

Western New York

# PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

A photograph of four medical professionals standing on a staircase. From left to right: a man with a beard in a grey suit and blue shirt; a woman in a green blazer and maroon turtleneck; a man in a dark suit and tie; and a man in a dark suit and glasses. They are all looking towards the camera.

## Rochester Brain & Spine Neurosurgery and Pain Management

*Combined Disciplines for Optimal Care*

Urological Issues for an  
Aging Population



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PORTRAITS

# LISA HUGHES

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The physicians of Rochester Brain & Spine Neurosurgery and Pain Management. L to R: Seth M. Zeidman, MD, Christie M. McMorrow, MD, Roger Ng, MD, David Chang, MD. Not appearing is Satish Acharya, MD.



## Welcome to the December Issue of Western New York Physician

*At the close of another year, I offer my best wishes for a happy and safe holiday and all good things in the coming year. 2011 will prove to be an interesting time as reform laws begin to be implemented and the healthcare landscape transitions going forward. Locally, RGH and the Medical Society have proactively initiated a forum for physicians to help better understand the affect these changes will have in our region - an important first step to share information and become better informed of the anticipated impact. With advance attendance reported a near "full house" many of you may have participated. Surely there will be similar opportunities to keep the dialogue alive creating a powerful collaboration.*

It's no surprise then, to share that the preliminary results from the ongoing readership survey identify Health Care Reform a topic of overwhelming interest - 85 percent. In response, we're launching a column that will reach out to area leaders and experts for perspective. To nominate someone for this series, please email or call me directly. Other notable preliminary results:

- **100% readership**
- **70% enjoy the clinical articles**

Many thanks to those who've already participated. Your feedback provides meaningful guidance as I look ahead editorially in 2011.

The invitation continues to share your opinion. Find the brief, confidential online survey at the address below. Join your colleagues in refining the shape and value of *Western New York Physician* as we tap area expertise to comment and offer insight on what's important to you.

[www.SurveyMonkey.com/s/WesternNYPhysician](http://www.SurveyMonkey.com/s/WesternNYPhysician)

According to the American Academy of Pain Medicine, pain affects more Americans than diabetes, heart disease and cancer combined with an estimate of 76.2 million sufferers estimated by the National Centers for Health Statistics. This month's cover story highlights the talented team of experts at Rochester Brain & Spine Neurosurgery and explores the latest approaches to treat chronic and acute pain.

For a glimpse of what is coming up in the first half of 2011, see the editorial calendar found on page 14. Please contact me directly if you would like to be included in an upcoming issue.

My thanks to each of you who contribute to and support *Western New York Physician*. These informative and educational articles provide all physicians in our region a more in-depth look at the resources available to their practice and their patients and your advertising support makes it possible to deliver the magazine to readers each month.

All the best,  
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## Western New York PHYSICIAN

THE LOCAL VOICE OF  
PRACTICE MANAGEMENT AND  
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# Urological Issues for an Aging Population



Frederick W. Tonetti, MD

As our population ages more and more of us will experience age related health issues. The most frequent being cardiovascular and cancer related problems. In urology, prostate, bladder and kidney cancers are more common in the geriatric population. In men benign prostatic hypertrophy begins to cause more urinary problems and disease as we get older.

Two other more common benign conditions causing more health related issues in the geriatric population are hypogonadism and urinary incontinence.

**Hypogonadism** is defined as low testosterone with levels in the blood less than 300 ng/ml. Hypogonadism increases with age as the proportion of males 65 years is expected to increase about 5% over the next 15 years, physicians will see a growing number of patients requiring treatment. Hypogonadism has been associated with obesity, type 2 diabetes, hypertension, osteoporosis, and metabolic syndrome.

Diagnosis requires the presence of a low testosterone and the presence of symptoms. There are a number of treatments available to correct testosterone levels. Restoration of normal levels improves libido and sexual function, reverses osteoporosis and reduces fat body mass. After institution of therapy, prostate health should be monitored with digital rectal exam and prostatic specific antigen levels, hematocrit levels, and liver

function tests. Levels should be drawn at 3 months and 1 year. Testosterone therapy should be used cautiously in patients with BPH and prostate cancer and has shown to be safe to use in patients who have been treated for localized prostate cancer and have shown no evidence of recurrent disease. Testosterone therapy can increase the red blood cell count and if the hematocrit rises above 50% therapy should be stopped.

**Hypogonadism** is a common condition in the male population.

## Testosterone Treatments

subcutaneous pellets • intramuscular injections  
transdermal patches/gels • buccal patches

With a high prevalence in older men, the obese, and men with metabolic syndrome and type 2 diabetes, makes it more likely that primary care physicians will need to treat these patients. It's important to consider treating symptomatic patients, not leaving them untreated because of anxiety over possible adverse events from testosterone replacement therapy, after discussing the potential benefits and risks of treatment with them.

**Urinary incontinence** defined as involuntary loss of urine with social and hygienic issues is a problem that affects more than 16 million Americans – most of them women. Although nearly half of the elderly in America have episodes of urinary incontinence, it is not a normal consequence of aging. It remains a largely neglected problem despite its considerable prevalence, morbidity, and expense.

There are several types of urinary incontinence; stress incontinence (leakage associated with coughing or physical activity), overflow incontinence (associated with urinary retention and continual leakage), urge incontinence (associated with a strong desire to void and leakage of moderate to large

## Typical Symptoms

reduced libido  
erectile dysfunction  
muscle fatigue  
reduced strength  
increased adiposity  
osteoporosis  
low bone mass  
depressed mood  
fatigue

amounts of urine prior to the bathroom), and functional incontinence (associated with impaired, mobility, dexterity and mental status). It is not unusual to have a mix of these types of incontinence which can easily be defined with urodynamic studies and cystoscopy.

Treatment options can be behavioral and dietary modifications, medical therapies and surgical treatments. Behavioral and dietary changes include reduction in caffeine, prompted voiding, decreased evening fluids, and Kegel exercises. Medical therapy is not only addition of medication such as anticholinergic medication but adjustment of diuretics or psychoactive drugs. Minor surgical procedures such as transurethral bulking agents or pubovaginal suspension procedures are available. More complex anti continence procedures may also be necessary with artificial sphincters and vaginal repairs may be needed.

Prior to any treatment complicating disease states such as urinary tract infection, bladder cancer, diabetes, Parkinson's disease, and other neurologic disorders need to be diagnosed and treated. Urodynamics, an office based study, tests bladder emptying and storage and will help to sort out the types of urinary incontinence allowing more effective treatment.

The most commonly used treatment is anticholinergic

therapy with medication directed at suppressing the urge to urinate. They block the bladder contraction, thus increasing volume and decrease the amplitude of bladder contraction. These medications can have some significant side effects of dry mouth and constipation resulting in discontinuation of medication. Pubovaginal suspensions for the treatment of stress incontinence are 80-85% successful. Surgeries are often done as an outpatient with minimal possible complications of urinary retention, bleeding, infections, and erosions are very unusual.

The most effective approach to urinary incontinence is to use a combination of the therapeutic approaches. Follow-up is essential to encourage continued behavioral and dietary modification, check for adverse effects of medication, monitor effects of continued incontinence, skin breakdown and infection, and surgical complications.

*Dr. Tonetti, is a Board-certified urologist at the Center for Urology. He received his medical degree at the State University of New York at Buffalo School of Medicine, and his urology residency at the University of Rochester School of Medicine and Dentistry. Dr. Tonetti's special interests include bladder and prostate cancer treatments. He has extensive experience in prostate radioactive seed implantation and is currently using innovative technologies such as cryoablation of the prostate and robotic surgery.*

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# Everyone Should Boost Intake of Vitamin D, IOM says



Kevin Fiscella, MD

*The nation's top scientific advisory panel today recommended that most children and adults modestly increase their intake of vitamin D, known as the "sunshine vitamin," from a daily dietary intake of 200 international units to 600 international units. The panel also extended the safe upper limit for older children and adults from 2000 IU to 4000 IU daily.*

The Institute of Medicine (IOM) released its report November 30, 2010, after two years of study and debate. The IOM had not changed its dietary guidelines for vitamin D since 1997.

