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Is the New Apple TV Any Good?

By Rob Beschizza

Reviews of the app-capable, Siri-equipped new Apple TV box are filtering in, and the consensus is that it’s … OK.

Walt Mossberg writes that it’s a much “smarter” box, but one that lacks vision—and has UI flaws.

I don’t know when, if ever, Apple will reinvent TV. But this isn’t the moment. I can say that, if I were buying a streaming box right now, this is the one I’d buy, if only for the promise of lots of apps. By making the set-top box a part of its giant app and services ecosystem, the company is moving Apple TV into a future that’s much broader and bigger than Roku’s or Amazon’s. And that makes the case. In effect, while it may not have reinvented all of TV, Apple has reinvented the streaming set-top box.

The Wall Street Journal calls it “a giant iphone for your living room,” though, and likes it a lot.

Ultimately, the Apple TV’s advantage is that it isn’t tied to the idea of channels, live TV or even streaming. It’s the place where developers are able to do the most cool interactive stuff for the widest audience. There’s already a workout show on the Apple TV that’s smart enough to know if you’re really working out.

The TV of the future needs to be as powerful and easy to use as an iPhone, and this Apple TV is the first box—and the first Apple TV—to achieve that.

Siri is now present, but she’s not the Siri you’re used to. Nilay Patel likes the new box, but…

…limitations are everywhere. Only a small handful of apps work with Siri search right now — iTunes, Netflix, Hulu, HBO, and Showtime — so finding something in, say, the ESPN or CBS apps isn’t possible. Siri can’t find you a funny YouTube video, which seems like a shame. Tim Cook says a Siri search API is coming, but I get the feeling Apple wants Siri search to be a differentiator for the more premium services, so we’ll see how wide open that API is when it gets here.

Rounding up the competition, CNET provides all the details you could ever want on what you can watch on each box.

The New York Times’ Brian X. Chen reports “a plethora of innovations.” Of the options, available, it’s his favorite, but here comes the “but…” there are some weaknesses.

Setting it up can be tedious. When you install streaming apps like Hulu and Netflix from the App Store, you type in your login credentials by swiping left and right with the remote to select letters of the alphabet one at a time — you have no option to do this by speaking into the microphone or using a keyboard on a smartphone.

The Apple TV may also not be the best streaming device for everyone because of one missing feature: the ability to stream content available in Ultra HD 4K TV, the latest high-definition resolution supported by some of the newest TV sets.

Apple TV is $149 for the 32GB version, and $199 for the 64GB model.
When it came to being a pediatrician, Dr. Mobeen Rathore said he never wanted to be anything else.

“I just thought that it would be very nice to be able to be a physician and be able to serve humanity - if you will - and I particularly wanted to be a pediatrician because I love kids,” he said. “They are so energetic and bring so much to your life.”

Born and raised in Lahor, Pakistan, Dr. Rathore came to the United States for medical training. He graduated in 1983 and achieved his goal of becoming a pediatrician. But while most people would say that becoming an MD is accomplishment enough, Dr. Rathore continued to get involved in the community and take on leadership positions, including becoming the Duval County Medical Society President in 2014.

Dr. Rathore said he didn’t go looking to become the DCMS president, but he understood the importance of advocacy for physicians. It wasn’t until he was elected, however, that he truly realized the significance of the position.

“I was the face of the medical community in Duval County,” he said, “As the president, you get to do things and make an impact on what happens in health care in Jacksonville. So it was a very fulfilling position.”

The former DCMS president said he encourages people to get involved in the society because of how critical he believes advocacy is for the medical community. Dr. Rathore said that if doctors aren’t at the table as a part of the discussion then others will make decisions, and they might not be the decisions physicians find favorable.

“Being part of organized medicine is very important for all physicians,” he said. “I think in some capacity, we all need to be a part of organized medicine. I’ve been very active in DCMS and on the
state level, and national level on several professional organizations.”

Dr. Rathore also has many community roles. He is the Chief of Infectious Diseases at Wolfson Children's Hospital and is the founding director of UF CARES, UF's Center for HIV/AIDS Research, Education and Service. Dr. Rathore was the 2013-2014 president of the Florida chapter of the Medical Academy of Pediatrics. On top of these roles, he also runs the free clinic Social Services Mass Inc. and serves on the boards for Leadership Jacksonville and One Jax, an interfaith non-profit organization that promotes diversity as the foundation for a strong community.

“I’ve always felt that I’ve had to give something back to the community,” Dr. Rathore said. “I look for opportunities and if I’ve been invited, I’ve taken those opportunities. I mean, of course when you’re in the healthcare field, it’s your profession; you love that. But there’s much more to life, especially more than your work.”

His pride and joy is UF Cares, which provides primary, secondary and tertiary care for HIV-exposed and infected individuals and families.

“I think HIV chose me, I didn’t choose HIV,” Dr. Rathore said. “When I came here in 1991, I saw there was a huge need for HIV; there were no HIV services. So I started building a program first for children. Then we added adolescents to it. But then I realized the mothers were not getting care, so we added women to that program. It became a comprehensive program, and we are now the largest HIV program in Jacksonville, providing services more services than anybody else—to pregnant women to birth to elderly.”

His medical passions span beyond HIV care; Dr. Rathore said he is also zealous about being able to advocate for children, whether it’s for immunizations, safety from gun violence or access to health care.

“I think that we have the direct relationship with patients, and we need to make sure that we are able to advocate for not only our profession, but also for our patients, who are such a critical part of what we do,” he said.

When Dr. Rathore isn’t busy with work or his community ventures, he enjoys spending time with his family, reading medical historical narratives and traveling. Dr. Rathore has visited every continent except Antarctica and his travels have taken him to a variety of countries including New Zealand, China, Nepal and his native home of Pakistan.

“It was a very nice, beautiful, safe place to group up,” he said. “At the time, Pakistan was a safer place to be than here. But it is what it is. There are problems, but it’s not everywhere, only in certain parts. Lahor is where I visit and it’s fine; it’s safe. Sometimes [my family] goes with me and sometimes they don’t. It’s hard to get everyone on the same schedule.”

Regardless of his busy schedule, Dr. Rathore says that every day is fun because of his love for medicine.

“I still believe that this is the best profession to be in, but you have to love what you do,” he said. “You need to be in this profession for the right reasons. Medicine should not be a profession, it should be a passion.”

Dr. Rathore at the Friendship Clinic in Nepal in February 2014.
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Top Caribbean Christmas Destinations and Events
By Robert Curley, Caribbean Travel Expert

Celebrate Christmas and New Years in the Caribbean

Like Christians all over the world, Caribbean residents regard Christmas as a joyful time of faith and put their own unique spin on the celebration of Christ’s birth. For a memorable holiday, swap your mittens and snow shovels for suntan lotion and palm trees and head to the islands this Christmas!

