

Western New York

# PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



## Rochester Colon & Rectal Surgeons

*Experience Matters*

Navigating the Great Retirement Shift



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*With volumes of surgical cases, a breadth and depth of clinical experience that spans more than three decades and a commitment to collaborative and coordinated patient care, the RCRS team is poised at the vanguard of colorectal care in the region.*

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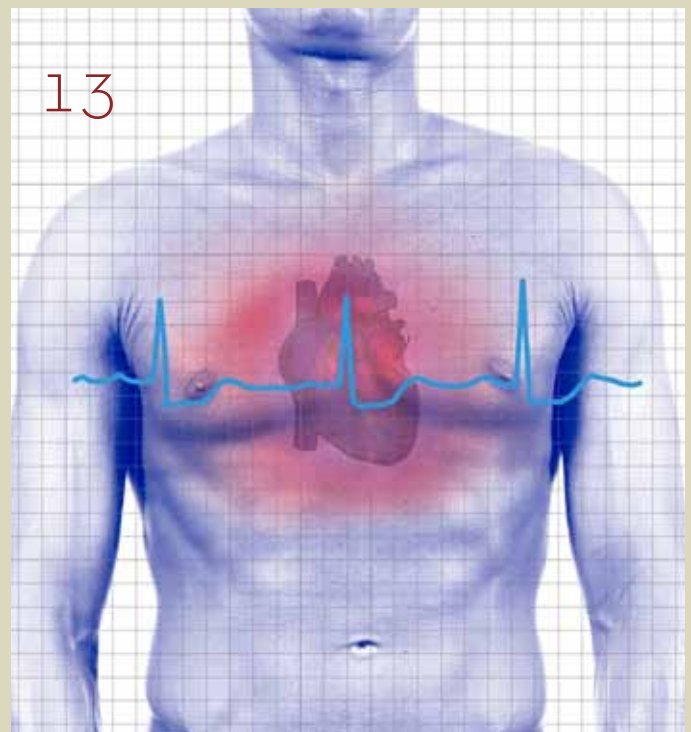
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Cover Photo: Dr. Mary Lou O'Neill and PA Liesel Hand are regular fixtures at the L.M. Salmen Surgical Center at Unity Hospital. Having performed thousands of complex, minimally invasive procedures, Dr. O'Neill brings an extraordinary level of surgical expertise to patients in the region.

# Welcome to the September Issue of Western New York Physician

*With many thanks to readers, advertisers and contributors, I am pleased to report that with this issue Western New York Physician is now 100% local - written by local experts - people you know, names you can trust - and now printed and produced locally - keeping jobs and resources right here in our region. We thought you'd like to know.*

Medical innovations in robotics, minimally invasive surgical techniques and diagnostic screening tests continue to offer great promise for patients. When it comes to colorectal care - the highly-trained team of experts at **Rochester Colon & Rectal Surgeons (RCRS)** is at the forefront of the specialty. Learn more about this privately owned practice in our cover story as they discuss the latest diagnostic screening tools, advanced colorectal surgical approaches and their unique patient-centered approach to coordinated and collaborative care and education.

Sooner or perhaps later we would all like to retire. Many have had to adjust plans, timelines and maybe even expectations. The article - ***Navigating the Great Retirement Shift: Boosting Contributions to Your Qualified Retirement Plans*** offers a look at how maximized contributions to retirement plans can boost savings and reduce taxes.

We welcome **James Szalados, MD, MBA, Esq.** to the *WNY Physician* Medical Advisory Board and as a regular editorial contributor. His unique background offers an insightful perspective to physicians in our region. If you have a specific question or topic of interest for Dr. Szalados, please drop me an email - we welcome your ideas for future articles.

### ***Baby Boomers Turn 65 in 2010!***

The November issue will focus exclusively on Geriatrics and the varied aspects of caring for this expanding patient base. With greater needs for geriatric services and geriatrics- savvy healthcare providers, awareness of the regional resources available will be increasingly important. To be a part of this issue - please call or email me directly.

