

Interview with Dr. Jack Kublin
Marquette Michigan
May 4, 2011

START OF INTERVIEW

Russell Magnaghi (RM): We'll start the interview with my, always with my first question, your birth date?

Jack Kublin (JK): Birthday was May 8th 1934.

RM: Oh, right around the corner then?

JK: Yes.

RM: Yep, okay, could you give us a little background of where you were from and something about your, you know, your family and growing up and that experience and so on. Was that influential in getting you into medicine?

JK: I grew up as an only child, primarily in Detroit, having been born in Fort Wayne Indiana, lived in Auburn, Indiana. My father was an automotive engineer. He designed the front wheel drive [system] of the Cord and Auburn automobiles [both manufactured by the Auburn Automobile Company, Auburn, Indiana]. And then he saw the writing on the wall in 1933 that the car was high priced and the market was limited for that particular car during the depression. He sought employment elsewhere and was hired by General Motors. And so we moved to Detroit in 1935 and lived in northwest Detroit. I went to Parochial School, Gesu School, corner of Livernois and Six Mile [Road] first through eighth grade and then I went to a Jesuit high school, the University of Detroit High School, where I took the classical course: four years of Latin, two years of Greek and some science (not enough, as I found out when I got into pre-med). My dad thought that I might be interested in going into the engineering field but I was interested in medicine from as far back as I can remember. Maybe [I was] influenced by the relationship of my family with the local GPs (general practioners) who would come to the house when one of us was sick. And I was sick with pneumonia a couple times and the doctor came and he called me buddy and he was [a] very [warm] hearted but authoritative man. I liked him. I think at an early age I saw what he did with people and how he helped people and how people were relieved when he would come and how they warmed to him as I did. And so I was at an early age very interested in medicine and I never changed my mind, much to the consternation of my parents who thought it would be a hard road, which it was of course. But I didn't think of that. So, I was at the high school and I applied to Holy Cross and Georgetown. I guess that, at that time, the Jesuits encouraged all of us to go to a catholic college and particularly a Jesuit one so I was accepted at Georgetown

and decided to go there. I was in the pre-med course for four years at Georgetown and Georgetown's pre-med [program] was quite difficult. [It was] quite difficult for me because I had had very little science in high school - physics, algebra, geometry, that was it. [I had taken] no chemistry and so on, so that was difficult but I came around finished my pre-med at Georgetown and applied to St. Louis University (I had some relatives there) and the University of Michigan. [I] was accepted at both and went to the University of Michigan where I spent, of course, four years after which I interned in Detroit at Providence Hospital for a year and then I didn't know exactly what I was going to do so I picked internal medicine. Dr. Robinson was the head of the [internal medicine] department at the University of Michigan at the time I was accepted. It (internal medicine residency) began in July as they usually do.

RM: What year was that?

JK: That was 1960 to '61 so, in March of '61, I was enrolled to go there and I was up in the intern's quarters and Roy Berry was there (at that time it was strictly a men's quarters, so that the bathroom was open) and he was shaving and he said, "So, what are you going to do in July?" and I said, "I'm going to go into internal medicine at University of Michigan". He said, "what are you going to do that for?" He said "It's awful, you get all these old people, diabetics, heart patients, and you can't do anything for them and they die on you and they keep coming back and they're worse. It's terrible". So, I was shocked, I thought, "My goodness, maybe he has something here" so I called a good friend of the family who was an ophthalmologist. And I had been in his operating room when he was doing cataract surgery and when he was doing muscle surgery for children with in-turning or out-turning of the eye. I liked it. I called him and he said, right off the bat he said, "Look" he said, "Eye is a great specialty, ophthalmology. I'll call Wilbert Rucker at the Mayo Clinic tonight, and I'll see if there's any openings. Then I'll call you back tomorrow", which he did. He called Dr. Rucker. Dr. Rucker wanted to know my grades. He said, "There is an opening, if he wants it he can have it". So Dr. Cusick called me back the next day and he said, "Well, you can go to Rochester if you want". So, you know, I talked to my wife and we decided to go. So the next thing I did was [that] I traveled to Rochester, I got some, I rented a place. We moved there in July, of 1961 with one child in tow and I started my residency. I found I liked it very much, the teaching was excellent, the clinical selection was incredible in that we would see things that in private practice you might see once in a decade; we'd see five in a week. So, it (my ophthalmology residency) was a great experience. Then the Cuban Missile crisis came up and doctors were being drafted. And that was after two and a half years [of my residency] and things were looking pretty certain for me to have to make a decision here about [going into] the service. An opportunity presented in Gallup, New Mexico, at the Navajo Indian Hospital (Gallup Indian Medical Center). At that time there was a male [ophthalmology] resident there for two years. He was finishing and I had an opportunity to go in his place. I grabbed that opportunity. I was accepted, so I left the Mayo clinic for two years and went to the Gallup Navajo Indian Hospital. I was chief of ophthalmology there and took care of the Indians there. Then I went back to Mayo for six months. While in New Mexico I, my wife and I, started looking for a place

to practice and we just didn't know where we wanted to go. My parents had moved to Florida and we heard of all kinds of opportunities. I looked into one (practice opportunity) in Albuquerque, [and one in] Flagstaff, [Arizona]. We went to Santa Cruz, California, looked at that, [but thought], "That's too far, lets see what Florida has". We liked the water, went to Delray Beach and Fort Myers, Florida, looked at opportunities there, [but we] still couldn't decide. And meanwhile, we would come to the Upper Peninsula to visit my wife's parents, who retired to Skandia from Detroit.

