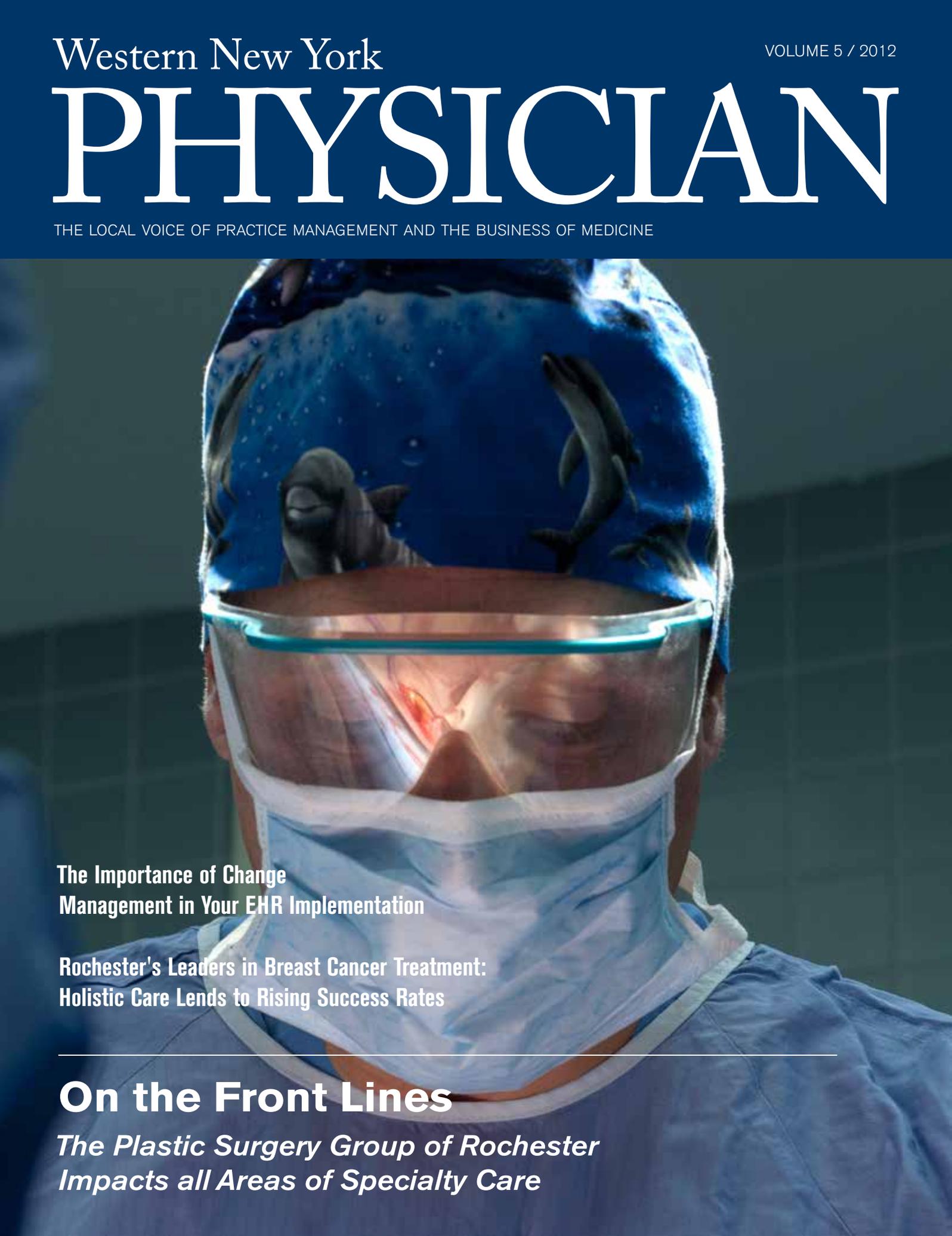


Western New York

VOLUME 5 / 2012

PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



**The Importance of Change
Management in Your EHR Implementation**

**Rochester's Leaders in Breast Cancer Treatment:
Holistic Care Lends to Rising Success Rates**

On the Front Lines

*The Plastic Surgery Group of Rochester
Impacts all Areas of Specialty Care*



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On the Front Lines

The Plastic Surgery Group of Rochester Impacts all Areas of Specialty Care

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On the cover: Dr. Mark Davenport in the operating room.

Credit: RIT Biomedical Photographic Communications Surgical Photography Thomas Way 2010



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Welcome to Vol #5 of *Western New York Physician* where you will find informative stories and articles about and for physicians in western NY.

As the magazine has grown in popularity, it's often the case where there are more articles than there are pages – and this was true in this issue. My thanks to each of the invited experts who shared their time, insight and perspective on a variety of issues related to the care of patients with cancer.

Our Cover Story visits the expanding group of surgeons at The Plastic Surgery Group of Rochester. While plastic surgery commonly conjures up images of breast implants and Botox, more often plastic surgeons play the critical role of helping patients surgically recover their physical form and function after devastation from cancer treatment, burns and other trauma or deformity. As one of the larger, private plastic surgery groups in the state, the highly-specialized and esteemed team of surgeons at The Plastic Surgery Group of Rochester is caring for countless patients in our community and around the globe.

In the Practice Management section, Boylan Code provides legal clarity on the impact of entity selection in the private practice setting and the inherent value of having well-developed shareholder and partner contracts in place. Change Management – what is it and why is it so important? The savvy experts at Innovative Solutions offer three critical steps to ease your office successfully through the transition.

We hope you enjoy and find value in these and all the other articles included in this issue. As always, please feel free to contact me with any comments or suggestions.

Best,

Vol #6 focuses on The Aging Patient – if you would like join in the discussion or submit an article, please email the publisher – Andrea Sperry at:

www.WNYPhysician.com.

Western New York PHYSICIAN

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Pain Management in Cancer Patients



Calvin Chiang, M.D.



Approximately one million patients are diagnosed with cancer each year, with pain being among their most common symptoms. In fact, up to 90 percent of patients with advanced cancer have significant pain, making the management of this symptom a vexing challenge for practitioners.

A gamut of etiologies can cause or contribute to a patient's pain: it may be due to inflammatory response or mass effect from the primary or metastatic lesions, or from hypercalcemia or other neuroendocrine effects. Lesions can also cause radicular pain. For example, patients with breast, lung and prostate malignancies frequently develop mets to the thoracic spine, resulting in local back pain or radicular pain. Severe neuropathic pain may also be secondary to treatment from chemotherapy, such as plant alkaloids (vincristine/vinblastine), platinum-based drugs (carboplatin), taxenes or epothilones. Pain can also be due to other treatments, including post-surgical pain and radiation-induced etiologies.

Clearly, cancer pain needs to be treated aggressively, particularly for those who have more aggressive and life-limiting diseases. "Step therapy" is advocated by the World Health Organization, with Tylenol and nonsteroidal anti-inflammatory agents recommended as initial therapy. These may be particularly beneficial in patients with bone metastases, but they do tend to be forgotten when "moving up the ladder," when opioid therapy is initiated.

Opioid medications, however, are not without significant side effects that limit their use, including excessive sedation, pruritis, and respiratory depression. Patients can become tolerant to these side effects, with the exception of constipation. Simple bowel regimens can manage the constipation, but more extreme symptoms may require treatment such as methylal-trexone, given SQ every other day as needed, to produce rescue bowel movements, or tapering of the opioid. Additionally,

with respect to the risk of opioid therapy, recent studies suggest that cellular immune suppression due to opioid therapy may potentially stimulate the growth of cancer cells. Finally, certain painful conditions are more resistant to traditional opioid therapy, particularly neuropathic pain, and the excessively high doses required to achieve benefit often are limited by severe side effects.

Other medication therapies that can have benefits for patients dealing with pain symptoms include neuromodulator therapy such as gabapentin, Lyrica, or Cymbalta. Gabapentin and Lyrica are calcium channel blockers that are also used as anti-seizure drugs. Cymbalta is a nonspecific reuptake inhibitor, with the noradrenergic contribution. Tramadol and Tapentadol are also reuptake inhibitors that may be more efficacious for neuropathic pain. Tricyclic antidepressants are also utilized, and have an additional benefit of altering sleep hygiene.

At the RGHS Center for Pain Management, injection therapy is offered for temporary pain relief. Injections of steroids and local anesthetics have a suggested effective duration of two to three months. Longer duration of pain may be obtained via chemical neurolysis or radiofrequency ablation. Recurrence of pain does occur after neurolysis, but the pain relief typically lasts for three to six months or more. Repeat neurolysis is often appropriate. Common injections include epidurals and peripheral nerve blocks. Abdominal pain and pelvic pain are more commonly treated with sympathetic nerve blocks such as celiac plexus blocks or ganglion impar injections.

For those patients in whom high dose opioid therapy is limited by side effects, intrathecal and epidural pumps may be offered to reduce some of the side effects. Pumps have the additional benefit of allowing local anesthetics or other medications to be infused; this may reduce the overall necessary dose of opioids.

Calvin Chiang, MD, is Medical Director of the RGHS Center for Pain Management, which employs a multi-disciplinary approach to helping patients gain control over their pain and improve the quality of their lives.

Learn more at www.rochestergeneral.org/paincenter.

Unity Rehabilitation and Neurology



Joy Burke, M.D.

Neuro-oncology is a burgeoning neurological subspecialty dealing with both primary nervous system tumors and the neurological complications of cancer.

The need for a neuro-oncologist stems not only from the need for a specialist in primary brain tumors, but from the fact that neurological complications of cancer are common. In fact, neurological complications of cancer are increasing as patients are living longer with their cancers. This broad topic includes disease states such as systemic cancers with direct metastatic disease to the nervous system, paraneoplastic or non-metastatic (vascular, infectious, metabolic etc) effects of cancer and finally complications of the treatment of systemic cancers which affect the nervous system. To manage neurological complications of cancer requires a neurologist with awareness of the potential side effects of standard chemotherapies and newer biological agents, radiation effects (both acute and long-term), and the unique metastatic propensities of the different solid and hematological cancers.

