your career as an experimentalist."

That sounds just right to me. In today's rapidly changing world, let's all be experimentalists.

The uncertainties and changing policies we're navigating provide great fodder to experiment, to try something new, to learn, to adapt, to find even better approaches than we ever envisioned before. And if we can do that while upholding the scientific and ethical standards that our organizations are built upon, including our fearless commitment to data and evidence-based approaches, I believe firmly that we will ultimately make a lasting impact, not only on our patients, but on the health of the nation.

I look forward to learning from the rest of the speakers and hearing your questions and good ideas as experimentalists. I thank you, Roy, for asking me, and I thank you for listening. Thank you.

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