RM: Oh.

JK: They retired there in 1957 and so we would drive from Rochester, [Minnesota], to Skandia to see them. It just so happened that the place we were living in [in] Rochester was owned by a lady named Lila Kendall. It had a flat on the first and second floors [and] it just so happened that Dr. Fred Sabin (Frederick C. Sabin, MD, ophthalmologist) had lived, during his residency in Rochester, on the upper floor, the upper flat. So Lila would tell us to call Dr. Sabin when we got to the area and give her regards to him, which we did. And [when I'd] come back, I'd call him again and he asked me about where I was planning to practice and I said I didn't know. One thing led to another and he made an offer and I thought, "Well, I will. I'll go there and we'll see how it works out, maybe we'll stay, maybe we won't". So that's how we ended up in Marquette, although when we moved here we lived in Negaunee for five years. We had ten acres out in Negaunee with a nice house and then decided to move into Marquette. So I joined Dr. Hornbogan [in practice] (Daniel P. Hornbogen, MD, eye, ear, nose and throat specialist). At that time he was about 64 years old and [was in practice with] Fred Sabin who was in his 50's. And I came on as a third person in that practice. At that time they had just moved into the medical center building (The Marquette Medical-Dental Center at 1414 W. Fair Avenue), which is Peninsula Medical (The Upper Peninsula Medical Center) now. The first building had been built which was [had] a brick exterior and we had an office there. That (the medical center building), having been built because the doctors in the community at that time did not have sufficient office space. So they picked up the property out there (on West Fair Avenue) and then put this place up and moved in. Well then I practiced with them, [doing] general practice, (general ophthalmology practice), meaning we would do primarily cataract surgery, also what's called muscle surgery for children with crossing or out-turning of the eyes. We do glaucoma surgery. I had done corneal transplants in New Mexico (as a matter of fact I did the first corneal transplant under the auspices of the New Mexico Lions Club [Eye] Bank. [I] came to Marquette and continued to do occasional corneal transplants and then [also] routine eye exams along with the surgery, of course. At that time it was a small medical community. The staff (hospital medical staff) meetings everyone (all the doctors) would come to. The doctor's investment in the goings on at the hospital was very strong at that time. The doctors looked upon it as an obligation and also as a kind of a defensive necessity to make sure that their interests were represented so that the doctors attended the staff meetings in good numbers. I'd say 90 percent of the doctors would attend (the meetings) and also [attend] social gatherings. We'd find a lot of the doctors at the

social gatherings, everyone would go it seemed. And at that time there were only 20 specialists I suppose? And then a number of GPs (general practitioners) also.

RM: Now what year would this have been?

JK: That was in 1966. And it (Marquette) was a small town with a small town atmosphere. After all, we didn't have our Shopko (a discount department store or a "big box" store) at that time. When Shopko came to Marquette that was considered a big deal, "Shopko of all things", and when we got the Holiday Inn, of course, that was really something. You know, the Holiday Inn turned out to be a social center for Marquette and so it was an interesting time. [It was] far different from what it is now and from what it was ten years later. The strong nucleus of the medical community was the internal medicine group, particularly with Doctor Wright (Kenneth Charles Wright, MD, internal medicine). He was just a very pleasant, very knowledgeable, very persistent man who [with] crossing the t's and dotting the i's was able to get doctors to move ahead. He had a knack for that and of course he was in the internal medicine group (Marquette Internal Medicine Associates and later Marquette Internal Medicine and Pediatrics Associates, PC). Also Dr. Huffman (Elston Francis Huffman, MD, internal medicine) [was] the same way, very engaged with the goings on in Marquette and with the goings on at the hospital. John English (John W. English, MD, internal medicine) also [was very engaged]. And then my own partners were very, very active in this respect. Dr. Hornbogen, being a community institution, started out with his father, or his father. Excuse me, his father had started out in 19—, well let's see, his grandfather began to practice in the Savings Bank Building (southeast corner of Front and Washington Streets) on what I think was the fourth floor in the corner office in 1895. And then he had died in 1929 at which point Dr. Hornbogen, Daniel P. Hornbogen, MD, came back to Marquette a little early from his residency (double E NT, eye care, eye, ears, nose and throat) down in Chicago. [He] came back a little bit early because his dad died in 1929 and then he retired in 1997. Fred Sabin (Fred Sabin, MD) came on in 1954 [or] something like that, but anyway there were a number of strong personalities: Wright, Huffman, English, Hornbogen, Sabin. interestingly in the ophthalmologist I mean they weren't 'Bogen and Sabin, ophthalmology really is a very, it's limited to the eyes but certainly these men did not feel limited because they were ophthalmologists, they were very engaged with policies at the hospital and all kinds of other things that had to do with medicine. At the time Dr. Hornbogen came [to Marquette] there were no antibiotics. He would do mastoidectomies [to treat] acute mastoiditis; a number of these mastoiditis children died without the help of antibiotics. He eventually limited his practice to eyes after he came back from World War II. During the war, probably back in 1934-35 he started limiting himself (his practice) to eyes (ophthalmology). So I joined [Drs. Hornbogen and Sabin] and I was very fortunate to join this practice. And I've been able to see some astonishing changes in ophthalmology. Whereas, at the beginning we would use a magnifying loop, 2X, giving us two times magnification, and you just wore [it] right on your head, like a pair of glasses. At that time, we took the entire, if there was a cataract in the lens of the eye, we took the entire lens out. And we had no lens implants so we replaced their (the lenses) focusing power (which was removed because we took their lenses

