

Healthlink On Air

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[ Music ]

>> Trisha Torrey: Well, we've watched it become part of the Syracuse cityscape for almost three years now. So far, the reviews are just great, and what is it? It's University Hospital's new addition, the East Tower, and a familiar voice joins us this morning to tell us more about it. Dr. John McCabe [assumed spelling] is here. Good morning, Dr. McCabe.

>> Dr. John McCabe: Good morning again.

>> Trisha Torrey: And listeners know you as the go-to guy on emergency medicine, but this morning we're introducing you as the interim CEO of University Hospital, a new job for you.

>> Dr. John McCabe: Yes. It's a new job that I'll do for a little while here to, to help the institution and keep us on, on track.

>> Trisha Torrey: Well, you know, what a great way to kick off this new job opening the East Tower. That's fun.

>> Dr. John McCabe: Well, it was fun, and last week, we had a ribbon cutting, and as I said to people, when you got off the elevator in the new part of the hospital, it was a jawdropper. People saw something that they hadn't seen around Syracuse or Central New York, and it was wonderful for me to be able to help people celebrate this success.

>> Trisha Torrey: Well, let's go back three years ago when the groundbreaking took place. What was the intent? What was the goal in building the new addition?

>> Dr. John McCabe: Well, there's a couple of intents. One was, obviously, to update our patient care space, which had become a little bit old and antiquated. The second was to be sure that we built inpatient space where every patient had their own single room. Very important.

>> Trisha Torrey: And that's a big shift, isn't it?

>> Dr. John McCabe: That's a huge shift, but the shift that's occurred in the hospital industry all around us around the country, and so it's, it was a really important goal. And the third was to increase our bed size a little bit, capacity, and of course, the fourth, which will be something for the future, was to get the children's hospital in place.

>> Trisha Torrey: Right. We're going to talk about the children's hospital in just a moment, but which patients are moving into the new tower?

>> Dr. John McCabe: So the patients that have moved already are patients on three specific floors - neurosciences, oncology, and cardiovascular. So patients with those kinds of complaints, which really run the gamut in most of the, the medical kinds of patients that we have, and some of the surgical patients are admitted to the University Hospital.

>> Trisha Torrey: They are, and so now they've come out of old space, quote on quote, in University Hospital. What happens to the old space?

>> Dr. John McCabe: Well, the old space is getting cleaned up now, and long-term, over the next few years we're planning and will renovate that space to, again, better meet patients needs and to ensure that private rooms are there and that we have the ability to do the services we want to have for the future for Central New York.

>> Trisha Torrey: Sounds great. Talk to me about the patient experience. You said more elbow room in effect, but how does that change the patient experience. Are they going to heal quicker?

>> Dr. John McCabe: Well, you certainly would hope they'll heal quicker, and everything from the choice of the colors to how the rooms are organized is really carefully considered. If you walk into one of the new rooms, the new patient room has about the, actually, a little more square footage than a patient room for two patients in the old part of the hospital.

>> Trisha Torrey: Wow.

>> Dr. John McCabe: And included in there are things like space for the family, sleeping space for the family -

>> Trisha Torrey: Really?

>> Dr. John McCabe: There's much less noise. Patients should be able to sleep better. The environment's much brighter. And there are also some functional things like nurses are deployed differently so that nurses are much closer to the

patient rooms in many places, and so we think all of that makes both a better patient experience and also, hopefully, a more soothing and better healing environment.

>> Trisha Torrey: Well, I like that word "soothing" because when I think of hospital rooms, I think it's something very stark and institutional and not at all soothing. Not at all comfortable. So it sounds like all of that has changed?

>> Dr. John McCabe: It has. I mean, the colors are different when you walk off. It's very soft. The hallways kind of open up to, to engage you, and even down to simple things like how the rooms are numbered. It's no, no longer a six-digit number. It's rooms 21 to 42.

>> Trisha Torrey: Oh.

>> Dr. John McCabe: It's almost like, in that sense, being in a hotel space instead of a hospital space.

>> Trisha Torrey: Wow. Sounds, you know, I hate to say it, but it almost sounds like a desirable place to be, in a hospital.

>> Dr. John McCabe: Well, we always say you're, you're always better not being sick and being out of the hospital. But when you are sick, and you need a hospital, we ought to make it as good an experience for you and as a healing an environment as we can.