Primary glial nervous system tumors of the brain and spinal cord are rare and cause unique symptoms depending up the part of the CNS that is involved. Dural or meningeal tumors are much more common and although usually benign can sometimes be atypical or malignant. A neuro-oncologist is ideally suited to treat these patients because of familiarity in the management of seizures, headaches, weakness and spasticity as well as the use of chemotherapy, radiation, and newer biological agents in the treatment of these cancers. The neuro-oncologist works in conjunction with the neurosurgeon and radiation oncologist to deliver specialized care to these patients.

Aside from dealing directly with the diagnosis, treatment and management of primary nervous system cancers, complications of cancer are the most common type of referral to a neuro-oncologist. There are several different types of typical referrals

that I might see. Commonly, I would be involved in the management of brain metastases, particularly when they produce weakness, seizures, headaches, or other neurologic dysfunction. The care of patients with brain metastases involves recommendations for surgery, whole brain radiation versus stereotactic radiosurgery or a combination of all of these modalities, as well as prognostic information and symptom management. I also see patients for leptomeningeal disease, which can produce a myriad of symptoms including pain, headaches, and peripheral nerve dysfunction. Another common referral is for chemotherapy-associated cognitive changes (“chemo-brain”) and/or radiation related cognitive effects. With the combination of a neurological evaluation and the neuro-psychology testing that we have available at Unity we are able to delineate between true neurological cognitive deficits versus cancer related fatigue and depression which also affect cognition. I also see patients for chemotherapy associated neuropathy, and management of the pain and, rarely, weakness that may produce as well as prognosticating for them. Finally, radiation can have a myriad of effects on the nervous system including vascular complications such as stroke, cognitive changes, radiation plexopathies, and radiation necrosis producing neurologic symptoms.

One of my favorite examples of the utility of a neuro-oncologist, and one with a positive outcome, is of a patient that I saw during my fellowship. She had breast cancer and had devel-

Consider referring patients with cancer for the following problems:

- Cognitive dysfunction
- Neuropathic pain
- Brain metastases
- Spinal cord compression/ metastases
- Leptomeningeal disease
- Peripheral Neuropathies
- Cranial neuropathies
- Meningiomas
- Schwannomas
- Primary glial brain tumors:
 - Glioblastoma, Astro/ Oligocytomas
- Stroke
- Headaches
- Encephalopathy
- Seizures/ loss of consciousness

oped severe, intractable pain in her arms. Multiple different pain medications had been tried, including narcotics, and she was still in pain. The oncologist was worried about metastatic involvement in the brachial plexus, which would have meant a poor prognosis. After her neurological exam, and review of the fact that she was taking an aromatase inhibitor drug, we determined that she might have carpal tunnel syndrome. After a few weeks with wrist splints, she was able to come off of several pain medications and her prognosis from the breast cancer remained positive.

As a neuro-oncologist and general neurologist I enjoy seeing any type of neurological dysfunction in a patient with cancer, and helping the primary oncologist or primary care physician determine whether their symptoms are cancer related and how to aid in treatment.

Joy Burke, MD, is a neurologist and neuro-oncologist at Unity Rehabilitation and Neurology. She has been local for many years, having gone to medical school at the University of Rochester, and then staying for both her neurology residency and neuro-oncology fellowship at the University of Rochester, Strong Memorial Hospital. She is board certified in neurology (ABPN) and neuro-oncology (UCNS). She now has a full-time outpatient practice at Unity and is also available for inpatient consultations. Dr. Burke is accepting new patients, and will expedite visits for patients with cancer. For appointments, call Unity Rehabilitation and Neurology at (585) 723-7972.

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- Related Orthopaedic Issues
- Chronic Pain
- Imaging

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- Alternative Medicine
- The Rural Patient

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February 4, 2013

Volume II

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- Gastrointestinal Medicine
- Sports Medicine & Imaging

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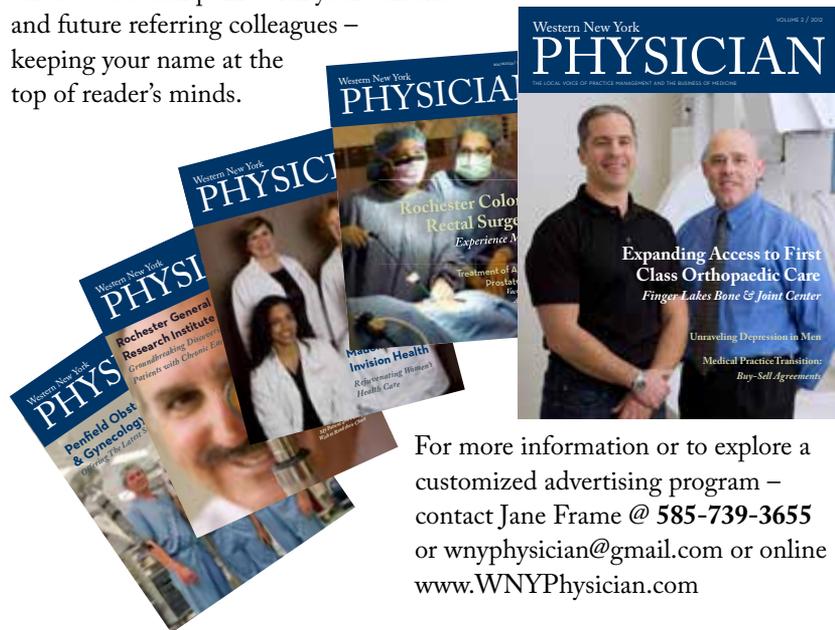
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ON THE FRONT LINES

The Plastic Surgery Group of Rochester Impacts All Areas of Specialty Care

By Julie Van Benthuisen



The surgical team. Front row L to R: Jeffrey A. Fink, MD, Ralph P. Pennino, MD, FACS, Andrew W. Smith, MD FACS. Second row L to R: Emily Beers, MD, Mark S. Davenport, MD, and Timothy P. O'Connor, MD, FACS.

As one of the world's oldest healing arts, plastic surgery is a complex discipline that improves and restores form and function to numerous parts of the body. In fact, the word "plastic" derives from the ancient Greek word "plastikos," which means to mold or give form. Despite remarkable strides in the field of plastic surgery over the past century, a common mis-

conception still exists that plastic surgery applies primarily to artificial breasts and nose jobs.

Though cosmetic or aesthetic surgery is still the best-known kind of plastic surgery, most plastic surgery is actually not cosmetic at all. Reconstructive and hand surgery are performed by highly-specialized and skilled plastic surgeons, often working in tandem with other surgical specialists.



Dr. Ralph Pennino, PA Melissa Tubulino, and Resident performing surgery in the operating room. Credit: RIT Biomedical Photographic Communications Surgical Photography Nathan Pallace 2009

A Group of Six

For the six-surgeon team at The Plastic Surgery Group of Rochester, cosmetic surgery is one category in a wide range of areas of specialization and expertise.

“This isn’t Beverly Hills 90210,” jokes practice member Dr. Timothy O’Connor, practice co-founder and 30-year veteran of the field and Chief of Plastic Surgery at Rochester General Hospital (RGH). “While many of our patients benefit from elective breast augmentation or eye lifts, our practice touches on virtually all areas of medical care requiring surgery.”

As one of the larger, private practice plastic surgery groups in the state, the team prides itself on its ability to work together to the greater benefit of each patient, improving function and quality of life after surgery. Pediatric patients, baby boomers and the elderly all benefit from plastic surgery procedures.

“We are highly committed to top flight health care and have been extremely active in many health care organization and boards which have helped implement countless improvements,” says Dr. Ralph Pennino, practice co-founder and RGH’s Chief of Surgery. “As a group, everyone has been involved, and some for up to 20 years.” This includes administrative and committee membership within RGHS, Unity Health System, as well as at Newark-Wayne Community Hospital.

In addition to the group’s major involvement at RGH, each surgeon also performs surgery at Unity Hospital, Highland Hospital, and the Lattimore Community Surgery Center. Additionally, they support and consult at a wide variety of other locations including urgent care centers and nursing homes.

The majority of minor surgeries requiring only local anesthesia are performed at its central Linden Oaks headquarters, eliminating the need for and potential stress of a hospital visit. “We’re rigorous on certification here,” says Dr. O’Connor. “We choose to be over-certified, actually, for what we’re able to perform outside the hospital setting.”

The doctors handle a tremendous number of emergency room visits. “Our neighborhood is quite large,” says O’Connor. “We’re on the front lines in the ER, taking the majority of calls for hand injuries and *maxillofacial* wounds at the hospitals we cover, as well as lots of Urgent Care follow-up.” At RGH alone, where more than 120,000 patients visit the ER annually, this represents a notable time commitment.

A Hybrid of Talent & Collaboration

Although the group’s roots run deep in local medical training, their reach has expanded throughout the region and the world. All six have completed part or all of their medical school or surgical training at the University of Rochester School of Medicine and Dentistry. All teach residents in the University of Rochester’s plastic surgery residency and five are Clinical Assistant or Associate Professors of Surgery. All of the doctors are Board Certified (or eligible) by the American Board of Plastic Surgery, and their extra fellowship training includes microsurgery and cancer reconstruction at Memorial Sloan Kettering, Hand Fellowships at Brown University and the University of New Mexico, and an Aesthetic Fellowship at Manhattan Eye, Ear, Nose and Throat Hospital in New York.

It’s much more than extensive certification and training, however. The ability to play off each other’s strengths and collaborate within the group sets them apart. “Plastic surgeons don’t typically work together,” O’Connor says, “but we consult with each other all the time and that makes us a bit of an anomaly.”

Because of the group’s size, at least one surgeon is always available to a patient. “From there, we can direct patients to whoever has the most experience and expertise for their particular needs,” he says. “We all have our niches, but we can often help each other as we work together on an individual patient case. It helps us consistently deliver the highest level of care.”

In August, Dr. Emily Beers joined the practice as one of only



Dr. Timothy O'Connor, Chief of Plastic Surgery at RGH teaches a medical student while in the operating room.

Credit: RIT Biomedical Photographic Communications Surgical Photography Jessica Peterson 2009

three female plastic surgeons in the entire Rochester region, after completing her residency in 2012. As a specialty, there are about 5,000 practicing board certified plastic surgeons nationwide. The trend of sub-specialty growth continues, and plastic surgery is one of the country's most sought after residencies. Dr. Beers was drawn to the group by the many opportunities it presented, particularly as the only female. "Many women prefer a female physician these days, especially when it comes to breast surgery," says Dr. Pennino. "Dr. Beers was a good fit for us in balancing out our practice even more. In fact, we're actively looking to add more surgeons to our group."

