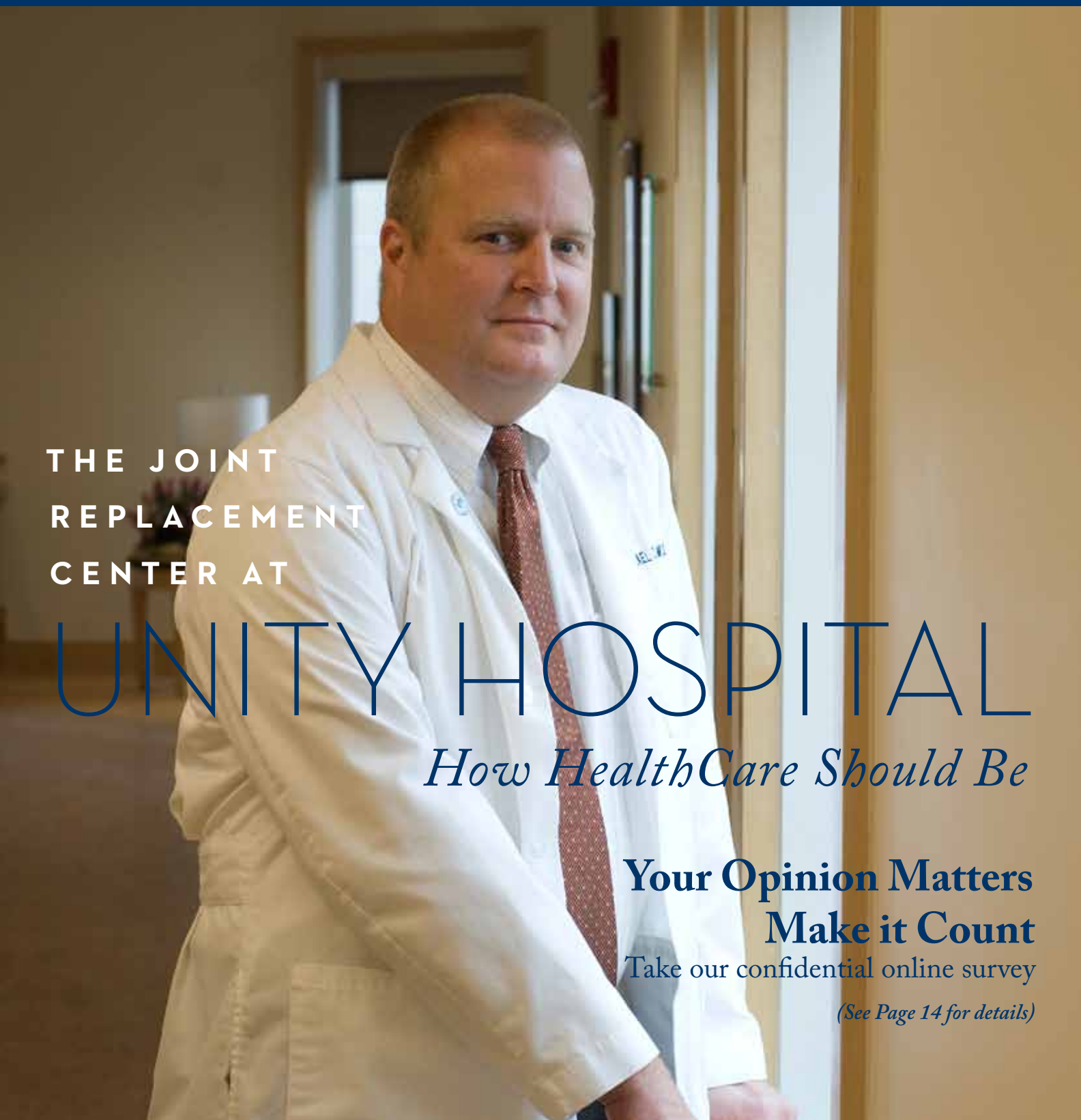
ROCHESTER / NOVEMBER 2010

Western New York PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



THE JOINT REPLACEMENT CENTER AT

UNITY HOSPITAL

How HealthCare Should Be

Your Opinion Matters
Make it Count

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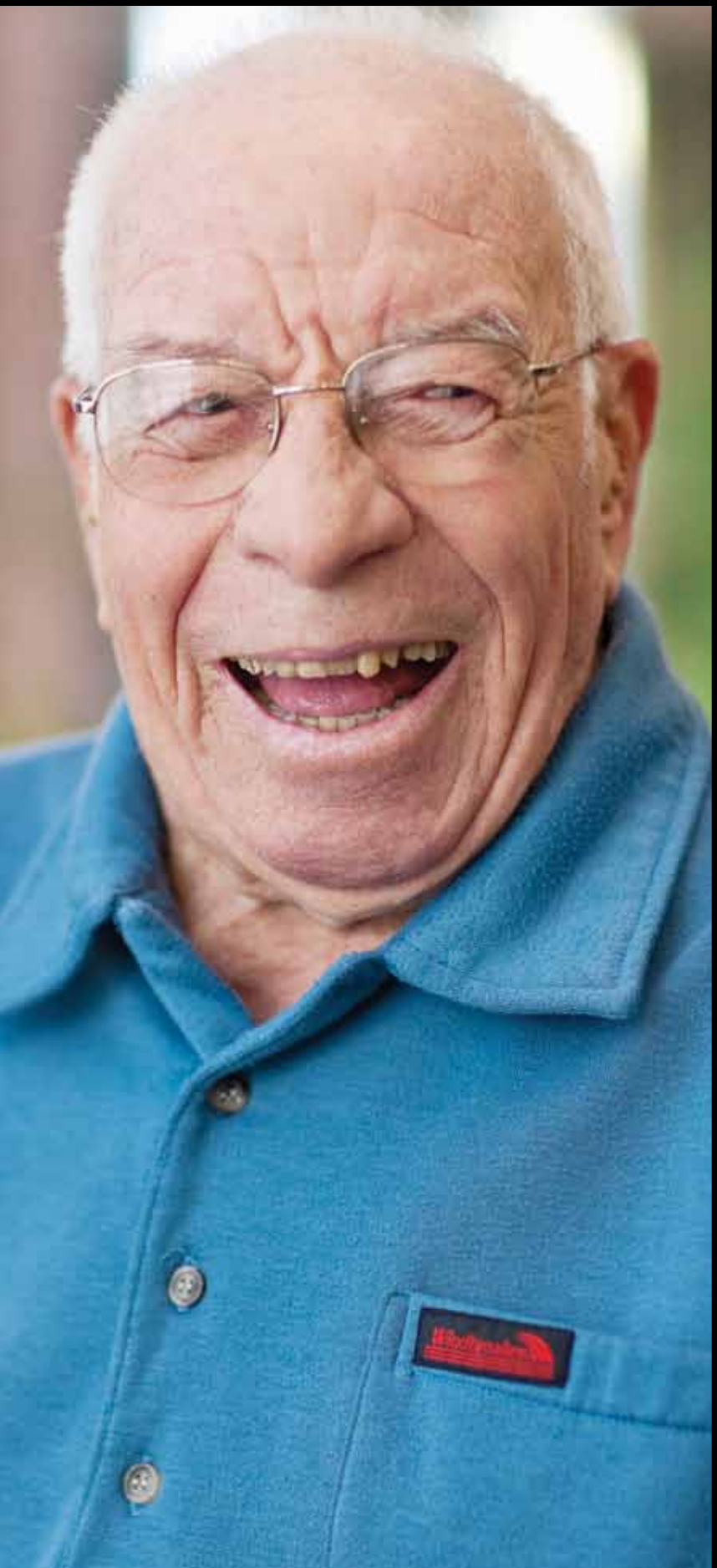
(See Page 14 for details)

SMOOTH SAILING



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—Ernie Coleman

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Welcome to the November Issue of Western New York Physician

In a recent conversation with a seasoned area specialist, I was interested to hear his reflection on the past – how PCP's and specialists had regular opportunities to share information – maintaining a flow of communication and building trusted relationships during daily or weekly rounds at the hospital. While there are numerous and obvious reasons why these valuable opportunities for interaction are far less common if not entirely nonexistent in today's model of healthcare, he shared his view that Western New York Physician plays a role in helping to fill this void – creating a forum for practitioners to impart valuable and current thinking.