>> Trisha Torrey: Absolutely. It all sounds expensive. How was it paid for?

>> Dr. John McCabe: Well, the costs to date is about 150 million dollars. It's a huge construction project for Syracuse, but people should remember that these are bonded dollars. It's not as if the State of New York just gave the money to, to Upstate.

>> Trisha Torrey: And not as if we all coughed it up out of our pockets?

>> Dr. John McCabe: No. You didn't cough it up, and, and it will be paid down. I mean, there's a debt service, and revenues from taking care of patients like any hospital will be what's used to pay down the debt to, to keep the building functional and make it a reality for all of Central New York.

>> Trisha Torrey: It, it sounds like a mortgage.

>> Dr. John McCabe: It really is a mortgage. Yeah.

>> Trisha Torrey: [laughs] OK. So, and you have to earn the money to pay it back, right. So you have to be doing something right. Now, of course, we all know that a big part of the East Tower is the children's hospital. How does that fit in?

>> Dr. John McCabe: So the East Tower is the top two floors of the building. We've opened three floors. Then there's a mechanical floor where all the air conditioning and heating and the like is stored, and then there's two floors for the children's hospital. They'll open in September.

>> Trisha Torrey: OK.

>> Dr. John McCabe: And it's really a wonderful way to put all the pediatric services in the same place, and to really upgrade the, the pediatric and family experience.

>> Trisha Torrey: And you know, we've heard so much about the children's hospital. I think that a lot of people probably thought the entire addition was going to be the children's hospital, but that's not the case.

>> Dr. John McCabe: That's not the case. It really is a mixture of new space for our inpatient beds and then new space specifically designed in many ways for children and for families.

>> Trisha Torrey: You know, I also find it fascinating that when you think of additions, typically we think of moving out, you know, horizontally, and this one went vertically. And do you know anything, now, I know you weren't there, but do you know anything about the decision to go up?

>> Dr. John McCabe: Well, I know the decision that we might go up goes back to when the lower parts of that building were built ten or 15 years ago.

>> Trisha Torrey: Oh really, they anticipated it then.

>> Dr. John McCabe: And it really is a testament to the folks who designed and built it that if you think about it, the lower floors, which are the emergency

department, the operating rooms, the ICU's, all functioned throughout this construction process really without much difficulty, and there's not a lot of space for things to have come and be delivered and for trucks to unload, and most of the people on the hill would say this project was accomplished without a huge amount of inconvenience.

>> Trisha Torrey: You know, that absolutely is true because I drive by the hospital all the time, and very few interferences with anything I wanted to do. Well, very good. Well, Dr. John McCabe, thanks so much for coming by this morning. It's an exciting time for University Hospital.

>> Dr. John McCabe: My pleasure. It is. Thank you.

[ Music ]

>> Dr. Richard O'Neill: Hi. I'm psychologist, Dr. Rich O'Neill, with this week's "Check-Up From The Neck-Up". Well, dear listeners. Summertime's a great time to try new things. About 31 summers ago, I went to visit my brother, Charlie, in Alaska. I'd never been there before, didn't know a soul besides Charlie. One day, hitchhiking into town from his log cabin, really I had this sudden insight that I could be anybody I wanted to be. Try out totally new behaviors with people, and I thought I felt this really because nobody there knew me. Nobody knew what box to put me in. I was thinking about that the other day, and I realized we can always be anybody we want. No matter where we are, who we're with, or how much they pressure us, we could try out new ways of being anytime we want. Usually, however, what happens is when the sun rises, one wakes up, and our own brain automatically put us back in the bag known as myself. My Dr. Rich