During the last 13 years, though, some studies had suggested that much higher doses of vitamin D could prevent a variety of illnesses, from bone diseases to strokes and cancer. But the IOM panel was more cautious, and said that although more vitamin D is beneficial to bone health, studies related to other conditions were inconsistent and inconclusive. Furthermore, the panel said taking mega doses over a long period of time might harm some people. The IOM recommended:

**Everyone ages 1 to 70 should take 600 IU daily.**

**Adults older than 70 should take 800 IU daily to optimize bone health.**

**The safe upper limit for infants up to 6 months is 1000 IU daily.**

**The safe upper limit for infants 6 to 12 months is 1500 IU daily.**

**The safe upper limit for children 1 to 3 years old is 2500 IU daily.**

**The safe upper limit for children 4 to 8 years old is 3000 IU daily.**

**The safe upper limit for everyone older than 8 is 4000 IU daily.**

Kevin Fiscella, MD, a URMC family physician who studies health disparities, noted that African Americans often have lower serum vitamin D levels than whites.

He published an observational study earlier this year

suggesting a link between D deficiency and a higher number of heart and stroke-related deaths among blacks compared to whites. A second study showed that a lack of vitamin D among blacks may also explain a higher death rate in colon cancer among blacks compared to whites. A third URMC study suggested a link between lower vitamin D levels among black women and more aggressive breast cancer.

"While most U.S. adults may achieve reasonable blood levels of vitamin D through diet and sun light, national data show that persons with darker skin, particularly African Americans, commonly have D levels believed to be suboptimal," Fiscella said. "This is particularly true among those who are lactose intolerant and avoid vitamin D fortified milk products. Research is sorely needed among this group to firmly establish optimal levels."

The IOM report will resonate differently with various health providers and patients, Fiscella added. Physicians will most likely be a bit more conservative in terms of testing for vitamin D deficiencies and prescribing supplements, he said.

"My own view is that this is an area of great uncertainty and it is ripe for research," Fiscella said. "We have reasonable observational data suggesting that vitamin D can be of benefit in the prevention of some cancers, insulin resistance, and vascular conditions. But we've been here before with other nutrients, where promising observational data was not born out by subsequent clinical trials."

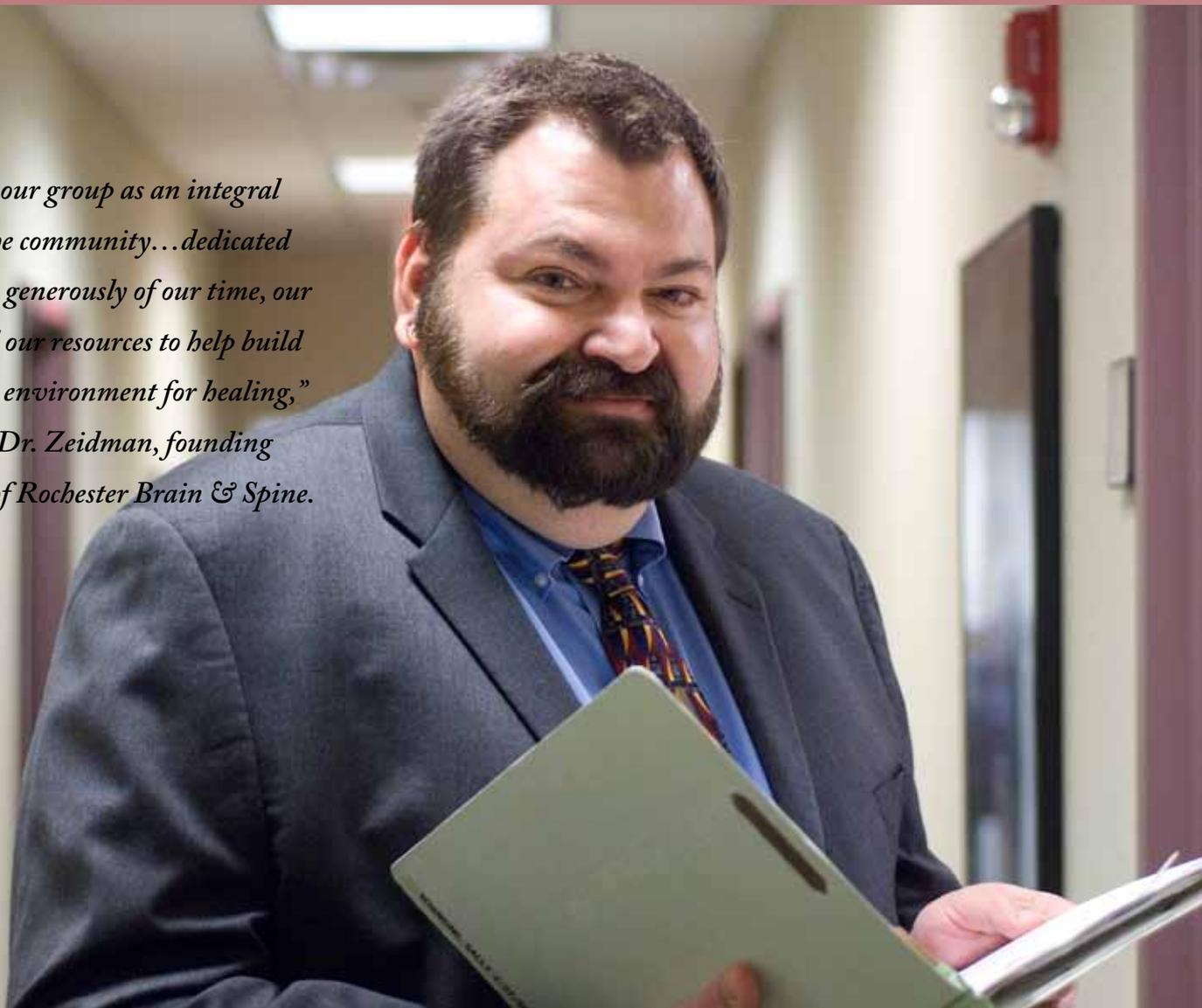
Until we have stronger evidence one way or another, Fiscella said, physicians should be honest with patients about the current state of evidence and help them to make an informed decision on use of vitamin D supplements.

The IOM found that the majority of Americans are getting sufficient vitamin D, which can be consumed through fortified dairy foods, orange juice, fatty fish, and D-containing dietary supplements, or produced by the skin during sun exposure.

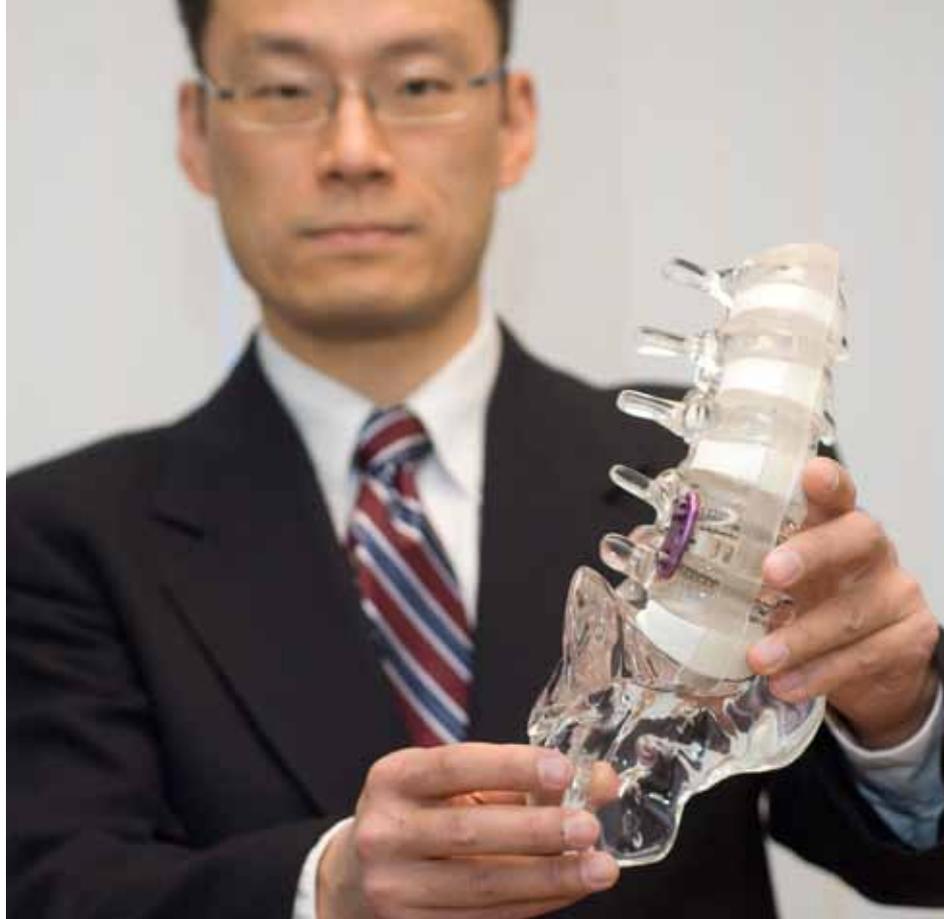
# Rochester Brain & Spine Neurosurgery and Pain Management

*Combined Disciplines for Optimal Care*

*“We view our group as an integral part of the community...dedicated to giving generously of our time, our skill, and our resources to help build a greater environment for healing,” explains Dr. Zeidman, founding partner of Rochester Brain & Spine.*



Last April, Rochester consumer radio host Carlos Rodriguez began to experience tingling in his fingers, which quickly progressed to the point where he could barely bend them. His frustrating medical journey took him first to his family physician, who ordered a hand MRI and a painful nerve conduction study to determine if Mr. Rodriguez, a lifelong diabetic, had developed carpal tunnel syndrome, which is often associated with that disease.