With this in mind, the invitation continues to share your thoughts, offer your feedback. Last month I initiated a confidential online readership survey – if you haven't already participated, please spend 5 minutes to share your opinion and ideas. Take this opportunity to tell us what topics are of interest and value to you. Your opinion matters and the feedback we receive will directly impact the expertise we deliver in the coming year. Thank you in advance for taking the time to share.

www.SurveyMonkey.com/s/WesternNYPhysician

It's an exciting time at Unity – notably in the Joint Replacement Center. With a 10-year anniversary on the horizon and a major expansion underway, we wanted to look inside to understand Unity's view on *"how health care should be."* We sat down with Dr. Michael Klotz, Medical Director of Unity's Joint Replacement Center to discover he is simply the tip of the iceberg. What we discovered beneath is a highly-trained, dynamic and impassioned team of experts seamlessly collaborating under a model deliberately designed to provide a continuum of care to patients in the region.

To see what's coming up in the first half of 2011, see the editorial calendar found on page 21. Please contact me directly if you would like to be included in an upcoming issue.

Many 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.

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Cardiovascular Disease (CVD) and Periodontal Disease:

The Inflammation Connection

Mary Ann Lester, DMD

Over the past 10 years the dental community has seen an accumulation of scientific studies with evidence suggesting that periodontal disease may be a contributing risk factor for heart disease. The American Academy of Periodontology reported in the early 1990's that periodontitis was one of the most prevalent chronic inflammatory diseases in the western world. Currently, mild forms of periodontitis affect about 75-80% of adults with more severe forms affecting 20-30 % in the United States. It has long been thought that untreated and unstable periodontitis account for a significant amount of risk in stroke and CVD patients. Medical researchers also found evidence in the early 1990's indicating that inflammation was a major risk factor in heart attacks and strokes. This begs the question: Should chronic periodontitis be included in our already growing list of risk factors for CVD such as high cholesterol, genetics, high dietary fat ingestion smoking, etc...? The answer seems to be yes. Recently a number of reports and studies are making some preliminary recommendations regarding this evolving theme.

In July 2009 a landmark consensus report was released in both the American Journal of Cardiology and the Journal of Periodontology entitled "Periodontitis and Atherosclerotic Cardiovascular Disease. It was written to provide health professionals, specifically Cardiologists and Periodontists with a better understanding of the link between periodontitis and CVD and to provide guidelines for reducing the risk of CVD events in patients with periodontitis. In September 2009, Dr. Paul Ridker, a cardiologist and researcher at Harvard Medical School, was the Keynote speaker at the Annual American Academy of Periodontology meeting. He discussed the results of the 17,802 person (Jupiter) study and the emerging somber link between atherosclerotic CVD and periodontitis (among other inflammatory diseases).

What is Periodontal Disease?

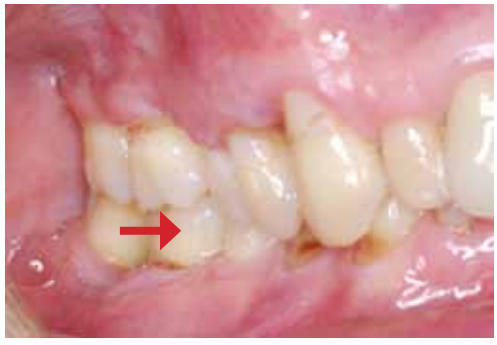
Periodontal disease is a bacterially induced chronic inflammatory disease that destroys the connective tissues and bone that support the teeth. Periodontitis is often undetected until the patient complains of loose or abscessed teeth. Other signs include bleeding gums, halitosis, receding gums, pus between teeth and tenderness. When the patient presents these issues to the periodontist they may have already lost about 10-15% of the bone and connective tissue support. The pathophysiology of this disease occurs via a microbial infection and subsequent host mediated cascade of inflammatory response events leading to destruction of the tooth support. Genetics and environmental factors like smoking, poor oral hygiene (plaque biofilm buildup)) along with diabetes can accelerate the process. As the disease progressed the result is an unchecked release of inflammatory cytokines, prostaglandins, and destructive enzymes from white blood cells such as neutrophils and monocytes. The chronic inflammation in the tissue is what leads to the pathologic anatomic changes clinically detectable as periodontal pockets and alveolar bone loss.

Periodontal treatment

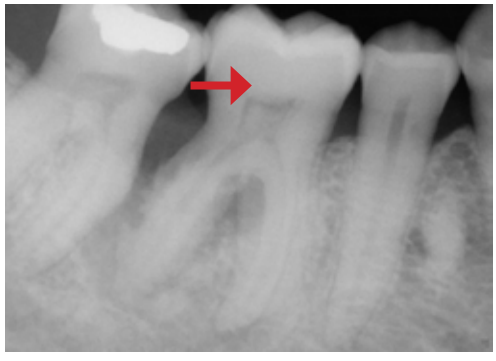
The treatment and management of patients with periodontitis require proper diagnosis, risk assessment and re-evaluation on a continuing basis. Definitive periodontal therapy includes elimination and control of the inflammation through removal of local irritants (calculus and plaque) via scaling of the teeth, flap surgery and if possible repair of lost tissues with osseous grafting and guided tissue regeneration. In some cases the only answer is to extract the infected tooth or teeth. Appropriate care is critical to successful treatment and management of patients with periodontal diseases. Maintenance via regular cleaning intervals with their periodontist, education and compliance can reduce the disease progression in many at risk individuals.

Cardiovascular disease

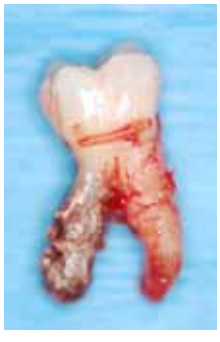
Cardiovascular disease accounts for 2400 deaths of men and women in the US each day. Ironically, ½ of these patients have low cholesterol levels. Suspect in CVD is the process of inflammation and the initiation and formation of an atherosclerotic plaque. These same inflammatory cells also cause the atherosclerotic plaque to break loose which can lead to a heart attack or stroke. Recently the JUPITER study was conducted to test a statin drug called rosuvastatin (Crestor 20mgs 1x/day) against placebo in 17,802 men and women with low cholesterol levels (LDL of less than130mg/dL) but high levels of CRP (C-reactive protein at least 2mg/L) a known marker of inflammation. The patients who received the statin would not normally receive a script from their physicians because they had low LDL levels. Most of the participants were obese (about 70%) and some had metabolic syndrome (40%). Half of the subjects received statin (Crestor) therapy and half placebo. The results showed that statin therapy resulted in about a 50% reduction in heart attack, a 49% reduction in stroke, and a 47% reduction in bypass surgery or coronary angioplasty. The statin appeared to have an anti-inflammatory effect in the subjects taking it but the study was stopped early (at 2 years) because the statin takers were less likely to die by 20% compared to the placebo takers. The statin takers were also less likely by ½ to have a heart attack or stroke or other CV event needing treatment. Measurement of inflammation with CRP is a somewhat controversial subject since it is a measurement of inflammation that is not necessarily specific to the level of the vascularity (arterial wall) but speaks more to the overall systemic inflammation. Some critics in the cardiovascular community say the study was flawed but still it has caught the attention of the public and sparked the beginning of a crucial initiative for public health because the best way to save money is to prevent disease in the first place. Future research may show that preventing inflammation may significantly reduce the risk for other diseases beyond cardiovascular disease.



Right side photo before surgery



Radiograph of 2nd tooth from back is the tooth that was extracted



Hopeless tooth #30 with calculus and plaque

Intervention and Periodontal treatment of CVD patient

A 57-year-old male presented to my office with a medical history which included smoking, hypertension and poor compliance with dental home care and professional cleanings. His medications included daily aspirin, Crestor and Metoprolol. I discussed his treatment recommendations and counseled him on reducing his intake of carbohydrates (reducing his decay risk), intake of high fat foods, reducing salt, exercising regularly, to quit smoking and drop weight. He completed preliminary cleanings, however, it was important to remove some hopeless teeth to resolve the severe localized inflammation. The radiograph illustrates this patient's mandibular right quadrant and hopeless tooth #30. (See radiograph). Surgical treatment involved flap surgery, deep scaling, osteoplasty and removal of

the tooth (photo) illustrating the extent of the calculus and bacterial accumulations. Is this patient's poor periodontal status and chronic inflammation putting him at higher risk for a cardiac event? Is the treatment of this patient and his resolving inflammation going to reduce his risk of a cardiac event? I say yes. Is this a leap of faith? Perhaps, however, we do see that our patients do get "healthier" when they have resolved their periodontal issues and start to make positive lifestyle changes. In this case the patient "feels" better and is out of pain. Or, could it be that his blood pressure is lowered because he doesn't have to see me for surgery anymore!