Festive Christmas boat at the St. Croix Boat Parade.
• St. Croix, U.S.V.I.: Crucian Christmas Festival
The annual, month-long Crucian Christmas Festival on St. Croix in the U.S. Virgin Islands begins the first Saturday in December and ends the first Saturday of the New Year; like traditional Caribbean carnivals, it features Jouvert parties, the crowning of a Queen and King, calypso contests, parades, and a special festival village. In mid-December, folks gather along the Christensted boardwalk to enjoy the annual St. Croix Boat Parade, an evening procession of watercraft of all shapes and sizes ablaze with Christmas lights and accompanied by music and fireworks.

Sinterklaas and Zwarte Piet in Curacao.
• The Dutch Caribbean: Sinterklaas and the Zwarte Piet
The islands of the Netherlands Antilles have a unique Christmas celebration that comes straight from Holland, with visits from Sinterklaas and his mysterious minions, the Zwarte Piet (Black Petes). In Aruba, Curacao, Bonaire, St. Maarten, St. Eustatius, and Saba, children receive their holiday gifts not only on Christmas morning but also on Dec. 6, the birthday of St. Nicholas. In Curacao, for example, Sinterklaas, the equivalent of Santa Claus only taller and thinner, arrives by boat in Willemstad in mid-November to give candy to children, aided by his Black Pete helpers with their black-painted faces and elaborate costumes. Island children welcome Sinterklaas with carrots for his white horse and shoes in which to place gifts.

Bermuda town hall decorated for Christmas.
• Bermuda: Christmas Boat Parade
The Bermuda Christmas Boat Parade cruises through Hamilton Harbor each year, with boats adorned in Christmas lights and depicting various holiday characters. The event ends with a bang -- a spectacular fireworks display to kick off the Christmas season in Bermuda. Crowds gather at the Hamilton waterfront and along Pitts Bay Road, but smart travelers will book a table at a

A palm tree is decorated for the holidays in the Cayman Islands.
• Cayman Islands: White (Sand) Christmas
If you dream of a Caribbean holiday getaway but pine for a “White Christmas,” head for the Cayman Islands, where local tradition calls for “backing sand” from local beaches on moonlit nights and spreading it around their yards and homes to stand in for a snowy welcome for Santa. Many old Caymanian houses are ringed with White Sand Yards for the holidays starting on Christmas Eve, and “first tracks” are forbidden until Christmas Day. As with Christmas lights and decorations up north, Cayman residents compete to have the whitest and most beautiful sand yard on Christmas morning.

Clown costumes at the St. Kitts National Carnival. © St. Kitts Tourism Authority
• St. Kitts: National Carnival
Most Carnival celebrations focus on Easter, but the St. Kitts National Carnival kicks off the day after Christmas -- known as Boxing Day in many parts of the world -- with a traditional Jouvert party and runs through New Year’s Day. The Kittsian carnival celebrates local folklore and traditions through song, dance, drama and poetry, and like other Caribbean carnivals there are street parties, performances, and musical competitions.
Parang Festival parade in Trinidad.

- **Trinidad & Tobago and Grenada: Parang Festivals**
  Trinidad & Tobago is one of the Caribbean's most diverse islands -- it's one of the few places in the region, for example, that has a sizable Muslim population. Still, Christianity is the dominant faith, and the annual Parang Festival celebrates the holiday season through song. At Christmas concerts and parties across the two-island nation -- but especially the eastern Trinidad towns of Paramin and Arima -- costumed bands perform traditional folk songs in Spanish Creole, accompanied by instruments such as mandolin, cuatro, and box bass. The island of Carriacou in Grenada also has a well-known parang festival during the Christmas season -- a lively celebration of one of the Caribbean's oldest indigenous art forms.

Costumed revelers at Festival in Montserrat.

- **Montserrat: Festival**
  Montserrat's culture is a mix of Irish and African traditions, and the latter take precedent during the annual celebration known as Festival, which runs from mid-December to early January. Highlights of the island's annual carnival celebration include a Soca Monarch competition, the "Night of Pan" party, the crowning of a pageant queen, calypso contest, and a street party and parade on Jan. 1.
Doctors give chilling account of treating casualties of Paris terrorist attacks

Prof Antoine Lafont, MD on behalf of the health professionals of Assistance Publique-Hôpitaux de Paris (APHP)

A group of doctors from the Assistance Publique-Hôpitaux de Paris (APHP) describe in chilling detail how they coped with the large influx of wounded on the night of Friday November 13, 2015, following the co-ordinated attacks. Operating continuously through the night, 35 surgical teams from 10 hospitals across Paris operated on the most seriously injured. Most of the patients were less than 40 years old. The doctors praise the efficiency of the crisis plan in Paris that ensured casualties were dispatched to appropriate hospitals across the region and prevented medical staff from being overwhelmed in case of additional attacks.

Friday, Nov 13, 2015. It’s 2130 hour when the Assistance Publique-Hôpitaux de Paris (APHP) is alerted to the explosions that have just occurred at the Stade de France, a stadium in Saint-Denis just outside Paris. Within 20 min, there are shootings at four sites and three bloody explosions in the capital. At 2140 h, a massacre takes place and hundreds of people are held hostage for 3 h in Bataclan concert hall.

The emergency medical services (service d’aide médicale d’urgence, SAMU) are immediately mobilised and the crisis cell at the APHP is opened. The APHP crisis unit is able to coordinate 40 hospitals, the biggest entity in Europe with a total of 100 000 health professionals, a capacity of 22 000 beds, and 200 operating rooms. It is very quickly confirmed that the attacks are multiple and that the situation is highly scalable and progressing dangerously. These facts led to a first decision: the activation of the “White Plan” (by the APHP Director General) at 2234 h—mobilizing all hospitals, recalling staff, and releasing beds to cope with a large influx of wounded people. The concept of the White Plan was developed 20 years ago, but this is the first time that the plan has been activated. It is a big decision, and timing is key: it would lose its effectiveness if taken too late. On the night of Friday Nov 13 to Saturday Nov 14, the activation of the White Plan had a critical effect. At no time during the emergency was there a shortage of personnel. During these hours, as the number of victims increased, with a sharp increase after the assault was launched inside the Bataclan, we were able to reassure the public and government that our abilities matched the demand. And when we felt that it might be necessary to deal with an influx of severely injured people, two further “reservoir” capacities were prepared: other hospitals in the area were put on alert, together with some university hospitals, more distant from Paris, but with the ability to mobilize ten helicopters to organize the transport of the wounded. These other two reservoirs have not been used, and we believe that despite this unprecedented number of wounded, the available services were far from being saturated. While hospitals were receiving and directing patients to specific institutions based on capacity and specialty, a psychological support center was set up. 35 psychiatrists, together with psychologists, nurses, and volunteers were gathered in a central Paris hospital, Hôtel Dieu. Most of them had played a similar role during the attacks against Charlie Hebdo. Most of the emergency
workers and health professionals working on the evening of Nov 13 had already been involved in serious crises, were used to working together, and had participated, especially in recent months, in exercises or in updating emergency plans.

