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In modern India the government supports different medical traditions. This is unusual. Individuals may choose from a vast range of practices, treatments and therapies, including biomedicine, Ayurveda, yoga, naturopathy, Unani Tibb, Siddha and homeopathy.

India's medical past
For over 2000 years most of the Indian population have used Ayurveda as their main type of health care. From the early 11th century, Unani Tibb’s influence spread with the increasing Muslim presence in India. Unani Tibb and Ayurveda have influenced each other since, especially the herbs on which they base their medicines.

In the 1500s the colonial Portuguese in Goa exchanged medical knowledge and methods with local Asian practitioners. In 1563, Garcia d’Orta published volumes about Indian plants and medicine, which spread to Europe. By the early 1600s the Portuguese lost their interest in local knowledge and effectively outlawed Indian practices.

The British arrived in India at the beginning of the 1600s. Missionaries promoted European medical ideas and learned from local practitioners. Shipping medical supplies from Britain was expensive and difficult, so local medical practices continued. Ayurveda was a cheap and practical health-care system for the local population. However, most British officials and physicians thought traditional systems of medicine would die out because Western medicine was superior.

Indian reactions to European medicine
Many Indian practitioners were impressed by European surgery and teaching. They updated their practice by adapting its ‘modern’ methods. Ayurvedic and Unani Tibb practitioners traditionally made up a unique prescription for each patient. They believed standardised preparations in factories modernised their traditions and weeded out practices regarded as quackery. This led to a move away from highly individualised medicine toward mass production.

From the 1830s the British government no longer tolerated Indian medicine. Only those trained in Western medicine could be registered as doctors. However, local traditions continued. They adapted and became more professional to compete with medicine introduced by the British administration.

Many Ayurvedic and Unani Tibb practitioners wanted individual drugs and therapies from traditional Indian systems incorporated into biomedicine. They explored Indian materia medica, looking for ingredients compatible with European pharmacology. However, others argued for separate traditions using a different framework to understand health and disease. For instance, Unani Tibb relies on the theory of the humours, while biomedicine is based on germ theory. Support for Indian traditions became more political in the early 1900s. The revival of local medical traditions was a source of national pride, and Indian independence was linked with reinvigorating Indian traditions and knowledge.

Adopting new traditions - homeopathy in India
Systems of medical knowledge can develop different meanings when they move between places. One European system taken up in India is homeopathy, which spread in India during the 1850s. It was seen as a modern tradition, but was not associated with the British colonial regime because it originated in Germany. Homeopathy was cheap, relatively easy to learn and required no registration. It became popular in the fight against cholera and malaria. These diseases were widespread in the late 1800s, and European medicine seemed ineffective. Cures were sought among other traditions, which also had little impact.

Homeopathy in India was seen as a meeting ground between Western and Eastern traditions. In the 1930s there were attempts to create a medical system incorporating both homeopathic and Ayurvedic ideas. In the 1970s homeopathy was regulated alongside other local medical traditions. While biomedicine is now the most common tradition, the Indian government is also responsible for education, training and research into these other traditions.
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What Is Your Mission?
Mayor Lenny Curry & DCMS President Dr. Sunil Joshi
Challenge the 904 to Lose One Million Pounds

By Michelle McCormick, Duval County Medical Society Foundation

One of the leading factors impacting the health of our community is weight. Two out of three people in the 904 area code are overweight. This is the leading cause of preventable disease such as type 2 diabetes, heart disease, high blood pressure and stroke.

The journey of a thousand miles begins with a single step. We're asking you to take a step with us to become One in a Million.

Mission One Million (M1M) is a movement founded by the Duval County Medical Society (DCMS) Foundation and co-chaired by Jacksonville Mayor Lenny Curry and DCMS President Dr. Sunil Joshi. The DCMS Foundation was established by the DCMS in 1959 as a 501 c3 not-for-profit corporation to serve as an institute of scientific research and learning, dealing primarily with medical science.

“Instead of sitting back and letting others figure out what to do, the DCMS and DCMS Foundation is going to take the lead on improving this number,” Dr. Joshi explained.

On April 7, 2016, Mayor Curry issued the Mission One Million challenge to the residents of the First Coast to collectively lose one million pounds. Many factors led to this unprecedented announcement. Recently, the Robert Wood Johnson Foundation released its county health rankings for 2016. In Florida, Duval County came in at 48 out of 67 counties. This is a drop from 43rd in 2015. Factors that make up this ranking include length of life, quality of life, health behaviors (such as smoking and adult obesity), social and economic factors and physical environment. In order for Duval County to better position itself in the county health rankings, many things must improve.
"Improving from 48 to number one is no small task," said Mayor Curry.

Journey to One is the City of Jacksonville’s answer to making the city a healthier place to live. The City of Jacksonville website explains part of the mission: “With Journey to One, we (the City of Jacksonville) commit to building, and strengthening partnerships that promote nutrition, exercise, walkability, weight loss, disease prevention, and safety in all communities. Throughout the planning of the campaign, we met with a great number of partners leading and conducting outstanding work to improve the health of our citizens and communities. They provided valuable feedback that contributed to the first set of priorities we’ve identified for Journey to One.”

Only one other city in the United States has completed a million pound challenge. In 2007, the Mayor of Oklahoma City, Mick Cornett, announced he needed to lose weight, and therefore the entire city was going on a diet. At the time, Oklahoma was ranked 46th out of 50 states in the American Health Rankings, in part because of high rates of smoking and obesity. Fast forward three and half years: Mayor Cornett achieved his goal and the city lost one million pounds. While Oklahoma is still near the bottom of the rankings (now 45), Oklahoma County is ranked 28th out of 77 counties in Oklahoma’s county health rankings. Before the challenge, the county was 30th. It took dedication and perseverance to get there, but Oklahoma City is on the right path.