The American Academy of Periodontology and the American Association of Cardiologists have pledged to move forward with prospective long term studies that will give us better insight and recommendations for treatment and resolution of chronic inflammatory periodontitis and CVD. The dental profession can be the conduit to educate, treat and refer these patients to the appropriate medical specialist such as internists and cardiologists and vice versa. My hope is that this type of communication will positively impact our patients' current and future oral and systemic health.

Dr. Mary Ann Lester completed her 3 year Periodontal and Implant Surgical training with a fellowship from the NIDR (National Institute of Dental Health) at Eastman Dental Center and the University of Rochester in 1994. Her research on genetic markers in juvenile and aggressive periodontal disease has been published in peer reviewed journals. Dr. Lester is a Diplomate of the American Board of Periodontology and has lectured extensively. She is a clinical Instructor in the Department of Periodontology at the Eastman Institute for Oral Health at the University of Rochester since 1996. She is currently a member of the International Team for Implantology, the principal investigator in a 5 year prospective multicenter dental implant study and co-investigator in clinical trials with a new CT scan guided dental implant surgical template. She has been in full time private practice at PHS Dental Implant and Periodontal Surgical Center in Rochester since 1994.

THE JOINT REPLACEMENT CENTER AT UNITY HOSPITAL

How HealthCare Should Be

By Julie VanBenthuysen

Lauren Feola, physical therapist, (left) and Debbie Wellington (right) assist a patient during group therapy at Unity's Joint Replacement Center.

Not long ago, patients undergoing surgery for a total hip replacement could expect to spend at least two weeks in the hospital followed by months of intensive physical therapy. But the face of joint replacement surgery has changed dramatically in recent years, offering patients the latest advances in surgical and rehabilitation techniques for the joints they receive – resulting in notably shorter hospital stays, recovery times and better long-term effects.

The Joint Replacement Center at Unity Hospital, with the region's largest and most experienced team of joint replacement surgeons, has been at the forefront of this remarkable change, helping hundreds of patients each year restore joint motion and activity to the highest possible level.

"Clearly, one of the biggest trends in joint replacement in the last 20 years has been performing surgery with an eye on maximizing a patient's short-term recovery," says Medical Director Dr. Michael J. Klotz. "Improved instrumentation, smaller incisions, understanding how to minimize the surgical trauma, and enhancing our patient care overall have been key to our success."

Skyrocketing Demand

Combined with improved techniques, Dr. Klotz attributes the staggering rise in joint replacement surgeries to a growing population of both the elderly and baby boomers electing to have surgery before their condition worsens. "More patients are realizing there is no way to reverse debilitating joint disease or return a joint to its optimum, pain-free function without joint replacement."

The rising numbers speak to his point. Just five years ago, an estimated 285,000 total hip replacements and 523,000 total knee replacements were performed in the United States alone. Industry estimates suggest that by 2030, hip replacements will increase to more than half a million and knee replacements to 3.4 million annually – representing an astounding increase in hip and knee replacements within a 25-year span. Shoulder replacements, while not nearly as common, are also on the rise.

The Joint Replacement Center has been responding to this growing demand since opening its doors at Unity Hospital in 2001, performing nearly 500 total joint replacements then with expectations of tripling that number this year. The Center's ability to handle the exploding case load with the highest level of care is a tribute to Unity Hospital's commitment, says Dr. Klotz, who joined the Center in 2007. With 15 orthopaedic surgeons and a hospital support staff of dozens more, the Center receives tremendous backing from hospital administration. "They are very responsive and really empower us," he says. "They know we're doing top notch work and they make sure the facilities work best for our patients."

Debbie Wellington, Orthopaedic Program Director, greets a patient at a reunion luncheon.

Partnership at All Levels

With an administration so strongly committed to orthopaedics, the Center's staff is able to better collaborate at all levels. "We pride ourselves on having a streamlined and efficient process for patients and their families," says Dr. Klotz. "That's why surgery, hospitalization and physical therapy take place in one convenient location at Unity Hospital."

Fellowship trained, Dr. Klotz has practiced orthopaedic surgery in the Rochester area for more than twelve years, specializing in primary and revision hip and knee arthroplasty, and handling referrals for a significant number of the region's revision surgeries. Dr. Klotz and the Center's entire team of board certified orthopaedic surgeons, who all maintain private practices within the Rochester region, provide a wealth of experience and expertise in all areas of orthopaedic surgery.

Michael Klotz, M.D. reviews a patient chart with Mary Culotta, physician assistant at the McCormick Transitional Care Center.

Debbie Wellington, BSN, RN, ONC, and Orthopaedic Program Director, oversees all aspects of the Center's day to day operations. Mrs. Wellington cites the focused partnerships between staff in all areas as the vital ingredient responsible for the Center's continued growth and stature.

"We have been able to take our Joint Replacement Center to the next level since Dr. Klotz arrived," says Mrs. Wellington, who has been with the Center since 2001. "He knows how important it is that the operating surgeons collaborate with the entire staff involved. From the nurses and physical and occupational therapists, to the dietitians, social workers, pharmacists and other support staff, all groups come together to gain the best perspective on each patient." This also extends to the Transitional Care Center and the home care coordinators, discussing the expectations for each patient once they leave the hospital. "From six weeks pre-surgery to a year afterwards," she says, "we offer support every step of the way."

Once patients decide on joint replacement, they attend a preoperative educational program several weeks prior to surgery. For former patient Joseph Aleo, who underwent a total knee replacement, the teaching class played a critical role in his successful surgery. "I received all the information I needed right from the get-go, and none of the details were sugar-coated," he says. "I had a chance to ask questions and hear questions other patients had prior to surgery, so once the day of surgery arrived, I was ready." Today, Mr. Aleo is living virtually pain-free.

Three weeks before surgery, patients come to the Center for a physical, health history analysis and any required lab tests. On the morning of surgery, they meet the surgical team. After surgery and recovery, patients are admitted to the Orthopaedic Unit and begin physical therapy right away. "From the time patients make a decision to have surgery to well after they're home, we have ensured they've received consistent, attentive personalized care, and that is the difference at Unity's Joint Replacement Center," says Mrs. Wellington.

Critical Role of Therapy

"We maintain a wellness philosophy with our patients," says Michele Yax, Physical Therapist at the Center since 2006. Since patients spend only two or three days in the hospital after a total joint replacement, she says, it's critical that staff discuss up front with patients and their families what to expect during the recovery process. "We work hard to get patients home where they're more comfortable and supported by their families."

During their stay, therapy staff tracks how far patients walk and their range of motion if they have had a total knee replacement. They also, within a short amount of time, make sure patients accomplish bed mobility, stairs, and general independence in caring for themselves. Discharge education ensures they go home well equipped with the confidence necessary to care for themselves.

"We provide discharge teaching covering issues such as prevention of blood clots and guidelines for increasing their activity," says Mrs. Wellington.

Seventy-five percent of the Center's patients meet their goals to go home in just a few days' time. If they haven't, some may need a short stay at the Transitional Care Center located at Unity Hospital, the region's only rehab facility within a hospital setting.

For former patient Linda Labrake, the rehab center was the way to go. Prior to total hip replacement, her pain was so debilitating she could barely walk to her car. Rather than attempting physical therapy at home, her orthopaedic team recommended a stay at the Transitional Care Center. "It was excellent," she says. "The rehabilitation and nursing staff just seemed to really care about their patients." Today, Ms. Labrake mows her lawn, rakes leaves and snow blows her driveway.

With more than a dozen full and part-time physical and occupational therapists on site, patients complete a comprehensive, motivating program for regaining their mobility.