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

We invite you to share your clinical and practice expertise with your medical colleagues through *Western New York Physician*.

Regards,

Andrea Sperry  
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# Treatment of Advanced Prostate Cancer

## *Vaccine Therapy: A Closer Look*



John Valvo, MD, FACS

John R. Valvo, MD, FACS

September is prostate cancer awareness month. Prostate cancer is the second most common form of cancer found in males in the United States. Approximately 220,000 new cases will be diagnosed in 2010 and 32,000 will succumb to this disease this year. Sixteen percent of American men will be diagnosed with this disease sometime during their lifetime. For a majority of those men, treatment results in positive outcomes and a return to good health. With greater awareness it is now being detected earlier and mortality rates are declining.

Nevertheless, there remain a significant number of men whose disease may escape local control, metastasize and become hormonal independent. This stage is referred to as metastatic castration-resistant prostate cancer (mCRPC) formally known as hormone-refractory prostate cancer (HRPC). This advanced disease state occurs once tumors progress through androgen blockade but still retain some dependence on the androgen receptor. However, not infrequently something other than androgen blockade is needed to slow tumor progression.

Earlier this year the food and drug administration (FDA) approved a new immunotherapy, Sipuleucel-T for the treatment of patients with asymptomatic or minimally symptomatic mCRPC. Using the patient's own immune system to produce targeted T-cell immunity may provide the most effective form of therapy for mCRPC.

Sipuleucel-T is a form of active specific immunotherapy. The

patient's peripheral-blood mononuclear cells (PBMC) are harvested, cultivated with a chimeric containing granulocyte-macrophage collecting-stimulating factor (GM-CSF) to active prostatic acid phosphate (PAP) as a tumor associated antigen. The antigen-pulsed, antigen-presenting cells (APC) are intravenously infused back into the patient in three treatments - administered in two week intervals over a one month period.

In clinical trials, the men who received Sipuleucel-T lived an average of 4 months longer than men who received the placebo (25.8 months versus 21.7 months). Interestingly, there was no objective response observed other than survival.

Vaccine therapies may be better suited for use in patients with lower tumor volume and longer predicted survival.

Overall survival remains the best determination of clinical benefits in patients with prostate cancer.

Another concern with Sipuleucel-T is the cost. It is estimated that the cost of care for a man with prostate cancer is approximately \$1,800 per month. The manufacturer of Sipuleucel-T has set the cost of a 1-month course at \$93,000 or \$23,000 per month of survival advantage. In an area of health care reform and cost containment this high cost may affect usage.

Finally, it is likely that vaccine therapies such as Sipuleucel-T will unlock some of the mysteries as to why some prostate cancer cells progress and others do not, why some prostate cancers remain hormonally dependent and some do not.

**“In the midst of cost containment and healthcare reform, we must ask ourselves... how much is a life worth”**

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## FOLLOWING UP MISSED OR CANCELLED APPOINTMENTS



### THE RISK

*A missed or cancelled appointment, and the failure of a practice to follow up with or contact the patient, may result in a serious delay in diagnosis or treatment and a subsequent risk of liability for the provider.*