With Community Partners such as the Mayor’s Council for Fitness and Well-Being, the YMCA of Northeast Florida, the American Heart Association, Jacksonville University, The Donna Foundation, Duval County Public Schools and so many more, Mission One Million is able to direct its users to resources that are already available in the area. M1M won’t be starting its own workout programs or 5K runs, but its presence will be felt at health fairs, community events and citywide programs.

Through M1M, the DCMS Foundation has set up a website (904MissionOneMillion.com) for users to log in, track their weight, set missions and be part of a larger support system. Even though the city’s mission is to lose one million pounds, the M1M movement is much more than just weight loss:

Audrey’s mission is to, “manage depression, increase immunity, keep up with students and children.”

Carol’s goal is, “to increase my weekly exercise to 3 hours per week and lose weight in the process.”

Marvin wants to, “achieve a healthy BMI.”

Corey, “just turned 60 and I want to lose 60 pounds!”

The website also allows users to download a printable sign that they can use to declare their mission and share with their social media contacts. The hashtag #904MissionAccepted is spreading throughout the community as people are becoming more aware.

“The 904 is a wonderful place to live, work, and play,” said Dr. Joshi. “There is no reason why we can't move up the rankings of the healthiest Florida counties with the Mission One Million approach to both physical and mental well-being. With support from big and small businesses, Mayor Curry’s office, and the people of the first coast, Mission One Million has a chance to make the 904 an example for the rest of the country to follow.”

These Duval County women have different Missions with one goal: to get healthier!
Good buzz has served Naples well since the late 1800s when the first settlers compared the area to an Italian paradise, a vote of confidence that gave the city its name and launched its resort reputation. Although it has some of the old-school tendencies that can accompany a wealthy enclave, the downtown dining scene has seen some inventive new twists in recent years, and East Naples is now blossoming into a destination in its own right, anchored by the Botanical Garden. The combination of stylish downtown bars and restaurants with beautiful beaches make this our Florida pick for a girl’s getaway weekend. Gather your friends and check out the newest hotspots and some old favorites. – By LoAnn Halden

**Friday**
1. Start the evening with one of the city’s famous sunsets, best viewed from Naples Pier, an easy walk from the Third Street South shopping district.

2. Go for dinner at Chops City Grill, a long-running favorite in the heart of downtown that tends to stay open later in low season. Although it’s a steakhouse, the menu mixes it up with Asian flavors and a raw bar.

3. Walk to Osetra, a new champagne and caviar bar on Fifth Avenue South, to end the evening on an indulgent note. The menu ranges from affordable sparkling wine by the glass and black caviar with crème fraîche to bottles of Cristal and bank-breaking servings of the finest Russian caviar.

**Saturday**
1. Drive over to East Naples for breakfast—and to stock the hotel kitchen—at Three60 Market. This Dean & DeLuca-esque gourmet deli has waterfront tables and specializes in fresh baked goods and unique salads.

2. Head north about twenty minutes to lounge on the white sand at Vanderbilt Beach Park near the Ritz-Carlton. This is one of Naples’ most popular sunbathing spots so arrive before 10 a.m. during high season to ensure a spot.

3. Make your way south with a detour for lunch at Inca’s Kitchen, just north of Golden Gate Parkway. The Peruvian restaurant features a don’t-miss selection of ceviche.

4. Head back to the east side for one of the city’s top draws, the Naples Botanical Garden. The grounds include six cultivated gardens, 90 acres of restored native preserve, and 2.5 miles of walking trails.

5. Browse the downtown shopping districts, Fifth Avenue South and Third Street South, which is anchored by Maris-sa Collections, a women’s clothing store with pieces straight from the New York runways.

6. For dinner, meander over to Third Street newcomer Barbatella, which has already earned a following for its wood-oven pizzas and homemade pasta and for helping fill the gap of
moderately priced downtown dining options. We recommend the Pescatora pizza with shrimp, squid, and mussels.

7. Wind down with a martini at the downstairs bar of Fifth Avenue's Café Lurcat, a no longer new but still shiny example of Naples moving in a hipper direction.

**Sunday**


2. Take the 30-minute drive south to Marco Island to board the Dolphin Explorer, a three-hour eco-tour that observes Southwest Florida's dolphin population and makes a beachcombing stop on one of the area's unspoiled barrier islands. Book in advance. There's a cruise at 9 a.m. and also a 1 p.m. option if you are planning for a late Saturday night.

3. Before leaving the area, grab a quick, cheap Mexican lunch at local favorite Taqueria San Julian 3575 Bayshore Drive; in East Naples. This is strictly no-frills, but it's authentic. Chipotle, habanero, and green tomatillo sauces accompany the fresh tortillas.

**Where to Stay**

Our pick for downtown convenience that doesn't skimp on charm is the Bellasera Hotel (rooms from $129/night), a Tuscan-flavored property hidden in plain sight on the east side of historic Naples. The larger suites with kitchens are ideally suited for groups of friends.