In addition to working well together, collaboration between the Plastic Surgery Group and other specialists occurs frequently. Given the broad scope of plastic surgery, there isn't a surgical subspecialty in which they don't collaborate. The team regularly works with colon and rectal surgeons, general surgeons, urologists, radiologists, orthopedics, heart surgeons, vascular surgeons, neurosurgeons, ENT surgeons, and dermatologists. "For cancer surgery reconstruction, trauma, and wound care, we're often part of a team that's really a hybrid of private and hospital-employed practitioners from various backgrounds working together in the most comprehensive way," says Dr. Pennino. "As an example, we are seeing more head and neck cancers these days. Because the cancer is removed and reconstruction is performed in one operation, it's vital that we collaborate closely with our Ear, Nose and Throat colleagues."

Whether it's representation on a hospital or insurance board or academically, the group prides itself on its collaborative involvement. "We're always community-focused," he says. Despite the heavy time demands, the teaching component of the practice is also notable. On any given day, residents in plastic surgery and family medicine, as well as PA students, shadow the doctors on rounds, in the operating room, and in the clinic. "Teaching takes time, but it's well worth it," adds Dr. Fink, who specializes in surgery of the hand and upper extremity and serves as the Director of the Rochester Hand Center.

Making Strides in Reconstruction Surgery

The group practices a broad range of reconstructive plastic surgery to correct problems caused by burns, traumatic injuries, congenital and developmental abnormalities, infection and [cancer](#). The surgeons use many surgical techniques to restore form and function. Reconstruction ranges from wound closures to microsurgery, where a part of a patient's own body is transferred to a new area to repair a defect.

The surgeons have seen great advancements, particularly with breast reconstruction after a mastectomy or lumpectomy. More options exist for breast reconstruction, including several different tissue flaps as well as procedures using skin expansion and a breast implant.

"Our breast reconstruction patients have been uniformly grateful," adds Dr. O'Connor. More patients are choosing an implant-based reconstruction with silicone gel implants. The newer silicone gel is more cohesive and is softer than the saline version. Many of the previous concerns regarding silicone implant safety have been laid to rest. "There are newer implants coming to the market including the so called 'gummy bear' which may offer additional options for patients."

At age 37, Kathleen Cook discovered a breast lump, which upon diagnosis was determined to be cancer that had already spread to her lymph nodes. After consulting with two breast surgeons, she chose Dr. Mark Davenport to perform her double mastectomy and reconstruction surgery after 16 weeks of chemotherapy

"I was absolutely confident in choosing Dr. Davenport. I researched my options and decided against flap reconstruction because as a young mother with two small children, I was concerned about the recovery time involved," says Ms. Cook. For the past year, she has felt like her normal self again. "I loved Dr. Davenport. He was awesome," she says. "I liked his personality and how caring he was. He worked at my pace, and I'm very happy with the results. I've become a big advocate for others going through the same diagnosis, and I would definitely recommend the Plastic Surgery Group of Rochester to others." If Ms. Cook decides to undergo areola and nipple reconstruction, she insists Dr. Davenport will perform the surgery.

Carol Mileo, another recent breast reconstruction patient, speaks of a similar experience. "Dr. Andy Smith was fabulous," she says. "He gave me my body back."

The Rochester Hand Center

The Plastic Surgery Group developed the Rochester Hand Center as a unit dedicated to both non-operative and surgical management of hand and wrist pathology. Drs. O'Connor, Pennino and Fink underwent subspecialty training to earn certificates of added Qualification in Surgery of the Hand, and

combined, the Rochester Hand Center surgeons have over 100 years of experience in the treatment of hand disorders. The group combines use of the latest techniques with an overall conservative and cost-conscious approach.

The Hand Center collaborates with the Hand Therapy Unit at both RGHS and Unity to offer an exercise program to treat thumb basal joint arthritis. This approach has decreased the need for surgery 30%, compared to more common conservative management with splints and/or injections. While routine management of Dupuytren's contracture involves surgical incisions and a significant rehabilitation and recovery period, the Rochester Hand Center offers newer alternatives like percutaneous needle fasciotomy and collagenase injection with rapid and easier recoveries. Often the commonest of hand surgeries, like carpal tunnel release, trigger finger or thumb release and cyst excision can be performed more efficiently and cost-effectively under local anesthesia within the Plastic Surgery Group's office setting.

Rising Demand for Body Contouring Surgery

Post gastric bypass surgery patients represent yet another area where plastic surgeons are playing a larger role. As obesity rates continue to rise and the long-term effectiveness of the surgery improves, more patients are electing to have bariatric surgery. "The obesity epidemic is happening at an earlier age," says Dr. O'Connor. Gastric bypass has been shown to result in greater weight loss and less weight regain, while lowering the risk of diabetes and high blood pressure.

As a result of the boom in bariatric surgery, a fast-growing population of patients is seeking body contouring surgery to remove excess skin after massive weight loss. For many who have undergone significant weight loss, body contouring surgery represents the final step in reclaiming their new bodies.

Bariatric Surgeon Dr. Alok Gandhi has collaborated with the practice for years. "The Plastic Surgery Group of Rochester plays a vital role in my patient care," he says. "Weight loss or bariatric surgery often cause significant and desired weight loss. However, my patients are often faced with aesthetic and functional body habitus issues afterwards, which can affect their self esteem or their daily physical activities." He notes the complexity of these issues because there is not necessarily one problem area — the patient's entire shape and body composition changes after drastic weight loss.

The surgeons' expertise in body contouring, coupled with compassionate care, allows them to identify the special needs of his patients. "This leads to a great patient experience and fantastic clinical and aesthetic outcomes in complex cases. My patients always come back thanking me for the referral to the Plastic Surgery Group of Rochester - and to show off their



Dr. Andrew Smith performing surgery in the operating room.
Credit: RIT Biomedical Photographic Communications Surgical Photography Andrea Samuels 2009

work! The body contouring after bariatric surgery completes the cycle for my patients as a rebirth of their lives."

Dr. Gandhi also cites these plastic surgeons as an invaluable resource to general surgeons. "Their knowledge and skill are often put to test when dealing with complex abdominal wall reconstructions."

Developments in Cosmetic and Aesthetic Surgery

The group's expertise in cosmetic surgery has also expanded as techniques and technology have evolved in recent years. Demand has grown for procedures like tummy tucks and breast augmentation. Unfortunately, since cosmetic surgery has become such a lucrative industry, many doctors are performing cosmetic procedures without proper training.

"Cosmetic surgery is not what many people think it is," says Dr. Davenport. "It requires surgical training and mastery of techniques approved by the American Board of Plastic Surgery." "Patients looking for cosmetic surgery need to make sure their surgeon is board certified and actually specializes in the procedure.



“Many women prefer a female physician these days, especially when it comes to breast surgery,” says Dr. Pennino. Dr. Emily Beers seen here in the operating room.

RIT Biomedical Photographic Communications Surgical Photography Emily Morse 2009

Just last December, the group invested in the region’s only Vectra machine – which enables computer imaging simulation of what a patient would look like after a cosmetic surgical procedure. “The Vectra machine uses very sophisticated software to give patients an extremely accurate 3D version of what they can expect to look like after surgery” says Dr. Davenport.

Taking Plastic Surgery’s Roots Global

While rudimentary plastic surgery has been around for centuries, the modern specialty took shape after World Wars I and II. Surgeons were faced with treating the horrendous wounds inflicted by modern warfare. Never before had surgeons been required to treat such extensive injuries – from gaping skull wounds to severe burns. Treatment required tremendous research, innovative thinking, and the development of entirely new procedures.

The Plastic Surgery Group of Rochester prides itself on having similar first-hand experience. “Outside of the military itself, plastic surgeons are often on the front lines,” says Dr. Pennino. The surgeons have participated in medical missions all over the world. Dr. Beers participated in a foreign trip as a resident, and is now actively involved with Intervol, the group’s international organization to treat patients in underserved areas, natural disaster zones, and war zones.

“It’s all about being part of it,” says Dr. Beers. Whether it’s traveling to Belize, Haiti or war-ravaged Rwanda, these doctors have seen it all. As part of Intervol, Drs. Pennino and Smith have spent time in Rwanda performing surgery on patients who suffered disfiguring facial injuries as a result of the genocide. They worked side by side with Rwanda’s first and only plastic surgeon, a war survivor himself. Most recently, the group’s members have traveled to Haiti many times to treat recovering earthquake victims.

These trips are also about teaching, say the doctors. Drs. Pen-

nino and O’Connor have organized and participated in many trips to the Rosebud Indian Reservation in South Dakota, helping Lakota Sioux Indians in medical training and overseeing the first Native American certified in the state to become an EMT. At the time, Native American EMT trainees were restricted from using the off-reservation training vehicles. “We brought three of the trainees back here to Rochester to make sure they received their certification,” he says.

The Future

The surgeons at The Plastic Surgery Group of Rochester all express enthusiasm about the exciting developments coming down the pike. “Plastic surgeons are starting to do reconstruction at the molecular level,” says Dr. Pennino, citing the work being done to fabricate various types of tissue via non-embryonic stem cells. “Because we all do reconstruction surgery, we’ll be involved with this as well.”

Staying at the forefront of developments remains key to the practice’s continued success. “Plastic surgeons have always been pioneers.” For instance, most people don’t realize the first kidney transplant was performed by a plastic surgeon. “We used to have only one way to do things, but now we have three or four options. Everything is in an evolutionary stage.” In addition to molecular level research, plastic surgeons remain extremely active in scientific advancements in face and hand transplantation.