out) with a thick pair of glasses which were very, very difficult to wear, very cumbersome. Patients who had these glasses had kind of a tunnel vision. Peripheral distortion was tremendous and it was really a handicap. We would remove the cataract and we would substitute one disability for another because it was difficult for them to walk with these things (glasses) on. But, on the other hand, we were dealing with a cataract surgery population [that] was in many instances less than 80 years of age. The longevity [of these patients] was not such that these people were living into the mid 80s and beyond so that they weren't quite as infirm as many of our patients are today [as today's patients tend to be older]. So, [being younger] they could handle this situation after the cataract surgery. But, of course, the mammoth, huge advance [in cataract surgery] was the advent of the intraocular lens which was inserted into the eye after the natural lens was removed. And, with that, the majority of the [visual] correction was taken up [was provided] by that intraocular lens and any additional correction was provided by a pair of glasses like I'm wearing right now. That revolutionized cataract surgery. But with it [with these improved surgical techniques] we needed to have better control of the operating field [and better control of the eye]. We had to see things better so we started using an operating microscope [and] so at that point ophthalmology changed drastically to the benefit of the patient.

RM: Now this would have been what year?

JK: 19... I did my first lens implant in 1976 or '77; I was the first one in the U.P. to do that and the results astonished me. You rehabilitate a patient to the degree that we were able to when we started doing that (lens implants - intraocular lenses), to the point even where they just needed, maybe, reading glasses occasionally. Otherwise they were sometimes without glasses at all.

RM: Now, wasn't - let me just - wasn't also in the process of cataract surgery, didn't the patient have to remain in an almost locked position in bed, they couldn't move their head, they were weighed down with sand or something?

JK: Prior to, prior to, I would say, 1960. The patients needed to be quite immobile after surgery, cataract surgery. The suturing technique of the time just did not close the wound sufficiently so that this wound, this incision in the eye, which was about 180 degrees. (The eye is a circle - 360 degrees). So this incision was half the circumference of the eye. This incision was fragile. Coughing, moving, squeezing, could open it up and you could have just all kinds of catastrophic consequences. So, immobility (immobilizing the eye) was generally used, practiced by ophthalmologists, I would say prior to 1960, 1958, [or] something like that. Then smaller sutures were developed and began to be used on a broader basis and so the wound was more secure [after surgery]. So when I came here I was using six sutures, but I still kept the patient in [the hospital] for one week per eye, so, if they came in for both eyes they were in for two weeks. And now, a beveled self-sealing 3 mm incision is used and the patient is in and out the same day with no sutures [and no stay in the hospital].

RM: Now is this done with...?

JK: Ultrasound is what's used.

RM: Ultrasound?

JK: Yeah, to emulsify, to soften the lens material and then aspirate it.

RM: Oh.

JK: It's done with an ultrasound instrument, which has been around since 1975 or so, but it was not generally accepted for doing the cataract surgery until the past 10 years or so.

RM: And then the... So the natural lens is taken out?

JK: It's sucked out of the eye.

RM: Taken out and then?

JK: At least the front half of it, the natural lens, is within what we call the [capsule]; it's like an envelope. So the surgeon opens the front of that envelope, goes into the sack, sucks out the cataract material and then slips an artificial lens into that envelope to substitute for the natural lens which was removed. [The surgeon] folds the lens (he has a 3.2 mm incision so this lens is folded), inserts it in the eye, into the eye with a special insertion instrument. In the eye it (the artificial lens) unfolds and it goes into this sack where the original lens (lens material) was sucked out.

RM: And so this is all done, I saw it with my mom when she had it done...

JK: Mhm.

RM: Then we waited and an hour or so later she was out with it.

JK: Yeah, that's it.

RM: Because I remember my Jesuit mentor at St. Louis, I remember he had cataract surgery and, oh my word, his lenses were like coke bottles and then he had, he'd watch everything very carefully but when we'd go someplace he would count the steps going up to make sure when he came down there were four steps and he wasn't taking a fall. So that was all part of the old procedure?

JK: That's correct. With that particular type of (pair of) glasses which had to be worn after the cataract procedure at that time the magnification was about 30 percent. So everything was bigger than it, in fact, is. Couple that with the distortion though the

periphery of these lenses and you really had a handicap. As I said, you were exchanging one [disability] for another. So it was difficult.

RM: See, and we didn't know any of this so he said hey look at those coke bottle lenses and what not and this is what he was, he could barely, barely get around.

JK: Yes, so you see.

RM: Now he was able to write, read and so on, that was, that would be a problem.

JK: Yes, can do that and through the center was pretty good.

RM: Oh, oh.

JK: But the periphery, the distortion in the periphery. What I mean is, "You know, with your pair of glasses and mine, you can look at anything and the vision here is pretty good, but it was awful in those [thick glasses]. So, and back then Dr. Cusick who was my mentor in Detroit...

RM: Now how do you spell that?