If easy beach access is a priority, pick the Naples Beach Hotel and Golf Club (rooms from $170/night). It's right on the Gulf of Mexico, but only two miles north of the shops and restaurants of downtown Naples.
Osman Khan used the skins of an orange and a Jamaican ugli fruit to illustrate Dr. Johann Gudjonsson’s research in psoriasis, Monday, April 18, 2016, in Detroit. The University of Michigan has forged collaborations between doctors and artists in an effort to fund medical research. Artwork yielded by the collaborations will be auctioned off Thursday, April 21 at the institute’s gala fundraiser at the Museum of Contemporary Art Detroit. Proceeds will benefit the institute’s Emerging Scholars Program, which helps junior medical faculty set up their own research laboratories to engage in work that might be too speculative or daring for conventional funding sources.

The University of Michigan has forged collaborations between doctors and artists in an effort to fund medical research -- and to stimulate each other’s creativity.

The university’s A. Alfred Taubman Medical Research Institute paired 19 clinician-scientists with some of the Detroit area’s most notable artists, including Beverly Fishman, Scott Hocking, Olayami Dabls, Catie Newell, Bryant Tillman, Sharon Que and Senghor Reid. Ann Arbor artist Christina Burch was paired with Dr. David Pinsky of the University of Michigan Hospital’s Frankel Cardiovascular Center. Burch’s painting, “Forest of Love: the Heart’s Great Repose,” illustrates her vision of Pinsky’s work at his lab.

“I’d just started a new series on hearts in my own work,” she says. “So it was cool to get hooked up with the university’s chief of cardiology.”

For his part in the collaboration, Pinsky visited Burch’s studio at the Tsogyelgar Dharma center and farm in the countryside west of Ann Arbor, where he was struck by the serenity that he feels is reflected in her artwork.

Although art and medicine seem like two completely different worlds, Pinsky admits that they overlap far more than one would commonly assume.

“As scientists,” he said, “we look through microscopes at shapes and how they turn and twist. The natural world has patterns, and as scientists, we try to reveal those patterns.”

Artwork yielded by the collaborations will be auctioned off Thursday at the institute’s third-annual gala fundraiser, “An Evening of Art + Science,” at the Museum of Contemporary Art Detroit. Proceeds will benefit the institute’s Emerging Scholars Program, which helps junior medical faculty set up their own research laboratories to engage in work that might be too speculative or daring for conventional funding sources.

The institute hopes to initially raise $200,000 to fund one new scholar over five years. But it eventually hopes to two or three scholars “as the event grows and gains more traction,” said director Dr. Eva Feldman.
In a letter to George Washington in 1794, the statesman Alexander Hamilton wrote, “It is long since I have learned to hold popular opinion of no value.”

But if he were alive today, he’d have a tough time ignoring the cheers and shouts and wild applause that greet Lin-Manuel Miranda’s canny and exuberant Hamilton, a fiercely original and dynamically quotational musical at the Public Theater.

Today we remember Hamilton from his handsome portrait on the $10 bill, a couple of half-recalled textbook paragraphs about the drafting of the constitution, and his senseless death on a New Jersey dueling ground. Miranda, best known for composing and starring in the jaunty Tony winner In the Heights, knew little more than that before reading Ron Chernow’s biography while bobbing in a swimming pool on vacation.

Miranda saw parallels between Hamilton’s story, a poor orphan from Nevis who proved himself on the streets of New York, and the up-by-the-questionably-legal-boot-straps narrative many hip-hop songs. Hamilton, here, is just “another immigrant, comin’ up from the bottom.” So while remaining faithful to the historical record, Miranda marries the facts of Hamilton’s life to a mostly sung through score that references and suggests and steals from rap, hip-hop, British invasion, indie rock, operetta and mega-musical. The show explores, as the lyrics in the chills-producing opening number explain:

“How does a bastard, orphan, son of a whore and a\nScotsman, dropped in the middle of a forgotten\nSpot in the Caribbean by providence, impoverished, in\nsqualor Grow up to be a hero and a scholar?”

This isn’t parody and it isn’t even pastiche. Sure, a lot of the lines are borrowed from elsewhere and a lot of the music sounds very familiar. (George III’s pop ballad You’ll Be Back, performed by the superlative Brian d’Arcy James, is a duplicate of the Monkees’ Daydream Believer.) But the styles complement and clash so extravagantly and exuberantly that they create new genres of their own. It takes real dash to write a song like The Schuyler Sisters, almost a throwaway number, which somehow combines TLC with the Andrews Sisters and a hat tip to Three Little Maids From School Are We. Didn’t expect to see a show that could pay homage to both Stephen Sondheim and Biggie Smalls? You’re welcome. Hamilton plays out on a mostly bare stage, adorned by a big, terrific, multicultural cast, led by Miranda himself. The Founding Fathers didn’t look like the men who portray them and the same holds true of their mistresses and wives. But director Thomas Kail’s corps reminds us of what the America that Hamilton helped to create looks like now, while also emphasizing Hamilton’s insider/outsider status. As the vibrant Daveed Diggs as the Marquis de Lafayette says to Hamilton, “Immigrants: We get the job done.” Then they high five. Then they win the war.

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Still, Miranda has a regiment of laurels to rest himself on. There’s a refrain that echoes through several of the songs and even makes its way on to the cover of the Playbill: “Who lives, who dies, who tells your story?” With a show this brash and nimble, this historically engaged and startlingly contemporary, Miranda confirms his promise as one hell of a teller.

Public Theater, New York
This exuberant and original new musical mashes up genres from rap to operetta, creating a flawed but glorious portrait of the face on the $10 bill

By Alexis Soloski
McNab Ridge Fred’s Red

When it comes to making good “have around” wines, there are few winemakers who do it better than Rich Parducci of McNab Winery. The first time I met Rich, he told me that his only goal is to make wines that people want to drink, enjoy and buy more. Since that time, I have featured five of his wines as club selections and numerous weekly selections because, well, people like them and come back to buy more. As if to subliminally reinforce this idea, he has a category of wines called the “Fun Bunch,” which includes this wine as well as another previous Explorer Club selection, the Year of the Snake, back in February 2013.