O'Neill, serious psychologist. But what if we want to try being like someone we admire. Try one of their ways of being. Well, turns out our brain has ways to pressure us to stay in the box. It thinks things like, I can't do that. Other people will think I'm weird. In 1972, some [inaudible] did a marvelous song "Pressure Drive" about how we drop this pressure on ourselves. Now, we psychologists call this self-limiting. If I do this, something will go wrong, kind of thoughts. Negative predictions about the future. To punch our way out of that brain bag, we can ask ourselves can I predict the future? Well, no. And then decide, are we up for acting new and different? To become somebody new and different? Yes. Then let's courageously step up to the microphone at the edge of the unknown and belt out our new self with gusto. For example, I've always wanted to unload the pressure to be serious Dr. O'Neill and sing with Toots. So when it drops, hope you're going to feel it. Know that you doing wrong. I said a when it drops, oh, you're going to feel it. Know what you're doing wrong. [humming] And dear listeners, you could go to Dr. Neck Up at upstate.edu, and let me know what you think of my singing, but I know I can predict that. I'm not getting into that box. I'm reggae singer Dr. Toots O'Neill. Thanks for listening. [humming] Yeah. Pressure drops, oh, pressure, oh, yeah, pressure dropping, drop on you. I said a pressure drop, oh, pressure, oh, yeah, pressure dropping, drop on you.

[ Music ]

>> Trisha Torrey: Well, welcome back to "HealthLink On Air" produced each week by Upstate Medical University, making the academic difference in health care in the Central New York community, and this is your host, Trisha Torrey, every patient's advocate. Health care reform. How often have you heard that topic mentioned in recent weeks? Well, this is a health show, and health care reform will affect all of us. So as we can, we at "HealthLink On Air" want to help you assess all the information that's out there to help you make up your own mind about what is or isn't important. So expect this will be the first of many of these kinds of conversation. There may be no one better to kick them off than my guest this morning, Dr. Dave Smith, President of Upstate Medical University. Good morning, Dr. Smith.

>> Dr. Dave Smith: Good morning, Trisha. How are you?

>> Trisha Torrey: And welcome back. We only bring you in for the biggest topics, and certainly health care reform is one of the biggest ones. It must be the like the elephant in the room for almost every conversation you have.

>> Dr. Dave Smith: Well, at, you know it really is, it's relevant to every family, and well, obviously, this, this hits every family in Central New York. It's vital for the State of New York, and, and to be honest, it is very important for the economic vitality in this region because without it, we're really not competitive when we try to bring jobs to the market or to be able to recruit and retain individuals in this region.

>> Trisha Torrey: You know, this may be the first time almost in the history of the conversation of health care reform that most of us have really understood that correlation between the cost of health care and jobs, and even manufactured items and every other business that's out there.

>> Dr. Dave Smith: I agree, and of course, what we also all know besides the fact that we're ultimately going to be patients, and we've got to put this in a personal perspective, is the fact that it's the right thing to do. And if we do it correctly, it really becomes health care reform rather than just medical reform or reactive medicine. We're really going to be setting the right message for the first time in this country, and by that I mean talking about prevention, primary care,

and some of the things that we're going to have to make sure the building blocks, the girders of this new health care reform.

>> Trisha Torrey: Well, I do want to get into those topics a little more in a moment, but first, I want to mention that Congressman Dan LaFay [assumed spelling] held a meeting here in Central New York just a couple of weeks ago, and he invited people to speak on the various topics having to do with health care reform, and you were there. I don't, I don't think the outcome was quite what the Congressman or perhaps you expected. Tell us about that meeting.

>> Dr. Dave Smith: Well, I, I don't know whether or not the outcome was, I, I thought it was a good dialogue. I think what individuals saw, you had I think about ten panel members working with the Congressman on this. And as you and I just talked about, it probably would have been nice to have a patient's perspective on the panel. But it was rather a large panel, and of course, that creates difficulty really getting a, an in-depth discussion, and I think that created frustration in the audience. I mean, my take home was is that this is a very emotional personal issue. So I wasn't part, particularly surprised by the angst or the anxiety within the room. I think it's person, [inaudible] to be very understandable in an economy that's in a downturn, and a lot of people potentially losing their health care or currently on COBRA. In other words, -

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: Long coverage after you lose your coverage, and I can understand the anxiety in the room. So I didn't take it that way. I thought it was

something we're going to see throughout the country in a debate, and we better be prepared with the right answers for them is a question -

>> Trisha Torrey: Well, I think you're absolutely right. Because if you look at, at what health care reform is, it's the, the two most important factors in any individual's or family's life. Their health and their money. I mean, you can't get anymore personal than that. Well, as I see it, there are basically three kinds of approaches to reform. One would be all public. One might be all private, and one is going to be a combination of the two. Do you see one direction or another taking the front, taking the lead right now?