In this report, we present the prehospital and hospital management of this unprecedented multisite attack in Paris from the viewpoint of the emergency physician, the trauma surgeon, and the anesthesiologist. This is a testimony on behalf of the health professionals involved in the night of Nov 13.

The emergency physician's perspective
Triage and prehospital care were the duty of SAMU. In the minutes that followed the suicide bombing at the Stade de France, the Paris SAMU unit regulatory crisis team began to send out medical workers to the emergency sites from all eight units of SAMU in the Paris region and from the Paris fire brigade (Brigade de sapeurs-pompiers de Paris), alongside rescue workers and police. The regulatory crisis team was composed of 15 individuals to answer the calls, and five physicians. Their mission was to organize triage and dispatch mobile units (composed of a physician, a nurse, and a driver) to the wounded and to the most appropriate hospitals. As part of the White Plan and ORSAN (organisation de la réponse du système de santé en situations sanitaires exceptionnelles), 45 medical teams from SAMU and the fire brigade were divided between the sites (figure) and 15 were kept in reserve, since we did not know how and when this nightmare would end. This approach avoided early saturation of services—often, in emergency situations, all the resources are focused on the first crisis site, leaving a shortage for following crisis sites. 256 wounded people were safely transferred to and treated in hospitals and the remaining patients arrived at hospitals by their own means. Three acute myocardial infarctions were treated. By the middle of the night, more than 35 surgical teams had operated on the most serious injury.

Since the wounds were principally bullet related, the strategy applied was prehospital damage control to allow the fastest possible hemostatic surgery.1, 2, 3, 4 This is the civil application of war medicine. Indeed, four out of five people shot in the head or the thorax will die. Among those without lethal wounds, damage control consists of maintaining the blood pressure at the lowest level ensuring consciousness (mean arterial pressure 60 mm Hg) using tourniquets, vasoconstrictors, antifibrinolytic agents (tranexamic acid), and prevention of temperature lowering instead of fluid filling (the demand for tourniquets was so high that the mobile teams came back without their belts).

After initial treatment the wounded were transferred by the Mobile Intensive Care Unit (MICU) teams to trauma centers or nearest hospitals when appropriate. Saint Louis Hospital is a few meters from two of the shooting sites (Le Petit Cambodge and Le Carillon restaurants, figure) and its physicians were able to take care of the patients immediately. Some wounded people were able to walk to the nearby Saint Antoine Hospital. To avoid overwhelming the hospital emergency department as ambulances arrived, triage also took place at the hospital entrances.

Despite their brutality and appalling human toll (129 dead on sites, and more than 300 injured) the attacks were not a surprise. Since January, 2015, all state departments had known that a mul-
tisite shooting could happen, and although the police and intelligence services had prevented several attacks, that possibility remained. For 2 years, the prehospital teams of SAMU and the fire brigade had been developing treatment protocols for victims of gunfire wounds, and three field exercises have mobilized doctors to practice prehospital damage control. SAMU is characterized by the presence of physicians who are able not only to stratify risk according to gathered information and send the patient to the appropriate place, but also to act during the prehospital period. In a cruel irony, on the morning of the day of the attacks, SAMU and the fire brigade participated in an exercise simulating the organization of emergency teams in the event of a multiple shooting in Paris. In the evening, when the same doctors were confronted with this situation in reality, some of them believed it was another simulation exercise. At the attack sites and in the hospital, the training received by the emergency and medical workers was a key factor in the success of treatment. Analysis of the experience of bombings in many other countries—Israel, Spain, England, and more recently in Boston, USA—as well as lessons learned from Paris, during the Charlie Hebdo attacks in January, were essential to improving the management and application of damage control. It is important to point out that the scientific publications that issued from these horrible events have had a huge effect on the improvement of medical strategies.5, 6, 7 But no simulation had ever anticipated such a boost in the scale of violence. During long periods of shooting, the streets surrounding the attacks remained difficult and dangerous for emergency intervention teams. Seriously injured hostages in the hands of terrorists or obstructed by fire could not be evacuated. Although emergency physicians have been receiving training in disaster medicine for more than 30 years, never before had such a number of victims been reached and so many wounded been operated on urgently. A new threshold has been crossed.

The approach of the anesthesiologist
Pitié-Salpêtrière Hospital is one of the five civilian level-one trauma centers in the APHP group involved in the treatment of patients after terrorist attack. It is located in the center of Paris. The shock trauma room is included inside a post-anesthesia care unit of 19 beds. The routine capacity of the emergency operating theatre is two operating rooms, which can be extended to three for multiple organ harvesting. After activation of the White Plan, which includes a process to call back all staff, but also because many physicians and nurses spontaneously arrived rapidly in the hospital, we were able to open ten operating rooms and treat injured patients (mostly with penetrating trauma), absolute emergencies (mostly admitted in the shock trauma unit), and relative emergencies (all admitted in the emergency department).

The number of admitted patients was far beyond what we could imagine we would treat at the same time. The resources available were never less than required, despite the unprecedented number of patients admitted during a very short period. Several factors may have contributed to these favorable outcomes. First, the injured patients arrived very quickly (in small groups of four or five) because we had worked for several months with the medical service of the French national police counter-terrorism department (RAID), prehospital emergency teams, and in-hospital trauma teams to be able to provide a fast-track service for penetrating trauma, particularly during a terrorist attack.8 Although penetrating traumas usually represent only 16% of our severe trauma cases,9 injuries from firearms, including war arms, are no longer rare events, and our anesthesiologists and surgeons have been trained to appropriately treat these cases. Before the arrival of the first patients, the postoperative care unit was rapidly emptied and the surgical and medical care unit made several beds available. This was important since, after emergency surgery, patients could be directly admitted into the units, enabling the shock trauma room to be free for new patients, in accordance with the so-called one-way progression concept (no return to the emergency or shock trauma room). A rapid triage was organized at the entrance of the emergency department, directing absolute emergencies to the shock trauma unit and relative emergencies to the emergency department, and this second rapid triage was able to confirm the initial triage done a few minutes previously by the prehospital team. Each absolute emergency patient was cared for by a dedicated trauma team (anesthesiologist, surgeon, fellow, and nurse), who decided whether or not to perform CT scans, radiology, and to send the patient to a prepared operating room where an operating team was available (with appropriate senior and fellow surgeons, anesthesiologist and nurse anesthetist, and operating room nurse). Other post-anesthesia care units were reopened to receive patients once surgery was done.