The name for this wine, Fred’s Red, is for one of the two “fox collies” that were imported by Alexander McNab, a Scottish immigrant who first settled the valley where the winery is located. McNab came to this area in 1868 and established a sheep ranch. Unfortunately, he found the California climate too hot for the sheep herding dogs used in Scotland and eventually bred a dog for the task that is now called a McNab. One legend has that he bred his dogs with females imported by Basque sheep herders so their hair would be shorter. Whatever is the truth behind the story, they are a breed that is still used by farmers and ranchers across California and are known for their devotion as loyal companions.

To make this wine, Rich uses a blend of primarily Portuguese grape varieties, which also appear in several other wines he makes. The varieties, Touriga Nacional, Tinta Roriz, Touriga Francesca, Tinta Cao and Tinta Barroca are starting to find favor with growers on the eastern side of the state in El Dorado county. These grapes are particularly hardy, able to survive the extreme climate of the Douro River in Portugal without the need for irrigation. There they were traditionally used to produce Port, a fortified sweet wine. Rich contracts to buy the grapes from three acres of vineyards to make the tasting room favorite, Torta Chocolate Port. Every year the vines produce a lot more grapes than he needs for the Torta, so he uses them to produce this wine. The final blend always changes, but it is approximately a third of Touriga Nacional with the rest in the other four varieties.

In order to temper the firm tannins for which these grapes are known, Rich employs a technique during the aging process called micro-oxygenation. This technique is no more complicated than bubbling a small and controlled amount of oxygen through the wine, which helps make it smoother by softening the tannins. It was originally developed to make the wines of the Southwest area of France, home to Malbec, more palatable, but it has become very popular in many wine producing regions.

When you open this wine, you will want to give it a splash in the decanter to open up the beautiful nose. Once you do, it offers a complex combination of blackberry jam, orange peel, jasmine and fresh sage. On the palate, it is soft with layers of earthy/stoney flavors that stretch out into the long finish. Drink over the next year with a grilled pork tenderloin or fish tacos with an orange/fennel slaw.

2012 Lone Birch Cabernet Sauvignon

Like McNab, the Airfield Winery, who produce Lone Birch, is no stranger to the TWM club members. In fact, if the label looks familiar, it is because I selected the Red Table Wine in November 2014, as a great wine to “have around” during the holidays. In the spirit of “have around” wines, what is better than an easy drinking Cabernet Sauvignon with a screw cap closure?

In case you are new to the club or have just forgotten the details, the Airfield winery is a four generation old farming operation owned by the Miller family. Like almost all of the big Washington State wine growers, the Millers started farming field crops in the 1950s. Then in 1968, they were approached by a group asking them to experiment with wine grapes. That group was Chateau St. Michelle, who were encouraging farmers all over the state
to plant a few acres of vines looking for the best locations. The Millers were impressed with the results and now farm 980 acres of vines.

The name Lone Birch is taken from the sentinel that watches over the vines on the property. The original owner, H. Lloyd Miller, was an early conservationist and planted hundreds of non-native trees in the high desert of eastern Washington. Over the years, the harsh climate claimed most, but a lone birch survived. The Miller’s consider it a symbol of their perseverance through the many hardships that the region has dealt them. While this is not a very expensive wine, winemaker Marcus Miller still gives it the high end treatment. One of the great things about dealing with multi-generational wineries in Washington is they usually own their land outright, so they are not saddled with debt. This allows them to put a lot of value in their wines that most California properties cannot. For this wine, the grapes are hand-picked and sorted before going into the fermentors. They use a combination of punch downs, pump-overs and rack-and-return to extract color and texture before racking into barrels right before the wine is dry. This allows the fermentations to finish in wood, which studies show produces a smoother product. After a year in oak, the wine was bottled. It is 100% Cabernet Sauvignon, and they produced 1759 cases. When you open this wine, please decant it for a half hour. Wines bottled under screw caps tend to be tighter and benefit from the oxygen. Once you do, it reveals a ripe nose of fresh cherries, cedar, pencil lead and red currant jam. On the palate, it is surprisingly very dense for the price, with smooth, soft tannins and a long sense of fruit. Drink this wine over the next five years with grilled anything, braised meats and pasta dishes.

Tim Varan and Brock Magruder opened Tim’s Wine Market in October, 1995 at the original location in Orlando, Florida. Based on twenty years of buying experience, each year Tim samples over 4000 wines to select only a few hundred each year for the Tim’s Wine Market stores. Tim’s Wine Market has a local store in Ponte Vedra Beach, owned and operated by Emery and Joan Clance.
Gold prices—the price per ounce of bullion or of coins, such as Kruggerand or American Eagle gold coins—have shot up in the past several years. Silver prices have followed suit (see the current price of silver, for example). If you listen to commercials or read advertisements, prices can only go up.

That means 2016 is a great time for investing in silver or gold, right? Not necessarily.

Investing in Silver, Why Bother?
People invest in gold and silver for two primary reasons. First, they might hope that prices will continue to increase (desire to gain money). Otherwise, they believe that other investments will decrease in value (desire not to lose money). Yet how do you know when either will happen? Gold and silver both have practical uses. A lump of precious metal is often pretty. You can admire it. You can make it into jewelry. You can use it as a component in certain industrial processes.