>> Dr. Dave Smith: You know, I, I said it that evening, and I, you always have to be careful because people might interpret what you say as their personal choice versus what you really believe pragmatically is going to happen, and I'm, I'm going to preface my comments with that again. You know, there's a lot of simpler ways, perhaps, to design a health care system, but we're going to have to build on some of the fundamentals of the existing system in place. One is we fundamentally don't have the money to do otherwise. You know, perhaps, even like a single-payer program.

>> Trisha Torrey: Unlimited funds would make this an entirely different conversation.

>> Dr. Dave Smith: And we're dealing with so many other challenges right now, and, and there's certainly pros and cons to every single one of these options, and, and individuals are passionate about those, and, and I certainly understand that passion. I believe, personally, that like we've seen in other health care

reform in this country, in the States, we're going to see a pluralistic response. By that, I mean, we're going to build on some of the public models that already exist, preserve the private payers, and I use the example that evening of a program which I think helped diagnosed how we're going to approach it. Program we developed a number of years ago called Vaccines for Children. That program was a, a debate over whether or not the government would essentially buy all the vaccines and distribute them to make sure every child had access. Huge public debate. Single payer for children for basically vaccines. Remember, this program was spun out of a time when we had the big measles outbreak in the early 90's, and we lost children and adults from measles. It's something no one ever believed could happen again when it did. And it could happen again by the way. So we needed to have some solutions, and we knew that access to vaccines and to guarantee a market for their development was necessary. Vaccine manufacturers very, very concerned and wanted to see a pluralistic response. Wanted to make sure there was preservation of the private purchasing of vaccines. End of the day, it was a compromise politically. At the end of the day, 55 percent of all vaccines are now purchased by the government with a guarantor, and about 45 [phonetic] of all vaccines delivered are paid for in the private sector. Ended up being a very nice balance, and manufacturers realized that it was very nice at the end of the day to have a governor, government guarantor because when a new vaccine came out to market, they knew that there would be a market for it because sometimes private payers will take anywhere from six months to a year to approve the new vaccine even though the government and other bodies say it's the right thing to do including pediatrics, family medicine, and others. So it turned out the compromise worked, and I think we're going to see the same thing. Again, everybody's going to have an opinion about it. My opinion is that pragmatics and the world of politics will probably rule the day. Again, whether or not I personally agree with that is another question.

>> Trisha Torrey: Right.

>> Dr. Dave Smith: But I think we also have to move on because there's other important aspects in health care reform in addition to paying for it. There's coverage. There's primary care. There's prevention. There's behaviors. Lot of things that we need to talk about.

>> Trisha Torrey: Let's, let's get to some of those, and let's, we only have a few minutes left, but let's talk about kind of top level, no matter what we're talking about, no matter how we're going to pay for it, these are some concerns we need to have, and one, let's start with that lack of primary care because no matter what model you're talking about, you are talking about having primary care physicians rise to the top of the, the doctor heap, if you will. Pardon my cliché. So talk about primary care, and how that affects medical education.

>> Dr. Dave Smith: Well, of course, you know, I have a little bit of a bias here. I'm a pediatrician. So, I would definitely be under the category-

>> Trisha Torrey: And you're the president of a university -

>> Dr. Dave Smith: University medical center and a, a college of medicine, but -

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: You know, we actually do know a good bit what works, and what we don't have is this country has not had a sustainable policy. And by the way, we can't hold, we can't leave out nurses, nurse practitioners -

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: Physician assistants and all this and other allied -

>> Trisha Torrey: When we're talking primary care, we're not just talking about doctors. We're talking about all the providers of primary -

>> Dr. Dave Smith: And a real teams that -

>> Trisha Torrey: Yes.

>> Dr. Dave Smith: Comes together because you want a team taking care of you when you're -

>> Trisha Torrey: Yes you do.