JK: C-U-S-I-C-K. He did a maximum of - and he did as many cataracts as anyone in Detroit - he did about 400 a year. And maybe he would do 5 or 6 in a morning or an afternoon. And that was considered a lot because you had to place all these sutures. Getting the lens out took not too long but then you had to place six or more sutures and that's what kept our uh [speed down]. So, if you were a cataract surgeon during that period and you did your cataract surgery in 40-45 minutes per eye you were going pretty fast. Now, without the necessity of using sutures and with this self sealing incision, a good cataract surgeon could do a cataract within 15 minutes. Retinal detachment surgery: at the time we had a success rate of retinal detachment surgery of about 20-25 percent; now it's 95 percent. [In] patients with retinal detachment there was [this high failure rate]. The failure rate was just so high because the re-detachment rate was considerable with the patients who had a retinal detachment. And we would do them. Well, we did [refer] them out of our office [but] occasionally we would do a detached retina surgery [as] there were no retinal specialists. That was not a sub-specialty yet. So, general ophthalmologist(s) would do retinal detachment surgery. If you wanted to go to a superspecialist you would go to Boston, Chicago or San Francisco. Dr. Pischel was in San Francisco. In Chicago I can't remember who it was and I can't remember who it was in Boston. But then that specialty developed as the retinal detachment surgery improved, the technique improved [and] success rate went up. It soon became apparent that general ophthalmologist shouldn't be doing retinal detachment surgery and the sub-specialty developed.

RM: Now as these new techniques and improvements came then you would get special training for it? Or how did that work out? You'd have to leave the practice and go for a period of time?

JK: Starting out as a general ophthalmologist in 1966 we would do all ophthalmic surgery. That would mean cataract surgery, glaucoma surgery, retinal detachment surgery, [and] if there was an orbital tumor we would do orbital surgery. We would do plastic surgery for the eyelids when they get a lot of skin hanging down, we'd do surgery on the children for crossed eyes or wall eyes, as we called them (wall eyes - looking out toward the wall). We'd do just about everything. Now, as new techniques came into play what general ophthalmologist(s) would do is they would pick the surgery that seemed to be of the highest volume that they could realistically be proficient at. [Higher] Volume generally encourages proficiency. Obviously, the more you do [the higher the proficiency]. So, that being the case, the cataracts were [the] first so the general ophthalmologist continued to do cataracts. So, whatever improvements in cataract surgery came along, the general ophthalmologist would take time to go to a meeting to learn a new technique and so on. Retinal detachment surgery, because it is difficult technically and there aren't that many detachments going around, the general ophthalmologist couldn't rely on a detachment a week to keep sharp. So [he/she] started sending those to the retinal specialist. Corneal transplants - [we] still did those because the corneal sub-specialty hadn't fully developed and you could, I could, do one or two a month in those days, so I kept sharp at it. As I say the volume kind of dictated which particular procedure you were going to continue doing. So [we operated on] glaucoma (lot of patients with glaucoma), [we did] cataract surgery, some corneal transplants. The rest of it, gradually, we started to send out.

RM: Now what, I know a colleague in the _____ department had this done but there was this operation I think it was pioneered by the Russians at some point to...

JK: RK, radial keratotomy or LASIK to change [refraction].

RM: Where you don't have to wear glasses.

JK: Primarily done for myopia, for nearsightedness, where it has met with a lot of success. It is a very successful operation and started out [in 1974] by Svyatoski Fyodorov, the Russian who would make incisions in the cornea to flatten the cornea. In other words, the dome of the cornea wasn't as convex. It was a flatter convexity as a result of these incisions which meant that the focusing power was decreased, so for a nearsighted patient they would be less nearsighted. And then that was superseded by so called LASIK [surgery] where, actually, the laser lathes off a certain thickness of the cornea in order to accomplish the same thing (decrease the focusing power of the cornea which would decrease the nearsightedness). So, it's primarily a procedure for nearsighted people who can then, really, many times go without any correction whatsoever except for reading [glasses].

RM: And that, I mean that has... I mean when I first heard some of this in the beginning, I kind of, sounded a little you know - the Russians were doing, sounded a little strange, you know, is it going to work? So it has proved to be a success?

JK: Their procedure (radial keratotomy) has been superseded though by LASIK, the laser, the lathing - the lathing procedure rather than the incisions. And yeah, it's come a long way and the results are quite predictable; complication rate is low and patients do very well, and a lot of patients have had it.

RM: Now, but that's only for nearsightedness?

JK: It's primarily for nearsightedness. Yeah, because that cornea can be shaped fairly easily to change the focal power of the cornea. Now when it comes to farsightedness, however, it doesn't work as well. Because it's a little trickier to shape the cornea properly in order to increase the focusing power of the cornea which you have to do for a so called farsighted patient. But the nearsighted - it works good for them. So those, all those, improvements have come through the years which makes for really a thrilling career. Now we have, with our macular degeneration patients, a disease of usually the older individual, perhaps beginning at 60, 65. Now we have, with them, the possibility of eliminating the little blood vessels that grow into the retina that hemorrhage and wipe out the central vision. We have injections that we can give directly into the eye for that that eliminate these blood vessels. So that has worked very nicely and we're doing that in the office now. We wouldn't even have dreamed of that ten years ago.

RM: Uh huh, because I've known my dad had it, I've known other people that have had it, and there's not much you can do.

JK: No, the dry kind, which does relentlessly decrease your vision, is less of an acute problem than the wet variety where these little blood vessels start to hemorrhage and, as I say, they can wipe out your central vision. So what you're looking at, for example, what you're looking directly at, you can't see. Your peripheral vision is intact, but what you're looking directly at you cannot see.

RM: So if I had it, if I want to look at you I would be looking this way.

JK: Yeah, if you looked at me directly you wouldn't see my head. Now you'd see everything around my head. You'd see the sides of the room but you wouldn't see my head.

RM: But as soon as I turned, then I would see.

JK: Well, but yeah, but you're using peripheral vision, actually what you're saying is that for example if you look right there, ok, now you can see me, but you're looking there, you can see me in the periphery but I'm not very clear because your central vision...

RM: Is gone.

JK: Your cones are gone. The cones are what give you your acute vision. You know your reading vision.

RM: Yeah.