Beyond that, a gold coin sits on your shelf and collects dust. Any value it gains is independent of its existence. It’s just a coin. Due to circumstances outside of your control it could be gaining value now—or it could be losing value.

Compare that to a business. Any good business worth owning will make you money. Even a lemonade stand that costs you $100 to start and makes you $125 every summer produces $25 in profit the first year. Every year you keep running the business, it produces more money. Remember that the money a business produces is the most important metric of success.
At any point you can take your profit, as the owner of that lemonade stand. You can pay yourself a dividend. You can invest back in the business, to serve more customers or build more lemonade stands. You can do a lot with the cash that business generates.

Every year, your gold or silver coin sits on the shelf and collects dust. There’s little you yourself can do to affect its price.

Are Precious Metals Good Investments?

Why do people invest in gold? What’s the point?

Is buying gold risky? Depending on your appetite for risk, sometimes it can make sense. Precious metals like gold and silver and platinum tend to move in directions opposite of the market. If there’s a market drop (like in 2008), gold prices tend to rise. You can’t count on that happening, but diversifying your investments into classes like stocks, bonds, and commodities can help you avoid losing everything.

Gold and silver prices can continue to increase. They may get more valuable because they get more scarce—mining and refining might produce far less gold or silver one year—but by the same token, they might lose value because the get more common, too. Can you predict that?

Gold and silver prices might increase because demand increases. More people want to buy them. (That’s probably why there are so many advertisements to buy gold or silver!) Then again, demand might decrease. Can you predict that?

Maybe they’ll do neither. Maybe they’ll hold their value. Maybe $1000 in gold bullion today will be worth about $1000 in gold bullion in five years, and you’ll only have lost inflation. That’s better than losing everything, right?

Meanwhile, all of those great businesses worth owning make real money every year. This profit gets returns to investors as dividends or stock buybacks or other investments to make even more money in the future.

Meanwhile, what’s the market for your Kruggerand? It’s not as easy to sell as a share of Coca-Cola. You need to have someone evaluate its condition and then find a buyer willing to negotiate with you for some fraction of what it might be worth. You could melt it down for its value as a fixed amount of gold, but that’s illegal for many currencies and you won’t necessarily get the full value of the coin.

How Do You Sell Gold?

If you do own gold and want to turn it back into cash, how can you do that? How easy is that? Or what if there’s no cash available? How are you going to trade a bar of bullion for a deer carcass and some hunting rifle ammunition? Is that a fair trade? (Is that a wild example? Yes, but the way some people talk, they seem to think that in an apocalyptic setting where there are no stocks, bonds, investments, markets, dollars, or governments, bartering bars and coins and nuggets will be more useful than bartering water purification tablets for example.)

If you buy gold coins (Where do you buy gold and silver coins? Often at a coin shop, but then you’re paying for the collectible value of the coin as well and that fluctuates based on perceived scarcity of the coin and the quality of the minting.), you’re not necessarily better off. In that post-apocalyptic world, owning a chicken which can lay eggs every day and make more chickens is more valuable than owning a shiny handful of metal that can’t make anything else.

Gold as an Investment

If you decide to invest in precious metals, does it matter whether it’s gold coins, silver certificates, or platinum bullion? Not really; the flaws of one are the flaws of the other. If you’ve already figured out why not to invest in silver, the same arguments suggest why not to invest in gold, platinum, diamonds, or whatever! Investing in gold is risky and unpredictable. So is investing in silver or precious art or other commodities which don’t themselves make money.

Do Precious Metals Have Stock Symbols?

Unlike stocks which get traded in shares, precious metals trade in troy ounces, also abbreviated as oz. (What you probably think of as an ounce is an avoirdupois ounce.) A troy ounce is slightly heavier than an avoirdupois ounce. A troy pound contains twelve troy ounces. Traders trade precious metals in troy ounces. The current price of gold (or spot price for gold) is always the cost of a single troy ounce. You can’t really buy precious metals like gold or silver on the open stock market. There’s no single stock symbol for gold, for example, though the pseudo-stock GOLD or GLD tracks its price. There are specialty funds you can buy which track precious metal prices or any other investment, but keep in mind that the underlying commodity—the lump of metal someone dug out of the ground—still has all of the advantages and disadvantages of a lump of inert metal someone dug out of the ground.

Should You Buy Gold? Should You Buy Silver?

Ask yourself this: why do people want to invest in gold? Why invest in silver? When you understand this, you’ll know whether precious metals make sense as an investment. If you’re looking for a safe, conservative investment, don’t try to predict what other investors will do or how other investors think. Buy pieces of companies that produce real value. (Buy the S&P 500 Index Fund to start!)

Is investing in gold worthwhile? Is silver worth buying? If you want a few gold coins or silver bars around for their aesthetic value, they have their uses—but you can find much better options for your portfolio.
Magic Leap Demonstrates The Potential Of Augmented Reality Via Video: This Is The Future

By Dave Calpito

Secretive Florida-based startup Magic Leap Inc. has released on April 19 its newest footage showing off the potential of augmented reality and how this upcoming wearable technology will benefit users down the road.

Uploaded via YouTube, this more than two-minute video with the title “A New Morning” demonstrates how users might see when wearing the startup’s headset, which it has yet to showcase to the public.

Set inside an office, we see a list of notifications from a slew of applications like YouTube, Gmail and, yes, Snapchat. While we have already known that Alphabet Inc.’s Google is among the investors of the company, which explains why we see some Google-owned apps in the teaser video, we do not know yet if Magic Leap has inked a deal with Snapchat.