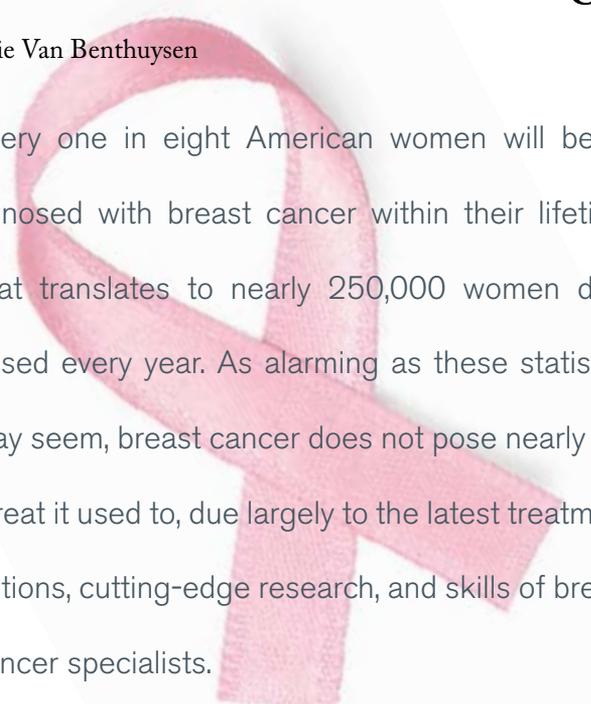
Dr. Jeffrey Fink, explains that the most common hand surgeries, like carpal tunnel release, trigger finger or thumb release and cyst excision can be performed more efficiently and cost-effectively under local anesthesia within the Plastic Surgery Group’s office setting.

“Despite our 100+ years of cumulative plastic surgery experience, we still see new things regularly,” says Dr. Smith “We’re constantly learning and integrating new techniques and knowledge into our practice in an effort to give our patients the absolute best care available.”

ROCHESTER'S LEADERS IN BREAST CANCER TREATMENT

Holistic Care Lends to Rising Success Rates

Julie Van Benthuisen



Every one in eight American women will be diagnosed with breast cancer within their lifetime. That translates to nearly 250,000 women diagnosed every year. As alarming as these statistics may seem, breast cancer does not pose nearly the threat it used to, due largely to the latest treatment options, cutting-edge research, and skills of breast cancer specialists.

Breast cancer treatment has evolved from the radical mastectomies initiated in the early 1900's to the combination therapies of today, which increasingly require only minimally invasive surgery. Heightened public awareness of breast cancer during the last several decades has spurred the demand for more clinical research and treatment options, and has encouraged more women to seek earlier and more regular breast screenings.

In more recent years, a multi-disciplinarian approach to breast cancer treatment has proven to garner better results. Here in the Rochester region, two of our most progressive leaders in breast cancer surgery are working hard to ensure that positive outcomes continue to gain ground. Dr. Lori Medeiros, Medical Director of the Rochester General Hospital Breast Center, and Dr. Kristen Skinner, Director of the [Wilmot Comprehensive Breast Care Center](#) at the University of Rochester Medical Center (URMC), have both championed a team approach to patient care that has led to notably high success rates.

"Our approach has to be holistic in order to individualize the treatment and the disease," says Dr. Medeiros. Taking a detailed approach to each patient means a broad team of experts weighing in. The Rochester General Breast Center, the

first in New York to be a Certified Quality Breast Center of Excellence™ by the National Consortium of Breast Centers, Inc., hosts a weekly breast conference. Leading local specialists from surgery, diagnostic imaging, radiation oncology, medical oncology, plastic surgery, pathology, clinical research and genetic counseling meet to discuss newly diagnosed or challenging breast cancer cases to offer the most up-to-date and individualized treatment plan for patients.

"We meet pre- and post-op, during chemotherapy and other stages of treatment," she says. "We review films, discuss any new studies available that may factor into the treatment plan, and then we work to customize treatment." The team's nurse navigator ensures that no patient falls through the cracks during any part of the treatment process. "People often look at breast cancer as a one-time event, but it's actually more like a chronic disease. You treat first, then there's the survivorship period when there's still relatively close follow-up for possible recurrence. With every future mammogram, that patient's suspicion is still heightened. That's why it's so important to have a point person to guide a patient every step of the way."

For the past 20 years, the URMC's Dr. Skinner has dealt exclusively with breast care, predominantly cancer surgery and clinical and translational breast cancer research to help advance the cause. She and her team take a similar, holistic approach to each breast cancer case.

"I feel very strongly that women need to be actively involved in the decision-making process," says Dr. Skinner. "I spend a long time talking with patients, identifying their values and their goals. We talk through the process and think outside of the box. While there's no 'one size fits all' in cancer treatment, we recognize a lot of ways can work depending on the patient."

Dr. Skinner acknowledges the advantages of taking a multi-care approach. "By including medical oncology, radiation and other specialty input, we can be comfortable that everything will get done, even if we're not exactly following the cookbook." Together, the team selects the optimal treatment available for the stage and biological characteristics of the cancer, the pa-

tient's age and preferences, and the risk and benefits associated with each treatment. "We have to do a risk/benefit analysis on every patient," she says. "This approach would be much harder if I was on my own."

The Role of Family History

"Everyone wants to take into account family history when looking at breast cancer, but it's not that simple," says Dr. Medeiros. "Each individual has different genetic 'stamps' that impact the potential of getting the disease. "While invasive carcinoma is the most common form of breast cancer, she explains, within that form are multiple sub-types that need to be evaluated on a case by case basis.

When a patient is diagnosed after a first-screening mammogram, family history is discussed thoroughly. If breast and/or ovarian cancer history is identified, genetic counseling factors into the treatment plan. "We sit down with the patient and discuss kids, sisters, and the rest of her family." While most women do not have a specific gene that causes breast cancer, two better known genes exist that women can be tested for via a simple blood test.

Through counseling, high-risk patients can learn about and mitigate their chances. Risks include multiple affected members on the same side of her family, a family or personal history of breast cancer diagnosed before age 50, pre-menopausal breast cancer, a personal history of two breast cancers, either in the same breast or in opposite breasts, Eastern European Jewish descent with breast or ovarian cancer at any age, a family history of breast and ovarian cancer, a family history of male breast cancer, a family history of BRCA1 or 2 mutation, and a history of Atypical Ductal Hyperplasia or Ductal Carcinoma in Situ. Family history of pancreatic and thyroid cancers have also shown to be linked to breast cancer.

High risk screening may include any, or a combination of diagnostic tests from a clinical breast exam and [mammography](#) to a [breast MRI](#) or [hormone](#) therapy, which is a medical treatment containing one or more female hormones and sometimes testosterone.

"Paying attention to your family history is the first defense," stresses Dr. Medeiros. There are several commercially-used blood tests for BRCA 2s and 2 genetic mutations, which are typically covered by insurance. If tests are positive for this mutation, patients are urged to seek proper counseling upfront to determine the best way to monitor it preventatively. "We strongly urge closer follow-up if patients have that gene, get screened and come in for clinical breast exams beginning at age 25. Because younger women have denser breasts, cancer is more difficult to see at that early age." MRIs might be recommended for those patients, particularly when a mammogram

proves difficult to read or suspicious.

"Because we have such a high volume Center," says Dr. Medeiros, "we are seeing younger women in their early 30s testing positive for that genetic mutation that causes breast cancer." Unfortunately, she says, breast cancer tends to advance more aggressively in younger women. "The onus is really on younger women to report a breast lump, since a mammography hasn't even entered into the equation yet. They often dismiss a lump as a cyst that will eventually go away on its own."

For patients with a family history of both breast and ovarian cancer, the doctors may often recommend removing ovaries after the age of 35 or after childbearing years. "Ovarian cancer is so hard to diagnose in its early stage when it can be best treated, so we like to be proactive."



Dr. Lori Medeiros, Medical Director of the Rochester General Hospital Breast Center.

Improving Quality of Life

Thanks to the rise in early screenings, both surgeons predominantly see patients whose breast cancers are in the early stage, where patients have a very good survival rate. This translates into more options available to treat the cancer – from lumpectomies instead of mastectomies, to more minimally invasive

surgeries, to even changing the traditional order of treatments. “We’re taking care of cancer and improving survival with a better quality of life,” says Dr. Skinner. “Surgically, we can do less with lumpectomies or lymph node biopsies than we used to.” In recent years doctors have developed better ways to identify patients who will or will not benefit from chemotherapy, and there are different types of radiations available now which lessen exposure to the heart.

Typically, a newly-diagnosed patient would undergo surgery, followed by chemotherapy and radiation if necessary. “In some cases, we can now change the timing and perform chemo first, especially for those patients with inflammatory breast cancer or a large tumor that may too big up front to remove surgically. “Since the patient is still likely to have chemo, we decide to perform it first because, in a large percentage of cases, we can shrink the tumor to avoid having to do a large re-section afterwards.”

Dr. Skinner’s team has been performing a procedure called a sentinel lymph node biopsy (SLNB), in which the sentinel lymph node is identified, removed, and examined to determine whether cancer cells are present. A negative SLNB result suggests that cancer has not developed the ability to spread to nearby lymph nodes or other organs. A positive SLNB result indicates that cancer is present in the sentinel lymph node and may be present in other nearby lymph nodes and, possibly, other organs. This information can help a doctor determine the stage of the cancer and develop an appropriate treatment plan.



Dr. Kristen Skinner, Director of the Wilmot Comprehensive Breast Care Center at the University of Rochester Medical Center.

“We mimic the spread of cancer through the injection of dyes, which lodge in the lymph nodes. We only eliminate the lymph nodes that fill with dye.” The doctors looked at survival rates for those who underwent a full vs. a sentinel node biopsy for women with tumors less than 5 centimeters, and found there was no advantage to one procedure over the other. “It becomes a quality of life question for the patient. If she’s not benefitting from full removal over partial, then we don’t need to take out all the lymph nodes.”

Breast reconstruction is another area that has experienced

great strides. Working in tandem with a highly specialized group of plastic surgeons, both doctors strive to provide the most compassionate approach to complex breast reconstructions. “Body image after breast cancer surgery is an important part of the road to recovery,” says Dr. Skinner. Reconstruction can be done with implants or with a “Free Flap Reconstruction” using natural tissue, where the breast is reshaped using muscle, skin and fat from another part of the patient’s body.

Prevention & Targeted Therapies

While many unknown factors remain as to why some women develop breast cancer, many of the risks are completely preventable. These include obesity, an unhealthy lifestyle, and high alcohol intake. Studies also show that low Vitamin D intake has a direct correlation to more aggressive breast tumors and poorer prognoses. Prevention, say the doctors, is the biggest fundamental goal for improving breast cancer statistics.