**A**s his symptoms progressed to growing shoulder pain despite no history of prior injury, his physical therapist suggested tendonitis, but the pain worsened. Weeks later an MRI was conducted which revealed a bulging disc in his neck severely impinging on the cervical spinal cord and nerve roots. Within a day, Mr. Rodriguez was referred to the specialists at Rochester Brain & Spine Neurosurgery and Pain Management. The next morning, he was limping into Unity Hospital for emergency spine surgery.

In the previous four months, Mr. Rodriguez's life had changed dramatically, from camping with inner city kids as an active Scout leader to hardly being able to walk. He credits Dr. David Chang and the staff at Rochester Brain & Spine with restoring him to his former active and healthy self.

"The experience has been tremendous," says Mr. Rodriguez. "If the diagnosis had taken any longer and I hadn't been placed in the expert hands of Dr. Chang, I could have been paralyzed. He truly saved my life."

At Rochester Brain & Spine, Dr. Chang and his four physician partners have developed a regional reputation for clinical and surgical excellence, particularly with some of the most challenging cases. Hundreds of patients who have tried and failed multiple operative and non-operative procedures elsewhere seek their clinical and surgical expertise.

With an entire range of treatment options available to them, the doctors can tailor a coordinated clinical regimen for each patient. "Since we deal predominantly with both chronic and acute conditions, we strive to treat patients with non-operative measures initially," says Dr. Chang. "If it's a particularly acute problem like Mr. Rodriguez's, we can progress rapidly and deliberately to surgical interventions."

Post-surgery, Mr. Rodriguez is virtually pain free, with close follow-up care under the Dr. Chang's direction. Despite some residual tingling in his fingers, he expects it to subside within a few weeks. "I thought I'd be wearing a halo or trapped in a stiff cervical collar and undergoing long-term physical therapy, but it's been like night and day." A retired New York State Assistant Attorney General and former triathlete, Mr. Rodriguez expects to be running on the treadmill again soon.

### **THE PRACTICE: CROSSING MULTI-DISCIPLINES**

The 25-person staff at Rochester Brain & Spine offers comprehensive evaluation and management of spine and musculoskeletal disorders. With exceptional training, experience and skill from multiple disciplines, the staff takes a comprehensive approach to the full spectrum of treatments for the adult cervical, thoracic and lumbar spine – from massage and electrical stimulation to interventional pain therapies and surgery.



Dr. McMorrow shares “Our goal is providing maximal improvement with minimal intervention.”

Johns Hopkins trained Dr. Seth M. Zeidman began the practice in 2002 after serving as director of Complex Spinal Neurosurgery first at Walter Reed Army Medical Center and later at Strong Memorial Hospital. With an eye on both proven and evolving non-operative techniques, he added Dr. Roger Ng to the team for his pain management expertise and skill.

Over nearly a decade, the practice maintains a unique dynamic in the region – whether specializing in neurosurgery or pain management, all members collaborate in the patient’s care and perform necessary interventional procedures or surgery as needed. “If someone has any of a variety of ailments including spinal stenosis, a brain tumor or even a work-related spinal fracture, together we discuss how to most successfully manage the patient.” Often, patients are seen and cared for by the entire team.

With 60-80% of patients suffering from chronic pain, a variety of modalities is available. Treatment recommendations include diet and lifestyle changes, chiropractic care, exercise and conditioning, injections, massage therapy, occupational or physical therapy, further diagnostic studies, consultations with other specialists or surgical treatment.

### WELCOMING, CONVENIENT ACCESS

Patients at Rochester Brain & Spine enjoy convenient access. At its Henrietta location, patients can also utilize the radiologic services of Borg and Ide Imaging and obtain braces, collars, and TENS units at Southern Cross Medical. “Having clinical labs service available here and at Highland and Unity Hospitals means our patients can be seen again quickly,” says Dr. Christie M. McMorrow.

Surgery is performed at Highland and Unity Hospitals, or at Lakeside Hospital in Brockport. “Our patients consistently give us positive feedback about the easy access and warm environment at our partner hospitals,” adds Dr. Zeidman.

As the region’s only neurosurgery and pain management practice with two fluoroscopic imaging suites on-site, patients are routed to the appropriate physician more rapidly. Using Electronic Medical Records (EMR), staff shares medical information in real time and prescriptions are sent to a patient’s chosen pharmacy, eliminating unnecessary waits. “We want every patient visit to be convenient and efficient.”

### KEY ROLE OF PAIN MANAGEMENT

Many non-operative treatments focus on pain management for the neck, low back and spine. While some patients receive Epidural Steroid injections providing pain relief to the affected area with satisfactory results, improved techniques have elevated pain management to higher success rates. “If injections aren’t working, we determine another way to treat their spine pain,” says Dr. Ng, who with Dr. Satish Acharya, specializes in non-surgical, fluoroscopic-guided interventional pain management.

Recommended by doctors since the 1970’s to relieve chronic pain and improve quality of life, spinal cord stimulation has greatly advanced. “Implanting spinal cord stimulators has helped our patients’ lives immensely.”

FDA-approved neurostimulation uses a small implanted system similar to a cardiac pacemaker to replace pain with a numbing or massaging sensation. Patients have reported a 50%



or greater reduction in pain and use of medications, increased activity levels and an improved overall quality of life.

Prime candidates for neurostimulation include those suffering chronic pain lasting far longer than expected after injury, neuropathic pain marked by burning, tingling, or numbness and those experiencing little or no relief from surgery or other treatments like pain medications, nerve blocks or physical therapy.



“If injections aren’t working, we determine another way to treat their spine pain,” says Dr. Ng, who with Dr. Satish Acharya, specializes in nonsurgical, fluoroscopic-guided interventional pain management.

### PATIENT TEST DRIVE

The practice ensures that patients considering neurostimulation can connect with a “patient ambassador” who has already undergone the procedure, to discuss what the sensation feels like, detail the trial procedure and emphasize how the therapy has improved their life.

“Our patients have the opportunity to test drive the system,” says Dr. Ng. As an outpatient procedure requiring only light sedation or local anesthesia, the surgeons place temporary, wire leads in the patient’s back connected to an external trial stimulator worn on a belt for two weeks. Depending on the patient’s response, the SmoothWave™ technology can be implanted permanently, or leads can be easily removed.

“Not long ago, the stimulators were the size of a tuna can, but are now battery-sized, making for much smaller surgeries,” says Dr. Ng. “With more advanced and streamlined technology, we can perform the procedure in a far less invasive way.”

While the stimulator doesn’t help everyone, the vast majority are thrilled with the difference. Using a cordless remote control,

patients control stimulation at their own discretion, increase and decrease the levels and target different pain areas using settings or programs designed specifically for them.

“People’s personalities change when they’re in pain,” says Dr. Ng, citing a recent patient who was overweight and wheelchair-bound after four unsuccessful spine surgeries. “Once we inserted a stimulator, she was walking around without a cane. Her entire emotional and physical well-being improved, even including her hairstyle and makeup. “When their pain is relieved they can revert to the lovely, fun and exciting person they once were.”

### LESS INVASIVE PROCEDURES

Within the past three years, the surgeons have been performing a direct lateral approach to the spine that’s dramatically less invasive, time consuming and risky. Intraoperative imaging is used for more accurate localization and visualization of the target tissue. “While the procedure is rising in acceptance nationally, no one else in Rochester is doing it,” says Dr. Zeidman.

Another minimally invasive technique used is Radiofrequency Ablation, which sends electrical energy used to create heat to a specific location at a specific temperature. An ablation probe is placed directly into the target tissue, typically requiring less than a few minutes exposure time.