JK: You know the cones do that so those are wiped out by macular degeneration when it gets to the quote “wet type”.

RM: So now would you say that is what state of development are we limit, it's uh...?

JK: Right now it's going by leaps and bounds because we've got the injection which will eliminate the blood vessels. The little blood vessels just go away and we've got that and some other things on the horizon, so it's just moving along very rapidly.

RM: So it's, because in the old days, once you got that, it was...?

JK: Hopeless.

RM: You were done.

JK: Hopeless.

RM: And I know people would say, “Well, you know I'm going to... My dad or something is going to get special glasses”, or so on.

JK: Right.

RM: Never happened.

JK: No, no never happened; we had absolutely nothing. I became quite accustomed in my practice to telling people, “Well, you have macular degeneration, that's why your vision is so bad, and we can't do anything about it, but you're not going to go blind.” You know people really appreciate hearing that. They're not going to go blind in the sense that they'll lose all their vision, but they will go blind in the sense that they can't see the 20/20 [20/200] 'E' and they will be legally blind because their central vision has been affected. So we had to tell people that and we didn't have anything for them.

RM: Yeah, sort of like Alzheimer's today.

JK: Yeah, Alzheimer's today, that's a perfect example. We know we got the Aricept, but Aricept doesn't cure anything with Alzheimer's, it increases alertness.

RM: But as time goes on, they'll find something, it's just...

JK: Yeah.

RM: It's just a big problem if you have it. If you get it now, you're not going to have any escape.

JK: Right, so that, yeah, it's, it's interesting as intensive as the research has been. I mean, research for Alzheimer's. Alzheimer's isn't a new diagnosis; we've known about Alzheimer's and its effects on our increasingly aging population for 15 years. We're nowhere, unfortunately,

RM: Oh so it hasn't... There haven't been any... I mean you kind of hear...

JK: Yeah.

RM: Of things that kind of drift around, but there's nothing.

JK: Right, and there are some trials going on right now with some drugs, you know, so the results of those are probably five years out before we get any improvement, you know.

RM: Now how did the practice that you entered did... When you started out there was one group of ophthalmologists?

JK: Mhmm.

RM: Then how did their practice, the one that you were in, how did that develop? Then did you get specialist(s) coming in? Did you add to the number and were there other offices that were...?

JK: Added to the number at the time I was here. When I first came, Dr. Koenig, Harry Koenig, MD, was in Ishpeming and there was an ophthalmologist in Escanaba, one in Iron Mountain, one in the Soo.

RM: Now you're talking about one, not a practice of several in a group.

JK: Correct, not a group, these were all one person [practices]. There was one in Ironwood. And [regarding] our practice: Dr. Ahmad (Dr. Busharat Ahmad), joined us in 1972, I believe it was. He was a corneal surgeon; he could do corneal transplants. I still did some but he did most of them at that point and he did cataract surgery also. Dr. Sabin then retired. I'll start with Dr. Hornbogen. He retired in 1977 at which time it was just then Sabin, me and Ahmad. And then Dr. Sabin retired in, oh, must have been, about 1990, 90 or 91, maybe 89. And so that left Dr. Ahmad and me. Meanwhile, Bob Dellangelo (Robert Dellangelo, MD, ophthalmologist) came back to Ishpeming. He was a native of Ishpeming, had gone to Michigan Tech (Michigan Technological University), had started a general surgery residency, decided he wanted to go into ophthalmology, went to Henry Ford (Henry Ford Hospital in Detroit, MI) and he came back to Ishpeming, and Doug Shearer (Douglas R. Shearer, MD,

ophthalmologist) joined him. So now it was Shearer and Dellangelo. They opened an office in the Medical Center (Marquette Medical-Dental Center, later the U.P. Medical Center) where we were, so there were two ophthalmology practices in the medical center building, Dr. Ahmad and me and then Dellangelo and Shearer. then Dr. Ahmad left [Marquette] in 1992 and I was...

RM: What, just to get back to him, what was the, he just wanted to, didn't he have, weren't there some issues about the Koran (Qur'an) and who was the writer of that time, did that enter into it? You know the fellow that had died I can't think of his name now, that was, had written some anti-inflammatory novel about Muhammad and so on and I don't know.

JK: I do know that the largest Muslim population in the United States, the largest concentration in is southeast Michigan, in the Monroe area, where the largest Mosque in the United states is. He had two daughters and I think he wanted to be among, within a Muslim community.

RM: Ah, okay.

JK: And so that was a great opportunity for him. He got an offer, or, I don't know exactly how it transpired, but he left [Marquette]. And I think the big reason was the community down there.

RM: Ah so he went to Monroe?

JK: Yeah.

RM: Because he was my doctor until he went away.

JK: And then I was alone from '92 until... and I was constantly looking for somebody, and finally Dr. Winkler (Neil R. Winkler, MD, ophthalmologist) looked at our area here. He was, at that time, in Rochester, MN, in the Mayo residency, Mayo eye residency, and he... his wife, Laurie Junack, was from the Iron Mountain area and so also... The Junacks are from Ishpeming, I don't mean Iron Mountain, Ishpeming, Junacks. Laurie Junack. And so they would come to visit her family and he dropped by one day and it clicked between the two of us and I went after him. And so we eventually settled on a contract and he came. [I was] very fortunate to get Neal, and then in '03 we added Sean Rooney (Sean M. Rooney, MD, PhD, ophthalmologist) to the practice. Meanwhile, Dr. Dellangelo retired, he retired at the age of 54 or 55, early, so Shearer and Mark Ulrickson (Mark W. Ulrickson, MD, ophthalmologist) are now upstairs in the medical center above us. And so that kind of gives you a sketch of what...