A key element was the excellent cooperation of all care-givers under the supervision of two trauma leaders in the shock trauma unit and an operating room allocation leader, who were not directly involved in the care of the patients and who continuously communicated between each other and regularly collated information concerning the entire cohort of injured patients. Furthermore, hospital management could immediately provide logistic support. Another key element was related to the dramatic characteristic of the event—each participant wanted to do more than his or her best for the victims. And they did it! Only 9 h after the event, we were able to decrease the number of operating rooms to six and send back home some of the more exhausted staff. Within 24 h, all emergency surgeries (absolute and relative emergencies) had been done and no victims were still in the emergency department or the shock trauma unit. The hospital was nearly ready to cope with another attack that we all feared could occur.

The point of view of the trauma surgeon
If I had to summarize the “winning formula” in the recent tragic hours that we lived, in an orthopedic center of APHP, I would say that spontaneity and professionalism were the key ingredients. When I arrived in Laribosière Hospital 2 h after the beginning of the events, I was surprised to discover that at least six or seven of my colleagues of different specialties were already there in addition to the doctors on duty that night. The on-call anesthetists and intensive care doctors were helped by three colleagues who joined them spontaneously. Extra nursing staff also came to help. All these extra personnel allowed us to open two operating rooms for orthopedic surgery, one for neurosurgery, one for ear, nose, and throat surgery, and two for abdominal surgery. The first seriously injured patients were operated on within half an hour of admission. The triage of the later patients was done in two locations: in the postoperative care unit next to the operating rooms for the most seriously wounded patients, who were brought directly by the mobile medical units, and in the emergency department for the less critically wounded patients. Triage was done by the most experienced physician in each specialty. During the first night, we operated continuously. On Saturday Nov 14, the orthopedic surgery
team was helped spontaneously by two other teams. The sequence of operations was determined after the last patients were admitted, including five patients who came from hospitals in which orthopedic surgery was not available. With the anesthetists and the nursing staff we operated continuously all day long. On Sunday Nov 15, the usual services resumed.

On Monday Nov 16, when all the medical staff reviewed what had been done during the weekend, the common observation was that all but one of the patients were less than 40 years old. All the patients we received had had a high-energy ballistic trauma. All upper limb fractures had been treated with external fixation because of the open nature of the fractures and extensive bone loss.10 The two lower limb ballistic traumas were treated with plates. Nerve damage was frequent, including two patients with median nerve section, one with radial nerve section, one with cubital nerve section, and one with peroneal nerve section. Only one nerve was repaired; for the others, gaps of several centimeters were observed and secondary reconstruction will be needed.11 Vascular damage was not observed in our patients because patients with suspected problems of this sort were directed from the mobile medical unit to a hospital where vascular surgery was available. Psychiatrists were involved in treatment and had contact with all patients during this early period to assess for acute stress disorder and begin the follow-up of potential post-traumatic stress disorder.

Professionalism was present at each level. While the operating room is often described as a difficult place—where the human factor is crucial—during this “stress test” difficulties vanished, working together appeared fluid and somehow harmonious. Trust and communication between different specialties and jobs were apparent. The common goal was so clear that no stakeholder tried to impose an individual view. Solidarity was observable inside the hospital but also between the different APHP hospitals: when a specialist was not available in one hospital the patient was transferred easily to another hospital where the expertise was available. The APHP network demonstrated its efficiency.

All operations were performed without any delay. The sterile supply chain was augmented to allow a fluid workflow, and administrative staff supported the medical work, finding logistic solutions when necessary (eg, patient registration, finding free beds, etc).

Timing might also have played a part in the success of the response. This disaster occurred at the beginning of a weekend and during the night. Some of the aspects might have been more difficult if it had happened during a working day, when the sterile stock is partly unavailable and when doctors and staff are already busy. Unfortunately, the current situation requires us to be prepared to face even more difficult situations in the future.
An Interesting Neurosurgeon

By Micheal J. Mooney

His name is Duke Samson. He knows how to throw a punch, fire a pistol, and he wrote the book on brain surgery. Someone should make a television show based on the life of Dr. Samson. America would love a character like this. He’s 6-foot-2 but seems several inches taller. He embodies his name, Duke, as if one of John Wayne’s characters had grown up to be a doctor. At 69, he walks with the swagger of a West Texan, sometimes reviewing cases with a cigar in his mouth, casually calling people he’s just met Ace.

His voice is deep, gentle, almost always calm and measured, but it’s often said that he doesn’t suffer fools gladly. Maybe the TV show is set in Dallas in the ’80s, and there are a lot of fast muscle cars and flashy ’80s clothes. It would be cool if the opening credits showed the doc walking down the hospital halls, his cowboys boots clicking beneath his scrubs, as women swoon and orderlies give him high-fives. I’ll just throw this out there now, and we’ll touch on it again later, but I think there should be a magazine writer character somewhere in the show, too. He’d want to write a story about the doctor, but he’d do it as a long pitch for a new TV show set in the ’80s. He’d have an editor—yes, this sounds like a tangential plot line for so early in the pitch, but I think you’ll understand why it’s important later—and the editor would initially like the idea of the TV show thing, but he would find it tiresome and gimmicky as the story progressed. So the writer would rewrite the story with much less of the TV stuff and more shape and narrative to it, but then, right before turning it in, he’d go the other direction and put a whole bunch more of the TV show stuff right up front. It’d be ridiculous and way too meta for readers. So that’s all going on. Meanwhile, it’s mostly about this Duke guy.

He played high school football in Odessa, Texas, the town that gave us Friday Night Lights, and went on to play at Stanford. He played rugby and once faced off against the famed New Zealand national team known as the All Blacks. He’s a skilled horseman, an avid gun enthusiast, and a part-time boxer. He served in the Army Medical Corps at the end of the war in Vietnam, he’s parachuted out of more than a dozen planes, and he once medaled in a taekwondo tournament in France. He also happens to be arguably the best brain surgeon on the planet.

Duke wrote the book on aneurysm removal, a manual doctors around the globe still consult nearly 20 years after its publication. The techniques he developed are regularly discussed at international neurosurgery conferences. His is known simply as The Southwestern Method. He is the chair of the neurosurgery department at UT Southwestern Medical Center and performs most of his operations at the associated hospitals. Medical students come from all over the world to study under him. Highly accomplished doctors call him “the most calm, collected genius ever to step into an operating room” and “some sort of god, walking around among mere mortals.”

Of course, the real Duke Samson is too busy to watch TV (except for the occasion-
al Cowboys game), but he's the kind of character who could tell a new, amazing story every week. One episode could be about the time a hospital administrator came into Duke's operating room and said something he shouldn't have. As the legend goes, Duke stayed cool at the moment. But a little later, in the locker room, he was holding the administrator up by the collar, conversing loudly about the transgression. The administrator, far from being upset over the incident, bragged to people that he'd been set straight by the great Duke Samson.