We have also seen an image of the sun hiding behind a cloud with words “Sunset 7:40.” Then a message of the user’s daughter shows up, asking her dad to get a glimpse of her Mt. Everest project. Upon opening up the attached project, the user was shown a three-dimensional map of Mt. Everest rising from the desk plus the timeline of prominent climbers.

The YouTube video likewise shows how ecommerce will be like, with the use of Magic Leap’s new system. Upon selecting a shoe on display, the item is then enlarged as a three-dimensional product right on the desk.
This somehow demonstrates how the company’s new technology, which it calls “Mixed Reality Lightfield” will soon change the way users shop on the Web by providing an interactive experience that is not yet offered at this day and age.

Another interesting part of the video is the school of jellyfish swimming across the room as if they are in real water. “No special effects or composting were used in the creation of this video (except for this text),” the video says.

What’s lacking in the video, though, is the explanation on how this new technology will work and how users will operate the wearable device.

However, a report from Wired offers a few hints as to how this technology functions.

“The user sees the outside world through the glass, while the virtual elements are projected from a light source at the edge of the glass and then reflected into the user’s eyes by the beam-splitting nano-ridges,” says the report.

The startup has already raised almost $1.4 billion on a $4.5 billion valuation. To date, it already has more than 500 employees.

We have yet to know how much the device is going to be priced and when it will see the light of day.
Each year medical schools turn out well-trained doctors, highly skilled and competent in every phase of practice -- except surviving economically. Medical training programs do not provide young physicians basic information about doctors' options in the workforce -- for example, the pros and cons of private practice vs employment -- nor is there any effort to explain to them the larger economic forces at work in healthcare in the United States, so physicians do not understand the competitive forces that are shaping today's radically changing economic climate. One attempt to institute a seminar-style course in “real-world” healthcare economics at a major State University School of Medicine was met with a refusal to fund even the modest travel stipends for the national experts lined up to teach the course. Also, disillusionment with the realities of the profession is not limited to our broken healthcare system. For the first time in its history, McGill University School of Medicine, Montreal, Quebec, Canada, is experiencing fourth-year students dropping out after being exposed to real-world medicine in their preceptorships.

Few American physicians -- young or old -- understand that in the last 15 years healthcare economics have been radically changed. Physicians have largely abandoned the pure fee-for-service model that has been the economic cornerstone of Western medicine since Roman times. In its place doctors now contract with health plans for rates negotiated in bulk under so-called “managed care” plans. Economically, there can be no greater change in a personal services industry than changing how people get paid; yet medical students, residents, and fellows are provided virtually no education on the nature or implications of this profound change. The need for such practical education has never been greater.

In the meantime, while taking advantage of physician’s failure to comprehend and respond to these economic changes, health plans across the country have systematically merged into huge monolithic companies and have converted from nonprofit to for-profit status. According to Fortune Magazine, there are 7 healthcare insurance and managed care companies in its 2006 “Top 500” list, generating revenues of over $212 billion. As a result of the for-profit consolidation of the health plan industry, the well-being of health plan profit margins for shareholders must now compete with the well-being of patients’ health.

Just as health plans have merged over the last decade, hospitals, too, have aligned. Most local markets now have just 1 or 2 hospital systems that have complete control over these markets. Many of these systems are generating significant net revenues and behaving like for-profit companies despite their tax status as charities. Meanwhile, in the face of these ever-consolidating markets, doctors remain locked in a cottage industry model. The latest available statistics have shown that 82% of physicians practice in groups of 9 or fewer.

[1] Doctors, having received no training in adapting to the current market conditions that are occurring rapidly around them, are ill-equipped to function in this radically changed economic -- and ethical -- landscape. These changes unavoidably are undermining the very core of the physician-patient relationship. In place of old-fashioned fee-for-service medicine in virtually every medical market in America, the economic lifeblood of today’s medical practice depends almost entirely on contracts. Almost all of a physician’s private patient flow depends on his or her contractual relationships:

The Training of the “Helpless” Physician

Charles Bond, Esq
Private patients are provided either under an employment contract with an employer or they come into the practice through a contract between the physician and a health maintenance organization (HMO) or preferred provider organization (PPO). However, few young physicians are trained in how to analyze contracts, or when, where, and how to get the appropriate help with their contracting relationships. Instead, unfortunately, they are blithely following the model of older physicians who literally signed away fee-for-service medicine and continue, for the most part, to accept what health plans offer without significant legal or economic scrutiny.

As for non-private patients, 36% of the average physician’s patient base is paid for by the federal and state government, yet no medical training program offers a practical course in coping with Medicare and Medicaid regulations and claims procedures. Nor is there any medical school training about the practical implications and economic ramifications of treating the 45 million Americans without any health insurance.

Beyond the basics of medical economics, young physicians are generally not introduced to the regulatory and political environment in which they will have to practice. Although most trainees quickly comprehend the concept of malpractice, few appreciate the impact of interlocking laws that require reporting and disclosure of any malpractice claim or disciplinary investigation. The tight web of mandatory reporting requirements runs from every hospital and state licensing board to the National Practitioners’ Data Bank and is reinforced by self-disclosure requirements on virtually every professional application. (“Have you ever been named in a lawsuit or been the subject of disciplinary investigation” is a typical question on such applications.) The combined effect of reporting and disclosure means that any black mark on a doctor’s record — even the disclosure of a mere unproven allegation — can deprive the doctor of economically valuable advantages, such as hospital privileges, employment, or participation in a managed care plan. Understanding the power of this reporting network, including the possibility of its abuse, should be an essential part of every doctor’s preparation for the real world.

