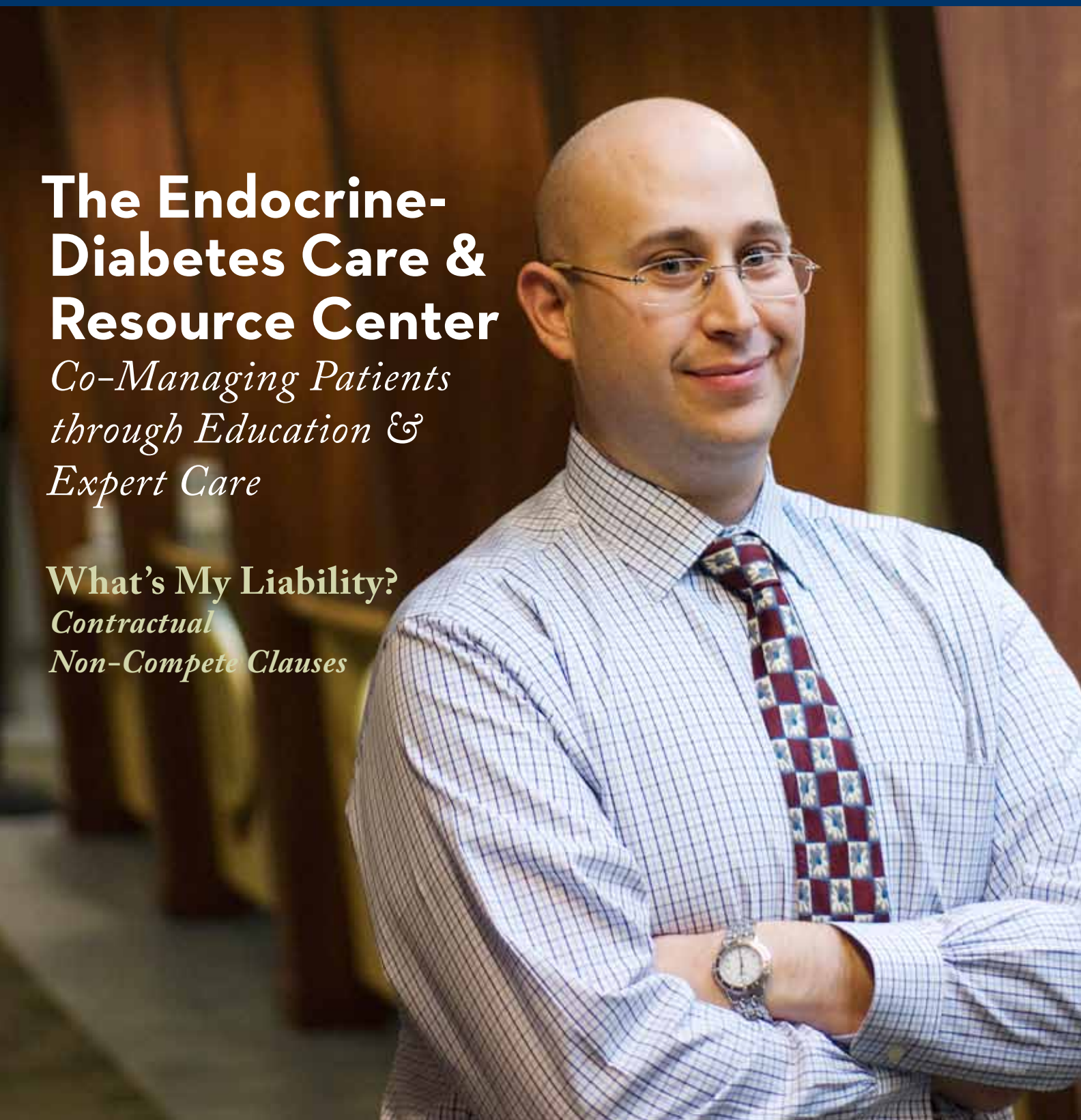
ROCHESTER / FEBRUARY 2010

Western New York
PHYSICIAN
THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



The Endocrine-Diabetes Care & Resource Center

Co-Managing Patients through Education & Expert Care

What's My Liability?

Contractual Non-Compete Clauses

MEDICAL

ADVERTISING

PORTRAITS

LISA HUGHES
PHOTOGRAPHY

www.lisahughesphoto.com
585.264.0409

Contents

COVER STORY

CLINICAL FEATURES

RISK MANAGEMENT

LEGAL

MEDICAL RESEARCH

Welcome to the Premier Issue of 2011

For many, the start of a new year represents a new beginning – a resolve to make a change, begin something new, tackle an obstacle. For the nearly 26 million Americans with Diabetes, the challenge is complex and the stakes are high. The CDC's recently reported statistics estimate an additional 79 million American adults have prediabetes. The health implications to this patient population are profound and the cost of treating this disease is staggering. Diabetes is the seventh leading cause of death in the U.S. and people with Diabetes are more likely to suffer from other health complications such as heart attacks, strokes, high blood pressure, kidney failure, blindness and amputations of feet and legs.

This month's cover story highlights the Endocrine-Diabetes Care & Resource Center. With a keen focus on proactive patient education and individualized expert medical management, this growing team of experts is committed to empowering patients with the resources and medical support so that they can succeed in self-managing their disease.

January marks Cervical Cancer Awareness month – Dr. Eugene Toy offers current guidelines on screening, prevention and treatment. Also in this issue, hear from regional experts on bariatric surgery, innovative approaches to laparoscopic adrenalectomy, risk management tips on caring for obese patients in the office setting, and managing the liability of contractual non-compete clauses.

We hope you enjoy the read. If you would like to contribute to an upcoming issue, please email me directly.

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,

Andrea Sperry
Publisher
WNYPhysician@rochester.rr.com
(585) 721-5238

Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

PUBLISHER
Andrea Sperry

MANAGING EDITOR
Julie VanBenthuysen

CREATIVE DIRECTOR
Lisa Mauro

PHOTOGRAPHY
Lisa Hughes

ADVERTISING DIRECTOR
Melissa Henderson

Contact Us
For information on being highlighted in a cover story or special feature, article submission, or advertising in

Western New York Physician
WNYPhysician@Rochester.rr.com
Phone: 585.721.5238

Update on Bariatric Surgery: The Diabetic Consideration

Alok D. Gandhi, DO, FACOS, FASMBS

Twenty years ago, the National Institutes of Health issued the consensus statement outlining the indications for the surgical treatment of morbid obesity. Many factors have since brought weight loss surgery into the forefront of medical practices - not just the extremes of morbid obesity, but for the estimated 60% of Americans suffering from various degrees of obesity and associated diseases. These diseases include diabetes, high blood pressure, high cholesterol, heart disease, chronic joint pain, sleep apnea, urinary incontinence and acid reflux.

Essentially every bariatric operation is now performed laparoscopically with safety outcomes better than those of major operations such as joint replacement and open-heart surgery. Technology has also allowed for some procedures to be performed using "single incision" technique where the operation is performed through an incision in the belly button that is "hidden away."

The meticulous data and outcomes recording by the American Society for Metabolic and Bariatric Surgery has been invaluable for bringing to light the significant long term health and quality of life benefits of weight loss surgery.

The various common operations being performed today including the adjustable gastric band, Roux-en-Y gastric bypass and the sleeve gastrectomy work by several different mechanisms including the restriction of food and bypassing of intestines to limit absorption. Various hormonal and metabolic changes after this surgery cannot be overlooked as significant contributors to weight loss as well.