Each week, between 25 and 35 patients attend "Joint Camp," a group approach to physical therapy, where they encourage and motivate each other. Camaraderie and gentle competitiveness help each patient reach their maximum potential. "In the spirit of wellness, they all receive "I Love This Joint" t-shirts," says Mrs. Wellington. "We encourage their loved ones to be their coach and cheerleader on their road to independence."

Long Lasting Connections

Staff at The Joint Replacement Center wants to ensure that patients are welcomed from the moment they arrive at Unity Hospital, starting with convenient access to the Center and free parking. "Everyone on our team feels the connection, and has the passion," says Dr. Klotz. "Patients can always expect responsiveness and anticipation of their needs. We want our patients to be happy, which means they can call us 24/7 and we'll answer their questions and give them reassurance." For Debbie Wellington, that often means a late night call to her home.

The experience would not be complete without the special amenities that Unity provides and the ability to sustain new friendships. These amenities include an exercise strap, t- shirt, complimentary newspaper, a special Joint Replacement Center menu, and daily patient newsletters.

That welcoming, group approach translates for patients far beyond post-surgery care. The Center's staff holds a Reunion Lunch for patients one month after surgery. "It's great for patients as well as staff," says Mrs. Wellington. "It offers a wonderful opportunity for continuous feedback."

Speaking volumes about the kind of care patients receive at the Center, several former patients have helped launch a Volunteer Program to support incoming patients -- visiting with them and making rounds to share a copy of the Center's newsletter. "We recruit former patients at our Reunion Lunch," says Mrs. Wellington. She jokes that even after some patients run out of joints to replace – the "repeat offenders" – they want to maintain their connection with the Center and help others through the program.

Former patient Mary Ann Ehrmentraut speaks warmly of the care she received and commends how the staff works as a whole. "As a volunteer, it's easy to put a smile on your face when everyone around you wears a smile," she says. "I love working and talking with patients here. I can make a difference and get so much back for giving a little time."

Michael Klotz, M.D. and Debbie Wellington reviewing a patient's chart.

Center of Excellence

Patient satisfaction rates remain consistently high. The Center recently earned the Gold Seal of Approval (TM) for health care quality from the Joint Commission and was awarded a Disease-Specific Care Certification for knee and hip replacement. To earn this distinction, the Center voluntarily underwent an on-site evaluation, including extensive interviews with staff and patients. The Joint Commission determined that the Center met rigorous quality and safety standards and awarded full certification with no recommendations for improvement.

In recent years, the Joint Replacement program has standardized its delivery of care which ensures consistency across all levels of staff. "Now that we've standardized the way we do

things, we can truly focus on each patient as an individual in a comprehensive way."

At the same time, he says, the Center supports an evidence-based practice by challenging every assumption made over time, constantly reevaluating patient outcomes to make them even better. Patients are contacted after three months and asked questions about their recovery and ability to function. Just this year, the team began reviewing patient outcomes at one year post-surgery, hoping to identify such things as why a certain person didn't do as well as another.

Preparing for Continued Growth

As the Center celebrates its 10th Anniversary in 2011, a major renovation is already underway that will result in a new joint replacement unit with a large community room. Expected to be completed in 2013, the new Center will increase in size and add more hospital beds. "We can't take it to the next level without a better physical plant," says Dr. Klotz.

In the next decade, Dr. Klotz expects volumes of total hip and knee replacements at the Center to be significantly greater than what's being done now, but expresses concern that there will be enough orthopaedic surgeons to accommodate the projected rise in surgeries. "We are always recruiting more orthopaedic surgeons to continue to serve the growing need."

Former patient Beverly Potter, who moved away since her recent total shoulder replacement, says she wouldn't go anywhere else. As a school bus driver with arthritis, she suffered a back injury that required surgery recently. "I tell everyone if anything happens to my left shoulder, I'm hopping on a plane to fly back east and have my surgery with Dr. Stenclik at Unity!"

Happy patient testimonials abound, with 98% of patients saying they would recommend the Center to family and friends needing a joint replacement. By treating patients with compassion, dignity and respect, the Joint Replacement Center continues to offer patients a team approach to surgical care beyond compare. "Clearly, our patients' experiences are worth sharing," says Mrs. Wellington. "It's the combination of all the giving people and our ongoing commitment that ensures every patient gets a new lease on life."

Using digital technology, Michael Klotz, M.D. (left) and Mark Stenclik, M.D. review a patient's information.

Happy patient testimonials abound, with 98% of patients saying they would recommend the Center to family and friends needing a joint replacement.

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(Pictured below from L to R)

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The Diabetic Foot Ulcer

Ron M. Freeling, DPM

The most serious complication associated with chronic diabetes as far as the foot is concerned is amputation. The foot ulcer that is untreated will often result in lower extremity amputation (LEA). Because the mechanical causes of the ulcer are either not addressed at all or because they are only addressed on a temporary basis, a pattern of continual ulceration, immobilization, hospitalization, physical therapy and recovery is seen time and again.

Numerous mechanisms have been suggested as the causative factor in the formation of foot ulcerations in diabetics. Clearly vascular supply plays some role in the formation of the diabetic ulcer, however, foot ulcerations occur more often in association with neuropathic changes and mechanical forces applied to the tissue surfaces, which result in the ulceration. Due to the repetitive loads upon the foot during gait, increased peak pressures on a particular area result in the diabetic ulcer. Walking or running is a series of repetitive traumatic pressures, which create the mechanical force to form the lower extremity ulcer. Therefore, the high incidents of diabetic foot ulcerations are due primarily to an altered mechanical etiology.

When there is an altered mechanical alignment of the foot and leg during the normal gait cycle, changes in the soft tissue take place, which further enhance the development of the ulceration. The non-diabetic foot can withstand the mechanical alterations without a continuous breakdown. Patients with diabetes demonstrate changes in the soft tissue mechanical properties, which may further predispose these patients to ulcerations.

Glycosolation of the tissues directly affects the collagen, causing excessive cross-linking between collagen strands making the collagen much stiffer. Thus stiffened tissues are not able to deform as quickly and may be more susceptible to splitting and cracking in response to rapid deformation associated with high velocity foot impact. These changes of the skin are also associated with atrophy of the plantar fat pad associated with chronic diabetes especially in the forefoot area during the gait cycle. These two conditions, namely, atrophy of the plantar fat pad and glycosolation or hardening of the skin, directly affect the resiliency of the skin to mechanical forces. Excessive callous formation associated with diabetes leads to thickening of the skin making it even less malleable. As a result, it may simply split in response to the applied load.

Current treatment regimens have been to re-establish the normal forces with parallelism rather than shearing stresses. This is usually accomplished by means of orthotic-type devices with various synthetic materials that are placed in the shoe to reduce the peak pressures on the foot. Therefore, if diabetes is present, evaluation of the foot structure and accommodation for the altered mechanical forces will prevent the increased morbidity associated with the diabetic ulcer. Eventually, either due to lack of patient compliance, uncontrolled infection, formation of scar tissue or progression of vascular disease, the ulcer can no longer be closed or amputation becomes inevitable.

Dr. Freeling is a Podiatrist with Westside Podiatry Group, which has three Rochester locations. He also is the Chair of Unity Hospital Podiatry staff, as well as on the staff at Unity Hospital, Rochester General Hospital and the Brighton/Westfall Surgery Center.

RISK FACTORS FOR DIABETIC FOOT ULCERATION

- **Neuropathy:** Sensorimotor, Autonomic
- **Vasculardisease:** Microvascular, Macrovascular
- **Immunopathy:** susceptibility to infection
- Structural deformity
- Limited joint mobility
- Nephropathy
- Duration of Diabetes
- Blindness
- Age
- Previous ulceration
- **Minor trauma (mechanical):** high plantar pressures, shoe pressure, high impact
- **Thermal injury:** hot soaks, frostbite
- Chemical burns
- Bathroom surgery
- Occupational hazards
- Poor knowledge of Diabetes
- Cigarette smoking
- Living Alone

Strengthening Your Practice

What You Can Do To Protect Your Practice and Your Employees from Higher Income Taxes and Health Insurance Premiums

Sammy Azzouz, J.D., CFP®

Two of the biggest problems facing physicians' groups today are rising taxes, especially for high wage earners, and escalating health care costs driving up the insurance premiums they pay to maintain competitive benefits packages.