The surgeons also utilize the ProDisc-C total Disc Replacement procedure (Artificial Disc), which removes the patient’s diseased disc, restores normal disc height, decompresses neural structures and provides motion at the affected segment.

“Our goal is providing maximal improvement with minimal intervention,” says Dr. McMorrow, who specializes in restoring spine function following injury and maximal supportive care for brain injury.

Recent advancements in pain management medications are also less invasive, including non- or modified narcotics. “We try a variety of methods to reduce discomfort and medication amounts patients take because of potential addiction or adverse side effects,” says Dr. Acharya.

### PATIENT SATISFACTION SPEAKS VOLUMES

The practice’s reputation spans far beyond its ability to offer personalized, comprehensive spine care. “I can’t tell you how many patients tell me about our wonderful staff,” says Dr. Zeid-

man. “They’re constantly bringing gifts in appreciation for their warmth and compassion.”

Dr. McMorrow agrees. “Patients who come here aren’t a number. They have a name, a life, a family, and deserve to be treated with respect the way we would expect to be treated if in the same situation.”

Patient Thomas Kayser says he would recommend anyone to Rochester Brain & Spine after his recent emergency subdural hematoma surgery. Mr. Kayser, 65, leads a busy lifestyle as a part-time auto parts deliveryman, avid hunter and volunteer trail groomer for the Town of Perinton. “Bending over trees pulling and pushing logs and hunting in the woods, I’ve hit my head lots of times,” he jokes, “but I must have a high threshold for pain.”

Last August, he began experiencing mild headaches but ignored the symptoms, attributing them to heat exhaustion. Within a month, he found himself often tripping on his right foot. A friend later noticed he was holding his right hand perpendicular to his body, which prompted him to visit his local volunteer Ambulance corps to be checked for a mild stroke. Evaluation there and later at an urgent care center identified nothing -- but the symptoms continued. After his doctor ultimately ordered an MRI, the results showed a dangerous subdural hematoma. The scans were immediately dispatched to Rochester Brain & Spine, and Mr. Kayser was prepped for surgery. “Dr. McMorrow says this came from a pretty good rap to the head,” he says.

Mr. Kayser commends the anesthesiologist, nurses, doctors and the support staff. “Everyone was just super with their bedside manner,” he says. “I’m a kidder and no matter how bad something is I have to crack a joke. Even after a long surgery, Dr. McMorrow had a great sense of humor.”

While he still experiences occasional dizzy spells and headaches, recovery has gone well, including the start of physical therapy. “I can’t wait to get back to normal,” he says, which for him includes driving, hunting and using his power tools again. “In the meantime, I plan to do anything Dr. McMorrow tells me.”

Impressed with his recovery, Dr. McMorrow is pleased to have made a positive outcome out of potentially fatal one. “As part of the Rochester community, it’s always rewarding to make a connection and a difference,” she says. When any of the members of Rochester Brain & Spine run into their patients or their patient’s families at the Public Market or Wegman’s, they are always eager to express their heartfelt thanks and share their experience.

## PATIENT VOLUMES SOAR

Serving 15,000+ patients, the practice continues to thrive, in part by a growing aging population. “Our patients tend to come back or refer their families and friends,” says Dr. Zeidman. “They want someone they can trust who will treat them well. When you are nice to people and do a good job, they want to tell others about it.



Guided by a collaborative team approach to care, patients benefit from the comprehensive expertise of this highly-trained team of specialists which tailor a coordinated clinical regimen for each patient.

Solid relationships with primary care providers also keep the numbers high. “Our referring physicians appreciate us keeping them apprised of their patient’s status.”

As new procedures like robotic neurosurgery become available, the team intends to stay at the forefront of neurosurgery and pain management care. “It’s truly an exciting time for the fields of Neurosurgery and Pain Management,” says Dr. Zeidman. “In the last five years alone, the technology and materials have been improving so much. It’s amazing, it’s just that fast.”

The practice’s operating philosophy – taking on the challenging cases others won’t – continues to ensure a collaborative approach to cutting-edge care delivered with kindness and compassion. “Our goal has always been to work together to improve our patients’ condition with the most sophisticated, least invasive means possible. We can offer hope for relieving pain and suffering where little hope existed before.”

# For Some, Laparoscopic Technique Not Always Better



John R.T. Monson, MD, FACS

*When Appendicitis Strikes, Open Surgery Reduces Infection Risk for Some Patients*

Deep organ space infections are expensive to treat – to the tune of \$50,000. And that figure doesn't begin to account for unrealized income (due to missed work) and other incalculable costs, like distress to families. If skin is the body's fortress against germ invaders, shouldn't minimally invasive surgeries – operations guided by camera probes, conducted entirely within the abdomen – carry less risk for serious infection than procedures that slice the same cavity wide open?

New research published in the December *Annals of Surgery* is challenging that assumption – at least for a subset of patients. Researchers from the University of Rochester Medical Center (URMC) analyzed thousands of appendectomies (appendix removals) and found that, for a small group, the danger of deep abdominal infections was markedly less if the old-fashioned, open surgical approach was used.



“Our study corroborates a common theme in medicine: one size does not fit all,” said study author John Monson, MD, FACS, chief of the Division of Colorectal Surgery at URMC. “While the data suggest that the laparoscopic approach is still best for most patients, it might not be best for all.”

U.S. surgeons perform more than a quarter million appendectomies annually, most of them laparoscopically – that is, inflating the abdomen with air, and using a popcorn-kernel-sized camera to pilot surgical instruments through tiny, centimeter-long holes in the skin.

“Since laparoscopy first came into vogue the early 90s, its gone mainstream – mostly because its advantages are so obvious to the patient,” Monson said. “The cuts through the skin are extremely small. There's less visible scarring and postoperative pain; patients have short hospital stays and return to work sooner.”

But for a small group of patients undergoing appendix removal, the study found that these perks come with a cost – greater risk for serious infection. But why? Why would a laparoscopic approach – which seems closed-off and sterile by design – carry a bigger risk for deep infection?

“We think it comes down to balance. It’s not just about how much a procedure exposes the body to potential infection – it’s also about how easily that procedure allows you to mitigate infection risk,” Monson said. “Consider the open approach. Admittedly there’s more chance of exposure to microbes – the wound is wide open. But there’s also more opportunity to sterilize, since you can meticulously clean the operating space before closing it.”

The laparoscopic approach, on the other hand, is much more ginger.

“There’s less exposure to the outside environment, but there’s also less opportunity to disinfect the organ space,” he said. “The philosophy is to be delicate as possible, perform the surgery, then get out.”

If a deep infection takes root, it’s expensive to treat – to the tune of \$50,000, and that figure doesn’t begin to account for unrealized income due to missed work (potentially three to six months) while hospitalized, not to mention incalculable costs like distress to families.

“Compare this to an uncomplicated laparoscopic appendectomy – after which patients return to work in a week and a half – you see how devastating a deep infection can be,” Monson said.

Some earlier analyses have implicated a connection between laparoscopic surgery and risk for infection in the organ space, but even meta-analyses (studies of studies) had relatively small sample sizes – too small for surgeons to draw definitive recommendations.

“This larger study afforded us that opportunity,” Monson said. “By tapping the National Surgical Quality Improvement Program database, we were able to analyze almost 40,000 appendectomies performed between 2005 and 2008.”

The study also begins to paint a picture of the type of patients who might fare better with an open procedure. Poring over the data, the team noticed trends – factors that might pre-dispose some patients to being at higher risk for a serious infection. For instance, presenting at the hospital with a high white blood cell count (which signals that the body is already fighting infection); being male (perhaps because men “stomach” pain longer, and wait to go to the Emergency Department until their condition is more advanced); having diabetes; simply being older; or being a smoker (chemicals in cigarettes have a detrimental impact on wound healing – and, smoking tends to be a marker for other unhealthy habits, such as excessive alcohol consumption).

“We found that, for a small group ‘high-risk’ patients – those who have several risk-elevating factors working against them at the same time – the risk of a deep infection is about 8.9 percent with an open surgery. But that risk jumped to 12.3 percent when the appendix was removed laparoscopically.”

For most other (low-risk) patients, the type of surgery had little bearing on their chance of developing a deep infection (though risk did rise slightly – from 0.3 to 0.4 percent – when choosing a laparoscopy over an open procedure).