It is estimated that 10% of adult Americans currently suffer from diabetes. A recent report from the Centers for Disease Control (CDC) predicts that in our lifetime, 1 in 3 Americans will suffer from diabetes. Undoubtedly, bariatric surgery will develop a more prominent role in the management of this public health problem.

Several factors have brought the health benefits of weight loss surgery to the attention of virtually all medical disciplines including primary care physicians, endocrinologists, cardiologists, orthopedic surgeons, gynecologists, rheumatologists and pulmonologists. These include the safety profile of weight loss surgery, the irrefutable success of improving and putting into remission many chronic medical comorbidities and the significant long-term savings of public health dollars.

The American Diabetes Association has included bariatric surgery into the treatment algorithm of diabetes in patients suffering from obesity (BMI ≥ 35) and most bariatric surgeons suspect this trend will follow with other metabolic specialties. The improvement or remission type 2 diabetes after adjustable gastric banding occurs through significant weight loss primarily, whereas the remission of diabetes after gastric bypass occurs though metabolic changes in addition to weight loss. It is common for diabetes to leave the hospital after gastric bypass on a significantly reduced amount of their medications, if needed at all.

Recently the Food and Drug Administration (FDA) issued a panel advisory statement supporting the outcomes from an industry study revealing the statistically significant health benefits of gastric banding in patients suffering from obesity with lower body mass index. Though this will need further studies, it seems that eventually the American studies will fall in line with the guidelines of health care regions, such as Asia.

As the prevalence of bariatric surgery grows, the encounters between providers and bariatric surgery patients will increase. Long-term follow-up of these patients is instrumental to ensure long-term weight loss and the remission of health issues. The coordinated care between bariatric surgeons, primary care physicians and endocrinologists will ensure that vitamin needs, micro and macro nutritional considerations and the metabolic needs of the bariatric surgery patient will be meet.

Moalem Jacob, MD

Innovative Approach to Laparoscopic Adrenalectomy is Quicker, Reduces Pain in Recovery

A new surgical technique to remove benign adrenal tumors literally overturns a traditional laparoscopic approach.

Called posterior retroperitoneoscopic adrenalectomy, the procedure requires a patient to lay face-down while surgeons access the adrenal glands via three small incisions in the back. URMC is one of just a handful of U.S. medical institutions to offer the technique, joining prestigious centers such as Cleveland Clinic, Columbia University Medical Center, MD Anderson Cancer Center, and Brigham and Women's Hospital.

"Since the adrenal glands sit atop the kidneys, near the back of the body, a traditional laparoscopic approach through the front requires that other organs first be mobilized out of the way," said Jacob Moalem, M.D., assistant professor of Surgery at URMC. "But using this newer approach, the abdominal cavity does not even need to be entered. The adrenals can be approached much more directly, restricting the operation to the patient's retroperitoneum."

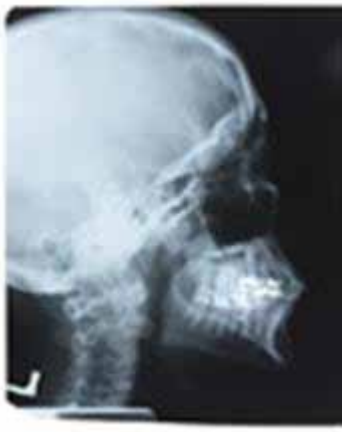
The technique offers fewer anatomical landmarks to guide the surgeon, which is the main reason it has been slow to catch on.

"Since the patient is lying face down, the anatomy is turned upside-down, making this operation unlike most other laparoscopic operations we're trained to do. A surgeon can feel like he's working through a rearview mirror," said Moalem, who trained in Germany to learn the procedure. "But once learned, we think it's better medicine. Not only does the surgery take less time than an anterior adrenalectomy, but it's safer, since no abdominal organs need to be manipulated, less painful, and the patient's recovery is much more rapid."

An assistant professor of Surgery at URMC, Moalem's clinical and research concentrations focus on cancerous and benign lesions and disorders of the thyroid, parathyroid and adrenal glands, and endocrine tumors of the pancreas. He also brings expertise in minimally invasive thyroidectomy and parathyroidectomy, and laparoscopic transabdominal and retroperitoneoscopic adrenalectomy.

"Since the adrenal glands sit atop the kidneys, near the back of the body, a traditional laparoscopic approach through the front requires that other organs first be mobilized out of the way"

Decades after Childhood Radiation, Thyroid Cancer a Concern



When children are exposed to head and neck radiation, whether due to cancer treatment or multiple diagnostic CT scans, the result is an increased risk of thyroid cancer for the next 58 years or longer, according to University of Rochester Medical Center research.

The study is believed to be the longest of any group of children exposed to medical irradiation and followed for thyroid cancer incidence. It was published in the December 2010 edition of the journal, Radiation Research.

The data also might provide some insight about why the rates of thyroid cancer continue to rise, as the general public is increasingly exposed to higher doses of radiation through more frequently used imaging tests such as computed tomography (CT), said lead author Jacob Adams, MD, MPH, an associate professor in the Department of Community and Preventive Medicine at URMC.

"Ionizing radiation is a known carcinogen and, in fact, about 1 million CT scans are performed every year on children five years or younger," Adams said. "Although CTs and other imaging tests are an important diagnostic tool and radiotherapy is an important treatment modality for cancer, with everything comes a risk. Our study attempted to measure the very long-term impact on thyroid cancer from medical irradiation. Our findings strongly suggest that those individuals exposed to irradiation from multiple CT scans to the head, neck and chest during early childhood and individuals treated with radiotherapy to the upper body as children have a lifelong increased risk of thyroid cancer."

Adams and colleagues indirectly evaluated the future risks of modern patients by assessing the rates of thyroid cancer in a group that was treated with lower-dose chest radiotherapy in Rochester, NY, between 1953 and 1987. The cohort had been treated during infancy for an enlarged thymus, a condition that physicians used to believe was a health problem. None of the radiation administered was for cancer, and thus the research is not confounded by a susceptibility to the disease.

Adams re-surveyed the population between 2004 and 2008, and compared the health status of the group to their siblings who had not received radiation. Thyroid cancer occurred in 50 of the 1,303 irradiated patients compared to only 13 of the 1,768 siblings. The association between radiation and thyroid cancer remained strong even after researchers accounted for other factors that could contribute to thyroid cancer risk.

Radiation doses in the mid-century group overlapped with current medical practices; however, in general, higher doses and less precision were used years ago. Doses at the lower end of the study cohort were comparable to a diagnostic pediatric chest CT given today, the study said. Not surprisingly, researchers found that thyroid cancer risk increased with higher doses of radiation.

The Rochester study confirmed the findings of a pooled review of five earlier population studies, and adds to the literature by showing that, at least in children, the risk of cancer due to radiation exposure continues for a median of 57.5 years.

The James P. Wilmot Cancer Center at URMC and the National Heart Lung and Blood Institute funded the study.

