

Paul E. Tornambe, MD

Paul E. Tornambe, MD, is in private practice in San Diego. He is an instructor in the departments of ophthalmology and family practice at the University of California, San Diego.

1. What drove your decision to choose the specialty of ophthalmology and the subspecialty of retina?

I was a third-year medical student when I chose a month-long externship with Bruce E. Spivey, MD, in ophthalmology at the Pacific Medical Center in San Francisco. I made this decision because, frankly, I wanted to see San Francisco. It was during that month, however, that I fell in love with ophthalmology.

My next step was an internship at Highland General Hospital in Oakland, CA, because I wanted to put all the things I learned in medical school together before focusing on a single specialty. There I experienced everything from delivering newborns to tending to patients with gunshot wounds—it was an exciting year.

When I entered into my ophthalmology residency at Pacific Medical Center, I met and worked with three individuals who had significant impacts on my future: medical retina specialist John Cavendar, MD, and retina surgeons Wayne E. Fung, MD, and George Hilton, MD. These three gentlemen lit my retina fire, so to speak.



2. Since your involvement in the pneumatic retinopexy trial early in your career as a retina specialist, you have been at the forefront of many surgical and medical developments. What do you consider most exciting?

I think the biggest breakthrough in my career has been the ability to treat macular holes, although to this day I don't understand why patients are forced to be positioned face down. Next, our surgical instruments and techniques have evolved significantly in terms of refinement and reliability. In the early days of vitrectomy surgery, you never knew if your instruments were going to last for an entire case. Our vitrectomy cutters were reusable (and very expensive) and had to be sent to Switzerland to

be sharpened—there was far more OR hassle then. Recently developed surgical tools, such as the wide-angle binocular indirect microscope, perfluorocarbon liquids, triamcinolone acetonide and other dyes for staining and visualization, have made surgery much easier and have improved our outcomes.

Of course, spectral domain optical coherence tomography and digital photography have changed our approach to many surgical and medical diseases.

On the medical side of retina, we are moving quickly toward the pharmacologic manipulation of disease, which is revolutionizing how we treat patients.

3. How would you describe your approach to treating your patients and medicine in general?

When I completed medical school, I remember my father, who also was a physician, offering the following advice: Always do what's best for the patient, and everything else will follow. For every patient I treat, I ask myself what decision I would make if the person were my father, my mother, or my child. With this approach, surgical decision-making is simple.

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Regarding the direction of medicine in general, I am very concerned. Many of my colleagues, including myself, are not encouraging their children to go into medicine, which says a lot about how doctors feel about the course medicine is taking. It will always be a rewarding and satisfying profession, but it takes 14 years after high school to become a retina specialist, and a lot of personal sacrifice. At the end of that long road is a system that takes for granted the wonderful skills we have acquired. I knew we were in trouble when we began to be called (and accepted) the title of "provider" instead of "doctor."

4. How have the roles of specialty groups such as the American Society of Retina Specialists (ASRS) evolved with the subspecialty?

When the ASRS (formerly the Vitreous Society) was formed, the goal was to have an open society permitting anyone trained in retina to share his or her ideas in a relaxed collegial environment. We felt all our members had something to contribute. The pluralistic nature of the society and the exponential growth of our membership have, in my opinion, resulted in the ASRS being considered the political voice of retina. Unfortunately, our growth has forced us to trade a "one-on-one meeting" philosophy for a large "subspecialty day" type meeting. As an alternative, I have tried to fashion the International Masters of Retina meeting along the lines of the old Vitreous Society.

Looking ahead, the ASRS will be required to apply this leadership position to some of the pressing issues in retina, which in my opinion are accreditation (of programs) and certification (of fellows). First, we need to work with government officials to redefine what a retina fellowship is, so that teaching programs are compensated fairly for training high-quality retina specialists. Once the training programs are accredited, their graduates can be certified (boarded). As things stand today, any ophthalmologist can profess to be a retina specialist and can even train fellows! It really is a public health issue.

5. Where might one find you when you are not in clinic or teaching students?

When I was an undergraduate, I wanted to play professional golf. I played on the golf team at Colgate, but when we traveled to the South for golf matches, I realized that most of these guys from Sunbelt states were far above my level of play. I still enjoy the game, so I suppose if I am not working you can find me at the country club practicing. Usually I don't have the time to play entire rounds, but I like to practice every chance I get. It clears my mind. ■