“I think the data is pretty clear: for a select cohort of folks needing their appendix removed, we would be wise to consider an open procedure,” Monson said. “This is what good medicine is about – tailoring our approach based on the patient. It’s about being willing to adapt.”

*“This is what  
good medicine is about –  
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based on the patient.  
It’s about being  
willing to adapt.”*

# Managing Chronic Pain Patients

## The Risk

The management of chronic pain, through the prescription of medication, poses challenges and risks to both the patient and the healthcare provider (physician, physician assistant, or nurse practitioner). These risks include the potential for patient addiction, diversion, the possibility of overdose, and death, whether accidental or the result of suicide. The provider's fear of the following risks may lead to inadequate treatment of the patient:

*liability for failure to adequately treat pain;*  
*liability for allegedly inappropriately prescribing controlled substances;*  
*potential for civil charges being brought against a physician or other provider for the patient's diversion of narcotics and/or drug abuse or overdose; and*  
*liability for failing to recognize a patient's addiction and/or diversion and to refer the patient for treatment*

## Recommendations

1. Perform and document a thorough initial evaluation of the patient. This should include: a history and assessment of the impact of the pain on the patient; the nature, type and causation of the pain; and, a focused physical examination to determine if there are objective signs and symptoms of pain. The provider must also review pertinent diagnostic studies and previous interventions, a drug history, and assess the extent of co-existing medical conditions which impact the patient's pain. It is important to obtain the names of all other providers the patient is seeing or has seen, and the pharmacies the patient uses.
2. Develop a specific treatment plan based upon the evaluation.
3. Maintain accurate, legible, and complete medical records which clearly support the rationale for the proposed treatment plan.
4. Perform a thorough informed consent discussion regarding the plan of care, including the risks, benefits, and alternatives, and the risks of the alternatives, including no treatment with controlled substances.
5. Request the patient's consent to obtain copies of the records of all prior treating physicians, and review these records before prescribing narcotics, to determine if there is a history of drug seeking behavior or abuse.
6. Use a written pain management agreement when prescribing controlled substances for patients with chronic pain. If the patient has a prior history of drug abuse, refer the patient to a pain management practice or clinic, if possible. A pain man-

agement agreement outlines the expectations of the provider and the responsibilities of the patient, including:

*baseline screening of urine/serum medication levels*

*periodic unannounced urine/ serum toxicology screening*

*medications to be used, including dosage(s) and frequency of refills*

*a requirement that the patient receive medications from only one physician and use only one pharmacy*

*frequency of office visits*

*reasons for discontinuance of drug therapy (e.g. violation of agreement)*

A sample pain management agreement can be obtained by contacting Fager and Amsler, LLP at (877) 426-9555

7. Document and monitor all prescriptions and prescription refills.
8. Protect prescription blanks. Limit and monitor staff access to computer-generated prescriptions.
9. Take positive action if you suspect patient addiction or diversion. Public Health Law §3372 requires a physician to report to the New York State Bureau of Controlled Substances any patient who is reasonably believed to be a habitual user or abuser of controlled substances at (518) 402-0707.
10. Refer the patient for treatment of addiction if appropriate, and document this discussion with the patient in the medical record.
11. If a patient is believed to be selling/diverting narcotics, and the patient's random urine test confirms no drug use or there has been a forgery or theft of prescriptions, contact the law firm of Fager and Amsler, LLP to discuss how to discharge the patient and how to handle requests for medications from the patient before the discharge is final.

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## 2011 EDITORIAL CALENDAR JANUARY-JUNE

### JANUARY

Endocrinology  
Cervical Cancer • Glaucoma • Obesity

### FEBRUARY

Heart Disease – Trends, Treatment, Rehabilitation  
Organ Transplants • Stem Cell Research

### MARCH

Colorectal Cancer Awareness  
Kidney Disease • Eating Disorders • Depression

### APRIL

Top 10 Men's Health Issues  
Sports Medicine: Treating the Sports Injury

### MAY

Top 10 Women's Health Issues  
Sleep Disorders  
Digestive Diseases  
Stress and the Impact on Health

### JUNE

Ophthalmology / Imaging  
Medical Technology • Dermatology



### SPECIAL COLUMNS

#### *Healthcare Reform Update*

Invited experts offer perspective on the impact of healthcare reform – what it means, what it might cost, and the impact to the healthcare system and patients in western New York.

#### *Primary Care Perspective*

A forum created to share insights from the physicians who deliver primary care to area patients.

#### *Medical Technology & the Future of Medicine*

Learn about the latest developments in technology to improve practice management, patient care and the delivery of medicine.

#### *Electronic Health Records*

Area experts and practitioners share valuable expertise in managing the implementation process, avoiding pitfalls and guiding your practice into the transition.

# What is My Liability?

## I Would Like to Communicate Electronically with my Patients



James E. Szalados, MD, MBA, Esq.

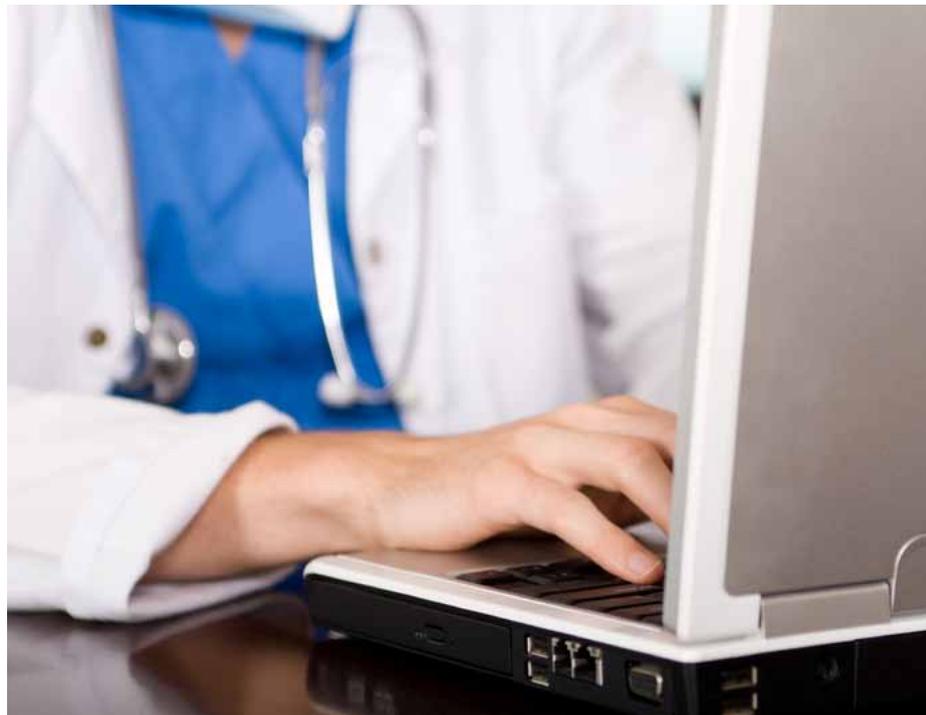
### Issue

Electronic communications promise continual connectivity; our business and private worlds are characterized by the immediate availability of news, information, and even medical records via the internet, on and off-line electronic mail (email) communications, and on-the-go cell phone and text-messaging availability. Naturally, many would believe that such technology could enhance the continuity of physician-patient relationship, increase patient satisfaction, and perhaps even attract a demographic of patients who are motivated to better participate in their medical care. However, the use of electronic clinical communication is associated with significant time and practice management, ethical, and legal implications which must be carefully considered before communicating with patients using any non-traditional (digital) media.

Electronic health information exchange is governed by a variety of federal and state laws, the best known of which are the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which mandate protection of individually-identifiable health-related information (PHI); and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 which simultaneously promotes the adoption and meaningful use of health information technology and also strengthens the civil and criminal enforcement of the HIPAA digital privacy rules. Physicians, practices, and providers should consult

with an attorney prior to initiating a digital-media communications venture.

Websites are ubiquitous and serve many purposes including practice advertising, data collection, guideline dissemination, and library and link resources. Websites should include



a disclaimer statement about the intent and limitations of the resource, and provide contact information should the user have further questions. Contracts or agreements with internet service providers, routing server managers, and website links, where appropriate, should be construed in accordance with the HIPAA Privacy and Security Rules which provides a foundation for electronic health information exchange relationships

between covered entities, or 'Business Associates' within business models.