RM: Mhmm, so it was like, from the interviews I've done earlier, with other people, I mean in terms of the ophthalmologists you had...?

[SIDE A ENDS]

[SIDE B BEGINS]

RM: So you had the same problem of how do you attract new doctors and you end up, so you were then in the office by yourself, for a period of time?

JK: Yeah, yes.

RM: Now that must have been very hectic.

JK: Was very difficult; I was working constantly. The patient load was huge but I was confident that I could get somebody. I mean, there's somebody out there who's going to like all the aspects of this Marquette community (which are considerably more now than they were back then) and you know, my optimism paid off because sure enough, Neal liked everything he saw and he came.

RM: And he sort of just walked in one day?

JK: Yeah, walked in one day.

RM: I mean you didn't communicate with him earlier?

JK: No, actually he had. I don't know how he made a connection with a doctor named Archie Narotski, who was a general practitioner in Ishpeming, and he, Archie told him, you've got to see Dr. Kublin. You've got to, you know, check out his office too, because he had checked out Dr. Dellangelo's office. And so he came down, and that's how it happened - really fortuitous.

RM: Yeah, but on the other hand, kind of, you know, you think about it, it's just happenstance. He just, you could have been out that day or something.

JK: Absolutely, yeah, that's exactly it, so you and I may think about the little influences that come into situations like that.

RM: Yeah, now how did the doctors, the ophthalmologists, then work? How did they interact with the hospital? Was there, did it work out well? Were there problems? Or...?

JK: In general, ophthalmologist did all their surgery at hospitals, the reason being, for that particular operation that we did frequently, the patient was better served. [Be]cause we're talking about being on the operating table for maybe 45 minutes the patient was better served by a general anesthetic. Because with just a block (local or regional anesthesia), an anesthetic block that is an injection around the eye, you still had a patient who might get disoriented and might start moving all over the place. And the control the oxygen delivery was better if they were asleep. Perhaps as many as half of our patients needed a general anesthetic so the hospital environment was assumed to be the best and the only environment to do cataract surgery in. So we

needed the hospital and they needed us. We provided consultations at the hospital in addition to doing surgery there. We would see the patients every day after their surgery; we would go up [to the hospital wards] on rounds. Dr. Sabin, Hornbogen and I sometimes would all have [hospitalized] patients so we'd make rounds together every day; before office hours we'd go to the hospital and make rounds. Now, [at this time] those patients have their cataract surgery, they are seen the next day and then they're not seen for two weeks. At that time, I cannot forget this, Dr. Sabin was a smoker. As a matter of fact, he died of lung cancer. Fred smoked constantly so he'd smoke on rounds. So he'd be seeing patients. We had a little cart with all the drops on it, so we'd take the dressing off, we'd put the drops in and so on. And I can see him now, with the cigarette in his mouth, talking to the patient. Both hands are up here, taking the dressing off, putting the drops in. He's talking to the patient and his cigarette is doing this and the ashes are flicking all over the place. So yeah, that was so. Anyway, we relied on the hospital. They had, [and] we needed them to provide us with operating space and equipment and all the rest.

RM: But then you also had in the earlier days, I don't know exactly when that ended, but you also had the - the patient had to be in the hospital with the...?

JK: Sand bags.

RM: With the... They had sand bags you know so I mean you needed all that.

JK: We needed all that; that's right. We needed nursing care. We needed - you know the morbidity for these patients was pretty high, we're talking about maybe a 70-75 year old patient, lying in bed, immobile. Talking about blood clots from their leg veins, talking about disorientation. Sometimes they would get psychotic. You take away someone's vision because they would have eye pads on both eyes plus the sand bags, so they would get disoriented. It was pretty tough on them. So when we could eventually get [operate on] these patients, put an implant in the eye [using] nylon sutures, which they could not feel [and] which were very small, our rehabilitation was astonishing when that happened, compared to being in the hospital like this (like the older procedure required).

RM: Mhmm I remember as a kid, my, or this older woman who was a sort of surrogate grandmother to me, I remember they made a big fuss. She needed cataract surgery, we're talking now, mid '50s and the doctor, she must have been probably pushing her 80s or so, and the doctor said absolutely not, you can't, given your age and all you can't have it done.

JK: This is the other thing and I did the same thing [in the past] when patients - if I had a patient of 85 and that patient, lets say had a few health problems, not major, but lets say he had a few of them. They are getting along so-so. Maybe they've given up driving because of their cataracts and I'm looking at that patient and that patient's going to need a general anesthetic. [Now, with the newer procedures], I wouldn't tell someone they're too old and at this point in our office we don't turn

away anybody. So there's been a patient or two, 101, 103 [years of age] who have been done.

RM: Oh my.

JK: Yeah, so, and you look at that and you wonder, "Well, what's going on here? This patient's awfully old". Well, their health is pretty good and we can do this without impacting their general condition at all because they get a little sedative that wears off in 15 minutes [and then] they're up and ambulatory immediately, just about. There's no justification for not doing it to restore some quality of life. So our hands aren't tied for that reason anymore.

RM: Now were there any, are there any sort of new, you know, new ophthalmologist research that looks toward any breakthroughs that will improve, I don't know, eye operations, or...?