“The good thing is, women have choices,” says Dr. Medeiros, “and more of them are choosing to be routinely checked, so detection is early and the majority of cases are considered early stage.” She adds that there is some confusion about the appropriate guidelines for screening mammograms. “We still recommend that beginning at age 40, women should undergo an annual exam.” The reality is, she says, that even though family history plays a role, most women with breast cancer actually don’t have a family history. All women with a family history should begin screenings at 40, they urge, since cancer at this age tends to be far more aggressive.

They agree that the latest breast cancer breakthroughs are about doing less while achieving the same goals, with surgeries and procedures continuing to get less invasive. “More and more we’re looking at the biology of an individual tumor,” says Dr. Skinner. “Taking a needle biopsy will help us to understand what drives that tumor.” She also sees the future as a menu of targeted treatments, many of which will not require surgery at all. Ultrasound biopsies are already being performed as an outpatient procedure within the office, where a large volume of breast tissue can be removed for a small tumor. “This way, there’s more likelihood there will be nothing left to do surgically if everything looks clear after the biopsy. We need to go in this direction. It’s all about targeted therapies and being as minimally invasive as possible.”

“It’s been an amazing 100 years — the progress since the first cured breast cancer to the explosion of information which has translated into new therapies. It’s given us every reason to be hopeful,” she adds. “With so many more options and abilities to manage side effects better, breast cancer treatment is not as painful a process as it used to be. In fact, the majority of patients do very well now.”



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THE IMPORTANCE OF Change Management in Your EHR Implementation



Elizabeth Amato Fleck, MSHA

Perhaps one of the biggest benefits of implementing an EHR system and/or other forms of Health Information Technology (Health IT) is the transformational change this technology brings to a healthcare organization. Such changes include improved efficiency for providers and staff, the use of clinical tools to ensure patient safety and increase health outcomes, and fundamentally changing the way that patient care is documented in real time as well as in follow up. While these changes are ultimately positive, they also present significant challenges due to the fact that they alter the day-to-day operations of healthcare workers. It is common for organizations to be met with resistance from providers and staff (and even patients) during an EHR implementation, therefore, it is essential to understand and plan for effective change management strategies and skills.

The three most important steps to take in the office

ESTABLISH THE ROLE OF LEADERSHIP

During any implementation, be it large (EHR) or small (a new insurance card scanner at check-in), it is critical that those affected by the change understand the reason *why* the change is taking place coupled with realistic dialogue about *how* it will take place. This is where leadership becomes so vital. Healthcare leaders must not only focus on patients and the ever-changing healthcare landscape, but must also focus on staff and organizational cultures when undergoing an implementation. Engaging stakeholders early and often shows the leadership understands and validates the ways that change will impact staff and providers. Healthcare leaders are charged with developing the vision for their organization and aligning Health IT in order to support this vision and future state. Likewise, the role of such leaders is to serve as "Project Champions"; those who act as the advocate for the project, guide the implementation team, and clear obstacles that may threaten the success of the project. Ultimately, the role of the organization's leaders is to

recognize the faults in the "If you build it, they will come" mentality, and employ strategies to ensure acceptance of the significant changes that Health IT will bring.

COMMUNICATE, AND THEN COMMUNICATE SOME MORE

All good projects have a solid plan, but it is essential to share this plan with your providers and staff. Health IT implementations are complex and have many moving parts. It is not necessary for everyone to know the details of every project milestone and task, but it is important for them to know the basics. *Some examples are:*

What system is being implemented (this may seem obvious, but you may be surprised what "details" can get left out in hasty communication)

Why was this system selected over others (give high level benefits and align them to your practice's vision)

Target implementation start date and duration

Implementation team members (who will be working on this project and will their primary role in the practice change during the implementation, if so who is taking over for them)

Upcoming trainings

Target go live dates

Will the implementation be phased or big bang?

How will this implementation benefit patients, the practice, providers, and staff (quality, compliance, satisfaction)

Some ideas to keep staff informed and engaged include newsletters, email distribution lists, lunch and learns, and staff meetings. The goal is to keep it the communication frequent, brief, focused, and positive.

COMMIT RESOURCES AND PROTECT THEIR TIME

As mentioned above, your EHR implementation will include teams. EHR vendors use different terms for these teams, but best practice is to have groups of individuals

from your office who address the ways in which the system will support providers, billers, medical records, office operations, and finance. Your teams will have tasks that need to be accomplished to keep the project moving and on schedule. Tasks range from analysis and documentation of current state workflows, to template and file build in the application, and testing and training on the new system. The workload for your teams will at times be demanding and can become stressful. By ensuring that your teams are adequately staffed with individuals who know your current operations well and have a good comfort level with computers, you will be supporting these teams. Similarly, it is important to protect the time of your team members in order to allow them to implement and train on the new system. For example, if your office has only one biller it is not realistic that this one individual can configure all billing-related items in the system, test new claims processes, train staff, and keep up with all of their existing workload. This scenario is likely to lead to resistance toward the new system and possibly failure or perceived failure. By committing resources to support this biller and assisting them in offloading some work during the EHR implementation is appropriate and helpful. Lastly, when the time comes for staff and provider training, it is necessary to protect training time. Although it is hard to take staff "out of the numbers" to attend training, there is a direct correlation between the quantity and quality of training one receives and their acceptance of a new technology.

These tips are just a start on the path to creating a change management plan for your implementation. Professionals who specialize in Health IT implementations and/or change management are a valuable resource that can assist your practice in achieving successful change management.

Elizabeth is the Manager of Health Information Technology at Innovative Solutions based in Rochester, NY. She provides strategic consulting to medical organizations related to their use of Health IT.

Head and Neck Cancer:

An Emerging Infectious and Sexually Transmitted Disease?



Matthew C. Miller, MD

HEAD AND NECK CANCERS INCLUDE MALIGNANT TUMORS OF the lip, oral cavity, nasal cavity, paranasal sinuses, pharynx, larynx, and salivary glands. Collectively, these account for approximately 3% of all cancer diagnoses in the United States each year. Historically, head and neck cancers have been associated with heavy tobacco and alcohol use. Smoking trends and public health initiatives have led to an overall decrease in the incidence rates of head and neck cancer over the past three decades. However, that trend has not been observed for tumors of the oropharynx (i.e. the tonsils and base of tongue). In fact, the incidence of these tumors is actually on the rise. Oropharyngeal squamous cell carcinoma is now the most frequently encountered malignancy in most head and neck practices.

Perhaps more alarming than the increased incidence is the population that is being affected. On the whole, patients are younger than ever and in many cases they have minimal to no smoking history. Because of the patients' ages and their lack of traditional risk factors, head and neck cancer is often not even considered in the differential diagnosis. As a consequence, the average time between the onset of symptoms and the diagnosis is 8-9 months.

But why are young nonsmoking patients developing these tumors and how are they best recognized and treated? The answer to the first question may be a surprising one to those who do not routinely treat these tumors: Sexual activity. Beginning in the early 2000s, it was recognized that human papillomavirus (HPV) and specifically HPV type 16, was responsible for a significant proportion of head and neck cancers. Subsequent studies over the past decade have confirmed its role as a causative agent in up to 75% of oropharyngeal squamous cell carcinomas. HPV is implicated in a number of human malignancies and is most notable for its association with cervical carcinoma. The

virus itself is ubiquitous and it is estimated that over 80% of the population in this country has been exposed - with the bulk of those exposures occurring before 24 years of age.

HPV is transmitted sexually, but has also been demonstrated in the saliva of affected individuals. It is rapidly cleared by most individuals, but escapes immune surveillance and persists in a small percentage - likely deep within the crypts of the tonsils. Large case-control studies have demonstrated that the risk of oropharyngeal cancer is significantly associated with the lifetime number of sexual partners and oral sex partners. However, there is also a significant latency period (10-30 years) between exposure and development of malignancy, so a given patient's current sexual behaviors are not likely to have an influence on

their own risk of developing a head and neck malignancy or that of their partner(s). Patients with HPV-related head and neck cancer tend to be younger, of higher socioeconomic status, and have higher levels of education than do their counterparts with non-HPV related tumors. These patients typically will present with chronic sore throat, hemoptysis, dysphagia or odynophagia, unilateral otalgia, and/

or a neck mass. Persistence of any of these symptoms for greater than 2-3 weeks should prompt referral to an otolaryngologist-head and neck surgeon for further evaluation.

The informed patient will likely have perused the worldwide-web for data regarding prognosis of oropharyngeal cancers and will appropriately be concerned by the fact that the five-year survival rate across all oropharyngeal cancers is approximately 50%. For stage III and IV tumors, five-year survival is approximately 30%. However, recent data published in the *New England Journal of Medicine* has shown that HPV status is a strong predictor of survival among oropharyngeal cancers. Patients with HPV-related tumors who have less than

“ Patients with **HPV-related** head and neck cancer tend to be younger, of higher socioeconomic status, and have higher levels of education than do their counterparts with **non-HPV** related tumors. ”

10 pack year smoking history were shown to have an overall survival of 93% - independent of their stage. Smokers whose tumors were negative for the HPV virus had the worst prognosis. As a consequence of this and other studies, it is now standard practice to evaluate all oropharyngeal tumors for the presence or absence of HPV.

If the diagnosis of an oropharyngeal cancer is confirmed, several different treatment options exist. Early stage disease (i.e. stage I or II) may be treated with single modality surgery or radiotherapy. More advanced disease typically requires multimodality therapy including surgery and radiation, concurrent chemoradiotherapy, or a combination of the three. Such approaches are effective, but can carry significant cosmetic and functional consequences. Recent advances in minimally invasive procedures such as transoral robotic surgery (TORS) have allowed these tumors to be addressed with minimal effects on speech and swallowing but with equivalent oncologic efficacy. Treatments should be tailored to the individual patient and

their specific disease. Regardless of the treatment chosen, it is important that the treatment team be multidisciplinary and experienced in the management of head and neck cancers.

If the majority of oropharyngeal cancer can now be considered as a sexually transmitted infectious disease, it follows that there may be a role for primary prevention. The recent FDA approval of a polyvalent HPV vaccine for both boys and girls has potential implications for oropharyngeal cancer. Though not specifically approved for this indication, high-risk HPV16 is included in both of the commercially available preparations. The effects of these vaccines on the incidence and disease burden of oropharyngeal cancers remains to be seen.