The Endocrine-Diabetes Care & Resource Center

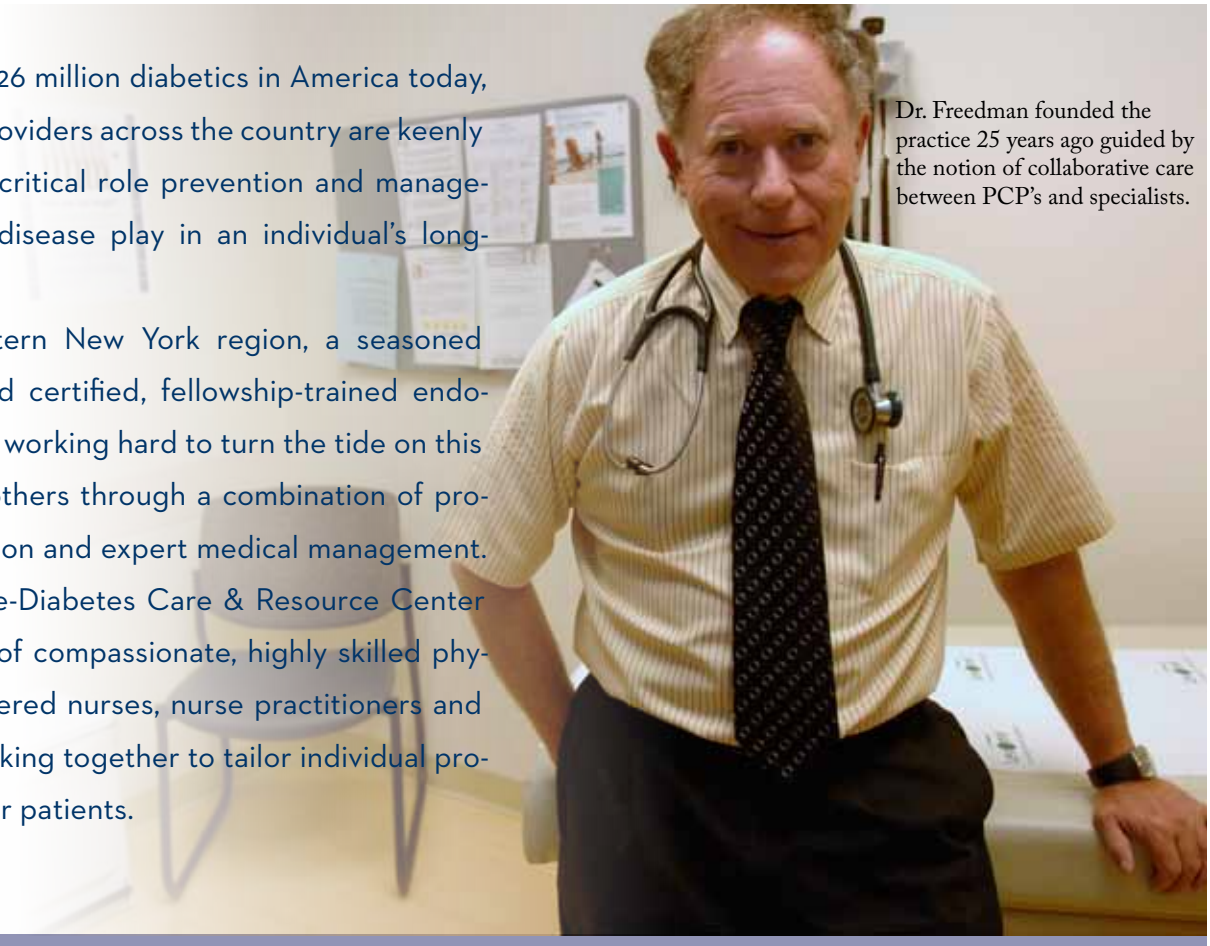
Co-Managing Patients through Education & Expert Care

By Julie VanBenthuysen

The Team works closely with each other - and with PCP's to tailor comprehensive and individualized programs for patients.

With nearly 26 million diabetics in America today, health care providers across the country are keenly aware of the critical role prevention and management of the disease play in an individual's long-term health.

In the Western New York region, a seasoned team of board certified, fellowship-trained endocrinologists is working hard to turn the tide on this disease and others through a combination of proactive education and expert medical management. The Endocrine-Diabetes Care & Resource Center is comprised of compassionate, highly skilled physicians, registered nurses, nurse practitioners and dieticians working together to tailor individual programs for their patients.



Dr. Freedman founded the practice 25 years ago guided by the notion of collaborative care between PCP's and specialists.

"Whatever stage of a condition our patients find themselves, we strive to provide a hands-on, personal approach so they can succeed in self-managing their disease," says Medical Director Dr. Zachary Freedman, Assistant Professor of Medicine at the University of Rochester.

The Vision

Dr. Freedman began the practice 25 years ago with the notion of collaborative care between primary care doctors and specialists treating patients for a scope of diabetic and endocrine conditions – from obesity and diabetes to hypothyroidism and adrenal diseases. "As a country with an exploding diabetic and obese population in particular, we recognized the need to provide broader resources to help our patients maximize disease control."

In recent years, the rising need has served to strengthen the Center's key areas of focus. Dr. Seth Charatz, DO and Senior Clinical Instructor in the University of Rochester's Endocrinology Division, says the multi-disciplinarian approach he shares with partners Dr. Freedman and Dr. Ritu Malik blossomed to the point where the Center needed to expand. With a new facility and wider community presence in place in 2001, the specialists could ensure more interaction between various providers and greater convenience for everyone. While they enjoy the broad aspects of the specialty, it's their commitment to helping patients improve their self-care that sets the practice apart. They also provide the latest infusions and injections and thoroughly evaluate patients to identify other potential underlying issues.

As a Center of Excellence, the practice has steadily grown. The Endocrine-Diabetes Care & Resource Center (DCRC) is the region's largest diabetes facility located conveniently on the Rochester General Hospital-Alexander Park Campus. The program is managed entirely in one location, offering patient's easier access to consultations and specialized care for Type 1, Type 2 and Gestational diabetes. Staff provides intensified insulin management utilizing insulin pumps and continuous glucose monitoring.

Education Critical

For more than a decade, the DCRC has provided quality individual and group education programs taught by experienced Certified Diabetes Educators (CDE). "Through a patient-focused, holistic approach, we can help patients in both preventing and managing diabetes," says Dr. Charatz.

"Insulin pens of today aren't the violent syringe of ten or 15 years ago."

With diabetes developing in even younger populations, the tremendous associated costs make compliance challenging, he says. While many insurance providers aren't required to provide education benefits, the majority of the Center's programs are covered with a nominal co-pay. "From the patient's first consultation, we can expedite care with all the resources at our disposal."

For women with Gestational diabetes, the Center has developed a program for pregnant women 24-40 weeks to help them optimize blood sugar control. "Once a patient is diagnosed by an ob/gyn, she can't afford to wait to be seen by a specialist," he adds. Within a week, patients are seen at the Center to work with the nurses and dieticians or an endocrinologist if insulin is required.

"An educated patient who self-manages the disease is the best possible patient." Many, he says, don't necessarily need to be followed by an endocrinologist to receive educational services. They can choose to work with their own PCP and come to the Center simply for further education. The Program is a four-time winner of the American Diabetes Association's Education Recognition Certificate, awarding efforts to help patients manage their condition at home.

Commitment to Thyroid Control

With the idea of "one-stop shopping" in mind, the practice has diversified to include a separate Thyroid Center within the same facility, offering comprehensive services in diagnosing and treating disorders of the thyroid gland. These include evaluation and treatment of thyroid nodules, hyper and hypo thyroidism and thyroid cancer.

"We discovered that patients were often undergoing a battery of tests, moving from point A to point B to point C," says Dr. Freedman. "One visit here can do quite a lot toward determining the patient's ultimate issue." This may include a Fine Needle Aspiration (FNA) to sample a thyroid nodule in an office-based setting. Using FNA, the doctors can often make a diagnosis within days and then proceed with referrals to surgery and nuclear medicine for treatment if necessary.