The possibility that the 2001 Federal tax cuts expire at the end of this year could cause marginal tax rates to increase, raise the capital gains rate, and revert the tax on qualified dividends back to the tax filer's marginal rate. In addition, the ability of high wage earners to utilize all their deductions could be limited and credits and exemptions may be detrimentally impacted. The recent health care reform bill also added to the potential tax burden of high wage earners by instituting a 0.9% Medicare tax and a 3.8% tax in passive income on single taxpayers making $200,000 or more and married taxpayers filing jointly and making $250,000 or more, according to whitehouse.gov. The end result may very well be a much higher tax burden for high wage earners going forward.

Fortunately, there are solutions that physicians' groups can consider to lower this ongoing, increasing federal tax burden. These solutions focus on physicians' groups redesigning their retirement plans to allow high wage earners to shelter more of their income. Certain plan design concepts, old and new, can be applied to retirement plans to not only do this but also increase the percentage of plan dollars that benefit the high wage earners in the plan. They vary from the basic introduction of a Safe Harbor contribution to your plan, to changing how you calculate your profit sharing contributions to benefit older, higher compensated employees, to introducing cash balance plans, and even looking at the brand new DB(k) plans allowed for the first time in 2010. With the right plan demographics, a combination of any of these strategies, and more, could end up allowing a plan's high wage earners to shelter more of their income from taxation and shifting plan dollars to benefit that same group.

The end result of implementing these strategies could lead to a reduction in the benefit dollars the group pays for its non-principals. One solution would be for the group to pocket these savings, but a more effective strategy might be to use those savings to attack another large problem facing all employers today – the rising health care costs mentioned above. Many studies have shown that by increasing consumerism through health savings accounts, costs are contained much more effectively than with plans that lack that feature. The philosophy behind this is simple, by getting employees to view health care spending as their own money versus the employers', employees are more likely to work with an employer at driving down health plan utilization and costs. This in turn has been shown to drive down an employer's health costs overall.

However, shifting to a consumer-based plan is a big adjustment for employees. One way to ease that transition could be to use some of the money saved through the retirement plan redesign by "kickstarting" employee health savings accounts, which can be established alongside a high deductible health plan. Contributions to a health savings account grow tax-deferred and withdrawals, when used for qualified medical expenses, are tax-free. Not only should this drive down plan health care costs, but it will also give the employees a chance to accumulate money to pay for the health care costs that they will face now and in retirement.

Higher taxes and higher health care costs – one is on the way and the other has been with us for a while. Through creative retirement plan design and adoption of consumer-based health plans, physicians' groups have a chance to attack both problems head-on.

Sammy Azzouz, J.D., CFP® is the Managing Director of Family Wealth Management at Manning &Napier Advisors, Inc.

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What is My Liability?

Off-Label Prescribing

James E. Szalados, MD, MBA, Esq.

Issue:

I prescribe a medication that is not approved by the manufacturer for the clinical indication that I am treating. What is my liability?

The relatively common practice of prescribing a pharmaceutical for an unapproved indication is defined by the US Food and Drug Administration [FDA] as 'off-label' prescribing. Approved indications are defined for each pharmaceutical product by the FDA based on the manufacturer's drug development data and through the FDA drug approval process. The FDA drug approval standard is based upon the legislatively defined and therefore mandatory dual standards of safety and efficacy which are established through the pre-clinical and clinical testing stages of drug development. Once clinical testing has established that a drug is safe and efficacious for the indications for which it has been tested, the data is submitted to the FDA. The FDA reviews that data, and, if satisfied, the drug may proceed to marketing. FDA approval allows the manufacturer to market that drug only for certain uses, treatments, and indications, all of which must be indicated on FDA-approved labeling. The FDA defines 'labeling' to include all informative materials which accompany the drug; including, but not limited to, the package insert.

Although manufacturers are statutorily prohibited from directly marketing a drug for any use other than the FDA approved indication(s) as defined in the product's labeling, the FDA does not have the legal authority to regulate the practice of the medicine, and the physician may prescribe any drug "'off label' according to his or her own best judgment. In Buckman1 the U.S. Supreme Court, in the context of medical devices, observed that "'off-label' usage ... is an accepted and necessary corollary of the FDA's mission to regulate ... without directly interfering with the practice of medicine."

Off-label prescribing is perhaps most commonly encountered in the specialties of pediatrics (since relatively few older drugs have been clinically tested directly in children), oncology, psychiatry, and cardiology. The Food and Drug Administration Modernization Act of 1997 did create an exception to the prohibition on direct off-label marketing by manufacturers in that manufacturers are now able to provide medical practitioners with off-label information only in response to an unsolicited request from that practitioner regarding data supporting that off-label use. Manufacturers cannot promote off-label uses or otherwise induce practitioners to use a drug off-label. In 2004, Pfizer was prosecuted for inducing physicians to prescribe the drug Neurontin for unapproved indications and was fined $430 million.

Off-label use is frequently an indirect venue for expansion of drug efficacy data when "off label" use generates written case reports, future experimental protocols, and may even prompt the manufacturer to amend the drug's labeling to make that "off-label" use an accepted indication. A Tennessee appellate court observed[2] in that: "[b]ecause the pace of medical discovery runs ahead of the FDA's regulatory machinery, the off-label use of some drugs is frequently considered to be 'state-of-the-art' treatment," and went on to state that "[i]n some circumstances, an off-label use of a particular drug or device may even define

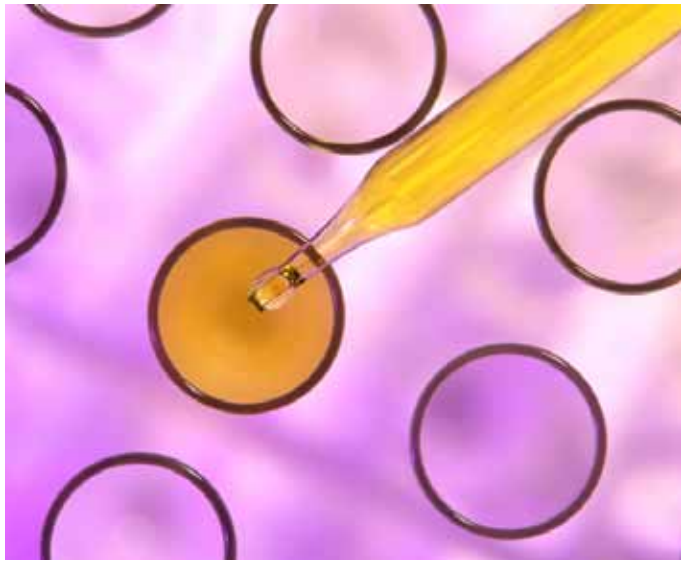
the standard of care." However, off-label prescribing must not be used for the purposes of research. The distinction between therapy and research lies in the prescriber's intent: if the primary intent is patient benefit then the intervention is considered therapeutic and lies within the practice of medicine; however, if the primary intent is to test a hypothesis, gather data, or publish findings, then the intervention is likely to be considered an experiment.

The fact that neither the FDA nor the drug manufacturers may engage in the practice of medicine also shifts liability on practitioners who exercise professional judgment in prescribing practice. The "learned intermediary doctrine" is a well-accepted defense doctrine primarily used by pharmaceutical and device manufacturers in defense of manufacturing liability tort claims. The doctrine essentially states that a manufacturer of a medical product satisfies the requisite duty of care when that manufacturer provides the necessary information regarding the use of that product to a "learned intermediary" who then assumes that position of interacting with the consumers of that product in their position as medical professionals. Ordinarily, product manufacturers have a duty to make and sell products that are reasonably safe and not defective; if that is not possible, (as in the case of inherently dangerous products) the duty of manufacturerbecomes one of warning about known defects or dangers. Legal theory recognizes that drugs, by their nature are "inherently dangerous."

Liability exposure to physicians may be increased when drugs are prescribed "off-label;" however, the standard to which the practitioner is held is that of "reasonableness". Liability can arise from a failure to conform to the standard of care. In an analysis of whether or not an off- label prescription meets the standard of care, the determining factor is the level of scientific or clinical evidence available to support the off-label use; and secondarily. In general, the more scientific evidence there is to support a given off-label use, the more likely it is that the off-label use will be found to conform to the standard of care.