Dr. Miller is an Assistant Professor of Otolaryngology and Neurosurgery, Head and Neck Oncologic and Microvascular Reconstructive Surgery at the University of Rochester Medical Center.



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Rochester General Health System is pleased to welcome the following new specialists.



Dr. Emily Beers, MD, has joined The Plastic Surgery Group of Rochester, specializing in plastic and reconstructive surgery. Dr. Beers attended the University of Michigan as an undergraduate, and earned her Medical Doctorate at The Ohio State University College of Medicine. She completed her residency in plastic and reconstructive surgery at University of Rochester Medical Center. Dr. Beers' roots are in the Midwest, where she grew up with a love of the Great Lakes and the great outdoors in Traverse City, Michigan. In her free time she enjoys running, travel, piano and photography. To learn more about Dr. Beers or to make a referral, please call **585-922-5840**.



Dr. Christopher Brown, MD, has joined Finger Lakes Bone and Joint Center, specializing in orthopaedics and sports medicine. Dr. Brown completed his orthopaedic residency at Duke University Medical Center and a fellowship in Sports Medicine at Stanford University. While at Stanford he provided team physician coverage for the NFL's San Francisco 49ers and the NCAA Division I Stanford Cardinals. Dr. Brown focuses on the shoulder and knee, with a particular interest in ACL or PCL reconstruction, cartilage replacement procedures, arthroscopic rotator cuff repair, and arthroscopic shoulder stabilization. To learn more about Dr. Brown or to make a referral, please call **315-359-2696**.



Dr. John Lovier Jr., MD, has joined The Women's Center at Newark-Wayne Community Hospital, specializing in obstetrics and gynecology. Dr. Lovier earned his Baccalaureate degree in Premedical Sciences, and his Master's in Early Modern European History, at East Carolina University. He attended medical school and completed his residency at the University of Rochester School of Medicine and Dentistry and the University of Rochester Medical Center. Dr. Lovier's areas of interest and specialty include infertility, polycystic ovarian syndrome and minimally invasive surgery. To learn more about Dr. Lovier or to make a referral, please call **315-332-2427**.



Dr. Peter Mroz, MD, has joined The Women's Center at Rochester General Hospital, specializing in obstetrics and gynecology. Dr. Mroz earned his Baccalaureate degree in Chemistry at Binghamton University before attending medical school at St. George's University School of Medicine. He completed his residency at Staten Island University Hospital. Dr. Mroz's areas of interest and specialty include obstetrics and minimally invasive surgery. In addition to Rochester General Hospital, Dr. Mroz will be seeing patients at The Women's Centers at Alexander Park and Clinton Family Medicine. To learn more about Dr. Mroz or to make a referral, please call **585-922-4200**.

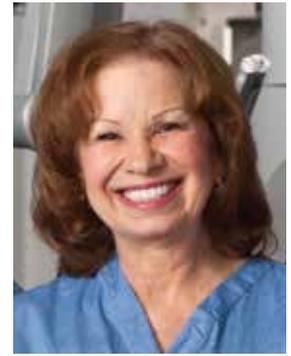


Dr. Maria Sbenzhe, MD, has joined the Lipson Cancer Center & Center for Blood Disorders, specializing in medical oncology and hematology. Dr. Sbenzhe is a native of Romania, where she attended medical school and completed her residency in dermatology. Upon relocating to the United States she completed a residency in internal medicine at Brooklyn's Interfaith Medical Center, followed by a fellowship in Medical Oncology and Hematology at Thomas Jefferson University in Philadelphia. Dr. Sbenzhe has a special interest in working with patients diagnosed with breast cancer. To learn more about Dr. Sbenzhe or to make a referral, please call **585-922-4020**.

Each is now accepting new patients and referrals.



Dispelling Myths about Ovarian Cancer Could Save Patient Lives



Cynthia Angel, MD

For years, doctors and patients have viewed ovarian cancer as a silent killer and a death sentence. But research and some of my patients have proven these and other thoughts on ovarian cancer wrong. There is reason for hope.

While ovarian cancer is the eighth most common malignancy of women in the United States (12.2 per 100,000), it is the fifth leading cancer mortality cause (8.0 per 100,000), according to the Centers for Disease Control and Prevention. The American Cancer Society (ACS) estimates ovarian cancer will account for 15,500 deaths in the United States in 2012, including 1010 deaths in New York State.

One of the most common myths about ovarian cancer is that it is a “silent” disease. Thirty years ago, many believed that ovarian cancer patients had no symptoms, but research in the last 10 years indicates there are warning signs.

In 2000, Barbara Goff, MD, and her associates demonstrated that 95 percent of patients have symptoms an average of three to six months prior to seeing their health care provider. The majority of these symptoms are not gynecologic. Most commonly, they include pain (58 percent), and/or abdominal (77 percent), gastrointestinal (70 percent), urinary (34 percent) and pelvic (26 percent) complaints. These symptoms often are vague such as bloating, constipation and fatigue. Some women complain of lack of appetite, abdominal pain or urinary problems.

Because symptoms can be vague, there often is a delay in diagnosis; in fact, most ovarian cancers are not discovered until stage 3 or stage 4. Some women are diagnosed with irritable bowel syndrome, stress or depression months before an ovarian cancer is found. In some cases, women do not recognize the seriousness of their symptoms and do not seek prompt medical attention.

Women with persistent symptoms for two weeks or more should see their primary care physicians. Most women with these symptoms will not have ovarian cancer, but physicians need to be on alert for this disease and whenever appropriate, refer women who present with these symptoms to their gynecologists.

Another myth I'd like to dispel: Many patients and even some physicians have traditionally believed the diagnosis of

ovarian cancer is a death sentence, and once detected, women rarely survive.

Chemotherapeutic options were limited 30 years ago, and prior to the discovery of cisplatin chemotherapy, median survival for patients with ovarian cancer was 12 months. However, advancements in the development of newer chemotherapeutic drugs and antiangiogenesis agents have resulted in prolonged survival. There are more than 12 chemotherapeutic agents that combat ovarian cancer. Patients can be treated with these as single drugs or in combinations. When progression occurs on one prescribed treatment, another combination of drugs may result in regression.

Surgical techniques have improved as well. Some ovarian



cancer patients have benefited from robotic surgery, which allows us to remove tumors and/or perform hysterectomies without making large incisions. As a result, women heal faster and can start chemotherapy sooner.

There are now many patients who live beyond five years. Because these patients often live with recurrent disease for a long time, some prefer to consider ovarian cancer a chronic disease.

One of my patients was diagnosed with ovarian cancer when her daughter and son were 5 years old and 2 years old, respectively. Twenty years and several rounds of chemotherapy later, she watched her daughter walk down the aisle and dropped off her son at law school.

Another patient has travelled around the world for the past 12 years while on chemotherapy for her advanced ovarian cancer.

Long-term survivors on treatment are not unusual. In fact, as many as one in three patients may survive more than 10 years with treatment. Even if they are not cured, women can live active, meaningful lives while being treated for ovarian cancer.

A final myth to address: It is thought familial ovarian cancer can only be inherited from the mother's side of the family. The discovery of the BRCA1 gene mutation in 1994 and the BRCA2 mutation soon after contradicts that notion.

These two genetic mutations account for 85 percent of the hereditary breast-ovarian cancer families. The BRCA1 gene is found on the 17th chromosome, while the BRCA2 gene is

found on the 13th chromosome. A deleterious mutation of either of these genes increases a woman's risk of ovarian cancer from 1 in 72 to nearly 40 percent (BRCA1) and 27 percent (BRCA2). The mutated gene can be inherited from either the father or the mother. The fact is that 50 percent of the women with a hereditary risk for ovarian cancer inherited it from their father. Encouraging women to obtain a thorough family history of ovarian, breast and prostate cancers from both sides of the family is imperative.

Ovarian cancer is not a silent disease, and we should be anything but silent about it. Physicians should have a heightened awareness of those vague abdominal symptoms and educate their patients – especially women who are at or beyond the age of menopause – on the warning signs and risk factors, including family history.

Partnering with each other and with our patients is essential in discovering ovarian cancer sooner to give women the best possible chance at survival.

Cynthia Angel, MD, Professor of Obstetrics and Gynecology at the University of Rochester Medical Center, has specialized in gynecologic oncology for more than 25 years. She is one of four physicians at URMC Gynecologic Oncology. The group performs the largest number of robotic gynecologic surgeries in the region at Highland Hospital.

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What is My Liability?

The Lost Chance Doctrine

Issue

The Lost Chance Doctrine represents an area of a pernicious emerging medical malpractice risk for physicians. This theory of recovery is steadily gaining ground in medical malpractice cases involving reduced life expectancy or increased risk of future harm. The doctrine creates a significantly expanded risk of liability for medical professionals, and therefore runs acutely counter to tort reform initiatives.

Traditionally, in medical malpractice actions, it is the plaintiff's burden of proof to demonstrate that (1) the defendant physician was negligent by deviating from the standard of care, and that (2) the injuries were "more likely than not" a direct result of that negligence. "More likely than not" defines the 'preponderance of the evidence' standard necessary to prove liability in a civil case and means that the probability of negligence must be greater than 50%; if it is not, the plaintiff loses and recovers nothing.

Under the "Lost Chance Doctrine" or the "Loss of Chance Doctrine" a plaintiff who cannot meet the traditional "more likely than not" burden, can nonetheless plead 'Lost Chance' and recover compensation. The doctrine compensates plaintiffs for injuries related to the likelihood that the outcome would have been better had some act or omission of medical care not occurred. Typically, the plaintiff will claim that the injuries caused by a disease or condition, usually cancer, became more severe the longer a diagnosis was delayed and thus the prospect (or "chance") of a cure or longer life decreases. 'Lost Chance'



James E. Szalados, MD, MBA, Esq.

is mostly invoked where a plaintiff suffers from a pre-existing condition sufficiently grave as to undermine the causal chain of events necessary to prove negligence. A case precedent for relaxing the 'preponderance of the evidence' standard and invoking the doctrine 'lost chance' is *Hicks v. United States*, wherein a physician failed to diagnose a small bowel obstruction from which the patient eventually died. The United States Court of Appeals for the Fourth Circuit stated that "[w]hen a defendant's negligent action or inaction has effectively terminated a person's chance of survival; it does not lie in the defendant's mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable."