### RECOMMENDATIONS

- 1 A pro-active system to follow up with patients about missed or cancelled appointments allows healthcare providers to promptly assess and respond to clinical situations, thereby maintaining continuity of patient care.
- 2 Develop policies and procedures in your practice for following up with patients who have missed or cancelled appointments.
- 3 Physicians should be made aware of all missed or cancelled appointments. The staff should inform the physician(s) of these patients at the end of the day and have the medical records ready for the physician's review.
- 4 The physician should assess the clinical importance of the appointment, the severity of the patient's medical condition, and the risk(s) associated with the missed or cancelled appointment.
- 5 A reminder telephone call from the office staff may suffice for patients at minimal risk. The time and date of the telephone call and the content of the message or conversation must be documented in the patient's record.
- 6 A telephone call from the physician may be indicated for patients at higher risk. The physician should emphasize the importance of follow-up care and the risks inherent in failing to obtain it. This telephone conversation must also be documented in the medical record.
- 7 If there is no response from the patient or the patient develops a pattern of not keeping or missing appointments, a certified letter, with a return receipt requested, should be mailed to the patient to advise him/her of the risk of non-compliance. A copy of the letter and the signed receipt must be maintained in the patient's chart.
- 8 All efforts to contact the patient, either by telephone or letter, must be documented in the medical record. This provides written evidence that the patient was clearly made aware of the importance of continuing medical care.
- 9 Educate your staff about patient follow-up policies and procedures in your practice. Conduct periodic record reviews to determine staff compliance and to evaluate the effectiveness of the processes you have implemented.
- 10 Continued failure of patients to keep appointments may be deemed non-compliance with treatment. Consideration should be given to discharging the patient from your practice since patient non-compliance may increase a physician's risk of liability. The attorneys at Fager & Amsler, LLP are available to assist you to determine how and when to properly discontinue a physician-patient relationship due to patient non-compliance.

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# Rochester Colon & Rectal Surgeons

## *Experience Matters*

*The dedicated team at Rochester Colon & Rectal Surgeons continues to set the region's highest standard for comprehensive colorectal care. This privately owned practice staffed by eight U.S. fellowship-trained surgeons has been caring for patients with diseases of the intestines, rectum and anus in the Rochester region for a collective 116 years. In maintaining their leadership role, RCRS surgical specialists and medical personnel have been recognized internationally for pioneering procedures like robotic colorectal surgery unavailable anywhere else in the Rochester area.*

### THE RCRS TEAM

#### 1st row L to R:

Craig Durie, MSN, NP-C  
Stephen M. Rauh, MD  
Asim Farid, MD.

#### 2nd row L to R:

Liesl Hand, RPA-C  
Marie A. Bianchi, MSN, ACNP  
Bastian Domajnko, MD  
Michael J. Graney, MD  
Mary Lou O'Neill, MD  
Barbara A. Macey, NP

#### 3rd row, L to R:

Claudia Hriesik, MD  
Steven Ognibene, MD



## THE RCRS DIFFERENCE

RCRS prides itself on offering a wide range of treatments to its patients, with a strong focus on prevention and screenings. Among its standout offerings, RCRS includes the region's first and only colorectal surgeon, Dr. Claudia Hriesik, also fellowship trained and certified in surgical oncology. Her seven RCRS colleagues are also fellowship trained in colon and rectal surgery. Another first, the practice began performing office-based colonoscopies years ago, a capability that continues to be the most comprehensive around.

Patients find the convenience of RCRS's in-office procedures appealing. From its three facilities across Rochester, patients receive treatment for a spectrum of conditions – from benign and malignant tumors of the colon and rectum, diverticulosis and diverticulitis to Crohn's disease, anorectal problems and fecal incontinence. The practice offers on-site screenings for anal cancer, including High Resolution Anoscopy (HRA), genetic testing for heritable colorectal neoplasia, comprehensive ostomy and certified wound care. Considered experts among their peers in advanced surgical techniques, including J-pouch surgery for ulcerative colitis, RCRS provides the latest in minimally invasive surgery and maintains a top 1% national ranking for robotic colorectal surgery. RCRS surgeons are also recognized regionally as the most experienced in sphincter saving procedures for rectal cancer, Inflammatory Bowel Disease, and familial polyposis and other heritable disorders.

“Our colleagues in primary care, GI, OB/GYN and oncology recognize that it really matters where their patients receive colon care,” says Managing Director Dr. Stephen Rauh, 22-year RCRS veteran. Through a combination of unparalleled experience and patient accessibility, the practice strives to make medical care as streamlined as possible from the moment someone is referred to the practice. Analysis by third party payers, he says, consistently confirms that RCRS patient's receive care with conscientious use of health care resources.