>> Dr. Dave Smith: But let's just talk about primary care for a moment, and, and particularly the physicians' side. Upstate has actually been a leader in this area with its real med program, with its new innovative to bring more students out of rural areas to look at how you build incentives. Actually how you build a pipeline that probably starts as far back as junior high school to build the right kind of sense about what we're looking for -

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: And the connectivity and the prestige that one can find within primary care. The biggest, the greatest rate limiting issue in primary care is more and more of these young professionals are coming up out increasing debt load within their medical school and undergraduate year, years in education. Sometimes in averaging well over \$150,000, \$160,000, and people will say, well, but they're going to make a lot of money. Well, they do, in a relative sense, but even in primary care in this state, you know, they may start out at a \$125,000 to \$130,000 a year, and again, a lot of people listening are going, wow.

>> Trisha Torrey: That's a lot of money.

>> Dr. Dave Smith: Lot of money.

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: And it, and it, and it is, but if you look at the, the comparative data where they could go into dermatology or surgery, perhaps, or radiology, and that figure could be, you know, in the seven, eight, hundred thousand dollars a year range.

>> Trisha Torrey: Sure.

>> Dr. Dave Smith: It's all relative to them, and we can certainly then put our values on this discussion that it won't work for them.

>> Trisha Torrey: And if you have loans to pay back, and if you want to pay your mortgage, and you want to send your kids to college, you're looking at a higher income.

>> Dr. Dave Smith: Well, and also as, as we know, the, many of them don't get out until they're almost 30 years of age -

>> Trisha Torrey: Yeah.

>> Dr. Dave Smith: So they're already moving on down their life, and they really would like to have a, be in a position to do the things we just discussed.

>> Trisha Torrey: Primary care also ties into prevention, and I think prevention is a real important part of what we're talking about in health care reform.

>> Dr. Dave Smith: Well, it is, and I was just going to add, by the way, that we're going to need to see the payers, including Medicaid, Medicare, and the private payers, value primary care.

>> Trisha Torrey: Ah, yes.

>> Dr. Dave Smith: There is going to have to be value, and that's a good lead-in to, to prevention as well. We're going to have to put it in the forefront. I mean, most of the time, in the articles we see are about some exotic new device, disease, or way for us to treat it. We're going to have to get to the fundamentals of how primary care is the place where you can intercede on diabetes and asthma and certainly issues related to the risk of stroke and cardiovascular disease and cancer. These are the big killers.

>> Trisha Torrey: Absolutely.

>> Dr. Dave Smith: And the, the right intersection for the behaviors is they have the access to a primary care provider. Again, could also be a nurse practitioner or a physician assistant or others, but the system is not set up currently to measure their ability to intercede, and number two, most importantly, the incentives are not in place. Are you financially and/or in the world of prestige to reinforce once we as medical schools produce more of them to be able to sustain that. We're talking a lot of sustainability these days. There's a fundamental break in the policy, and unless that changes in Washington this time around, this will be just rhetoric.

>> Trisha Torrey: And I, I agree. And also, you know, going back to what you were saying, you can't produce more of them until that changes. I mean, it's, it's a cycle, and when you, when they are improving the reward system, it will be easier for you to produce more of them from the universities. Let's just cover very quickly, pre-existing conditions is also something we're talking about, and that's something that affects a lot of our listeners, I'm sure. This has got to be addressed with health care reform.

>> Dr. Dave Smith: Well, it does, and of course, again, a chronic disease burden in general and the aging population, and of course, people working longer and now with the down economy, these are going to become more problematic, and we're going to have to have a way to make sure that we continuity of care as well as the ability to cover pre-existing and/or chronic conditions. And not all of this has to be what it is today, which is often out of pocket, and that is the first dollar out of your pocket for these previous -

>> Trisha Torrey: Well, it's out of pocket or its bankruptcy.

>> Dr. Dave Smith: Right.

>> Trisha Torrey: And that happens way too frequently. You know what, this conversation could go on probably for another hour. I don't know that our listeners could stick it out. I'd instead like to ask you to come back when you can to talk more about health care reform.

>> Dr. Dave Smith: Well, I'd be delighted to do that, and again, I think the thing we all have to remember, we're ultimately all going to be patients, and this needs to be personalized, but at the same time, think about how we can be active in the debate and substantive at the same time. I believe we do have to do something. We're at a crossroads with the changing demography of this state and country.

More and more, we're seeing obviously an aging population, chronic disease, and of course, more disparities where -

>> Trisha Torrey: Yes, yes.

>> Dr. Dave Smith: Relative to our demographic changes. Latino Hispanics, certainly our Indian population, and others.