The relaxed standard of causation inherent in the 'lost chance' doctrine allows a plaintiff to recover when the defendant's actions have substantially harmed plaintiff by decreasing his chance for survival, even if the actual probability of negligence is less than 50%. Theoretically, a physician could be liable in damages under Lost Chance if even a 1% reduction of a patient's optimal outcome can be proven. Courts which accept the 'Lost Chance' theory allow a plaintiff to be compensated in direct proportion to the probability of a more successful outcome if the opportunity had not been lost. For example, if it can be shown that a defendant physician deprived plaintiff of a 20% chance of a more successful recovery, and plaintiff's ultimate injury would normally be compensated with a \$100,000 verdict, the plaintiff's award would be \$20,000. Relaxing the standard of causation increases the plaintiff's odds of a favorable outcome in two possible ways: (1) a plaintiff is more likely to present the case to a jury; and, (2) it reduces the plaintiff's burden of persuasion, requiring the plaintiff to establish only that the act or omission was "more likely than not" a "substantial factor."

New York is among the states which recognize the Lost Chance Doctrine. In the 2011 case of *King v. St. Barnabas Hospital*, a man playing basketball at a gym suffered a cardiac

arrest. When medical personnel arrived, his cardiac rhythm was mixture of asystole and fibrillation, and the defendants defibrillated the plaintiff but were unsuccessful. The plaintiff's estate commenced a medical malpractice action alleging that it was a departure from ACLS protocols to defibrillate the decedent in asystole and that defendants failed to timely administer epinephrine and atropine. The defendants argued that their actions could not be proven to have a detrimental effect on the outcome. The trial court agreed noting that even under "the best circumstances, plaintiff's expert cannot predict whether [plaintiff] could have been saved or if cardiac function could have been restored." The First Department, however, reversed on appeal stating that New York permits claims for negligent resuscitation efforts to the extent the defendants departed from life support protocols and deprived the plaintiff of "any possibility of survival." According to the Court "The very fact that advanced life support protocols exist for patients in an asystolic state means that adherence to the protocols afford a chance of reviving the patient, notwithstanding the grave nature of the condition. It necessarily follows that failure to follow the protocols reduces the chances of reviving the patient."

Failure to diagnose has long been a leading cause of action in medical malpractice cases involving cancer. However, the Lost Chance Doctrine increasingly raises the risk of medical liability in cancer cases especially where there is an arguable delay in the diagnosis. Common high risk scenarios might include failure to follow-up on incidental radiographic findings, erroneous radiologic reports, missed follow-up visits, and improper communication between primary care physicians and consultants. In *Cudone v. Gebret*, the United States District Court for the District of Delaware allowed a 'lost chance' claim where there was an alleged delay in the timely diagnosis of a patient's breast cancer. At trial, plaintiff's expert testified that, based on a reasonable medical probability, the plaintiff's cancer would not have metastasized had there had been an earlier diagnosis; and, that defendant physician's negligence resulted in progression of plaintiff's cancer from a "stage I" lesion to a "stage II" lesion with a corresponding increase in the chance of cancer spread. The court reasoned that it could not be stated with a reasonable medical probability that the physician's negligence was the cause of patient's death. Nonetheless, the court held that the plaintiff should be compensated proportionately for the increased risk of death attributable the delayed diagnosis. In a similar Iowa Supreme Court case, *DeBurkarte v. Louvar*, plaintiff claimed a failure to diagnose a palpable breast cancer at an early based upon a mammogram erroneously read to be negative. The patient was advised to return a year later for follow-up, at which time a second mass was discovered and

biopsied and found to have already metastasized to her spine and leg. In this case, if the case would have been tried on the traditional preponderance of the evidence standard, that claim would most likely have failed for lack of proof of causation, since she there was no substantial evidence that the cancer actually spread after the initial visit. However, based on expert testimony regarding relative survival probabilities of lesions resected early versus late, the plaintiff recovered under the state's lost chance of survival statute.

In conclusion, the Lost Chance Doctrine is a legal theory which is gaining popularity among plaintiff attorneys and courts and clearly represents an enhanced liability risk. Physicians and other health providers should know and understand the legal argument, exercise due prudence, and adhere to protocols in order to minimize diagnostic and therapeutic delays.

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. Dr. Szalados is an attorney with healthcare law firm of Kern Augustine Conroy & Schoppmann, P.C.

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Medical Practice Transition Planning Series

How Important is Entity Selection Anyway?



Carol S. Maue, Jennifer N. Weidner and Paul S. Fusco, attorneys at Boylan Code, LLP

In the last publication of WNY Physician's Magazine, we described to you a fictional medical practice, Mensch Medical Group, P.C. (the "Group"), consisting of three physicians: Henry, the senior physician; Samuel, the middle-aged physician with a progressive disability, and Lucy, the newly-admitted physician to the practice. The Group is organized as a professional corporation ("P.C."). Presumably, the Group has elected Subchapter "S" status so that the corporation avoids the double taxation problem inherent in a Subchapter "C" corporation. If an S election was made, then the P.C. has the benefit of limited liability but its physician-shareholders receive pass-through taxation.

In practical terms, this means that each physician-shareholders' portion of the P.C.'s pro-rata taxable income on an annual basis "passes through" to the individual physician, who then reports the income and pays income taxes on his or her personal tax return, while still avoiding personal liability for the debts of the corporation in the event it becomes insolvent as well as for the bad acts of the other shareholder-physicians, with the exception of malpractice, for which the Group and all of its shareholders remain personally liable as a matter of law.

Assuming that Henry, Samuel and Lucy, the physician-shareholders of the Group, each hold one-third of the P.C.'s issued and outstanding shares of stock, then under the IRS rules, they must each declare and pay income taxes on one-third of the P.C.'s income, regardless of the actual contributions that they each may have made to the practice. This is the case because in the context of a P.C., profit and loss must be allocated to each physician-shareholder proportionate to stock ownership. Stated another way, in a P.C., there can be no unequal allocation of profit and loss.

If unequal allocation of profit and loss were important to our physician-shareholders, then organizing as a limited liability company ("LLC") (or converting to a limited liability partnership if they were initially organized as a general partnership) may have been a better choice in the first instance. Unlike an "S" corporation, a LLC permits unequal allocation of profit and loss (as if organized as a partnership), while affording the same limited liability that the equity owners receive when organized as a corporation. Keep in mind that a general partnership does not afford limited liability; hence, the LLC is a hybrid form of doing business that is increasingly popular with medical practices.

An added bonus to the limited liability company form of doing business is that it avoids most of the administrative complexity (and added expense) of a corporation. For example, in an LLC, there is no need for a Board of Directors and Officers. All that is required is a well thought-out Operating Agreement that includes management provisions that either appoint a Manager to be responsible for day to day operation and affairs of the Group or that require the physician owners to act collectively, typically by majority vote, to conduct the business of the practice.

However, our Group is organized as a P.C., not as an LLC. Given Henry's age, chances are that Henry started the practice many years ago, well before LLC's were a legally permitted form of doing business. Most likely, Samuel and then Lucy each were offered an opportunity to buy-in to the practice, probably at a point in time when Henry had already developed a very significant patient base. Accordingly, Henry may in fact have retained a significantly higher proportion of the corporation's issued stock, in most cases a majority interest that will not

Keep in mind that a
general partnership
does not afford
limited liability

only provide Henry with actual control of the corporation, but that will virtually guarantee that Henry will always receive a higher percentage of the P.C.'s net income at year end.

On the other hand, the P.C. may also have entered into an employment agreement with each physician, at a stated annual salary that may be different depending on each physician's contributions to the practice, including status as a founder, actual time commitment and other factors such as gross billings or services as the Manager of the practice. Under this scenario, the salary (which can vary by physician) is then treated as compensation for services rendered to the P.C. as opposed to a distribution or dividend paid as a consequence of the physician's status as a shareholder. Under this approach, any taxable income remaining at year end would then be distributed to each physician-shareholder pro rata to his or her stock ownership. So long as the salary paid to each physician is reasonable, the IRS will respect this arrangement.

Another important aspect of this P.C. arrangement is voting control. Assuming that Henry, as the founder, owns 51% or more of the issued and outstanding stock, Henry is in complete control of the P.C. and the Group. This is the case because the shareholders vote pro rata to their stock ownership to elect the Board of Directors, who ultimately set policy for the Group and make all significant decisions, appointing the officers to carry out their directives, voting on a per capita (or one vote for each director) basis. A young physician, like Lucy, with a minority stock interest, therefore has absolutely no control over her own destiny, unless of course, Lucy has a good lawyer and advocates for some control when she joins the Group.

There are number of ways for Lucy to accomplish this objective, including but not limited to insisting on a voting agreement among all of the physician-shareholders that requires each of them to vote their respective shares to appoint each other to the P.C.'s Board of Directors. This will assure Lucy (and Samuel too!) a seat on the Board of Directors. Another technique is for Lucy to insist on an employment agreement for a term of years that prohibits a termination of her employment as a physician with the Group except "for cause." Since the degree of protection afforded Lucy is directly proportional to the care with which "for cause" is defined in the employment agreement, this is one of those situations where hiring a good lawyer at the outset is a necessity. The issue of restrictive covenants, including covenants not to compete and not to solicit employees of the Group post-termination are also typically negotiated and included in the employment agreement. Likewise, a well-drafted shareholders' agreement is recommended in this situation that includes buy-sell provisions, both for the protection of the P.C. and each of the individual physician-

shareholders. Robert Frost taught us that, "good fences make good neighbors." Likewise, medical practices that make the investment in good contracts will stand the test of time and flourish.

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in Area Healthcare

HIGHLAND HOSPITAL

Garret Morris, MD, Joins URMCA Anesthesiology, Pain Management



Garret Morris, MD, has joined the University of Rochester Medical Center as Assistant Professor of Anesthesiology. He will see patients at the Pain Management Center at Highland

Hospital, the Pain Treatment Center at Sawgrass and the Perioperative Pain Service at Strong Memorial Hospital.

Previously, Dr. Morris was the medical director of a functional restoration program in Northern California, which specialized in multidisciplinary approaches to pain management.