Patient-Centric Care

The practice's operating philosophy shines through in its many success stories. Ray Gaffney, a 30-year Type 1 diabetic, began working with the Center after being dissatisfied with the level of care he was receiving elsewhere. "I wanted a practice that was more patient-oriented and interested in day-to-day diabetic care," says Mr. Gaffney, who appreciates the Center's more relaxed atmosphere that immediately put him at ease.

When he met with CDE Jane Lyons-Patterson, who specializes in advanced insulin pump techniques and glucose sensors, he knew he was in the right hands. "She was attuned to what I was working on and we hit it off right away." As a proactive participant in his own care, Mr. Gaffney has always been willing to try new technologies and medications. While he has used an insulin pump for 25 years with consistent success, he enthusiastically agreed to try a new sensor pump technology for better daily monitoring. "Ms. Patterson introduced me to the pump and trained me on how to use it properly," he says. "She even helped ensure that my insurance would cover the cost." The pump's sensor enables Mr. Gaffney to achieve almost real time accuracy on his glucose levels. As someone who thrives on technology, he appreciates the opportunity to manage his condition online -- reviewing his charts and identifying any necessary changes to be made.

Coupled with the new insulin pump and regular exercise, Mr. Gaffney has managed to lose 26 pounds in the last three months. Seen alternately by Dr. Malik and Nurse Patterson every three months, he commends their commitment to the

latest products available to improve patient outcomes.

By taking ownership over his care, Dr. Malik says Mr. Gaffney represents the ideal patient who, through a personalized regimen, can reduce his diabetes complication rate by 40 to 50%. "The technology has evolved so much over the years, including continuous glucose monitors and easy to use injectables," she says. "The insulin pens of today aren't the violent syringe of ten or 15 years ago."

The Center has an active clinical trials program, which helps the doctors understand more about the diseases they help to prevent and treat – from diabetes, diabetic retinopathy and diabetic gastroparesis to early renal insufficiency, growth hormone deficiency, hyperlipidemia and hypertension.

Dr. Malik dedicates her practice to those with diabetes and thyroid problems using a team approach, working with patients and their primary care physicians.

Co-Managing Care

The Center's doctors agree that support from referring PCPs has enhanced their ability to offer patients the best in endocrine and diabetes care. "In recent years, doctors are recognizing the benefits of co-managing care to ensure the education element is strongly in place. It's easier for them to skip the educational aspects like lifestyle and diet changes, because that can be more daunting than taking medication," says Dr. Freedman. "Working together, however, PCPS more familiar with their patients' history and habits help the Center's staff to tailor a personalized program with everything they need to succeed."

Internist Dr. Gil Rubin at Genesee Health Services has been referring patients to the Center for years. Patients range from those poorly managing their diabetes, the pre-diabetic or glucose intolerant in need of diabetic teaching and nutrition education, and the overweight with thyroid and adrenal gland issues. "The Center is very accessible to my patients and a great resource to the community," he says. By offering comprehensive programs for nutrition and living with diabetes, he says, his patients have been pleased. Both professionally and personally, Dr. Rubin commends the practice for their dedication to proactive patient care.

Wide Ranging Programs

To that end, the Center offers a full spectrum of programs designed to educate and help patients manage their conditions, led by its staff of experienced Registered Dieticians and Nurses. All classes are equipped with smartboard technology and videoconferencing equipment, along with a library of books, videos, computers with relevant Websites and other resources. The education programs don't require a referral to an endocrinologist; they can be accessed individually based on patient needs. "Some patients are better at reading educational materials, others prefer participating in a group setting," adds Dr. Charatz. "We provide all the necessary resources so they're more involved in how they eat and exercise and stay compliant with medications."

With compliance always a challenge, the staff helps patients to better understand the medicines. "Through our programs, we can eliminate their fears about possible side effects, and why they're worth the cost."

All diabetes programs are recognized by the American Diabetes Association. Living Well with Diabetes is a group session providing all the information needed to stay healthy with diabetes, including medical management, preventing complications and exercise options. Nutrition and Diabetes classes review how

to enjoy eating with diabetes while maintaining blood sugar values. Preventing Diabetes focuses on how lifestyle changes are shown to reduce risk of developing the disease by 58%. Patients can receive one-on-one instruction with a CDE on insulin and glucose meter instruction, blood sugar monitoring, instruction and control, and pre-pump screening.

Nutrition and Weight Management services, while not covered by insurance, address issues like high cholesterol, high blood pressure and pre-diabetes. Significant others are encour

"An Educated Patient who self-manages their disease is the best possible patient." The resource room puts numerous resources in patients reach.

aged to attend to help support their love ones' efforts at behavior modification and meal replacement diets. "Since some patients still prefer to exercise closer to home, we can direct them on the right path so they truly are managing their own care beyond our facility," says Dr. Malik.

Reaching Out

As the numbers of newly diagnosed patients continue to rise, the practice recognizes the need to expand its services beyond Monroe County. Tele-medicine, practiced now at Newark-Wayne Hospital, has provided a unique, proactive way for the doctors to help patients manage their condition long-distance.

Moving forward, the Center hopes to duplicate its efforts in diabetes and thyroid care by strengthening its focus on other critical areas like Osteoporosis. "Bone disease is a major, growing concern because it is often under treated," says Dr. Freedman. He adds that bone density scans are only one tool used to determine if a patient has osteoporosis. "With more options available including lifestyle changes and infusion therapies, the Center can get more involved in diagnosis and treatment. We can be a stronger resource for our patients by ensuring there are no other diseases involved and identifying the best treatment regime for patients with the osteoporosis."

Across the board, the doctors see bright opportunities down the road, from improved insulins to closed loop systems where a pump recognizes a patient's blood sugar level and allows an insulin dose to kick in automatically. "In the last 15 years, many different classes of medications and new technologies have been developed for all the diseases we address," says Dr. Freedman. "Patients no longer come in thinking their health outcome will be in a downhill direction. Through our ongoing efforts to be better advocates for their care, they see the positive aspects of having more alternatives available to them."

Certified Diabetes Educators conduct group educational programs to help patients gain better understanding and encourage their engagement in the management of their disease.

New Links Seen Between Depression and Diabetes

Study Shows Depression May Raise Risk of Diabetes and Vice Versa

Depression and diabetes may be linked, according to new research in the Archives of Internal Medicine.

"People usually think of these as two isolated conditions, but there is growing evidence that they are linked behaviorally and biologically," says study researcher Frank Hu, MD, PhD, MPH, professor of nutrition and epidemiology at the Harvard School of Public Health in Boston. "This data provide strong evidence that we should not consider these two isolated conditions any longer."

About 23.5 million Americans have diabetes, and about 14.8 million Americans have major depressive disorder in a given year, according to statistics in the new report.

Of the 65,381 women aged 50 to 75 in 1996 who were study participants, 2,844 women were newly diagnosed with type 2 diabetes and 7,415 women developed depression in the ensuing 10 years.

Depression and Diabetes Risk

Depression increased the risk for diabetes, and diabetes increased the risk for depression, the study shows. Specifically, women who were depressed were 17% more likely to develop diabetes even after the researchers adjusted for other risk factors such as weight and lack of regular exercise.

Those women who were taking antidepressants were 25% more likely to develop diabetes than their counterparts who were not depressed, the study shows.

Women with diabetes were 29% more likely to develop depression after taking into account other depression risk factors, and those women who took insulin for their diabetes were 53% more likely to develop depression during the 10-year study.

While certain factors such as physical activity and body mass index may partially explain the link between depression and diabetes, they do not completely explain the connection, Hu tells WebMD.

The common denominator may be stress, Hu says.

People who are depressed have elevated levels of stress hormones such as cortisol, which can lead to problems with glucose

or blood sugar metabolism, increased insulin resistance, and the accumulation of belly fat – all diabetes risk factors, he says.