>> Trisha Torrey: You know, I hope that one of the big things is that we move from the fighting to the collaborating. I think that that will go a long way. Well, Dr. Dave Smith, thank you so much for coming by this morning. Hopefully, we'll see you again soon.

>> Dr. Dave Smith: We will be happy to do that.

>> Trisha Torrey: And listeners, we do need to take a break. We'll be back shortly. Please stay with us. This is Upstate Medical University's "HealthLink On Air" on 570, WSYR.

[ Music ]

>> Trisha Torrey: Well, welcome back to "HealthLink On Air" produced each week by Upstate Medical University, making the academic difference in health care in the Central New York community, and this is your host, Trisha Torrey, every patient's advocate. Dr. Timothy Damron joins me in the studio this morning. Good morning, Dr. Damron.

>> Dr. Timothy Damron: Good morning.

>> Trisha Torrey: And welcome, and I want to share with our audience this morning that you and I have something in common that, thankfully, there aren't a lot of other people in this world that have in common. Each of us was diagnosed with cancer, and neither one of us really had it.

>> Dr. Timothy Damron: That's correct.

>> Trisha Torrey: And you have taken your, your experience, and you've moved it into a career for yourself as I have done, but tell me, what is it you do for a living, and how did your early experience affect that?

>> Dr. Timothy Damron: So what I do is orthopedic oncology. I deal with bone and soft-tissue tumors, and I take care of patients anywhere from very small patients that are kids to adults in their later years.

>> Trisha Torrey: So orthopedic oncology, and just to repeat what you just said, that's orthopedics, bones, and oncology, cancer. So tell us about your early experience that sent you in that direction.

>> Dr. Timothy Damron: So when I was in high school, I had some pain in my hip, and it, it affected me because I couldn't play football, and that really upset me. So, eventually, I was taken to a physician, and then referred to another physician, and eventually saw an orthopedic surgeon, and the orthopedic surgeon got an x-ray and told my parents that, unfortunately, your son has cancer, bone cancer.

>> Trisha Torrey: And as your, on behalf of your parents, I can tell you they were mortified and upset.

>> Dr. Timothy Damron: I'm sure they were. And, and we've talked about this many times. But they, my dad, to his credit, at that time, it was not really widely accepted to request a second opinion, and my dad asked for a second opinion, and the response of the orthopedic surgeon at that time was, that's fine, but you

know, you, you just have to face the fact that your son has cancer, and he needs to have his leg amputated.

>> Trisha Torrey: Oh, my gosh.

>> Dr. Timothy Damron: Yeah. So, and it would have meant basically my entire hindquarter, half of my pelvis, and the entire limb.

>> Trisha Torrey: Oh, my gosh.

>> Dr. Timothy Damron: So it would have been a devastating operation. So we got a second opinion at the Mayo Clinic, and we saw Dr. Doug Pritcher [assumed spelling] and Dr. Frank Sim [assumed spelling], and fortunately, they looked at the x-rays and made a completely different [laughs] diagnosis.

>> Trisha Torrey: Wow.

>> Dr. Timothy Damron: And that was a benign avulsion fracture off of the pelvis. And they can look very similar, and we, you know, I've seen these sorts of patients since I started orthopedic oncology, and it happens. It's a common trap that some physicians fall into where you, you misdiagnose a, a fault, a fracture for a sarcoma. But fortunately, instead of getting my leg taken off, I just had six weeks on crutches, and then I played the football season the next year. So.

>> Trisha Torrey: And here you are all these late years later, never having had any treatment for cancer -

>> Dr. Timothy Damron: Right.

>> Trisha Torrey: And you're doing just fine.

>> Dr. Timothy Damron: And the interesting, another interesting thing is I ended up doing part of my training with the two guys that I saw when I was a senior in high school.

>> Trisha Torrey: Which I find just absolutely fascinating, and as it turns out, in doing a little bit of research ahead of time, you're specialty of orthopedic oncology is very rare. There aren't too many of you out there, are there?

>> Dr. Timothy Damron: There are only about 120 to 130 people that do this full time in the United States, and I know all those people -

>> Trisha Torrey: You do.

>> Dr. Timothy Damron: Pretty well.