He completed a fellowship in pain medicine at Stanford University and did his residency in anesthesiology at Advocate Illinois Masonic Medical Center in Chicago. He earned his medical degree from the University of California, Irvine, School of Medicine.

Highland Hospital Welcomes Endocrinologist Laticia Valle, MD



Laticia Valle, MD, has joined Highland's Department of Medicine as an attending physician, specializing in Endocrinology. Currently, there is a shortage of endocrinologists in Rochester and other

communities around the country.

Dr. Valle recently completed a fellowship in Endocrinology at The Ohio State University Division of Endocrinology, Diabetes and Metabolism. She did her residency in Internal Medicine at the University of

Rochester Categorical Internal Medicine Residency Program and earned her medical degree from the University of Rochester School of Medicine and Dentistry.

Highland Hospital Welcomes Melissa Mroz, MD to Geriatrics and Medicine Associates



Dr. Mroz will be teaching residents as well as working at Strong Memorial Hospital as a general internist and preceptor. Prior to joining Highland, she was the Outpatient Chief

Resident at New York University (NYU) School of Medicine. Dr. Mroz earned her medical degree at Temple University School of Medicine in Philadelphia and is Board Certified in Internal Medicine.

ROCHESTER GENERAL HEALTH SYSTEM

Rochester General Hospital Named One of New York's Most Visitor-friendly Hospitals NYPIRG report lists RGH as leading the region in visitor relations.

Rochester General Hospital, the flagship affiliate of Rochester General Health System, has been named in a recently released report as a statewide leader in practices related to visitors, a key contributor to positive patient outcomes.

In the report, conducted by New Yorkers for Patient and Family Empowerment in conjunction with the New York Public Interest Research Group (NYPIRG), RGH was the only hospital in western New York to earn a 9 out of 10 rating for visiting hours and general visitation policies. By comparison, most hospitals statewide received a ranking of between 1 and 4 out of a possible 10.

General visiting hours at Rochester General are open, with some restrictions in areas including maternity, pediatric and intensive care units. The surgical waiting area is staffed each day by a hostess who works with family members to keep them informed about their loved one's status. These and other examples of flexible hours and visitor attentiveness have been found to improve the quality of patient care.

"Studies have linked the importance of visitors to healing outcomes for patients," said Doug Della Pietra, director of customer services and volunteers at RGH. "One of the core elements of patient- and family-centered care is to create as much of a homelike environment for patients as possible, and allowing visitors to interact with friends and loved ones who are patients definitely helps reinforce that homelike ideal."

"We are excited to be recognized by NYP-IRG for our commitment to enhancing the comfort and satisfaction of our patients and their families through our flexible visitors' policies," said Mark C. Clement, President and CEO of Rochester General Health System. "Our philosophy of 'Health + Care' is all about the essential pairing of clinical innovation and excellence with an absolute dedication to the satisfaction of each and every patient we serve. Attentiveness to families and loved ones is an important part of that promise that our dedicated team members make, and keep, every day."

Newark-Wayne Hospital Welcomes Five New Physicians



Deepak Advani, MD, an Internal Medicine physician, has joined the Rochester General Medical Group Internal Medicine practice in Newark. He earned his medical degree at

the Dow Medical College in Pakistan and completed his residency training at Queens Hospital Center in Jamaica, NY.



Amar V. Munsiff, MD, FACP, Hospitalist, is on staff at Newark-Wayne Community Hospital and Rochester General Hospital. Dr. Munsiff completed his undergraduate work at Columbia College, a

Master's program at New York University, and earned his medical degree at New York Medical College. He completed his residency training at Montefiore Medical Center in Bronx, NY and was chief resident at Griffin Hospital-Yale University, Derby, CT. Previously, he served as chairman of department of HIV Medicine in various programs in New York City, as the director of the Hospitalist Division of Delphi Healthcare, and he continues as the president of The Forum for Regional Clinical Education, Inc.



Justin V. Rymanowski, MD, Neurologist has joined Ontario Neurology Associates in Newark. Dr. Rymanowski earned his medical degree at the University of Rochester School of Medicine and Dentistry.

He completed both his residency training in Neurology and a fellowship in Neurophysiology at the University of Rochester Medical Center.

URMC

Golisano Chief Named President of Child Neurology Society

URMC's chair of pediatrics, neuroblastoma expert takes on national role.

Golisano Children's Hospital's pediatrician-in-chief has been elected president of the nation's largest organization of child neurologists.

Nina F. Schor, MD, PhD, William H. Eilinger chair of Pediatrics at the University of Rochester Medical Center, was voted into the presidency of this organization by fellow pediatric neurologists from around the

world and will assume the position of President-elect following the annual meeting of the Child Neurology Society in November. The Child Neurology Society is a non-profit professional association of 1,300 pediatric neurologists in the United States, Canada, and worldwide who are devoted to fostering the discipline of child neurology and promoting the optimal care and welfare of children with neurological and neurodevelopmental disorders. These disorders include epilepsy, cerebral palsy, mental retardation, learning disabilities, complex metabolic diseases, nerve and muscle diseases and a host of other highly challenging conditions.

"This position represents an enormous opportunity to champion internationally the cause of children and families with neurological and neurodevelopmental disorders and to enhance the ability of the health care community to meet their needs," Schor said. "It will grant me the honor of facilitating education and communication on behalf of these children, families, and health care professionals."

In addition to performing the dual roles of the seventh chair of Pediatrics at the University of Rochester and the pediatrician-in-chief of the Golisano Children's Hospital, Schor is a child neurologist and holds appointments in URMC's Departments of Neurology and Neurobiology & Anatomy. Before coming to Rochester, she held the Carol Ann Craumer Endowed Chair for Pediatric Research at Children's Hospital of Pittsburgh of the University of Pittsburgh Medical Center and was chief of the Division of Child Neurology, director of the Pediatric Center for Neuroscience, and associate dean for Medical Student Research at the University of Pittsburgh School of Medicine.

Schor trained in Pediatrics and Neurology at Boston Children's Hospital of Harvard University. She received her MD from Cornell University Medical School and her PhD in Medical Biochemistry from the Rockefeller University.

Schor is nationally recognized for her research on neuroblastoma (the most common tumor of the nervous system in children) and the role of oxygen radical damage in degenerative disease of the nervous system. She has spent the past two decades pursuing potential treatments for neuroblastoma, a frequently fatal cancer of childhood that grows from immature nerve cells.

UNITY

Unity Health System is pleased to welcome David J. Gill, MD, Ben L. LaPlante, DO, and Farhad Nasar, MD.



Dr. Gill will practice at Unity Neurosciences/Neurology. He earned his doctor of medicine degree from Medical University of Florida and is an assistant

professor in the Department of Neurology at Penn State Milton S. Hershey Medical Center. He is certified in the subspecialty of behavioral neurology and neuropsychiatry, specializing in dementia.



Dr. LaPlante will join the Unity Neurosciences/Spine Center team. He earned his doctor of osteopathic medicine from the University of New England College of Osteopathic medicine and completed

his residency in physical medicine and rehabilitation at the University of Rochester Medical Center and his fellowship in interventional spine treatment at the Virginia Spine Research Institute, in Richmond, VA. His areas of expertise include back and neck treatment, including epidural and cervical injections, facet injections, and pain blocks.



Dr. Nasar is a new addition to Unity's Hospitalist physician team. He graduated from Unity's Internal Medicine Residency Program and he earned his post-graduate qualification in medicine

from the Membership of Royal College of Physicians in the UK. Dr. Nasar completed his fellowship at Locum Medical Registrar in General Medicine.

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Anterior Scapular Rotation (ASR)

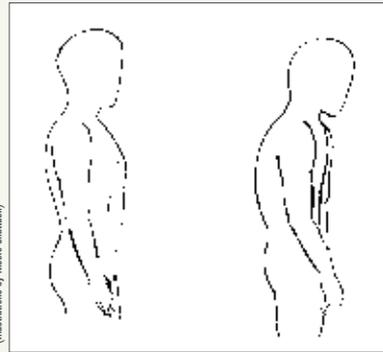
When you hear complaints such as neck pain, headaches, shoulder pain or knots between the shoulder blades; a complex but solvable muscle puzzle may be at play. This will help you think through muscle “puzzles” that cause soft tissue pain. Anterior Scapular Rotation (ASR) is a position of the scapulae that results from an imbalance of the muscles that stabilize and control scapular function. An indication of ASR is a slouched posture. It may be instigated by a strong and restrictive Pectoralis Major / Minor or scar tissue. It can also be caused by mastectomy and lymph tissue removal.

When assessing soft tissue pain there are four factors:

- 1) an instigation or cause
- 2) a result and
- 3) the compensation in which 2 and 3 are both areas of primary pain complaints, and
- 4) an allowance which is a weak, destabilizing muscle.

For Example: Neck Pain is result.

Result is when the two scapular elevators Levator Scapula, Upper Trapezius, and two humeral elevators, Supraspinatus and Deltoid, constantly contract to stabilize the downward pressure on the scapula from the scapular compressor muscles. Nine scapular compressor muscles push your arms and shoulder blades down. This is important because pain is alleviated in the neck by elongating the 9 scapular compressors.



(Illustrations by Nicole Stanich)

Proper Posture

Proper Anterior Scapular Rotation

Another result of the ASR position (slouch) is a thoracic flexion followed by a cervical protraction, causing spasm in the Splenius Capitus (neck muscle). Its function is cervical (neck) rotation, extension, and retraction; and is often responsible for a tension headache.

Compensation comes from the Middle Trapezius and Rhomboids major and minor trying to retract the scapulae and is simply a spasm between the shoulder blade and the spine. (This is also known as that painful knot between the blades).

The main allowance factor is the Serratus Anterior, where muscle stimulation for growth and isolation exercises strengthens the muscles. Identifying and treating the instigation and the allowance breaks the cycle of the formula while treating the symptoms of the result and compensation, thereby relieving the pain.

Brett W.Phillips, LMT, PDMT started his practice in 1994 specializing in Muscle Therapy where the focus is to analyze the dysfunction of muscle tissue and facilitate repair by restoring the original function of an affected muscle and the balance with its antagonist. Currently in practice as Muscle Maintenance at 465 West Commercial St. East Rochester.

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