Another episode could be about the time he came to the rescue of a Turkish dwarf. The patient, a baker from Turkey living in Abilene, Texas, had been diagnosed with an achondroplastic dwarf mutation. He was in for a complicated procedure with his spine. The surgery took a turn for the worse—there was a lot more bleeding than anticipated—before Duke swooped in from nowhere. He told the doctors in the operating room to go to lunch. They protested. No doctor wants to leave a patient mid-surgery, especially during a critical phase. But it was Duke. They left and he scrubbed in, and when they came back from the cafeteria, they found the problems rectified and Duke finishing up the operation.

There could be an episode about the time Duke was at the Walter Reed Army Medical Center in Washington, D.C.—he still does a lot of work with the local VA and the one up there—when a special agent, who'd been shot by a sniper, came in. The bullet, fired from above, out of a Soviet Dragunov sniper rifle, went in through the agent's left eye and out the back of his head. Less than 24 hours after he'd been shot, the agent was stateside, barely alive.

"There's a neurosurgeon downrange, right there," Duke says. "They get the thing cleaned up, and they get the bleeding stopped. They put a compressive dressing on it, and they put your ass on a plane and you're at Walter Reed the next afternoon."

The chances of survival were slim, and managing all of those issues at once—the entrance wound, the torn tissue and splintered bone, the profuse bleeding, the gaping hole in the back of the skull—was just about impossible. Duke didn't treat the man, and he can't talk about his patients, but these are things Duke can do. The special agent will probably be blind in both eyes, but he lived. He. Lived.

"He's gonna walk out of that hospital," Duke says.

In this line of work, there is no margin for error. A slip of 3 millimeters could mean the patient never speaks again. And there are so many precarious obstacles in the brain. A skilled neurosurgeon has to be a little like Indiana Jones, "except Indiana Jones doesn't know where he's going," Duke says.

He can come off as cocky sometimes—"the bravado of a star quarterback or an astronaut," one co-worker calls it. That's just confidence, a by-product of the courage required to saw someone's head open and pry through his brain.

"Fear is the worst enemy," Duke says. You just have to block it out. "It becomes easier the more you do it. If you are entranced by the physical act, it helps put the rest at bay."

Perhaps the first episode of the TV show should be about the time a magazine writer went to Duke's office to interview him. As the door opened, Duke, dressed in scrubs, turned down the Gregorian monk chanting coming from a desktop radio. There was an ice-fishing pole on a shelf near degrees and awards and photos of his family. A plastic skull covered in pink marker sat on his desk. On the walls hung a framed Ansel Adams photo of New Mexico and a shot of a tranquil Montana lake that Duke took himself. He dabbles in photography. A sleeping bag sat ready on a leather couch, for those times when operations go so long that he has to sleep at the hospital. And, behind him, a 13-inch television streamed footage of an aneurysm surgery under way in the operating room a few floors below.

On the screen, the brain sat glistening, pulsating ever so slightly with each respiration. "There it is," Duke said, just a bit of awe in his voice despite the thousands of brains he has seen. No matter your philosophies on life, he said, that 3-pound slippery loaf is who you are. "That's why you can never have a brain transplant," he said. "You can only have a body transplant." He gestured toward the screen.

"That's all there is. The rest is just appendages."

He pointed out that for all we still don't know about the brain—and that's a lot—what we do know is incredible. "The things the human brain is capable of," he said, "it's so fascinating." Not only can it write Beethoven's Ninth Symphony and calculate a series of complex movements no computer in the world could even begin to navigate, but it can contemplate a fictional surgeon on an imaginary television show while a real doctor talks about what a brain can contemplate—and it can contemplate itself contemplating all of that.

It's this setting, this challenge that has kept him interested for so many years. His wife is Dr. Patricia Bergen, a trauma surgeon at UT Southwestern. Their first date was in 1988, not long after Duke was the focus of the first ever episode of 48 Hours. She sees the long hours of preparation work he puts into the job. When he has a big case on Monday, he's already thinking about it and reading up on it Saturday afternoon. Their life together has involved a lot of balancing schedules. They never had time for the traditional family dinners, but they always made their vacations, which often lasted a month in the summers, an important part of family time.

"He's also one of the best dads on the planet," she says. They have two sons, ages 22 and 20. "There are a lot of myths and legends about him, but Duke is just a great guy who always does the right thing."

Back on the TV screen in Duke's office, the most complicated part of the surgery was about to begin. The patient had an aneurysm, a compromise in a blood vessel that's a little like a blister in your brain. The goal, after peeling back the muscle tissue and removing part of the skull, was to get to the blister and clip it with a clamp about the length of a fingernail.

When he's in the operating room, Duke often wears his trade-mark American flag bandana. As he's scrubbing in, he might tell a younger doctor, "Get your light on, Ace." Before cutting into the scalp, he'll ask a nurse, "You kill all those nasty germs?" And as he wrestles to remove a spongy tumor or to clamp and drain an aneurysm, he's been known to swear at the maladies.

"If you just walked in and saw it and heard this guy cussing out this tumor, you'd think it was pretty strange," says Dr. Babu G. Welch. Welch is another prominent neurosurgeon in the same practice. He is laid-back, a whiz nearly half Duke's age who not too many years ago was still studying at UT Southwestern. He thinks of the older surgeon like the Tommy Lee Jones character from No Country for Old Men.
“He’s very linear, very straightforward,” Welch says. “He’s very efficient with speech. If he means to insult you, you will be insulted. If he means to compliment you, which is less often, he’ll do that, too.” As the surgery progressed on the screen in his office, Duke went through the finer points of his legendary bio. For all the lore, he was remarkably humble and courteous. He has always been willing to try new things, to test himself in new ways, he said. But he was only really exceptional at one thing. That’s the way his brain works.

He explained that he often has to correct people and tell them that while he was on the Stanford team, he was not an All-American football player. He was actually rather slow. And when he played rugby against the New Zealand national team, they pummeled him.

He told the story about the time he was followed on his way home. He was riding his bicycle from the hospital to his house, near SMU. There had been a string of robberies in the neighborhood, and the criminals were following people home and going in through their garages. One man had even been murdered. It was dark, and the streets were mostly empty. As he often does, Duke had his .45 with him.

He noticed a pickup truck. When Duke turned, the truck turned. When Duke went down the alley behind his house, the truck turned in behind him. As he neared his garage, he slowed down. The truck slowed down. Duke could see there were two men in the cab. He rode past his house, then stopped. The truck stopped, too. Finally, cornered in the dark alley, Duke pulled his gun and told the two guys in the truck to put up their hands.

It turned out they were there to clean the neighbor’s pool. Duke apologized and, with the help of his neighbors, explained about the robberies and the murder and the tension. The pool guys understood. Soon, Duke brought out some cold beers, and a situation that could have been terrible turned into something the neighborhood still laughs about today.