>> Trisha Torrey: Well, I'm sure you do. And here you are in Central New York helping all kinds of people who have bone cancer problems. So let's talk about who some of those people are. When they come to you, they don't come to you directly typically, do they? They pretty much have an idea that they may have some kind of bone cancer.

>> Dr. Timothy Damron: Yeah. They've often seen at least a couple of physicians. Usually, they're seen by their primary care physician, and then they get referred to their local orthopedic surgeon, and the local orthopedic surgeons are the ones that recognize that there's a problem that they don't want to handle and that requires some additional expertise. And so the ones all the way up to the Canadian border, over to Rochester and then down to New York City and even northern Pennsylvania typically refer to this area.

>> Trisha Torrey: They are. And tell me what happens. They come to you, and, and you said earlier that some of them are younger, they're children, and some of them are older. They're coming to you with these bone cancers. What kinds of cancers are these?

>> Dr. Timothy Damron: Well, they're, the general term is sarcoma. And -

>> Trisha Torrey: And what does that mean?

>> Dr. Timothy Damron: It's a malignant tumor of bone or soft tissue.

>> Trisha Torrey: OK.

>> Dr. Timothy Damron: And some patients come in with other types of cancers that spread to bone, and that's typically in the older patients, and those are the carcinomas like breast carcinoma or prostate carcinoma. Some of the more common cancers overall, and those have a prevalence [phonetic] to spread to the bone. So we see those as well. Lymphoma can affect the bone. So I see a, a

wide spectrum of cancers that involve the bone, but when it's in kids, it's usually sarcomas.

>> Trisha Torrey: It is. So they come to you, and what kinds of treatment can you provide to them?

>> Dr. Timothy Damron: Well, I, I don't work in isolation. I work with a big team.

>> Trisha Torrey: OK.

>> Dr. Timothy Damron: And you have to, to do orthopedic oncology, you have to be in the center where you've got a big team that you can work with. And so I work with pathologists, radiologists, pediatric oncologists, adult medical oncologists, radiation oncologists, chest surgeons, and, you know -

>> Trisha Torrey: Wow.

>> Dr. Timothy Damron: Vascular surgeons, you name it. And you really need that full support to do the sort of complex things that we do, but in terms of what I do, as an orthopedic oncologist is to see patients, evaluate them, and try to make the diagnosis of exactly what they have from a muscular-skeletal perspective. And then if that is a tumor that requires someone else's expertise, then I work with, and we get those people involved.

>> Trisha Torrey: Alright, so -

>> Dr. Timothy Damron: For instance -

>> Trisha Torrey: Go ahead.

>> Dr. Timothy Damron: Soft-tissue sarcomas often require, if they're an adult, often require the involvement of both the radiation oncologists and the medical oncologists, and we work as a team. I would do the surgery. I would coordinate the care, and then the radiation oncologist would potentially give the radiation, and the medical oncologist, if they require chemotherapy, would give the chemotherapy. If it's a bone sarcoma, it's similar. In kids, we work with a pediatric oncologist. And they'll administer the chemotherapy. I'll do the surgery, and we work together as a team.

>> Trisha Torrey: Well, I love that whole team approach. I also find it fascinating that when I think of orthopedics, I think more in terms of, I think, I think you said it earlier, carpenters and construction. When I think of oncology, I think more in terms of, and maybe it would be right and left brain kind of work. They're very different approaches. You must be able to approach from all different kinds of directions to do your diagnosing to begin with.

>> Dr. Timothy Damron: Well, I don't think my partners would like it if I [laughs] called them all carpenters. [laughter] I mean, they're certainly not.

>> Trisha Torrey: Of course not.

>> Dr. Timothy Damron: There's, there's cerebral aspects to all parts of orthopedics, but I, the thing I like about orthopedic oncology when I think what attracted, attracted me to it when I was in medical school is that I liked the unknowns that you are presented with. So a patient comes in, and you don't know what they have. It's similar to a patient that comes into an internal medicine practice with symptoms, and you don't know exactly what they have. And so you have to do, you have to listen to the patient. You have to examine them. You have to do tests that are appropriate, and come up with a diagnosis, and often it requires a biopsy. So, you know, it requires some diagnostic skills, and then it, the big plus is then you get to do some surgery that's very interesting and that often helps the patients.