But "there is long-term stress and strain associated with diabetes management such as blood sugar control and treatment for complications, and this can lead to decreased quality of life and increased probability of depression," he says.

Second Opinion

"Both are very common diseases," says Leonid Poretsky, MD, director of the Friedman Diabetes Institute at Beth Israel Medical Center in New York City. "Diabetes can make depression worse because diabetes is chronic illness with a lot of worries."

"So much of the treatment for diabetes is self-care, and people who are depressed may not take good care of themselves," he says. "They don't exercise as much and may have other issues in terms of watching their diet, checking their blood sugar, and taking medications."

Certain medications used to treat depression can also increase risk for developing diabetes, he says.

"It can be a vicious cycle. Both diseases have to be addressed at the same time," Poretsky says. "If control of diabetes is deteriorating, look for depression as a possible cause of this deterioration."

"This study is interesting, and one of a number of studies that points to a bi-directional link between diabetes and depression," says Jeffrey Gonzalez, PhD, assistant professor of medicine and epidemiology and population health at Albert Einstein College of Medicine in the Bronx, N.Y. "The emotional side of diabetes is an important one to attend to in the treatments of this illness."

"This speaks to the burden associated with diabetes," Gonzalez says. "Changes in diet and lifestyle, having to take injections can lead to increased levels of distress."

Doctors need to do a better job of addressing the emotional side of diabetes, he says. "We know that if you are distressed once you do have diabetes, you are at increased risk for poor self-management, complications, and death."

Source: WebMD Health News

Cervical Cancer: Screening, Prevention and Treatment in 2011

Eugene P. Toy, MD

Worldwide, nearly half a million women each year are diagnosed with cervical cancer. Infection with the human papillomavirus (HPV) is the necessary cause of this disease. In New York State, over 900 women are diagnosed with cervical cancer with over 200 deaths reported each year. If diagnosed early, precancerous changes called dysplasia can be treated and prevent progression to invasive cancer. Late diagnosis will make surgical resection impossible and necessitate radiation and chemotherapy to attempt possible cure.

Infection with HPV is the single most contributory factor to the risk of developing cervical cancer. Factors associated with contracting HPV are related to sexual activity. Early age of sexual debut, multiple sexual partners, concomitant sexually transmitted disease, and smoking are all risk factors for cervical dysplasia and cancer. In addition, non-compliance or lack of routine screening especially in older post- menopausal patients can result in advanced presentation of cervical cancer.

The Pap test was developed as a screening tool to detect a pre-malignant state using a simple cervico-vaginal swab. The traditional Pap test using a wooden spatula to spread cells onto a slide for evaluation has evolved to current "brooms" and brushes that allow cervical cells to be suspended in liquid media and filtered then evenly spread onto a slide for more discriminatory evaluation. The first Pap test should be obtained at age 21 and continued annually until directed otherwise by one's provider. Pending the results of the screening Pap tests, further evaluation and tissue biopsy is warranted in the setting of an abnormal Pap result. When there is an equivocal abnormality known as "atypical cells", the recommendation is to perform HPV testing from the liquid based media obtained during the Pap test. Further triage of these abnormalities results in a more specialized viewing of the cervix called colposcopy. Simple vinegar or acetic acid is used to cleanse the cervix and remove obscuring mucous. Abnormal areas are magnified with aid of the colposcope and guided biopsies are obtained to document the severity of disease. If an actual tumor mass or lesion is present, colposcopic-guided biopsy may not be conclusive and a core biopsy of the tumor is warranted.

Once the diagnosis of cervical pre-cancer (dysplasia) or cancer is made, treatment is based on the severity of disease. Mild dysplasia related to HPV infection will usually resolve spontaneously but can be affected by a patient's inherent immune status and response to the disease. Individuals such as those with HIV infection or transplant patients with chronic immunosuppression may not be able to clear mild disease and will warrant closer follow-up. Moderate or severe dysplasia usually requires intervention using some form of ablative surgical procedure. These include cryotherapy (freezing), laser ablation, or excision by wire (loop excision) or scalpel (knife excision). Even the most severe pre-cancerous lesions can be effectively treated using ablative techniques which are usually performed in an outpatient setting.

In the event that invasive cancer is diagnosed, evaluation by a gynecologic oncologist that specializes in treatment of cervical cancer is absolutely necessary. A clinical stage of the disease will be ascertained by the treating physician and recommendations made for definitive treatment. Radical surgery can obviate the need for adjuvant therapy but many times both surgery and subsequent radiation combined with chemotherapy are necessary to prevent relapse.

> "even the most severe pre-cancerous lesions can be effectively treated using ablative techniques which are usually performed in an outpatient setting"

Two highly effective vaccination series have been developed which target the most common cancer-causing types of HPV. These HPV vaccines called Gardasil® (Merck) and Cervarix® (GlaxoSmithKline) have been shown to prevent persistent infection with these HPV types and prevent the resultant pre-cancerous changes that can occur in the stepwise progression to cervical cancer. The vaccine is approved for administration to young girls and women between ages 9-26 and is a series of three shots. These can be obtained through any primary care physician such as a family practitioner, pediatrician, internist, or gynecologist. The side effects are limited to local skin reaction and/or allergy to the vaccine. Long term follow-up data has shown continued protective immunity against the virus and prevention of cervical cancer.

ASK THE EXPERT

Do you have a clinical, financial, legal or business question for our experts? Our contributing authors and area specialists will respond.

Please email your question to WNYPhysician@rochester.rr.com.

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 through the transition.

What is My Liability?

Contractual Non-Compete Clauses

James E. Szalados, MD, MBA, Esq.

Issue

Contracts, as legal documents, contain language which has special meaning to the context in which it is written; such language is referred to as 'term of art.' In order to properly understand the meaning and legal implications of contract verbiage, consultation with an attorney is advised before any contractual agreement is entered into. A common mistake is to enter into a contract and not seek legal advice until the contract is about to be, or has already been, broken (and liability is imminent). Contractual terms may be subject to negotiation, but only before the contract is formalized and the terms become binding.

A non-compete clause (NCC), [also referred to as either a covenant not-to-compete or restrictive covenant], refers to contract language in which one party (generally the employed physician) agrees not to pursue similar work in competition against another party (usually a hospital-employer). A typical NCC might appear as follows:

For a period of two years after Employee is no longer employed by Employer, Employee shall not, directly or indirectly, within 25 miles of Employer, be employed by any competitor of Employer in any similar job position as that which Employee last held with Employer, nor carry on any business….

A contract should offer protection to both parties. NCCs must protect legitimate business interests. The intent of a NCC is to minimize the likelihood that following a period of employment, ended by either termination or resignation, an employee might start a similar practice either independently or with a competitor, and gain unfair competitive advantage over the former employer through a knowledge of confidential information such as business practices, operational secrets, client data, or marketing plans. Alternatively, the departing employee might use data or influence to solicit clients from the prior employer's business.

NCCs should be reviewed before signing the contract, since litigation of NCCs in the courts can be costly and the outcome may be uncertain. Some jurisdictions, such as Massachusetts and California, disfavor and invalidate NCCs for all but equity stakeholders. On the other hand, most jurisdictions, such as New York will presumptively enforce NCCs as long as the limitations contained in the NCC are 'reasonable.'