In the case of an adverse event, malpractice claims typically focus on the following types of off-label uses: (a) where the drug is prescribed for an unapproved indication as per the product labeling; (b) instances the dose prescribed deviates significantly from labeling recommendations; and (c) instances where patient is demographically outside (pediatrics, geriatrics) the populations in which the clinical trials supporting the labeling were conducted.

When prescribing a drug for clinical indications outside the scope of FDA approval and labeling, the practitioner will be held to a higher than usual standard to show that a risk-benefit



analysis balancing the potential risk to the patient against the potential benefits occurred. Risk minimization strategies center on careful documentation in the medical record. At the very least, there should be a documentation of the medical reasoning on which the prescription was based. Additional levels of risk minimization might include informed consent and a reference in the medical record to any peer reviewed publications which support the prescribing decision. In the case of off-label prescribing, such supplemental documentation may, in addition to potentially insulating the practitioner from liability in the case of malpractice litigation, may also be necessary in the case of an insurance payor or false claims audit to support "medical necessity."

Suggested Reading:

Szalados JE. "Statutory and Regulatory Controls for Drug Development" in Pharmaceutical Law: Regulation of Research, Development, and Marketing – 2008 Supplement. Clark ME. Ed. BNA Books. Pp 1 – 982. 2008. (ISBN 978-1-57018-765- 0).

References:

[1] Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 350 (2001).

[2] Richardson v. Miller, 44 S.W.3d 1, 13, n.11 (Tenn. Ct. App. 2000).

Robotic Surgery Offers Advantages for People with Head and Neck Cancers

Matthew Miller, MD.

Recent high-profile cases of oral, pharyngeal and laryngeal cancers, collectively referred to as 'throat cancer,' have brought these diseases into the public consciousness.

Treating these diseases can be challenging because of the impact that surgery, chemotherapy and radiation therapy have on the more than 50,000 people who are diagnosed each year in the United States.

Traditional surgery for some head and neck cancers requires large incisions – extending from the lip, across the chin and to the neck before entering the mouth or throat. Many times surgeons need to cut through the lower jaw and move aside vital cranial nerves to gain access to the back of the mouth and throat.

These surgical approaches have the potential to be invasive and disfiguring – oftentimes leading to an extensive recovery and rehabilitation period.

At the University of Rochester Medical Center, we have begun using minimally invasive robotic technology to perform these surgeries with tremendous advantages for our patients. Earlier this year, we began offering transoral robotic surgeries for cancers of the mouth and throat. The robot allows us to limit, or even eliminate, some of the side effects associated with more invasive surgeries while still effectively treating the cancer.

The daVinci Surgical Systems offers tremendous visualization and flexibility in getting at tumors that are very hard to reach. The 3-D visuals and the instruments give us 360-degree access and maneuverability, which means we're able to perform surgeries with greater precision than ever before.

Strong Memorial Hospital's system consists of robotic arms that replicate a surgeon's motions in real time. The movements are guided by a surgeon using high-definition images provided by cameras positioned within the patient's mouth. The surgeon is working from a console near the patient.

Using the high-precision robotic system, surgeons insert the slender instruments into the mouth to reach the base of the tongue, tonsils, and larynx (voice box).

The benefits for people with oral, head and neck cancers are dramatic because the surgeries can be done, primarily, without

RISK FACTORS FOR ORAL, HEAD AND NECK CANCERS

Oral, head and neck cancers affect more than 50,000 people every year in the United States. Risk factors vary according to the type of head or neck cancer.

Consistently, though, tobacco and alcohol use are strongly linked to the development of any of these types of cancers. In fact, 85 percent of head and neck cancers are linked to tobacco use, and people who use both tobacco and alcohol are at greater risk or developing these cancers than people who use either tobacco or alcohol alone. Another emerging risk factor is human papilloma virus, the same virus that contributes to cervical cancers in women.

Symptoms vary according to the type of head or neck cancer.

THE MOST COMMON SYMPTOMS ARE

Lump or sore that does not heal
Sore throat that does not go away
Difficulty swallowing
Change or hoarseness in the voice
Bringing up blood
Changes in the skin around the forehead, face and ears
Persistent earache

If you experience these symptoms for an extended period of time, please see your physician.

incisions and offer faster recovery time and a reduced risk of infection or other complications. The jaw is left intact and the cranial nerves are avoided.

Our ability to improve treatments – through surgical advances such as robotics, targeted radiation therapy and better chemotherapies – has had a dramatic impact on the quality of our patients' lives.

The new surgical technique is offered as part of the full complement of care available from our multidisciplinary head and neck cancer team, which includes otolaryngologists, oncologists, radiation oncologists and speech pathologist, nurses and other support staff. The team works together to review each person's cancer diagnosis and develops a treatment plan that offers the best chance for success and long-term survival. This multidisciplinary model is considered the gold standard in cancer care.

It's impressive to be a part of the robotic surgery team at the Medical Center, which has seen the volume of robotic surgeries rise dramatically in the past decade, as demand for the minimally invasive approach grows and surgeons grow more comfortable with the technology.

Strong Memorial Hospital was the first to introduce the Da-Vinci Surgical System in 2003 and continues to be the only hospital in Upstate and Western New York to offer robotic surgery for head and neck cancer treatment. Strong has two surgical robots, and a third is located at affiliate Highland Hospital.

The Medical Center is also creating a Center for Robotic Surgery and Innovation to expand the use of robotic technology at Strong Memorial Hospital and expand research into its use. The center also provides hands-on education for doctors who want to specialize in robot-assisted surgeries and use techniques honed by our surgeons.

Dr. Matthew Miller specializes in cancers of the head and neck, thyroid and parathyroid surgery, and anterior cranial base surgery at the James P. Wilmot Cancer Center - University of Rochester Medical Center. He also serves as an assistant professor in Otolaryngology. For more information about oral head and neck cancers, call (585) 758-5700 or to learn more about robotic surgery go to www.urmc.rochester.edu/robotic-surgery/index.cfm.

INTERNAL MEDICINE AND AGING

John Garneau, MD

AMERICA AS A NATION IS AGING.

Americans are living longer than ever because of new medical treatments and technologies and better prevention measures. However, more people are growing old enough to manage chronic conditions such as diabetes, heart disease, neuro-degenerative diseases, and even cancer. As we age, more of us are contending with multiple and complex chronic conditions that require a high degree of medical management and a strong commitment to encouraging and supporting patient self-management.

The high profile health care reform must acknowledge the aging American population and how changes in access and utilization will affect us. Policymakers must take into account the implications of Medicare beneficiaries managing chronic illness. It is estimated that 20 percent of beneficiaries have five or more chronic conditions, accounting for over two-thirds of Medicare spending. These same people might see up to 14 different physicians in a year and amass over 40 office visits. The truth is that the number of chronic conditions has more influence than age on health care spending in the Medicare population.

The role of the Internist/Primary Care Physician is paramount in the new health care model. Technology can provide increased access to data but cannot replace the relationship between the physician and the patient. The communication of information from specialists needs to be coordinated to the patient's overall health and not just filed as a system report. The care of people must remain the essential goal of the physician. This involves communicating results and discussing treatment options in conjunction with the patient's overall health and tailoring treatment options to each patient's unique situation. What is clear is that in order to be successful, a new health care endeavor will only work better with active involvement of the patient's physician.

The new challenges with health care reform place increased pressures on both patient and physician. The challenge is to provide excellent quality without causing fragmentation between providers and a diminished physician and patient interaction. Technology brings new advances, but runs the inherent risk of depersonalizing the act of caregiving and stripping physicians of their most treasured gifts, compassion and communication. Any change in health care cannot view patients as a commodity, because we are not dealing with cars or potatoes, we are dealing with lives. Physicians need time to explain, organize a plan of treatment, and talk about major issues so that patients genuinely feel that the care received is appropriate and in their best interest. The role of the Internist/Primary Care Physician must remain the strongest interaction as this provider spends the most time with the patient and has the keenest insight regarding the patient's overall health and well-being.