*“As a group, RCRS is extremely well-trained in the latest techniques in colorectal care...pioneers in robotic procedures...”*

*~Dr. Marc Berliant*

*Chief of the Division of General Medicine and Professor of Medicine at URM*

## EXPERTISE/COMMITMENT AT ALL LEVELS

This leadership position in colorectal care began three decades ago when RCRS's founding physician, Dr. Michael Graney, recognized the critical need for this specialty. The practice gradually grew to its current level of seasoned surgeons and mid-level staff serving the entire city's population and its outlying regions. “We give a lot of credit to our founder,” says Dr. Rauh. “He had the vision to support changing trends within our specialty, while maintaining a private practice philosophy where each staff member takes ownership over their patients' care.”

The breadth and depth of expertise and training, surgical vol-



Collaboration between the eight U.S. fellowship trained providers is routine at RCRS and ensures the best possible patient care.

umes and dedication to coordinated delivery of care, translates to outstanding patient satisfaction. Staff longevity continues to be a source of strength for RCRS, with a long-standing team of Nurse Practitioners, Physician Assistants and other support staff playing a vital role in daily operations. “Zero provider turnover,” says Dr. Rauh, “is a testament to our supportive work environment and patient-centric focus.”

Nurse Practitioner and Enterostomal Therapist, Marie Bianchi applauds the practice's ability to expand its excellence in clinical subspecialty care. RCRS doctors frequently refer patients to their NPs and PAs for enhanced education and follow-up. She regularly receives positive feedback from home care nurses who find staff easy to work with because of their collaborative, respectful approach that puts patient needs and concerns first.

Other NPs, including Craig Durie and Theresa Schwartz, provide expert care as it relates to anal cancer. They address anal dysplasia with Pap smears, diagnostic workup and High Resolution Anoscopy. “By identifying anal dysplasia early,” says Mr.

Durie, “we can effectively treat lesions with infrared cautery ablation to reduce the risk of anal cancer progression.”

Recently, Mr. Durie was referred a patient needing rubber band ligation of bleeding internal hemorrhoids. Mr. Durie biopsied what looked atypical for a hemorrhoid. “We ultimately treated this patient for early rectal cancer.”



Colonoscopy is the primary method of screening for colon polyps and colon cancer and an important diagnostic tool to evaluate intestinal symptoms. Dr. Domajnko and endoscopy tech Shantel Briggs in one of RCRS's on-site colonoscopy suites.

Working side by side with RCRS surgeons for 18 years, NP Barbara Macey and her fellow NPs make hospital rounds, assist in the OR and in post-op patient management. “Gradually, our NPs have expanded their role to now offer flexible sigmoidoscopy, office hemorrhoid treatment and other interventions previously handled only by physicians,” adds Dr. Steven Ognibene.

The same high level of expertise and commitment comes shining through in the daily efforts of RCRS's Physician Assistants. Liesel Hand, a veteran PA certified in genetic testing, developed an improved system to better track family history so patients can be appropriately referred for genetic

testing of heritable colon cancer. “In addition to my role in the OR, this has been a gratifying contribution to our practice,” says Ms. Hand, who is featured on this month's cover with Dr. Mary Lou O'Neill. Like their NP colleagues, RCRS PAs have integrated more into the hospital-based environment in recent years, ensuring seamless in-patient and outpatient coordination of care and education.

## FAMILY APPROACH TO PATIENT ACCESS

RCRS providers speak of a mutual respect for the talents, skills and personalities each brings to the practice. “We consider ourselves more a family, not individuals sharing the same space,” says Ms. Bianchi. It's not unusual for patients to regularly be seen by different RCRS providers and feel completely comfortable doing so, she says.

Despite being the largest regional group providing colorectal surgery care, RCRS staff works collaboratively to provide all aspects of peri-operative care. “Our NPs and PAs provide excellent continuity of care and are indispensable resources when the surgeons are unavailable,” adds Dr. Bastian Domajnko.