[2] The foregoing are but a few examples of the practical areas not addressed by medical training. More insidiously, however, medical training is inculcating a culture among physicians that may be deepening their woes and contributing to the decline of the profession. Training “Helplessness” Instead of resilience, Modern psychological theory has focused on how individuals can be trained to be “helpless” and how that feeling of “helplessness” contributes to a sense of depression and isolation.

[3] Helplessness can be trained into individuals when, regardless of repeated best efforts that should be rewarded, no reward is forthcoming; as a result, the individual eventually learns to give up and sinks into a lonely feeling of futility and malaise. It would appear that collectively the medical profession has mastered this art and is suffering the symptoms en masse. Unfortunately, medical training is helping to create the foundation for the profession’s helplessness. Regardless of the new limitations on work hours, conditions in many training programs remain reminiscent of medieval, monastic, ascetic orders. Self-deprivation -- especially sleep deprivation -- continues to be viewed as a necessary virtue, especially during subspecialty training. Learning is still most often imposed on the basis of the model of strict authoritarian discipline, with a high degree of emphasis on shame and fear of failing.

Good patient care is so expected of trainees that it is rarely rewarded. Residents’ pay is usually set at bare subsistence levels or below, so there is no financial reward for the hard work of medical training, and indeed most medical graduates emerge with huge school loan debts. Psychologically, young physicians often expect residency and fellowship to be the crowning experience of their long educational path. Since they were 5 years old, these young people were told that they were the brightest and the best, a message that was socially reinforced as they successfully progressed through school, college, and medical school. Everything about their experience reinforced their belief in the Puritan work ethic: If you work hard and do well, you will be rewarded -- until they reach residency, a point at which rewards are so few and far between that they begin to believe that if they work hard and do well they will be rewarded.

Young physicians become so well trained in deferring gratification that many give up on ever getting any meaningful rewards for their sacrifices. With their resilience worn away, many just give up the fight. A dispirited acceptance of one’s individual fate seems to be the dominant mood of physicians nowadays rather than a motivated mobilization toward a better lot for the individual practitioner and the profession as a whole. Most doctors focus so hard on trying to provide good patient care -- ie, taking care of others -- that they forget, or have no energy, to take care of themselves. Thus, when some doctors propose positive collective action, they are usually quickly quieted by a few naysayers whose negativity taps into the helplessness learned so well during medical training. The progress of the profession is being effectively paralyzed by its own failure to teach leadership and the skills of self-survival. Consequently, physicians have lost the social contract or bargain that medicine used to have with America.

As Paul Starr observed in The Social Transformation of American Medicine, the previous generation of physicians traded years of their earning power to become highly trained, in exchange for significantly higher income and enhanced social status. With physician earnings plummeting over the last decade, it is clear that the medical profession no longer enjoys the benefit of such a bargain. These changing socioeconomic conditions are undeniable, yet medical education has not adapted one iota. Virtually none of the training programs in the country offer 20 seconds of business administration or modern medical economics. The rigors of medical training prevent young physicians from acquiring economic sur-
vival skills on their own. Instead, medical training effectively places young doctors in a “cocoon,” shielding them from the lessons of the real world. While residents and fellows are going through their training, their young nonmedical contemporaries are out in the world making little mistakes with little amounts of money. Meanwhile, residents and fellows are working all the time, living on subpar wages, and amassing mammoth debt from student loans.

So training programs are sending forth untutored and unprepared graduates. Instead of teaching physicians the more businesslike approach of relying on deliberate due diligence and seeking the advice of experienced and qualified advisors, physicians are more inclined to make independent life-or-death decisions that are based on the rapid assessment of a situation and to go it alone and shoot from the hip on the basis of their best instincts. After all, that is how they have been trained to diagnose and treat.

Is this the model for training bold and competent leadership in our most important profession, or are we damning these young people to a future that will thrust them unprepared into a battle for the very survival of the medical profession -- a battle in which the stakes are whether our healthcare will be dominated by profit or by patient need -- a battle that will surely profoundly affect our lives and the lives of the ones we love?
How Doctors Think
by Jerome Groopman

On average, a physician will interrupt a patient describing her symptoms within eighteen seconds. In that short time, many doctors decide on the likely diagnosis and best treatment. Often, decisions made this way are correct, but at crucial moments they can also be wrong -- with catastrophic consequences. In this myth-shattering book, Jerome Groopman pinpoints the forces and thought processes behind the decisions doctors make. Groopman explores why doctors err and shows when and how they can -- with our help -- avoid snap judgments, embrace uncertainty, communicate effectively, and deploy other skills that can profoundly impact our health. This book is the first to describe in detail the warning signs of erroneous medical thinking and reveal how new technologies may actually hinder accurate diagnoses. How Doctors Think offers direct, intelligent questions patients can ask their doctors to help them get back on track.

Groopman draws on a wealth of research, extensive interviews with some of the country’s best doctors, and his own experiences as a doctor and as a patient. He has learned many of the lessons in this book the hard way, from his own mistakes and from errors his doctors made in treating his own debilitating medical problems.

How Doctors Think reveals a profound new view of twenty-first-century medical practice, giving doctors and patients the vital information they need to make better judgments together.