The challenge for Internists /Primary Care Providers is daunting especially in light of planned reductions in reimbursement and planned incorporation of technologies such as "medical home technology" to expand practices. Although remarkable, this technology may significantly decrease actual encounter time with providers. The lack of primary care physicians makes the entire situation problematic; each patient is complex and not able to be defined by a predetermined algorithm – a physician who truly knows the patient is most effective. As practioners, we must stay focused on our commitment to care for our patients despite the changes around us. Improvement can only come as a result of continued dedication to patient care.

Dr. Garneau is Board Certified in Internal Medicine and is in private practice in Henrietta, N.Y. He serves as a preceptor for first year medical students at the University of Rochester School of Medicine and is Medical Director of the Wellness Center at St John Fisher College.

Time for an EHR & Meaningful Use

Incentive Funds are Available - Final Rule is Out

Al Kinel

Currently your practice is challenged to improve quality, improve communications with patients, payers, and other providers, reduce costs, and address competitive pressures. It is for these reasons that physician practices, clinics, and hospitals should implement interoperable Electronic Health Records (EHRs) and modify processes. Competition provides your patients (aka customers) an alternative, so if you do not strive to meet or exceed their expectations, your business will suffer.

Because Medicare is providing eligible providers incentives of up to $44,000 or Medicaid incentives of up to $63,750 for eligible providers that implement certified EHRs and achieve Meaningful Use (MU), you should begin to make the move now.

The Final Rule on Meaningful Use

A program, called the Health Information Technology for Economic and Clinical Health (HITECH) Act, enables health care providers who demonstrate "Meaningful Use" of EHR technology to collect incentive payments through reimbursement premiums, and will result in decreases for those that do not.

On July 13, 2010 CMS issued the "final rule" specifying MU requirements for eligible medical entities. After considering feedback, the requirements to qualify for the incentives were relaxed.

Who is Eligible? Primary Care Physicians and Specialists

Medicare: Medicare eligible providers (EPs) include non-hospital based Medical Doctors (MD), Doctor of Osteopathy (DO), Doctor of Podiatry, and Doctor of Optometry.

Medicaid: Medicaid EPs includes non-hospital physicians, NPs, and DDS, with greater than 30% of patient encounters that are Medicaid. Additionally, PAs working in a FQHC or Rural Health Clinic (RHC) may qualify. Pediatricians may receive 2/3 of the incentive amount if Medicaid patient volume is 20% or greater. All must demonstrate contributions of 15% toward the investment of a certified EHR.

Requirements and Stages for MU

To qualify as a Meaningful User, providers must use certified EHR technology. The Final Rule establishes a Temporary Certification Program, whereby several organizations are approved to conduct the certification testing.

Requirements and Stages for MU

Providers must comply with the following:

- Use certified EHR technology in a meaningful manner, including e-prescribing
- Enable EHR to electronically exchange clinical information
- Enable quality measures, reporting, and decision support

Meaningful Use requirements are divided into three sequential stages. The Final Rule provides the definition for Stage One requirements only, but provides general program themes for all three stages:

The Focus of each Meaningful Use Stage

Stage 1: Electronically capturing structured health data
15 "core" requirements that EPs must demonstrate
10 "Menu Set," of which five must be satisfied

Stage 2: Exchanging health data among unaffiliated providers

Stage 3: Patient-centered healthcare based on quality measures and population health

How to Estimate Incentive Payments

EPs who qualify for both Medicare and Medicaid programs may participate in only one. EPs will be allowed to change their selection once.

Medicare Incentive Payments: A qualifying EP will receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the EP in a payment year. Initial incentive payment can be as high as $18,000 if their first payment year is 2011 or 2012. Otherwise, the annual incentive payment limits in the first, second, third, fourth, and fifth years are $15,000, $12,000, $8,000, $4000, and $2,000 respectively.

Medicaid Incentive Payments: A qualifying EP will receive an incentive payment equal to 85% of Net Average Allowable Costs (NAAC) paid for EHR systems up to a maximum of $21,250 for the first eligible year, and $8,500 for years 2-6, if cash received for EHR from other sources is less than or equal to $29,000. Reimbursement is eligible for expenses associated with systems previously implemented. If cash received exceeds, $29,000, EP will receive 85% of the amount of $54,000 less the cash contributions received.

Where to Get Help

Once you have decided give this change thoughtful consideration, you face some difficult decisions:

- *Which system should we select?*
- *What workflow changes should accompany systems? How will we train our staff? Should we convert paper charts?*
- *What IT infrastructure do we need? Should we implement IT infrastructure or have the solution hosted? How do we maintain business continuity?*
- *How much will it cost? Should we purchase systems? Lease them? Take out a loan?*

Federal funds established a Regional Extension Center (REC) for personnel to help primary carephysician offices of 10 or fewer physicians with major decisions, and to assist in changes to attain the promised benefits. Within the Rochester area, the following organizations can be contacted to help:

- **MCMS** (www.mcms.org)
- **RHIO** (www.grrhio.org)

Specialty and large primary care practices, long term care facilities, and hospitals should turn to their associations and professional consultants for assistance.

I encourage you to make the decision to implement an EHR to enable you to improve patient care, staff productivity and your ability to communicate with other providers. I appeal to

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Endocrinology
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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 through the transition.

your sense as a business professional to take the plunge now to allow the government to subsidize the investment. Once you have implemented an EHR, you can interface with the Regional Health Information Organization (RHIO) to augment your access to clinical information from hospitals, labs, radiology practices, and specialists, funds established a Regional Extension Center (REC) for personnel to help primary care and you can explore how the Patient-Centered Medical Home (PCMH) model can help you improve coordination with other providers and enhance care for your patients.

Al Kinel is President and founder of Strategic Interests, LLC, a consulting company dedicated to helping clients capture value from the strategic use of IT. Al and his network of colleagues bring significant expertise in the application of Healthcare Information Technology (HIT). Contact Al to discuss how his firm can help define the best path for your practice, and get the resources you need to ensure your project is a success. Visit his firm's website at www.strategicinterests.com, or contact him via e-mail at alk@strategicinterests.com.

WHAT'S NEW IN Area Healthcare

Regis O'Keefe, MD, PhD

Stephen L. Kates, MD

URMC Joins National Effort to Set Quality Guidelines for Joint Replacement

$12M program centers on standards of care for knee, hip replacement surgeries

The growing obesity epidemic and aging of baby boomers has driven demand for total joint replacement procedures to combat excruciating arthritis pain. Yet as more than 700,000 people go under the knife each year, doctors are without patient-centered outcomes research to show how the surgery impacts the quality of life for patients.

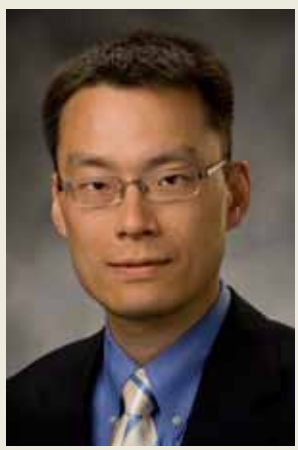
URMC's Department of Orthopaedics today joins a consortium of top academic medical centers in a $12 million effort to build a national registry for total joint replacement surgery. This database will help orthopaedists around the country improve care and make health policy decisions.

The URMC team, led by Orthopaedics Chair **Regis J. O'Keefe, MD, PhD**, and **Stephen Kates, MD**, associate professor, will collaborate with University of Massachusetts, **University of Maryland** and **Baylor University** as well as more than 130 private orthopedic surgeons to create the **National Orthopaedic Outcome Registry**, which will include more than 33,000 patients.

The four-year grant is from the **Health and Human Services' Agency for Healthcare Research and Quality**, and is the largest grant the Medical Center has been awarded from the federal agency charged with improving health care.

The limited research available today shows wide variations in doctors' decisions about when and how to replace joints and broad differences in patients' mobility and pain levels following surgery. Current data is limited to patients who receive Medicare coverage and the new registry will provide diverse information from all geographic regions of the country and a variety of clinical settings to assess outcomes and quality measures.

Rochester Brain & Spine Adds New Neurosurgeon



David Chang, MD, PhD

Dr. David Chang received a combined MD and PhD from **Johns Hopkins University School of Medicine** and a BS degree from **Johns Hopkins University**. He completed both internship and neurosurgery residency at **Mount Sinai Hospital** in New York, and a surgical neuro-oncology fellowship at the **National Institute of Health**, Bethesda, Maryland.