Courts, as a matter of law and public policy, will not typically allow an employer to 'restrain the trade' of former employees, beyond the extent which is absolutely necessary to protect the employer. NCCs will typically specify three elements: (a) the geographic scope; (b) the scope of services; and, (c) the duration. NY courts will consider NCCs to be reasonable if the weight of the evidence supports that (1) the NCC restrictions are no greater than required to protect the legitimate business interests of the employer; (2) does not impose undue hardship on the employee; and, (3) is not injurious to the public.

For example, using the clause above as an illustrative example, where an NCC is so great in geographic reach that it exceeds the catchment of the business or otherwise constitutes an unfair restraint on the employee, the NCC might be legally challenged. Contract terms should be defined as specifically as possible to avoid being construed as overly vague. Where the availability of similar services in the area is limited, such as a scarcity of similar specialists, the legal system may chose not to perpetuate an employer's monopoly. Geographic breadth is very dependent on the nature of the practice and the geographic circumstances. Physician employees in some specialties, such as Emergency Medicine or Anesthesiology, see patients as they arrive in hospitals for their care and these specialists do not

exercise a sufficient control over their patients so as to control referrals or patient flow. In such cases, the underlying business interest may be suspect. Furthermore, physicians may be held to a NCC in the specialty in which they were initially hired, but it may not be reasonable for a NCC to restrict a specialist from practicing as a generalist or in a different subspecialty. Two years is widely considered to be the upper reasonable limit of enforceability of an NCC, Nonetheless, even where the enforceability of the entire NCC clause is challenged, a court may decide to uphold some but not all elements of the clause or it may modify the NCC to make it 'reasonable.'

In cases where the employee signed a contract because the NCC was accompanied by a special 'consideration' such as a signing bonus, courts will usually weigh such consideration favorably, and be reluctant to strike or modify the clause, even where the clause is otherwise unreasonable on its face. In the case of an up-front consideration, courts will defer 'employee-choice' choosing to believe that where the employee was given a choice, made such an informed and voluntary choice, and the employer relied upon the employee's choice, that NCC provision must in fact be reasonable. Under some circumstances, a new prospective employer may be permitted to 'buy out' the clause and pay the former employer to release the employee from the NCC limitations.

It should be noted that NCCs are distinct from but very similar to two other contractual clauses which may also be written into a contract to protect employers' interests: (1) the non-solicitation clause, wherein employees, who leave voluntarily or are terminated for cause are prohibited from soliciting patients, employees, or referral sources from their former employer; and (2) the confidentiality agreement, which restricts a departing employee from disclosing proprietary employer information.

In conclusion, NCCs remain legally viable tools under NY contract law to protect employers from unfair competition by employees. Where such clauses are challenged, courts will scrutinize the NCC to determine if the provisions are reasonable to protect the interests of the employer. Each employment contract should be tailored to the unique and specific underlying circumstances which it addresses in order to minimize legal costs and liability.

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.

Helicopter Transport Increases Survival for Seriously Injured Patients

Mark Gestring, MD
Director of the Kessler Trauma Center

First National Study Shows Helicopters Have Positive Impact

Severely injured patients transported by helicopter from the scene of an accident are more likely to survive than patients brought to trauma centers by ground ambulance, according to a new study published in The Journal of Trauma: Injury, Infection, and Critical Care. The study is the first to examine the role of helicopter transport on a national level and includes the largest number of helicopter-transport patients in a single analysis.

The finding that helicopter transport positively impacts patient survival comes amid an ongoing debate surrounding the role of helicopter transport in civilian trauma care in the United States, with advocates citing the benefits of fast transport times and critics pointing to safety, utilization and cost concerns.

> "The goal is always to get the sickest people to the trauma center as fast as possible, and our data suggest that's exactly what's happening."

The new national data shows that patients selected for helicopter transport to trauma centers are more severely injured, come from greater distances and require more hospital resources, including admission to the intensive care unit, the use of a ventilator to assist breathing and urgent surgery, compared to patients transported by ground ambulance. Despite this, helicopter-transport patients are more likely than ground-transport patients to survive and be sent home following treatment.

"On the national level, it appears as though helicopters are being used appropriately to transport injured patients to trauma centers," said Mark Gestring, MD, lead study author and director of the Kessler Trauma Center at the University of Rochester Medical Center. "Air medical transport is a valuable resource which can make trauma center care more accessible to patients who would not otherwise be able to reach such centers."

Gestring serves as a volunteer board member for Mercy Flight Central Inc., a Canandaigua, NY-based air medical services company.

Previous studies on the use of helicopters to transport injured patients report mixed results, but are limited by small patient populations from single institutions or specific regions. Some smaller studies propose helicopters are overused, transporting patients with relatively minor injuries who would likely fare as well if transported by ground. However, the new national data does not reveal such a trend.

"The goal is always to get the sickest people to the trauma center as fast as possible, and our data suggest that's exactly what's happening. We're not seeing helicopters being used to transport trivial cases, which is undoubtedly a poor use of resources," noted Gestring.

The study included patients transported from the scene of an injury to a trauma center by helicopter or ground transportation in 2007. Gestring and his team used the National Trauma Databank to identify 258,387 patients – 16 percent were transported by helicopter and 84 percent were transported by ground.

The helicopter-transport patients were younger, more likely to be male and more likely to be victims of motor vehicle crashes

or falls, compared to ground-transport patients. Overall, almost half of the helicopter-transport patients were admitted to the intensive care unit, 20 percent required assistance breathing for an average of one week and close to 20 percent needed an operation. Even though they arrived at the hospital in worse condition, they ultimately fared better than those transported by ground.

While the study shows that air transport does make a difference in patient outcomes, there is no data available to explain why patients transported by helicopter do better than those transported by ground. Study authors assume that speed of transport – helicopters are capable of higher speeds over longer distances regardless of terrain – and the ability of air-medical crews to provide therapies and utilize technologies that are not universally available to ground unit crews, are the main drivers of positive patient outcomes.

Helicopter transport has been an integral component of trauma care in the United States since the 1970s, due in large part to the military's experience transporting sick or injured soldiers during war time. The availability of helicopters in the civilian setting has been credited with improving trauma center access for a significant percentage of the population.

According to Gestring, the study has some limitations. It is not possible to evaluate the multitude of factors that drive the individual decisions to transport a patient by helicopter in each and every case. In addition, the general nature of the dataset limits specific conclusions that may be drawn or applied to any individual trauma system.

The Kessler Trauma Center at the University of Rochester is Western New York's largest trauma center, serving Rochester and the nearly 2 million people in the 17 counties which surround the Finger Lakes Region. The Center is a Level-1 trauma center, providing 24-hour access to comprehensive emergency services. Physicians treat more than 3,000 traumatic injury patients a year.

In addition to Gestring, Joshua Brown, B.A., Nicole Stassen, M.D., Paul Bankey, M.D., Ph.D., Ayodele Sangosanya, M.D., and Julius Cheng, M.D., M.P.H., from the University of Rochester Medical Center participated in the research. The study was conducted and funded by the University of Rochester.

Your Opinion Matters

Spend 5 Minutes and Make an Impact

Each month *Western New York Physician* strives to publish relevant and interesting content that truly reflects the local voice of practice management and the business of medicine.

In an effort to keep improving, we need your help.

So that we may have a better understanding of the issues that are most important to you, your patients and your practice, we hope you will spend a few minutes and take our brief and confidential online survey.

www.surveymonkey.com/s/WesternNYPhysician

We thank you for participating.

Safely Caring for Obese Patients in the Office Practice Setting

The Risk

Obesity is a serious health issue of epic proportion in the United States. Physicians' offices may not be well equipped to accommodate obese patients. Injuries can occur if appropriate equipment is not available to care for these patients. Further, bias or ambivalence by the healthcare team in treating obese patients can negatively affect patient care and lead to poor outcomes.