>> Trisha Torrey: So, now we've treated these people with some surgery, perhaps some radiation, perhaps some oncology as well. Is this something that's going to help them live for a long time? Are these people who are now going to

come to you for the rest of their lives, or do you cure them, and they get to walk away?

>> Dr. Timothy Damron: It, it depends on what exactly the problem is. Of course, the benign conditions, we can usually follow for a relatively short period of time, and, and those patients do pretty well.

>> Trisha Torrey: Because not all the tumors then are cancerous?

>> Dr. Timothy Damron: No, no, no. In fact, it's the, it's really the tip of the iceberg that are, are malignant when we're talking about bone -

>> Trisha Torrey: Really?

>> Dr. Timothy Damron: And soft-tissue [inaudible].

>> Trisha Torrey: Well, let's make sure we make that point then. And I think that's important.

>> Dr. Timothy Damron: Yeah. Um, for every, for instance, for every soft-tissue sarcoma, there are probably 100 benign soft-tissue tumors [inaudible] -

>> Trisha Torrey: Ah ha.

>> Dr. Timothy Damron: So we have to sort of weed through those. But those require some treatment as well. So you know, it's important that people recognize that, and not every lump or bump is, is going to be a malignancy. It's usually the larger ones and the deeper ones that are more concerning in terms of soft-tissue masses, and, and in terms of bone lesions, we see an awful lot of benign bone lesions in kids that are picked up incidentally in the emergency room.

>> Trisha Torrey: Ah ha.

>> Dr. Timothy Damron: And some of those patients get referred in, unfortunately, having been told -

>> Trisha Torrey: Yes.

>> Dr. Timothy Damron: You know, by a physician that doesn't necessarily see these very frequently that this could be a cancer.

>> Trisha Torrey: And then, of course, they all panic, and they're coming to see you. At least you get to deliver some good news to them then.

>> Dr. Timothy Damron: Yeah. I tell those patients they're cured when they leave the office. [laughter]

>> Trisha Torrey: And now they have all kinds of wonderful thoughts about you. Well, let's, we only have a few more minutes. Let's talk quickly. You're a physician, physician scientist as well. You're doing some research.

>> Dr. Timothy Damron: Yes I am. And all the research I do really stems from the problems that I see in the office, and we start to you know, as you, as you're working as a clinician, you see these problems over and over, and you look in the literature, and you try to figure out what can offer them that's better. And in a lot of areas, particularly in what I do because these tumors are so rare, there hasn't

been a lot of research, good, good research done. And so there's a lot of room for improvement. And so some of the problems that I've gotten involved in are looking at the complications of treatments that we give the patients such as radiation. We give radiation to kids to try to cure their cancers when they're young, and the radiation has damaging effects on the growth plate. And also on the bone and the bone integrity, and we've done a fair amount of research looking at ways to try to alleviate that.

>> Trisha Torrey: Ah ha.

>> Dr. Timothy Damron: With, without protecting the tumors because the tumor treatment, of course, is the most important thing.

>> Trisha Torrey: So you're trying to get rid of the tumor, but keep the bone in tact.

>> Dr. Timothy Damron: Exactly. Exactly.

>> Trisha Torrey: And so you're working on these, is this one project you're working on?

>> Dr. Timothy Damron: Well, that encompasses a pretty broad array of things.

>> Trisha Torrey: And it must take a long time, too, because you have to be following, especially children, you have to follow for a long time.

>> Dr. Timothy Damron: Well, some of the research we do is, is clinically based, and some of the research we do goes back to the lab and looks at basic, you know, aspects of these clinical problems and tries to figure out in that manner how better to treat the patients.

>> Trisha Torrey: Fascinating. I am so glad you came by this morning, Dr. Timothy Damron. And you're an orthopedic oncologist, which I think we in Central New York need to understand how lucky we are to have you here. How lucky patients in this area are to have you here. And I appreciate meeting you because it's so nice to meet someone else who got some good news too. Thanks so much for coming by this morning.

>> Dr. Timothy Damron: Thank you.

>> Trisha Torrey: Listeners, we do need to take a break. We'll be back in just a few moments. Please stay with us. This is Upstate Medical University's "HealthLink On Air" on 570, WSYR.

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