Practices can further help insulate themselves from liability related to website content by not promising the most up-to-date information and by making it clear that information presented is always generic and may not apply to each patient's specific condition. Thus, the supportive and not directive role of the electronic resource should always be emphasized. Sites which collect sensitive information should have appropriate data encoding or encryption software. The ability of websites to collect PHI such as enrollment or routine interval follow-up health information, insurance or demographic data, blood sugar monitoring, personal health journal information, or even cardiopulmonary telemetry data is expanding. Verification and screening of the data should occur before it is transferred to a patient's electronic medical record (EMR) to verify that an urgent condition is not being overlooked; and, where the data is used as documentation to support a level of service, the record must indicate that an appropriate provider-level review and associated resulting decision-making has occurred.

Email communications have a variety of advantages, which are arguably also risks. For example, email communication can be conversational, is almost simultaneous in real-time, can be archived off-line for delayed responding, can be rapidly and widely disseminated, can contain attachments and active links, and is almost permanent.

The 'AMA Guidelines for Physician-Patient Electronic Communications' suggest guidelines for keeping communications succinct and pertinent, and also for defining and separating categories of communication transactions (such as prescription-related questions or refill requests, medical advice, appointments, or billing concerns) with the nature of the communication easily apparent in the subject heading of the email.

Guidelines for email communications should be formalized between physician practices and patients in the form of a formal contract, consent, or agreement discussed with and signed by the patient and both incorporated into the medical record and provided to the patient. In such agreements, the assignment of roles and responsibilities is extremely important. For example, patients who elect to share their passwords, choose to forward messages, or decline to use encryption software should be advised of the associated privacy risks and be made to understand that they share the privacy privilege regarding their

health information and can unilaterally and intentionally or unintentionally waive that privacy right.

Email communication with patients must be regarded as a formal communication, similar to a letter, and physicians must realize that the usual informality of emails does not apply in this instance. Electronic communications should fully reference the patient's name and incorporate patient-specific identifiers for later archival into either a printed or electronic record. Similar to telephone communications, patients must be made aware of procedures to follow in cases of emergency when on-line communications are not available. Finally, on-line communications should have a closed-loop mechanism for verifying receipt of communications by the patient.

Finally, electronic communications, as an integral part of the patient record, are subject to the discovery and disclosure rules applying to release of medical records subpoenaed in a lawsuit. Electronic discovery represents a field of legal forensics which specializes in the retrieval of electronic information and will likely supplement requests for medical records in cases where practices use electronic media.

Thus, physicians and practices must be fully aware that electronic communications with patients will be perceived, in a legal sense, to represent extensions of the existing patient-physician relationship. However, the electronic nature of digital communications imposes a heightened level of legal concerns which should be fully understood and considered by medical practices in the digital age.

#### *Suggested Further Reading:*

American Medical Association Guidelines for Physician-Patient Electronic Communications. Available online at: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/guidelines-physician-patient-electronic-communications.shtml>.

Kane B, Sands DZ. Guidelines for the clinical use of electronic mail with patients. The AMIA Internet Working Group, Task Force on Guidelines for the Use of Clinic-Patient Electronic Mail. *J Am Med Inform Assoc.* 1998;5(1):104-11.

*Dr. Szalados is a licensed physician engaged in the practice of anesthesiology and critical care; a senior-level hospital administrator, and an attorney admitted to the practice of Law in New York and concentrates his practice in the areas of Health Law.*

# Prescriptions for Teens and Young Adults on the Rise



Robert J. Fortuna, MD, MPH

Adolescents and young adults are most likely to abuse prescription medications. Yet prescription rates for controlled medications, or drugs the Drug Enforcement Administration deems as having the potential for abuse, have nearly doubled for those age groups in the past 14 years, according to a recent study published in *Pediatrics*. Overall, a controlled medication was prescribed for young adults at approximately one out of every six visits and for young adult by adolescents one out of every nine encounters.

“Physicians must balance the need to treat patients’ symptoms while remaining aware of the possibility that prescription medications can be misused or shared with others. At times, it can be a delicate balance between treating a problem and inadvertently causing one,” said Robert J. Fortuna, MD, MPH, principal investigator of the study and assistant professor of Pediatrics and Internal Medicine at the University of Rochester Medical Center.

The study found that between 1994 and 2007, prescription rates for controlled medications nearly doubled from 8.3 to 16.1 percent among young adults and rose from 6.4 to 11.2 percent in adolescents. This increase was observed for both males and females and across multiple settings – ambulatory offices, emergency departments, and for injury related and non-injury related visits.

The study examined prescription patterns for teens 15- to 19-years-old and young adults 20- to 29-years-old, using data from the National

Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS). The study’s authors compared data with data about prescription patterns from 1994 from NAMCS and NHAMCS.

The study broke down clinical visits by classification of drug prescribed, type of visit, place of visit and demographic and geographic factors. Drugs were classified as narcotics (or opioids), sedatives and stimulants.

Controlled medications were often prescribed for common conditions, such as headaches and back pain. While the study did not examine the appropriateness of prescriptions, researchers suggested that physicians take responsibility for monitoring patients receiving controlled medications to ensure that the treatment is effective and that the medications are being used appropriately.

Researchers partly attributed the rising trend in prescriptions for narcotics among young adults to evolving state and federal regulations increasing advocacy for pain management. For example, prescriptions for narcotics rose after 2001, when the Joint Commission on Accreditation of Healthcare Organizations launched an initiative to monitor and treat pain as a fifth vital sign (along with temperature, pulse, respiration and blood pressure).

Sedative medications were increasingly prescribed to young adults and adolescents. Researchers tied the rise to a heightened awareness of insomnia and anxiety, the



availability of new pharmaceuticals and widespread direct-to-consumer marketing.

The study found adolescents were also increasingly prescribed stimulant medications. While reports between 2002 and 2008 showed that the overall misuse of stimulant medications like Ritalin has decreased, a recent study found that poison centers are increasingly receiving calls from those who have intentionally misused stimulants, which could mean that the smaller numbers of those misusing stimulants are doing so more intensively. Further, stimulant medications are increasingly being shared with those who have not been prescribed the medication.

While researchers acknowledged that prescribing more controlled medications does not necessarily foster abuse or diversion – sharing medications with others – they advocated for more vigilance when physicians prescribe medications to young adults and adolescents.

“Physicians need to have open discussions with patients about the risks and benefits of using controlled medications, including the potential for misuse and diversion,” Fortuna said.

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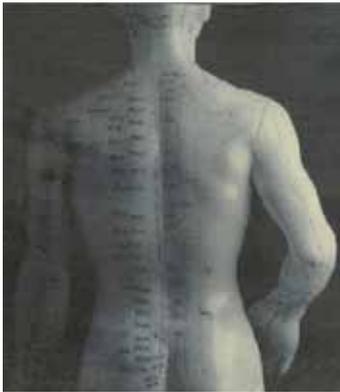
We thank you for participating.

# Acupuncture

## An Age-old Approach to Treating Pain



Paul Rooney, LAc, MAc



When Mary (not her real name) came into the office for acupuncture treatment, she had been suffering from migraine headaches for over 30 years. They would come on several times a week and she was now at the end of her rope. The headache medication she had been

taking had decreased in effectiveness over the years and now needed some other way to address the migraines. Her primary physician referred her to me after hearing of acupuncture's positive effect on some of her other patients.

The first 4 visits were the benchmark to see if acupuncture would work for her. They were spaced out between 1-2 times per week. After those first four visits she noticed a decrease in the intensity of the pain by 25 percent and a decrease in occurrence by 50 percent. I then started to spread the treatments out to once every 2-3 weeks for four treatments. After this time, Mary's described that her migraines had decreased in intensity by 50 percent and the occurrence by 75 percent. Her sleep started getting better and her mood improved as she regained control of her life. I now see her every 4-6 weeks as maintenance.

Mary is a good example of how acupuncture treatment is performed in the U.S. and highlights its importance in the medical community's toolbox. Like most other modalities it doesn't help everyone nor treat every ailment, it is safe and effective for a wide range of issues. A good review of the research by the WHO can be found at <http://apps.who.int/medicinedocs/pdf/s4926e/s4926e.pdf>.

Acupuncture is one part of the system of Chinese medicine which includes the use of herbal formulas and dietary change.

Acupuncture has been practiced for some 4,000 years and in this country ever since Chinese immigrants came to the U.S. Since the 1800's. It gained widespread notoriety after a NY Times reporter accompanying Richard Nixon's 1972 trip to China needed emergency gallbladder surgery and acupuncture was the only anesthetic used during the procedure. His widespread writing about his experience prompted research to begin on acupuncture's effects and possible mechanisms for these effects. While there have been hundreds of good studies, one most recently done at the University of Rochester by Maiken Nedergaard, M.D. and her team shed's light on a new possible pathway for acupuncture's analgesic effect. Her research found that in tissue near acupuncture sites adenosine increased during and after acupuncture needles were inserted. Adenosine has an ability to decrease pain and this would offer another mechanism for its effectiveness. Numerous studies have already pointed to acupuncture's ability to increase endorphins.