Recommendations

Providing a safe environment while optimizing sensitivity to the needs of the obese patient will enhance patient care and minimize your exposure to claims of negligence.

1. **Examination rooms and waiting areas should contain appropriate and safe furnishings, such as large sturdy chairs, high sofas, benches, or loveseats that can accommodate obese patients.**

2. Diagnostic and interventional equipment that can accommodate morbidly obese patients should be available, if regularly needed. This may include, but is not limited to:
   - Appropriate scales for patients who weigh more than 350 lbs.
   - Extra-large adult-size blood pressure cuffs
   - Gowns to accommodate patients weighing more than 350 lbs.
   - Extra-long phlebotomy needles and tourniquets
   - Large examination tables
   - Toilets that can accommodate patients who weigh more than 300 lbs.
   - Sturdy grab bars in bathrooms
   - Sturdy step stools in examination rooms

3. The staff must be knowledgeable about the weight limits of their office equipment. Color coded labels can be used to discreetly identify weight limits. Further, the office staff must be educated and trained in the use of safe techniques for lifting and transferring obese patients.

4. While there are many medical complications of obesity, these patients are less likely to obtain preventative care and more likely to postpone or cancel appointments because of embarrassment and/or a feeling of bias on the part of healthcare providers due to their weight. Patient support and follow-up are important.

5. Healthcare providers must address their own potential for weight bias. Recognize your pre- conceived ideas and attitudes regarding weight. Learn how to give appropriate feedback to patients to encourage healthful changes in behavior. Encourage patients to actively participate in their plan of care and set goals.

6. Educate the staff about the needs of this patient population to enhance their ability to demonstrate understanding, respect, and sensitivity to these patients.

Diagnosis of Posterior Tibial Tendon Dysfunction

David V. Chazan, DPM, FACFAS

Posterior tibial tendon dysfunction can be a painful and debilitating pathology.

A detailed history is imperative especially when determining whether any type of trauma has occurred. These patients present with the chief complaint of pain and lowering of the longitudinal arch.

Loads exceeding 200 lbs on the foot will increase muscle activity with the posterior tibial tendon being the most stressed. This can occur from trauma direct or indirect, obesity, heavy loading, severe twisting and over use. Other use factors such as inflammatory joint or collagen disease such as rheumatoid arthritis and vascular disease can cause or facilitate posterior tibial tendon dysfunction.

The actual pathology has been divided into four groups: Group I is an avulsion of the tendon from the insertion on the navicular Group II patients demonstrated a midsubstance rupture or tear Group III patients has a longitudinal tear with elongation Group IV patients presented with tenosynovitis only.

DIAGNOSIS

The most common presenting finding is a progressive unilateral loss of the longitudinal arch with subsequent heel valgus and forefoot abduction. There is a loss of endurance and difficulty performing previously mastered and tolerated tasks. Weakening or loss of function of the posterior tibial tendon makes inversion or supination of the foot difficult or impossible. A palpable defect can be present. In patients with an incomplete or longitudinal rupture a palpable enlargement of the tendon may be found.

CLINICAL EVALUATION

With the patient standing barefoot with his back to the examiner, one will see exaggerated heel valgus diminished or absent longitudinal arch, medial talar bulging, and forefoot abduction resulting in "too many toes sign." The number of toes seen can be indicative of the severity of the condition. Gait will tend to be slow, antalgic and a propulsive with a wider angle of gait on the affected side. The patient will have difficulty or be unable to perform toe raiser and the heel will remain everted and pronated when standing on their toes.

Radiograph may demonstrate unilateral pronation, increase in the talocalcaneal angle, displacement of the cyma line anteriorly, loss of the navicular coverage on the talar head and pseudo sinus tarsi formation. If posterior tibial tendon dysfunction has been present for a long time, degenerative changes of the ankle, tarsal and midtarsal joints may be seen.

While the diagnosis of posterior tibial tendon dysfunction comes from physical examination, confirmation is made from MRI studies. MRI studies can vividly show complete, incomplete ruptures as well as longitudinal tears of the tendon.

TREATMENT

One must consider the patient's age, physical status, vascular and neurologic status. In debilitated, inactive or elderly patient's conservative treatment may be all that is needed. The treatment protocols include immobilization, rest, NSAIDS, orthotics, ankle foot orthosis (AFO), shoe modification or double upright or patella tendon weight-bearing bracing. Inversion – eversion control devices may be helpful. Injectable cortico-steroids are contraindicated.

In patients who are healthy and where rupture or tear of the posterior tendon has been confirmed surgical repair maybe indicated.

In conclusion it is hoped that one will have a greater appreciation of this severely debilitating pathology.

David V. Chazan, D.P.M., F.A.C.F.A.S. and his partners, Dr. Edward J. Bonavilla and Dr. Joseph L. Carbone practice podiatric medicine and surgery at Rochester Foot Care Associates, LLP.

Why the other side hates to see us on your side.

- We go to bat for you and preserve your good name.
- We aggressively defend and resist any payment for frivolous claims.
- We are a tough team to beat and we don't give up.
- We have the finest defense attorneys in the State, respected medical experts, and the country's largest and most experienced claims staff.
- We are not just your liability insurer. We are your legal guardians.

We are MLMIC.
Our defense never rests.

Medical Liability Mutual Insurance Company (MLMIC) is the one ally you want when you enter the courtroom and your practice and reputation are on the line. The jury may be out. But, you can feel confident, knowing you are protected by the one company that has successfully defended more New York physicians than all other insurers combined.

Exclusively endorsed by MSSNY since 1975, MLMIC is a mutual company, owned and operated by the physicians we insure. For more information and an application, call 800-275-6565 (NYC), 800-356-4056 (Syracuse), 877-777-3560 (East Meadow), or 800-635-0666 (Latham). ■

Endorsed by MSSNY

MLMIC Medical Liability Mutual Insurance Company

Our defense never rests.

New York
Latham
Syracuse
East Meadow

WHAT'S NEW IN Area Healthcare

University Cardiovascular Associates is Pleased to Announce that Barbara Kircher, MD, FACC has Joined the Practice

Barbara Kircher, MD, FACC

Dr. Kircher earned her medical degree from the ***University of Virginia in Charlottsville***, completed her Residency at ***University of Michigan, Dept. of Medicine in Ann Arbor***, an Echocardiography Fellowship at the ***University of California in San Francisco*** and a Fellowship at the ***University of Maryland, Cardiology, in Baltimore.***

She is Board Certified in Internal Medicine and Cardiovascular Disease, and is a Fellow of the A***merican College of Cardiology, American Heart Association*** and the ***American Society of Cardiac Angiography.***

Greater Rochester Orthopaedics is pleased to announce that Gary B. Tebor, MD has joined the practice

Gary B. Tebor, MD

Dr. Tebor's expertise and clinical practice includes all aspects of pediatric orthopaedics including the treatment of developmental and neuromuscular conditions, scoliosis and trauma.

A graduate of the ***Albany College of Medicine***, Dr. Tebor completed his orthopaedic residency at ***Albany Medical Center, Albany College of Medicine.*** He completed his fellowship training in pediatric orthopaedics as a Peabody Fellow in ***Pediatric Orthopaedic Surgery at Massachusetts General Hospital, Harvard Medical School.***

Dr. Tebor is an active member of several professional organizations including the: ***American Academy for Cerebral Palsy & Developmental Medicine, American Board of Orthopaedic Surgeons, Pediatric Orthopaedic Society of North America and the Scoliosis Research Society***. He is an Associate Professor in the Department of Orthopaedics and Associate Professor of Clinical Pediatrics at the ***University of Rochester*** with privileges at ***Unity Hospital, Rochester General Hospital, Strong and Highland Hospitals***. Dr. Tebor is also Staff Consultant at the ***Schriner's Hospital for Children*** in Erie, Pennsylvania.