JK: You know, we're not really very far as far as the prevention of cataracts. Cataracts, the incidence of cataracts and macular degeneration is higher in people, for example, who smoke [as well as] those who have a high cholesterol, family history [of these eye conditions]. [Also at increased risk are] those who are out and getting a high dose of sun, sunshine every day, which we don't get up here. So, as far as prevention of these [eye diseases], well, we've got some inclinations, you know, about what is a healthy lifestyle. In general, a healthy lifestyle for the rest of the body is good for the eyes. Particularly this applies to cataracts and macular degeneration. So that, as far as glaucoma goes, there's nothing that we know that prevents it except we seem to think that also a healthy lifestyle is better for the glaucoma patients.

RM: Now how does glaucoma affect - what does that do to the eye?

JK: Glaucoma, if it's left untreated, can also take the vision, usually peripheral vision first, central vision last. So the patient doesn't, the patient with advanced glaucoma, doesn't know that they're in trouble because first involved is their peripheral vision and they don't notice that. So, [in] the patient with glaucoma who has a higher pressure in the eye, we want to lower that pressure and we do that with drops. We can also use a laser procedure and ultimately another operation in order to reduce the pressure.

RM: Now, can that be done once it starts and advances, can it be stopped?

JK: Yep, yeah, it can be done, because we'll see patients occasionally that haven't been checked for glaucoma. They come in and they have glaucoma, maybe they've lost a little of their peripheral vision. We can stop that by bringing the pressure in the eye down with drops, or again, if necessary, a laser procedure or surgery.

RM: So it can be done as simply in the beginning with just drops?

JK: Correct. Drops initially are what usually are used. Now we can offer a patient, instead of drops, we can offer them a laser procedure which takes about five minutes. Still I think in the United States we lean towards drops first and then if that doesn't do the trick we have the laser procedure, which acts as another medication - really in and of itself lowers the pressure also.

RM: So are those like, those are the major eye problems you would encounter?

JK: Yeah, cataracts, glaucoma, macular degeneration, those are the biggies.

RM: Uh huh, so there's not like some new procedure or something that you'd be looking for, you know, some other problems?

JK: There's the, there are some new techniques for glaucoma surgery that do the same thing as our old tested and true ones, lower the pressure. There's [a] new corneal transplant operation that does not necessitate using the entire thickness of the cornea, just one of the layers of the cornea that can be transplanted into the eye. There's the ongoing [issue] with the macular degeneration - how're we going to prevent it? And so there's research in all these areas and, you know, it starts and stops. I mean, the big deal with the injecting of this agent into the eye, that occurred about five years ago (to treat macular degeneration) and the cataract operation that's been refined and refined and refined, until we had this small incision now for it. So that you know these advances are made incrementally, usually, with occasional huge ones like lens implants or the injection for the macular degeneration or a whole new class of eye drops for glaucoma that do a better job than they used to. And meanwhile, of course we have antibiotics that now are very, very good that take care of just about any bacteria that can infect the eyes.

RM: So then maybe of the human body the eye is the one area that is sort of under control, I mean now you're just perfecting things that are going to improve some of these techniques.

JK: Right, yeah, we are, and maybe we're going to get into a prevention mode, maybe something's going to show up for macular degeneration, [which is the] leading cause of blindness in people over the age of 60 by a longshot. Maybe we're going to get something in that area, research is going on in that. We use some vitamins sometimes. Eye doses of some vitamins have proven successful in delaying the vision decrease with macular degeneration. Maybe some other things are going to come along.

RM: Now, what is the, what is the vitamin?

JK: We have a vitamin [and mineral] combination with, actually it has, copper sulfate in it, it has zinc in it, it has vitamin E, vitamin C, vitamin A, and this study showed

that this particular combination of vitamins slows down the progression of macular degeneration.

RM: And this is something you prescribe?

JK: Yeah, in people with macular degeneration.

RM: But I mean, it's not like somebody would go out and buy these different pills?

JK: No, it's all in one.

RM: It's all in one, I see, interesting, then so now how many... Okay the other thing is you talked about the doctors and you had one ophthalmologist in different towns and so on. Did, for instance, did you have then, did you work with them and have their patients come to you in Marquette, for operations, procedures and so on? Did you go out to their communities?

JK: When I was holding my outlying clinics I would go to Newberry, Iron Mountain, Escanaba, rarely to Houghton, and at that time, those communities were sending patients. Patients from those communities were coming to Marquette. I would occasionally see them at a clinic in their town and we would get referrals from the family doctors in those communities. We largely had our own practice of ophthalmology as did the other ophthalmologists. If they wanted subspecialty expertise, they wouldn't come to us for that, because they were also general ophthalmologists as we were. So they might want to send one of their retinal problems or particularly difficult glaucoma problems to Green Bay which has an excellent group of ophthalmologists.

RM: Okay, now is that still the case?

JK: Still the case. We have, there are some excellent retina people down there and so we [refer appropriate patients to them]. The Green Bay Eye Clinic is a frequent consultant for us when we need that.

RM: Yeah, I'm thinking a friend of mine. I drove him down to uh...

JK: Oh did you?

RM: Yeah, I drove him down to Green Bay. I just kind of, he didn't particularly say why he was going, but it would be because it was something special that he had done.

JK: Right.

RM: Could better... Well could *only* be done down there.

JK: And people these days are much more accustomed to consultation referrals. People like it, patients expect it, so that there's a willingness to go where you direct them.

RM: I'm finding the interview with you very interesting because it's different from, in terms of ophthalmology, it's different from some of the other, you know, the other physicians and what they do and so on and what they can do or couldn't do. It's very interesting.