Then Duke told the story about the time he was biking to work through a rough part of town, and saw a guy out in the middle of nowhere beating a woman. He pulled out his gun—“my reason for him to stop what he was doing,” Duke called it—and sent the man on his way. When he asked the woman if she needed the police or any medical attention, she just yelled and swore at him. “That’s what you get for trying to help people,” he said.

His wife says that, despite all of his crazy adventures and tough demeanor, he isn’t afraid to show his emotion. He can get pretty low when he loses a patient. She also remembers him tearing up both times their sons left for school. And, every so often, when he thinks about his dad. Duke never really thought much about brains when he was young. He liked sports, anything that allowed him to compete. When he realized he wasn’t going to become a professional athlete, medicine sounded like a nice backup. The challenge of learning how the human body functioned was alluring, as was the chance to compete intellectually with some of the smartest people in the country.

He says he’ll stop working only when the challenges of surgery no longer captivate him. But not long ago, he announced that he would step down as chair of the neurosurgery department. For 27 years, he has built one of the more respected programs in the world. He has worked on famous people he can’t talk about, and he has changed the profession forever. He’ll still operate and see patients, but his days of fundraising and being the primary advocate for new equipment and more in-depth training are over, he says. More time for adventures.

Once the Duke character is established with the audience, there could be an episode about a new endeavor he’s undertaking: writing a novel. He has always been a voracious reader, everything from Hemingway to history to new books about the war in Iraq. So he figured he’d try his hand at writing, too.

“Why not?” he says with a grin.

The book is tentatively called Grey Dogs, and it’s about a bank robbery that happened when he was stationed in the Philippines. The characters are based on Duke and a few of his buddies. He has an editor who likes the concept, but Duke has found that getting the brain of a reader to engage with even very interesting characters can be tricky. In all his life, he can remember giving up on only one thing—learning to play classical guitar. So he’s not going to quit. It’s just that writing is harder than he expected it to be. Of course, he points out, it’s not brain surgery.
10 Weird, Strange and Bizarre Medical Treatment Practices Around the World

By trendsnhealth.com

There are so many options for treatments like Allopathy, Homoeopathy, Acupressure, acupuncture, Ayurveda, Naturopathy and many more. But still people go for some really weird, strange, unusual, rare and Bizarre Medical treatment practices to get rid of their medical problems.

Dead Mouse Therapy
Would you like a dead mouse in the mouth as a medical treatment? Well Ancient Egyptians did try this bizarre medical treatment to ease toothache. Not just for toothache, but to ease pain of other body parts, Dead mouse paste was blended with other ingredients, and the paste was applied to the body parts paining. If you think only Egyptians used a mouse for medical treatments, read on. In Elizabethan England, a dead mouse remedy was used to treat warts. To treat warts, a mouse was cut in half and then the mouse was applied onto the wart. Mouses were also used to treat many other ailments like, whooping cough, measles, smallpox, and bed-wetting.

Sheep Liver Diagnosis
The most bizarre way to diagnose illness! Sheep Liver Diagnosis. No blood test, No medical equipment, just a sacrificed Sheep and its Liver. Seems weird, Isn’t it?
In Mesopotamia (modern-day Iraq), Patients were not examined, but the liver of the sheep sacrificed by the patient was examined by the medical practitioners and medical judgments were made accordingly. Do you want to sacrifice a sheep to get a medical judgement?

Hemiglossectomy
What’s the best treatment for stammering? Some therapy, counselling, medicines or Hemiglossectomy? Well, the Doctors in the 18th and 19th centuries often used to use the bizarre medical treatment called Hemiglossectomy to treat stammering. In Hemiglossectomy treatment, the tongue of the patient was cut off half. You will be shocked to know that Hemiglossectomy is still practiced. But only to treat oral cancer. Was, Hemiglossectomy such a big problem that cutting half of the tongue looked better to people? Weird!!

Goat Testicles Implant
John Brinkley was one of the richest doctors in early 1900 in America without any medical qualification. Shocked? Well Dr. John Brinkley claimed that he can cure impotency, infertility, and all other sexual medical problems. Do you want to know how? He used to surgically implant the testicles of a Goat into a man’s scrotum. There is no medical evidence if he succeeded in curing sexual medical problems, but many patients died during the surgery.

Curing Coughs with Snail Syrup
Would you like to cure your cough with a dead snail syrup? A doctor in 1728 wrote that, “They abound with a slimy juice; and are experienced very good in weaknesses and consumption, especially for children and tender constitutions. To make a syrup of snails, take Garden snails, early in the morning while the dew is upon them, one pound; take off their shells; slit them; and with half a pound of sugar, put them in a bag; hang them in a cellar and the syrup will melt and drop through; which keep for use. It possesses in the best manner all the virtues of snails.”
Not just cough, many people drop the slimy foamy juice they get after pricking a snail in their ears to treat ear ache.

Hirudotherapy or Leech Therapy
Hirudotherapy is also known as “treatment that sucks,”, The treatment involves European medical leeches to suck blood of the patient. Only Medical leeches are used in this healing treatment and not the wild or leeches you find in your garden. Hirudotherapy leeches are used to treat many medical problems like blood clotting, to relieve venous pressure to reduce swelling, to stimulate blood flow, and also to treat certain types of osteoarthritis. This bizarre medical treatment, Hirudotherapy is still used in many countries.

Dolphin Therapy
Dolphin therapy is used for pregnant ladies. During dolphin therapy, a dolphin touches the stomach of a pregnant woman. It is believed that the dolphins’ high-frequency sounds help stimulate the brain of an unborn baby inside the pregnant women who undergoes this therapy.

Secret Fish Medicine for Asthma
In Southern India, The Bathani Goud Brothers organize free camps to cure Asthma by making the patient swallow a live 2 inch fish dipped in medicine. The Bathani Goud family claims to be offering this treatment from last 160 years. After the swallowing the fish, the patient has to follow a strict diet for 45 days and the treatment should be taken for three consecutive years to completely cure the Asthma.

Hijama Therapy
Hijama therapy is a combination of two therapies, cupping and bloodletting. It is believed that this therapy is described by the prophet Mohammed and is religiously used in many Islamic countries. The bizarre medical treatment is used to treat chronic pain, rheumatism, eczema, and many other diseases. During Hijama therapy, the special cups are placed on the body where the patient claims to have pain. The cups are placed in a specific way, the vacuum is sucked out of the cups so that the tightly sealed cups can draw “decayed” blood from the body of the patient.