THREE REVIEWS BY READERS

A must read for every doctor who practices medicine and for those patients who forget that doctors are practicing medicine and make errors in judgment (and he explains why these mistakes are made in a very very entertaining way). The book served as a reminder that a patient needs to be the captain of their own ship, challenging the inflated notion of even the most respected doctor... The chapter "A New Mother’s Challenge" was probably one of the best examples of how and why doctors err and how the caregiver is oftentimes in the best position to solve the mystery. However, I couldn't help thinking about the patients who lack the resources and/or the intelligence to communicate effectively with ones doctor or to conduct research necessary in finding the correct diagnosis and/or doctor. A sad truth. Who will be their advocate? Nevertheless, intellectually pleasing.

Groopman’s free-flowing anecdotal style is his strength, and his unique perspective and journalistic skill are highlighted in the chapter entitled, "Marketing, Money, and Medical Decisions." Here he offers a nuanced perspective and a reasonable, if mundane solution. Medical decisions are indeed influenced by money, Groopman argues, but not in the way most of us might think with the bad guys dressed in black on one side and the good guys adorned in white on the other. Instead, medical decisions are influenced by a messy intersection of money, ego, and faith/hope. He guides the reader to this conclusion by recounting his interviews with many different specialists and even a pharmaceutical company executive. The solution is “informed choice,” a comprehensive understanding of the risks and benefits of all available treatments, which also encompasses an understanding of how different doctors think and how factors like money, personal bias, and tradition influence that thinking. This chapter is worth a read, and it’s unfortunate that it appears near the end of the book.

First of all, I should say that I’m a doc. his book was strongly recommended to me by several colleagues who I deeply respect. It makes for a reasonable read, and I see why they enjoy it. It’s pretty typical doctor-authored literature. It takes a half decent idea from the social sciences (in this case, that heuristic reasoning is essential for managing very complex environment, but that heuristics have predictable failings). It then illustrates this with a bunch of stories of touching stories of human tragedy and triumph. It has some reasonable suggestions for being aware of one’s limitations and trying to compensate for predictable lapses. The heuristics stuff is not terribly novel -- it seems to derive from a very minimal reading of Kahneman and Tversky. If you want to read the underlying social science, and can stomach more academese, you can get a lot deeper than this in "Judgment under Uncertainty". I found most frustrating the medical stories. Frankly, they seemed a little trite. Regrettably, Groopman’s good, but the bar has gotten set pretty damn high in the last few years. (see: Atul Gawande) Finally, Dr. Groopman is a professor of experimental medicine. He wants to argue that doing lots of extra tests, moving beyond accepted knowledge is essential. Sometimes it is. But his discussion of trying fourth or fifth line chemo agents on the off-chance one unexpectedly works seems to me to be underestimate the real human suffering eternally searching for miracles induces. I would have like a book about the limits of doctor’s thinking to be more thoughtful about that blindspot.
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MD Life May 2016 21
Bob’s Steak & Chop House – Every-thing’s Bigger (And Better) at Bob’s

Bob’s Steak and Chop House opened March 1st at The Omni Amelia Island Plantation. The Texas based chain seems to subscribe to the motto that everything’s bigger in Texas, with huge portions, giant bread, giant shrimp, steaks and more. Everything Bob’s serves is made in house except the ice cream which comes from Leopold’s, an amazing 95 year old creamery in Savannah.

Omni Amelia Island Plantation Resort

Every meal at Bob’s starts with a jar of pickles on the table and a giant hunk of bread served with butter. The bread was simple and nice. The pickles were quite peppery and a bit saltier than usual. Maybe they just didn’t match my taste buds. Next we sampled a couple of appetizers served family style. The shrimp platter offered up fried shrimp, cocktail shrimp topped with cocktail sauce, and cocktail shrimp topped with remoulade. The shrimp were HUGE! The person next to me asked jokingly, “Are these lobster?” One of these shrimp is the equivalent of at least two normal shrimp. Shrimp fans will be in heaven.

The calamari were straightforward typical calamari. Salad was next. The wedge salad I chose was a giant hunk of iceberg covered in dressing, blue cheese, and bacon. Exactly what you’d expect and nicely done. For the main course I choose a 14-ounce ribeye. Bob’s uses only USDA prime beef which is grain and corn fed. Only the top 2% of all beef raised in the US in considered prime beef. The ribeye was juicy with a nice fat layer around the outer edge and a beautiful sear. You could clearly tell the quality of this beef. If you want a great steak in the Amelia/Fernandina area this might just be the one for you. The steak was served with Bob’s signature giant carrot and mashed potatoes. The carrot had a wonderful sweet glaze which I really enjoyed. The potatoes tasted of butter and had a nice consistency. We also tried the Brussels sprouts. These had a deep smokey flavor and were served without all the fanciness of a sauce or bacon like we see so often now. It was refreshing to get Brussels sprouts done well in a no-frills sort of way.

Bob’s – Bone-in Ribeye

For dessert we indulged in a slice of key lime pie. So many of Jacksonville’s key lime pies are overly sweet with sugar coming through more than lime. This is the kind of key lime pie that will make your lips pucker. Fans of sour tastes will definitely be fans of this one. We also sampled the vanilla ice cream served up at Bob’s. Bob’s brings this in from Leopold’s Creamery in Savannah. This ice cream was wonderfully rich and creamy. As someone who even eats ice cream in the dead of winter I can vouch for the amazingness of this scoop.

We found Bob’s to be a fantastic steakhouse that could give Ruth’s Chris or any other high-end national chain a run for its money in terms of quality. From entrées to sides to desserts Bob’s really shines. If you are anywhere near Amelia Island and you’re looking for a great steak, head over to Bob’s to satisfy your craving.
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