Dr. Chang specializes in various spine disorders such as herniated discs, a common source of pain in the lower back or neck, spinal stenosis, a narrowing of the lumbar or cervical spinal canal that causes compression of nerve roots, degenerative scoliosis, a deterioration of the disc space and paired facet joints resulting in abnormal curvature of the spine, and spine tumors, abnormal growths that develop in or near the spinal cord or in the spinal column. He also has significant experience in repairing spine trauma, and revision spine surgery.

Prior to joining **Rochester Brain and Spine**, Dr Chang worked at **Neurological Surgery, PC**, Suffolk County, Long Island, and **St. Luke's Hospital** in Duluth, Minnesota. He is a member of the **Congress of Neurological Surgeons** (CNS) and the **American Association of Neurological Surgeons** (AANS).

Physiatrist Dr. Inzerillo Attains Board Certification

James Inzerillo, DC, MD

James Inzerillo, DC, MD, has recently been certified by the **American Board of Physical Medicine and Rehabilitation**. Dr. Inzerillo is a physiatrist specializing in rehabilitation medicine, and is the medical director of **Geneva General Hospital's Acute Physical Rehabilitation Unit** (ARU). The ARU is a 15-bed inpatient facility that provides physical, occupational and speech therapy services to meet the special needs of individuals who have experienced disabling injuries, illness, or surgery. It is nationally recognized by the **Commission on Accreditation of Rehabilitation Facilities**, and it has received a ***"Top Performer Award"*** three years in a row by the **Uniform Data System for Medical Rehabilitation** for patient outcomes, ranking the unit in the top 3% of acute rehabilitation units nationwide.

AAP's Landmark Award Goes To URMC's Dale Phelps

Dale Phelps, MD

Award honors neonatologist's pioneering work with retinopathy of prematurity **Dale Phelps, MD**, professor of Pediatrics at **Golisano Children's Hospital at the University of Rochester Medical Center**, received the ***Landmark Award*** Saturday at the annual **American Academy of Pediatrics** meeting in San Francisco. She was honored for her pioneering work collaborating with the ophthalmology investigators in treating retinopathy of prematurity (ROP), a common eyesight problem in babies born early.

Phelps is a leader in the research of how to identify and treat this sight-robbing disease among premature babies, having helped design the first clinical trial of cryotherapy for ROP. The trial was stopped early because it was so effective that researchers wanted to speed its implementation as a treatment. Based on the trial, ablation therapy became standard of care for ROP in 1988, and cryotherapy or later laser therapy has since preserved vision for thousands of preterm infants.

"Dr. Phelps' research is a remarkable example of how quickly science can move from research to treatment," said **William Maniscalco, MD**, chief of Neonatology at **Golisano Children's Hospital**. "ROP is a particularly upsetting problem for families whose babies have already been through so much and survived. Thanks to Dr. Phelps and her colleagues, we can help these babies keep their sight."

ROP primarily affects babies who are born before 31 weeks of gestation and weigh less than 3 pounds. The smaller a baby is at birth, the more likely that baby will develop ROP, which is one of the most common causes of vision impairment and blindness in childhood.

Ibrahim Joins Medical Center Dermatology, Skin Cancer Team

Sherrif Ibrahim, MD, PhD

Dermatologist **Sherrif Ibrahim, MD, PhD**, a fellowship-trained surgeon specializing in skin cancers and cosmetic, recently joined the **University of Rochester Medical Center**. He practices at **University Dermatology Associates'** offices at 400 Red Creek Drive in Henrietta.

Ibrahim recently completed fellowship training in Moh's micrographic surgery, a delicate procedure to remove melanoma and squamous cell cancers, at the **University of California-San Francisco**. He joins Marc D. Brown, MD, professor of Dermatology, in providing this specialty care.

A graduate of **Massachusetts Institute of Technology**, where studied chemical engineering, he earned a Ph.D. in molecular biotechnology from **University of Washington**, where he also completed his medical internship. Ibrahim came to Rochester for his residency training at the **University of Rochester School of Medicine and Dentistry** from 2006-2009.

Ibrahim has published several research articles and book chapters. He is a member of **American Society for Dermatologic Surgery, Society for Investigative Dermatology** and **American Academy of Dermatology**.

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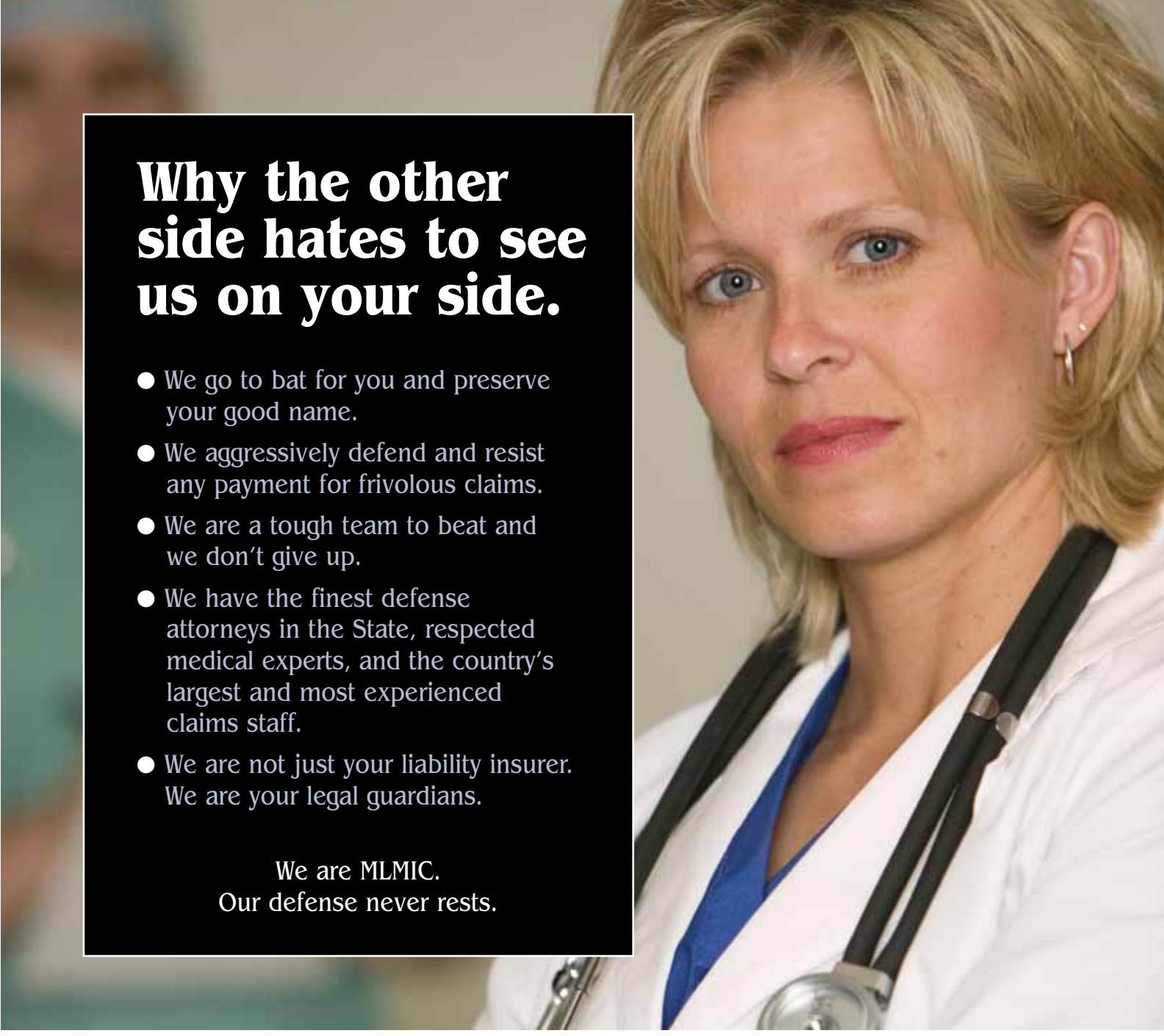

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