JK: Right. Diabetes has been another area where just incredible advances have been made. Oh, they all went blind, all the severe insulin dependent diabetics back in the early, in the 60s. Then, I think his name was Wedig, W-E-D-I-G, out in Colorado Springs, [who] discovered that if you treated these people with the laser and deliberately destroy peripheral retina [tissue] the stimulus to the formation of all these blood vessels that bleed so easily would be removed. Because now, instead of having retina that was merely ischemic, that is it's starving for oxygen, you had dead retina and dead retina did not produce this particular chemical, if you will, that caused the proliferation of these blood vessels. So we started using the laser on severe diabetics. We would take away their peripheral vision, not all of it but some of it, in the interest of decreasing this formation of VEGF (Vascular Endothelial Growth Factor) which is elicited by retina that's starving for oxygen. So if you kill the retina it's not starving anymore, because it's dead, and so this VEGF was not elicited (produced) anymore and they didn't get all these little blood vessels forming in the retina which ultimately bled and blinded them. This was a huge breakthrough. I mean when we could do that I started doing that, instead of watching these people go blind, that was really...

RM: Because that's usually synonymous with diabetes. You get diabetes, it's going to get bad and you're going to go blind.

JK: Yeah, you can get diabetic, what we call diabetic retinopathy. Severe diabetics can get that. They don't get severe [retinopathy]. They don't get diabetic retinopathy to the degree that it blinds them anymore because we intervene with laser.

RM: Now this is, and this friend of mine is a diabetic...

JK: Oh, okay.

RM: And so this is - he was going to Green bay for...

JK: Sure, so he was seeing [Dr.] Perkovich or Scattergood, or Wang.

RM: Yeah, see and I, he just, you know, I didn't get into the details with him and I just knew he was going down there to get his eyes taken care of.

JK: Yeah, we used to do all the laser treatments for the diabetics here. Now the LASIK, it's just become a little bit more of a subspecialized area so a lot of the diabetics that might have problems like this we send to the retina specialist, usually in Green Bay.

RM: And that's what kind of... I think we went down and back the same day so it's a...

JK: To be treated same day and then go home.

RM: Okay so it's not like, you're going to Green Bay and spending the week in recovery now?

JK: Right.

RM: Oh, okay.

JK: Ocular tumors, melanomas, for example, we see a melanoma occasionally in the eye.

RM: Melanoma in the eye?

JK: Yeah, oh yeah, melanoma in the eye. It's a formidable tumor and it does metastasize and cause death. It can. We don't see a lot of those; we see maybe two a year. [We] Send those out. Those go to Madison, or to Mayo Clinic.

RM: What do they have to do when they take it out then?

JK: What they do: depending on how big it is, usually the eye does not need to be removed. They can use, they can put a plaque, a radioactive plaque, over the lesion, way back, you know, behind the eye, or just about behind the eye to shrink the tumor so it can be dealt with without removing the eye. [Ophthalmologists] Used to remove the eye with a melanoma. And back then, this sounds awful, back then melanoma could be confused with other (benign) conditions of the eye, so it did happen that occasional eyes were removed and then examined histologically and it wasn't a melanoma. We didn't have the diagnostic ability to differentiate some of this stuff - MRIs, you know. We didn't have MRIs back when Dr... Back when I had a patient with headaches and I thought, "This isn't an ocular headache, this is - there's something [else] here maybe", I'd have to send them to Dr. Brish (Adam Brish, MD, neurosurgeon in Marquette, retired) who would do a neuro encephalogram where he'd inject air into the ventricles of the brain and so on. And that was a lousy test because they could have something awful going on and you couldn't find it with that particular test. He went to heaven when CT scanning came to Marquette, the neurosurgeons, because now they could see it. And now if I have a patient with severe headaches, I'll order an MRI. And, you know, in the past, before that, back in the 60s into the 70s, if patients had these things I'd tell them, now this, this would be a pretty standard piece of advice to patients, "Let's see how things are in two months and I'd like you

to return then and we'll see how this headache's going". I didn't know, they didn't know, I didn't know what was going on. I didn't have studies that were adequate to tell me what was going on so it was kind of primitive back then.

RM: It's sort of amazing, when you live through that time you know like, I didn't know that, that's the way things were. You know but kind of, and as I do the interviews with the different physicians, it's like, oh my word, yeah, this is, an improvement now, but back then in the '60s and '70s I came in '69 so kind of after you did and so as I'm listening to this I'm thinking gee, that's pretty primitive, something happened.

JK: Yeah, it was.

RM: Now are there any, is there anything I missed in terms of asking you that you'd like to add?

JK: Uh, except for saying that I'm delighted I went into medicine. That decision was the right decision for me. Very fulfilling. I get a tremendous kick out of the diagnostic challenges I still see, I work three and a half days a week.

RM: Oh.

JK: Occasionally a full day, I still love that. I can't imagine being in retirement and doing anything else that would be more exciting, but I think the move to Marquette was a blessed move and I'm delighted I ended up here. So, you know, it's been a great run.

RM: Now earlier in the interview, when you started out you had that encounter with the physician that said, don't go into general medicine?

JK: Internal medicine.

RM: Internal medicine. So would you say you found your life as an ophthalmologist then, one where you were able to truly help people?

JK: Yes, yes, definitely. And that's from the outset, because yes, the macular degeneration was incurable, [however] we could do something about glaucoma and we could do something about cataracts. What we did wasn't as good as what we can do now, but it was something, yes.

RM: But you were making improvements, you could see you were making improvements.

JK: Exactly, yeah, could see that.

RM: Yeah, okay.

JK: Good.

RM: I think that's it.

JK: Okay.

RM: I thank you.

JK: Thanks for listening and...

RM: Oh...

END OF INTERVIEW