From a Chinese medical perspective, acupuncture works by inserting sterile, hair thin, solid steel needles into acupuncture points. This affects the body's qi, or energy to either stimulate movement of the qi or to increase the body's production of qi. The effects of the needling depends on the combination of points used and the type of stimulation given to the needles. There are over 500 acupuncture points located along 12 different meridians or pathways.

For an acupuncturist practicing in NY he or she must have passed the national board exam (NCCAOM) and be licensed by the state. This can be seen by the abbreviation L.Ac. for licensed acupuncturist and NCCAOM Dipl. after their names. In our area most insurance covers a portion of the treatment cost and there is no formal referral needed. If physicians have further questions feel free to contact me at: [rochesteracupuncture@yahoo.com](mailto:rochesteracupuncture@yahoo.com) or (585) 720-0250.

# New York State Labor Department Targets Health Care Pay Practice



Sharon P. Stiller, Esq.

Medical practices are reeling from fines and penalties resulting from New York State Labor Department audits. In September, 2007, an interagency strike force was formed in New York to address employers who inappropriately classify employees as independent contractors or pay workers off the books. Health care employers are singularly exposed, because of the conundrum of exercising control over workers to ensure compliance with legal and regulatory requirements while maintaining the independence of those workers as independent contractors.

Labor department audits can also result from a fired worker seeking unemployment benefits or an injured worker seeking worker's compensation. These workers often advocated that the employer treat them as independent contractors, until they were injured or unemployed and then changed their tune to claim that they were, instead, employees.

Regardless of the reason for the audit, the consequences can be devastating. This is because improperly classifying an employee as an independent contractor exposes the business to liability not only for unpaid unemployment contributions, but also for worker's compensation and FICA and FUTA contributions, as well as fines and penalties. One employer, for example, was facing over a million dollars of penalties claimed by the IRS, as a result of the New York State Labor Department determining that fewer than seven sales representatives were employees, not contractors.

More limited exposure exists when employers label employees as "salaried" despite their job duties and earnings. Only employees who perform administrative, executive or professional duties (and other limited exceptions) are exempt from overtime and minimum wage requirements, and in order to be exempt, most employees must be paid on a salaried basis and meet income requirements imposed by both New York State and the federal government.

The New York State Labor Department can collect back wages and taxes for six years, unlike the Federal government, which collects for a shorter period of time.

Health care businesses can and should do something about this exposure. Here are some suggestions:

**Audit the work force** to determine if you have properly classified workers as independent contractors. If you exercise control over how the worker performs the job, it is likely that the worker will be deemed to be an employee, not an independent contractor.

**Make sure that your documentation** supports that you are treating the worker as an independent contractor and that the tests to be classified as a contractor are met. Draft a contract. Review what materials and equipment are provided to the contractor. Make sure that you do not restrict the contractor from working for other businesses.

**Perform the same tests** on an employee you believe to be exempt from the overtime and minimum wage laws. Review the employee's actual duties, whether the employee is being paid on a salaried basis, and whether the employee has been paid the necessary minimum salary. Make sure that there are no deductions from wages for less than full day absences, unless permitted by law.

These are some of the ways that a business can minimize its exposure to crippling back pay awards, and fines and penalties. The bottom line is that many businesses are either inadvertently or as a cost saving measure, exposing themselves to substantial liability. The lesson is to conduct your own audit before the Labor Department conducts one to make sure that your procedures and documents are in order.

*Ms. Stiller directs the employment law practice at Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP, a full service law firm with a concentration in health care.*

## Upcoming Event

### *Rochester Neuroscience Symposium: An Overview for Medical Providers*

Save The Date!

Wednesday, January 26, 2011

7:30 a.m. - 5:00 p.m.

Monroe Golf Club, 155 Golf Avenue, Pittsford, NY 14534

#### Objectives:

- Identify and describe key risk factors and different treatment options in the treatment of stroke.
- Discuss new advances in the multidisciplinary treatment of brain and spine tumors.
- Review several different treatment options for spinal disorders including: physical therapy, injections, observation, and surgery and describe the role of each.
- Describe the role of surgical, interventional, pharmacologic and non-pharmacologic approaches for treating pain of the spinal origin.

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## Rochester General Hospital Dedicates New Crisis Intervention Unit (CIU)

*Rochester General Hospital has dedicated the newly constructed Crisis Intervention Unit (CIU) to meet the needs of patients facing behavioral health emergencies. The CIU, which previously had been embedded within the hospital's Emergency Department, now has its own space providing a secure, quiet and dignified environment for patients and families.*

Construction of the CIU began a little more than a year ago as part of the overall redesign of Emergency Services at Rochester General Hospital.

The CIU, under the direction of Mary Marrocco MD, RGH Medical Director of Emergency and Consultative Psychiatry, treats approximately 3,500 patients a year.

The facility officially opened to the public on December 14th.

### **Rochester General Hospital and Bariatrics of Western New York Offer Monthly Informational Meetings to Patients**

#### *2011 Informational Seminars through March*

Informational sessions are designed to help patients learn more about bariatric (weight loss) surgery and whether it's appropriate for them. These free sessions are presented by the staff of Bariatrics of Western NY and for patient convenience are offered at Rochester General Hospital, Newark-Wayne Community Hospital and in Lockport, NY.

### **UPCOMING SESSIONS**

#### **Rochester General Hospital Seminars**

Jan 13, 2011: 2:00 & 6:00 pm - Dr. DiBenedetto

January 27, 2011: 6:00 pm - Dr. Gandhi

February 10, 2011: 2:00 & 6:00 pm - Dr. Gandhi

February 24, 2011: 6:00 pm - Dr. DiBenedetto

March 10, 2011: 2:00 & 6:00 pm -

Dr. DiBenedetto

March 24, 2011: 6:00 pm - Dr. Gandhi

#### **Newark-Wayne Community Hospital Seminars**

All seminars are held at the DeMay Living Center by Dr. Gandhi at 6:00 pm.

January 5, 2011 February 6, 2011 March 2, 2011

#### **Lockport Seminars**

All seminars will be at the Holiday Inn on South Transit in Lockport by Dr. DiBenedetto at 6:00 pm: January 20, 2011 March 17, 2011

**For more information about an upcoming seminar or to register, call (585) 922-LINK (5465).**

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## WHAT'S NEW IN

# Area Healthcare

### GILLESPIE TAPPED TO LEAD URMV VASCULAR SURGERY DIVISION

*Renowned surgeon David L. Gillespie, MD, FACS, RVT, DMCC, has been appointed chief of the Division of Vascular Surgery at URMV. He has been with the center for the past two years, leading both clinical and education programs.*

Since joining the Medical Center two years ago, Gillespie has served as **Director for the Vascular Surgery Integrated Residency and Fellowship Program** within the School of Medicine and Dentistry.

“Gillespie is a skilled clinician, an accomplished educator and a creative scientist who has rapidly earned the respect of his colleagues within the division and the overall Department of Surgery,” said **Jeffrey Peters, MD**, Seymour I. Schwartz Professor and Chair of the Department of Surgery. “He is a natural choice to lead the division at this time.”

Previously Gillespie had an impressive 23-year career with the **U.S. Army** as chief of Vascular Surgery, overseeing vascular procedures in Iraq. He led the vascular surgery program at **Walter Reed Army Medical Center**, Washington, DC, and served as chief of Vascular Surgery at **Uniformed Services University of the Health Sciences’ F. Edward Hebert School of Medicine** in Bethesda, Md. He was also a vascular surgery consultant with the Office of the Surgeon General.

In addition to his clinical expertise, Gillespie is a well-established senior clinical and basic science researcher. His research interests center on chronic venous disease, most notably cellular and molecular functioning within chronic ulceration.

Gillespie earned his medical degree from the **Uniformed Services University of the Health Sciences’ F. Edward Hebert School of Medicine**. He completed an internship at **Letterman Army Medical Center** in San Francisco; a surgical residency at **Boston University Medical Center**; and a fellowship at Boston University Medical Center where he served as the **Reginald Smithwick Fellow in Vascular Surgery**.