Railway Track Therapy
In Indonesia, a bizarre medical treatment is followed to treat Diabetes and High Blood Pressure. The therapy comes from the tale of a Chinese man who tried to commit suicide on railway track, but miraculously got cured by the electric train passing by on the railway tracks. Although, there is a high risk of danger involved in the therapy and people even get arrested, but still people faithfully follow the bizarre medical treatment to get rid of their medical problems.
Tesla unveils battery storage system for home, business and utility use

By John Anderson

The Powerwall home battery can be mounted indoors or out

The Tesla home battery system hinted at by CEO Elon Musk several months ago has finally been unveiled by Musk himself at the company’s design studio in Hawthorne, California. Dubbed the Powerwall, the stationary home battery offers 10 kWh of storage capacity for the relatively modest price of $3,500. A smaller unit is also available at 7 kWh for $3,000, and homeowners can stack multiple units if needed.

The facility and event where the announcement was made were powered by the new Tesla batteries, which were charged during the day by rooftop solar panels. Consisting of an DC to DC converter, the battery works with solar systems right out of the box (though installation is extra), to store energy during the day for powering the home at night or during outages due to storms or natural disasters.

With that in mind, Musk said the units can work in cold climates, operating within a temperature range of -20° C (−4° F) to 43° C (110° F). Non-solar homes can also benefit by storing energy from the grid during low rate periods and using it during expensive peak hours. The lithium-ion battery also consists of a liquid thermal control system and software that receives dispatch commands from a solar inverter.

"The fact that it's wall-mounted is vital," said Musk, pointing out that no special battery room is needed, and that the flat, roughly 4-ft by 3-ft (0.9 x 1.2 m) unit can be mounted indoors on a garage wall or the outdoor wall of a home.

Musk also envisioned the battery for use in remote areas of the world that lack an energy infrastructure, and likened their hopeful adoption to that of cell phones, which leapfrogged landlines in places previously without phone service. Even more ambitious was the introduction of a 100 kWh power pack battery block designed for utility applications, which can be grouped and scaled from 500 kWh to more than 10 MWh. The systems would be able to produce 2 or 4 hour continuous net discharge power using bi-directional inverters tied to the grid.

"It's designed to scale infinitely, to a gigawatt class or higher," said Musk. He added that a 250 kWh system is already installed and being used by an unnamed utility.

Musk went even further, saying a gigawatt power pack could power a small city, such as Boulder, Colorado. Doing the math, he added that 160 million of Tesla's power packs could power the US, and that 2 billion power packs could supply energy to the entire world, transportation included.

"This is within the power of humanity to do," he said. "It's not impossible, and we're starting to do it with Gigafactory 1."

While he might have been tempted to take a Dr. Evil pinky-pose at the thought, Musk added that Tesla has open source patents for its technology, with the hope that other companies will build gigafactories of their own.

The PowerWall is currently manufactured at the company's auto factory in Fremont, California, but production will ramp up following the shift to the Tesla Gigafactory in Nevada, which is expected to be completed in 2017.
Almost every day we read about physicians paying millions of dollars in fines or settlements, going to jail, losing their licenses or being excluded from participating in healthcare programs for allegations of healthcare fraud. Many of these situations could have been easily avoided with an effective compliance program. Below are some common compliance pitfalls that can be avoided with a few changes to your practice.

- Not having a compliance program. Federal law requires that Medicare, Medicaid, and CHIP providers have a compliance program. A compliance program is a compilation of fraud and abuse laws, regulations, policies, procedures, and training designed to detect and correct healthcare fraud and abuse within the practice. Some topics covered by a compliance program include billing practices, referral arrangements, and conflicts of interest. In the event your practice or providers are ever accused of or found guilty of violating federal laws, following a compliance program can help reduce sanctions.

- Not following up on claim denials. There is no such thing as a "routine denial" or audit by a payor. Practices should follow up on every denied claim and appeal improper denials or correct billing errors. The government views repeated submission of denied claims as proof of intent to defraud Medicare. Further, if you catch the error soon enough, you may be able to correct it and rebill the claim.

- Paying or receiving compensation for referrals. Practices should routinely examine their relationships with referring physicians. Every arrangement should be analyzed for compliance with applicable state and federal laws regarding referrals and kickbacks. The Department of Justice is cracking down on illegal referral arrangements.

- Improper compensation arrangements within the practice. Generally, in Florida, non-owners in a practice cannot participate in profit-sharing, and non-owners cannot receive payment from ancillary services. Practices with these types of compensation arrangements should seek the advice of healthcare legal counsel to ensure that arrangements are structured properly.

This Legal Bulletin is for informational purposes only and not intended as legal advice for specific situations.

Any questions regarding this article can be directed to Samantha Prokop at RezLegal, LLC; (904) 638-3065; Samantha@rezlegal.com.
Get schooled on financial aid – whatever your income level
Did you know that in the 2014-2015 academic year, more than $238.3 billion in financial aid (grants, federal loans, federal work-study, and federal tax credits and deductions) was awarded to undergraduate and graduate students? And that those students came from households spanning a wide range of household incomes?

During that same academic year, the average amount of aid for a full-time college student was $14,180, including $8,080 in grants (that don't have to be repaid) and $4,840 in federal loans.

Once you realize how many resources may be available and begin your research on financial assistance, you may be on your way toward easing some of the anxiety often associated with paying for college.

5 lessons on seeking financial help for college costs

Start planning during the high school years. Pay particular attention to your child's junior year of high school, and reposition assets or adjust income before that year begins. When financial aid officers review a family's need, they analyze the family's income in the calendar year beginning in January of the student's junior year of high school.

Assume you're eligible for aid … until you're told you're not. There are no specific guidelines or rules of thumb that can accurately predict the aid you and your child may be offered. Because each family's circumstances are different, keep an open mind as you consider financial aid alternatives. A number of factors—such as having several children in school at the same time—may increase your eligibility for assistance.

Reassess assets held by your children. Federal guidelines expect children to contribute 20% of their savings toward their education's costs, while parents are expected to contribute up to 5.64%. That's why assets held in custodial accounts in your children's names (bank accounts, trust funds, brokerage accounts) may reduce the aid for which the family qualifies.

But assets held in Coverdell Education Savings Accounts (ESAs with income limitations) and 529 plans (operated by states and educational institutions) will be factored into the parent's formula, having less effect on the aid for which the family qualifies.

Help grandparents' target their gifts. Grandparents' hearts often lead them to make gifts directly to grandchildren or pay their tuition expenses. Even though payments made directly to a college avoid gift taxes, financial aid sources generally count these payments as an additional resource the family has to pay for college expenses. Distributions from grandparent-owned 529 plans are also considered as resources and assessed as your child's income, which reduces the amount of eligible aid.

A better idea for grandparents may be to consider making a gift to a 529 plan owned by the parent or grandchild. The financial aid treatment of gifts to 529 plans is generally more favorable than for gifts made directly to the grandchild. Plus grandparents may also realize estate tax and gift benefits by using this alternative.