The American Academy of Orthopaedic Surgeons has selected Dr. Tebor as a member of their Developmental Dysplasia of the Hip Guideline work group. This group is developing guidelines for the treatment of all forms of hip dysplasia

Markowitz Joins OcuSight Eye Care Center

Gary D. Markowitz, MD

Gary D. Markowitz, MD recently joined the **OcuSight Eye Care Center** in Rochester, New York. Dr. Markowitz has 16 years' experience caring for the eye care needs of children from Rochester and throughout Western New York and caring for adults with strabismus.

Dr. Markowitz is a board certified ophthalmologist providing comprehensive medical and surgical pediatric eye care for routine and complicated conditions including strabismus, "lazy eye," tear duct abnormalities, and adult strabismus.

Dr. Markowitz is a Diplomat of the ***American Board of Ophthalmology***, a Fellow of the ***American Academy of Ophthalmology***, a Specialty Fellow of the ***American Academy of Pediatrics***, and a Member of the ***American Association for Pediatric Ophthalmology and Strabismus***. He is a Clinical Professor of Ophthalmology at the ***University of Rochester School of Medicine and Dentistry*** where he assists in the care of patients and the training of resident physicians on a voluntary basis. He continues to be involved in national, multicenter studies of new treatments for visually disabling conditions of childhood.

Dr. Roy Kim Joins the Rochester Eye Associates Team

Dr. Kim brings 16 years of experience to **Rochester Eye Associates**. He trained at the ***Illinois College of Optometry*** in Chicago, obtaining a Doctorate in Optometry, followed by Residency in Ocular Disease from ***Bedford VA Hospital*** in Massachusetts.

He is currently involved in professional societies, including ***American Optometric Association, New York State Optometric Society***, and ***Rochester Optometric Society*** and has participated in several international missions to provide ***Gift of Sight*** to third world countries such as Dominican Republic, Chile, Morocco, Honduras, and Mexico.

Pluta Cancer Center Promotes Dr. Marcia Krebs to Chief of Medical Oncology


Marcia Krebs, MD

Dr. Krebs joined Pluta Cancer Center in June, 2009 as a medical oncologist. In her new role, she will continue to see patients while coordinating such projects as electronic medical records and certification updates with the Center's medical oncology physicians.

"We are pleased to announce the promotion of Dr. Krebs," said Pluta Cancer Center President and CEO **John Oberlies.** "From her first day on the job, our patients have benefited from her oncology expertise and patient-centered approach."

Board certified in medical oncology and internal medicine, Dr. Krebs joined ***Pluta Cancer Center*** after serving as medical director and inpatient palliative care physician consultant at ***Shore Cancer Center***. She received medical training at the ***University of Iowa College of Medicine***, graduating in 1996, and completed residency and a fellowship in oncology at ***Barnes-Jewish Hospital*** at ***Washington University School of Medicine.*** Dr. Krebs resides in Pittsford, N.Y.

Highland Hospital Receives "Get With The Guidelines" Gold Plus Performance Achievement Award

Award demonstrates Highland's commitment to quality care for stroke patients

Highland Hospital has received the ***2010 American Heart Association/ American Stroke Association's Get With The Guidelines® Stroke Gold Plus Performance Achievement Award.*** The distinction is the highest honor of its kind and recognizes Highland's commitment and success in implementing excellent care for stroke patients, according to evidence-based guidelines.

"The care of stroke patients requires a collaborative, multidisciplinary approach from the time of emergency department arrival through hospital discharge," said **Adam Kelly, M.D.**, the director of the stroke program and Assistant Professor of Neurology, ***University of Rochester Medical Center***. "This award is a tribute to all current and past members of our Highland Hospital stroke program for their excellent clinical care."

"I'm very proud of our sustained focus on providing top-quality care to stroke patients, as this award demonstrates," said Vice President/Chief Operating Officer **Cindy Becker.** "This achievement, and the addition of our new Neuromedicine Unit scheduled to open in 2011, reflects our commitment to raising the level of care for stroke and other neurological conditions in our community."

Get Your Tickets to the Highland Hospital Gala 2011 on March 26

Ted Kennedy, Jr. will be the guest speaker at this year's event. Highland's gala is an annual fundraiser for the hospital presented by the ***Highland Foundation***. This year's proceeds will benefit the hospital's new Neuromedicine Unit, scheduled to open this summer. Unique to the Rochester area, the unit will provide integrated patient care. Neurologists, neurosurgeons and specially trained staff will work as a team to deliver specialized care to patients who have undergone brain and spine surgery, head and neck surgery or suffer stroke and other neurological issues. The 22-bed unit will include state-of-the-art private rooms as well as six step-down beds to ensure patients and their families recover in a comfortable environment.

In addition to Kennedy's keynote speech, the evening will include a special performance by **Garth Fagan Dance**, a silent auction, dinner, and live music and dancing. Tickets are $200 per person and available by contacting (585) 341-0530.

PHOTO CAPTION: Michael F. Kamali, MD

Michael F. Kamali, MD Named Chair of URMC Emergency Medicine

Michael F. Kamali, MD, associate professor of Clinical Emergency Medicine, has been named chair of the ***University of Rochester Medical Center*** (URMC) Department of Emergency Medicine after a 10-month national search.

Kamali has been a faculty member at URMC for more than 10 years, serving in the capacity of assistant medical director of the Department of Emergency Medicine, interim medical director, director of quality assurance, and most recently as acting chair of Emergency Medicine. He also currently is medical director of Monroe Ambulance.

"Dr. Kamali's strengths as a clinician, teacher and administrator have made a significant impact over the last decade in Emergency Medicine, particularly during his tenure as acting chair," said **Mark B. Taubman, MD**, professor of Medicine and dean of the ***University of Rochester School of Medicine and Dentistry.*** "We are pleased he will continue to lead the department into a future that undoubtedly will hold exciting challenges related to compassionate patient care, resident education, and clinical and translational research."

Advertiser Index

"Is there an easier way to monitor my financial progress?"

Comprehensive wealth management can provide the clarity you need.

With today's complex financial markets and tax laws, it is getting increasingly difficult to manage the multiple aspects of your financial life. At Manning & Napier Advisors, Inc., we recognize the importance of ongoing wealth management and offer a wide range of consulting services designed to properly position our clients' portfolios. By combining the expertise of our highly qualified team of analysts, we can offer solutions to questions regarding financial planning, asset allocation, transition planning, portfolio analysis and much more.

To learn more, please contact us at (585) 325-6880 or visit us at www.manningnapieradvisors.com.

40

CELEBRATING 40 YEARS

Manning & Napier Advisors, Inc.

Reach

Every Physician *Every* Month

Western New York Physician

More than 3,500 physicians, practice administrators and healthcare leaders turn to Western New York Physician for current information and a local perspective on healthcare in our region.

Each month delivers engaging and relevant articles on clinical advances, emerging technologies, new product news and current insight on practice management resources and tools.

Target this unparalleled audience of healthcare decision makers to

- **Strengthen Brand Identity**
- **Create Practice Visibility**
- **Increase Product and Service Sales**
- **Stimulate Referrals**
- **Invite New Patients and Business**

To discuss a customized marketing solution for your practice or business

WNYPhysician@rochester.rr.com *or* **(585) 721-5238**