David L. Gillespie, MD, FACS, RVT, DMCC

### BETHANY MARSTON, MD JOINS URMV RHEUMATOLOGY TEAM

*Dr. Marston will split her time between pediatric and adult rheumatology clinics, in an effort to cut waitlist delays for new patients with autoimmune conditions like arthritis, lupus, vasculitis and more.*

At the unique intersection of pediatric and adult rheumatologic care, Marston hopes to research how teens and young adults adjust to independently managing their own disease and hopes to educate residents – many of who will become tomorrow’s primary care physicians – about the importance of their role on the “front lines” of rheumatologic care. “With today’s rheumatologists so inundated with patients, training primary care physicians to be comfortable prescribing an introductory regimen of an inflammatory medicine could be invaluable, especially if a patient’s disease is fast-moving,” Marston said.

Marston completed her residency (Internal Medicine and Pediatrics) and rheumatology fellowship at **Strong Memorial Hospital**. She received her undergraduate degree in Genetics from **Dartmouth** and her MD from the **University of Maryland School of Medicine**.



Bethany Marston, MD

### RITU MALIK, MD JOINS DRs. FREEDMAN AND CHARETZ AT THE DIABETES CARE & RESOURCE CENTER

**Dr. Malik** earned her medical degree at **Maulana Azad Medical College** in New Delhi, India, completed her residency and a fellowship in endocrinology at the **University of Buffalo School of Medicine**. She is Board certified in Internal Medicine and Endocrinology and is a member of the **Endocrine Society and the American Association of Clinical Endocrinologists**. Dr. Malik dedicates her practice to those with diabetes and thyroid problems using a team approach, working with patients and their primary care physicians, to offer the best and latest treatments in returning patients to optimal health.



Ritu Malik, MD

**THE JOINT REPLACEMENT CENTER AT UNITY HOSPITAL WELCOMES**

**EVERETT S. WEISS, MD**

Dr. Weiss joined the medical staff at Unity Hospital in September 2010. After earning his medical degree from **University of Rochester School of Medicine and Dentistry**, he completed the **Otto E. Aufranc fellowship in Adult Reconstructive Surgery at New England Baptist Hospital**, Boston, Massachusetts and his Orthopaedic Surgery Residency at **SUNY Upstate Medical University, Department of Orthopaedic Surgery**, Syracuse, N.Y.



Everett S. Weiss, MD

**LOUISE WOERNER, HCR HOME CARE EARNS TOP SPOT AGAIN**

*Only agency in region to earn Top 500 designation five years in a row*

**HCR Home Care**, an award-winning, certified home health care agency, was named a Top 500 company for the fifth year in a row. The agency was graded on an analysis of measures in quality-of-care, quality improvement, and financial performance by **OCS HomeCare** and **DecisionHealth**, national home care benchmarking companies. HCR is one of only 42 home care agencies to receive this five-year ranking out of 9,375 agencies in the United States – and the only one in our region.

“We are thrilled to have earned this elite designation five years running,” said **Louise Woerner**, founder and CEO of HCR Home Care. “Our patient-focused approach to nursing care and on-going performance improvement initiatives are key to our success.”



Louise Woerner

**EAR, NOSE AND THROAT CARE AVAILABLE IN BROCKPORT**

*Specialist Provides Care Closer to Home for Westside Residents*

The **University of Rochester Medical Center** is improving access to specialty services for ear, nose and throat care with a new location in Brockport. **Matthew Miller, MD**, of **University Otolaryngology**, is accepting patients at 156 West Ave., Brockport, as well as providing care at the practice’s Rochester location and the **James P. Wilmot Cancer Center**.

In addition to general ear, nose and throat care, Miller specializes in head and neck cancer and microvascular



Matthew Miller, MD

reconstructive surgery. He is skilled in thyroid and parathyroid surgery, anterior cranial base and endoscopic skull base surgery, and laser microsurgery. Recently, Miller performed upstate New York’s first transoral robotic surgery, a less invasive alternative for head and neck cancers with the added benefits of robotic precision.

A Rochester native, Miller is a graduate of **SUNY Upstate Medical University** in Syracuse. He completed a residency at **Thomas Jefferson University in Philadelphia** and advanced fellowship training in head and neck oncologic surgery and microvascular reconstruction at **Ohio State University**.

**JONATHAN I. GOLDSTEIN, MD JOINS GASTROENTEROLOGY GROUP OF ROCHESTER**

Dr. Goldstein, a Rochester native and Brighton graduate, joined **Gastroenterology Group** earlier in 2010. He received his medical degree at **Dartmouth Medical School** where he graduated with honors, his **Internal Medicine Residency at Beth Israel Deaconess Medical Center**, an affiliate of **Harvard Medical School** and his GI Fellowship at the **University of Colorado at Denver**.

**GENEVA GENERAL HOSPITAL MEDICAL STAFF WELCOMES NEW PHYSICIAN**

**Andre H. Johnson, MD** has joined the medical staff of **Geneva General Hospital**, specializing in the field of **Orthopedic Surgery and Sports Medicine**. Dr. Johnson attended medical school at **Albany Medical Center**, Albany, NY; completed his residency at **Akron General Medical Center**, Akron, OH; and completed a fellowship in Orthopedic Surgery / Sports Medicine at **Georgetown University’s Nirschl Orthopedic Center for Sports Medicine**. He is board certified by the **American Board of Orthopedic Surgery** and is seeing patients at **FLH Medical, P.C. – Orthopedic Surgery** located in Geneva, NY.



Andre H. Johnson, MD

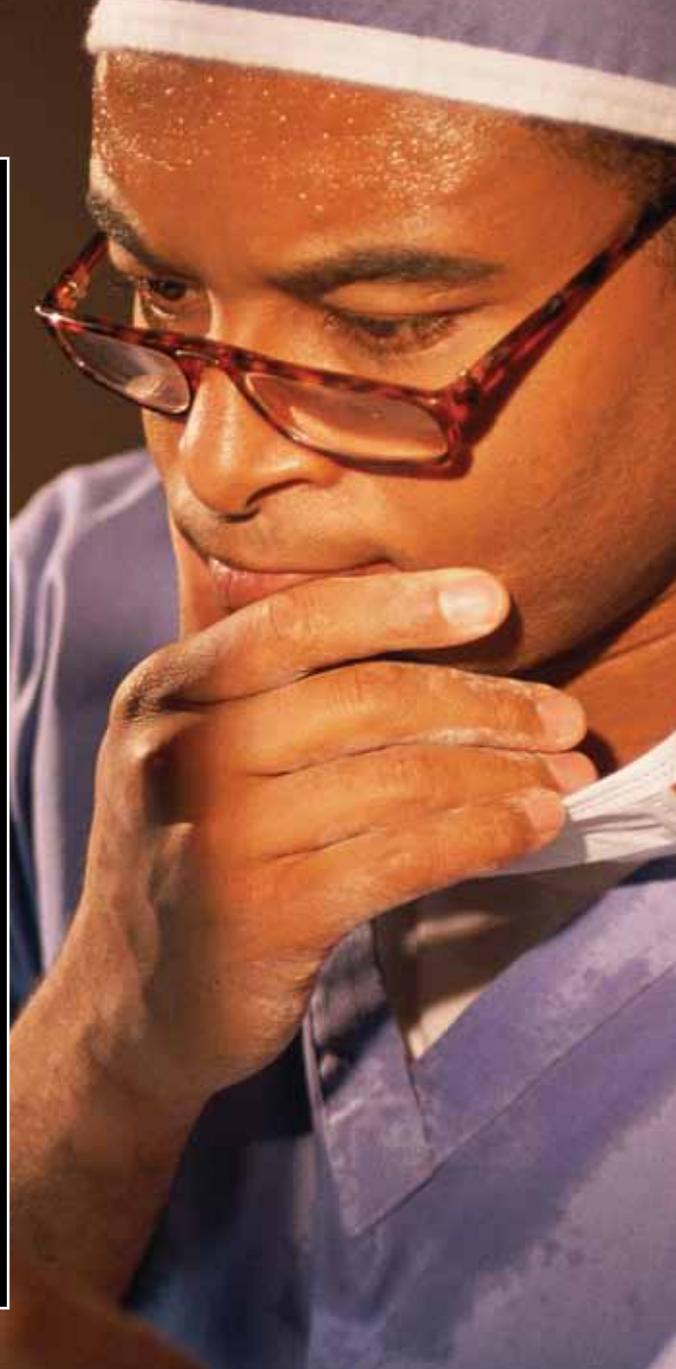
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