Assess your family's financial situation to determine what your children will need. Gather records and begin researching available financial aid, grants, loans and scholarships. Two forms will be key to your aid application process: the Free Application for Federal Student Aid (FAFSA) and the College Scholarship Service Financial Aid Profile (PROFILE). The FAFSA form helps you apply for federal aid, and many states also use it to determine a resident student's eligibility for state aid. You can find forms in high-school guidance offices and college financial-aid offices or online.
Please consider the investment objectives, risks, charges and expenses carefully before investing in a 529 savings plan. The official statement, which contains this and other information, can be obtained by calling your Financial Advisor. Read it carefully before you invest.

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2013 Tournon Shiraz “Mathilda” The theme for this review is great wines from grapes grown in cool climates. While some of you may crave powerful reds, there is a time and a place for those of subtlety.

My first pick creates a pairing I learned the very first Thanksgiving working in a wine shop in 1989. At the time I was still in college and on a tight budget so my boss gave me a bottle of Crozes-Hermitage from Chapoutier to serve with my Dad’s turkey. It is funny to think that at the time the wine was probably $8-9 dollars, because good examples from that part of France now cost upwards of $30! Anyway, the meaty, smokey quality of that Syrah was a great complement to the bird and forever ingrained in me that pairings can be unconventional and still work. The selection this month’s review is from the same family, although made by a new generation than those who made the 1985 Crozes-Hermitage. There are very few winemakers in the world who understand the Syrah grape better than Michel Chapoutier. After turning the Northern Rhone on its collective ear starting in the early 1990’s, he began making wine in Australia in 1997 as a consultant. For more than 10 years he experimented, making examples of Shiraz from across Australia and finally narrowed down the specific climate and soil he was seeking when he purchased the Tournon estate in 2009. This vineyard lies in the Victorian Pyrenees, a mountain range northeast of Melbourne. The area has a temperate climate and higher than average rainfall for Australia, which is the perfect conditions for growing both red and white wines. The vines are planted in soils that are shale and clay, which do not retain water and give the wine an undertone of minerality. His vineyards are also planted on relatively steep slopes, which while they do not rival the sheerness of the Northern Rhone, certainly add stress to the vine growing conditions. As with all of the Chapoutier properties, this one is farmed biodynamically although it will be a few years before the certification is complete. The fruit is hand harvested and the grapes are fermented on the skin for up to four weeks to develop long, smooth tannins. When you pour a glass of this wine the nose almost explodes out of the glass with notes of fresh blackberry, black currants, dried cherries, mint, eucalyptus and maduro cigar wrapper. In the mouth this wine has a nice pop of fruit up front, then picks up weight and structure as it rolls into a long finish. This is far from your standard $15 Aussie Shiraz and I would encourage any fan of Cotes du Rhone particularly Northern examples) to give this wine serious attention. Serve with a grilled tri-tip sandwich with peppers and onions, or with wild mushroom and beef stew. Drink over the next three to five years.

2013 Wildewood Pinot Noir
It is pretty rare to find an Oregon Pinot Noir for less than $25, particularly one from the Willamette Valley. The first time I tasted Wildewood, from the difficult 2011 vintage, I was impressed but convinced that for this price it must be a negotiant label. A negotiant is someone in the French tradition who does not own vineyards but bottles wine under their label made from purchased grapes, unfermented juice and finished wine from multiple sources. This is not to say the quality is not good but negotiants do cede a certain amount of control and that usually means that compromises must be made. To my surprise I learned there is an actual Wildewood Winery and that their owner, Laurent Montalieu, has a real strong commitment to quality and value, which is rare in the Willamette Valley. Since I do not often get the chance to write about Willamette Valley in the Explorers Club, and never for Pinot Noir, let me take a couple of paragraphs to explain why this region is so unique by New World wine standards. Unlike the more fruit forward examples of Pinot Noir made in California, there is a savory, almost umami-like quality to good Oregon Pinot Noir that has more in common with French Red Burgundy. This is due to the unique conditions of the Willamette Valley that impart upon the wines a distinctive sense of terroir. Geographically the Willamette Valley runs south from Portland to Eugene, Oregon, a distance of almost 150 miles. It is bordered by mountains on three sides; the Oregon Coast Range to the west, the Cascade Mountains to the east and the Calapooya Mountains to the south. The Willamette Valley runs north the length of the valley before joining the Columbia River, which forms the border with Washington State. Because of the river, and a series of late ice age events called the Mizzoula floods, the valley has incredibly fertile, sedimentary soils which make it an enormous source of agricultural products including hops, vegeta-
bles, Christmas trees and dairy. These soils impart an earthiness and intensity of flavor which is the foundation of the Willamette character. The style of wines from the Willamette also has a lot to do with the climate, which is often referred to as Mediterranean with strong ocean influences. Summers in this area are warm but the valley is regulated by the cool ocean breezes that roll down the Columbia River gorge then flow south through the Willamette, as well as through gap in the Coastal Mountains called the Van Duzer pass. This cools the area off quickly at night and as we have learned many times before, preserves natural acidity in the grapes. The vineyards for Wildewood lie at the edge of the Dundee Hills, in the northwestern edge of the Willamette wine region. This area is north of the Van Duzer pass so the climate is slightly warmer, producing some of the most distinctive wines in the region. Because of his experience, Laurent Montalieu planted many different clones of Pinot Noir in his vineyards to also build added complexity into the finished wine. To make the 2013, which is a very good vintage, the fruit was hand harvested and destemmed before being cold soaked for two days before fermentation. This helps to lock in color without extracting heavy tannins. The juice was then fermented and once complete the wine was left on the skins for an additional couple of days but build structure. After the wine was moved to French oak barrels for eight months before bottling. When you open this wine make sure to give it a splash in the decanter to help the bouquet develop. It shows classic Oregon color, light garnet and little staining in the tears. The nose is an enchanting combination of fresh raspberry and dried strawberry, dried sage, dried thyme and bay leaf. On the palate this wine has a moderate sense of fruit, deepened by a kiss of earth and rose petal, and a soft frame of tannins and acids. This is a fantastic wine to serve with turkey dinner, almost any preparation of salmon or mushroom risotto.
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Being a member of our club gives you many advantages over owning your own boat:

- It's much more cost-effective.
- You can choose from our several different types of boats to suit your needs – from deck boats to twin cabin express yachts.
- You don't have to clean the boats after you use them or keep them maintained – so you have no drain on your time or your cash.
- No loan payments.
- No insurance payments.
- No storage fees.
- No towing – or waiting in line at the ramp.
- Our exclusive valet service (including water toys and performance life jackets) removes all the frustration and aggravation so you and your guests can fully enjoy your day on the water.
- Membership includes using the express yachts for overnight stays for romantic getaways and family outings.

Make boating a part of your life the easy way. Please contact our Membership Director at 904.477.9794 for information on our individual, family or corporate memberships and visit us at jaxboatclub.com.

JaxBoatClub
jaxboatclub.com

Celebrating our 100th Anniversary