The practice's patient mix reflects a balance of males and females, with specific treatments spanning the needs from adolescents to geriatrics. RCRS is committed to multiple health care systems – including the University of Rochester's Highland Hospital, Rochester General Hospital, and Unity. RCRS patients and their referring physicians consistently benefit from the convenience of choice.

Better accessibility also means patients referred to RCRS recently diagnosed with cancer are secured appointments within a few days of diagnosis. “Providing patient care in an efficient, expeditious manner is critical in alleviating a patient's fears and concerns,” says Dr. Domajnko. Saturday colonoscopies are offered to accommodate patients' busy weekday work schedules.

“Patients feel a connection here and like the idea of one-stop shopping,” adds Dr. Ognibene, “and they're often less anxious than they might feel in a hospital setting.”

*“I've had many patients requiring very invasive surgeries – some of which have been life altering – the way the RCRS team managed the pre and post-surgical care got them through their experience in a very positive way...the support team excels at educating and supporting patients throughout.”*

*~Dr. Marc Berliant*

## PROACTIVE PREVENTION & COUNSELING – COLORECTAL CANCER

As with any medical specialty, prevention and counseling remain critical to successful treatment. All staff actively promote patient education – particularly for colorectal cancer (CRC), the third most common cancer and second leading cause of cancer mortality.

Drs. Mary Lou O'Neill and Claudia Hriesik offer a woman's medical perspective for those patients who feel more comfortable with a female surgeon. More than 26,000 American women die of CRC each year, taking as many lives as ovarian and cervical/uterine cancers combined. "A common misconception is that CRC is a 'man's disease,' but unfortunately, it's an equal opportunity killer," says Dr. O'Neill. "It's our job to help teach women the risk factors for developing CRC, and as women age, their risk doubles every five years."

While Dr. O'Neill agrees that screening exams have increased significantly over the past decade through greater public awareness, many individuals still ignore colorectal symptoms and only about half of adults over 50 undergo the recommended screening. She urges higher risk patients with a family history of polyps, breast cancer, chronic inflammatory conditions, uterine cancer or CRC to be screened regularly. Staff provides CRC screenings at age 50, and patients with a genetic defect linked to CRC are urged to be screened in their late teens. Following the latest guidelines, RCRS offers the widest variety of screening options of any single practice.

### EDUCATION/TREATMENT OF HPV AND ANAL DYSPLASIA

The same proactive approach is taken when caring for patients with another life-threatening condition. The Human Papillomavirus (HPV) has become a major focus for RCRS NP Terry Schwartz, an American Academy of HIV Medicine Specialist. Ms. Schwartz has been performing HRA procedures for five years, diagnosing precancerous lesions.

### RCRS Screening Tools

- Digital Rectal Examination
- Stool Occult Blood Testing
- Flexible Sigmoidoscopy
- Colonoscopy
  - Virtual Colonoscopy
  - Barium Enema
- Genetic Testing

The anal canal is examined and biopsied with a high resolution colonoscope.

She currently follows about 900 area patients, including about 75 HIV-negative women. Her referrals come from outside the region as well. "Few cities yet have an HRA provider," she says. With anal cancer more prevalent in our nation's gay population, adds Dr. Hriesik, screening specifically for this group should be started early.



Dr. Rauh discusses alternative treatment options with a patient. For many colorectal conditions, a variety of treatment options and surgical approaches, including minimally invasive techniques exist. Optimal treatment for a patient involves thorough evaluation and discussion with the patient.

### ROBOTIC AND LAPAROSCOPIC COLON SURGERY

RCRS is known for its minimally invasive surgery. Dr. Ognibene jokingly refers to his colleague, Dr. O'Neill, as the "Queen of Laparoscopic Surgery." Since 1997, Dr. O'Neill has performed thousands of complex, minimally invasive techniques. "Having that additional surgical experience, we know the finer details of each procedure," she says. Her personal experience is a source of pride for the practice as she has performed more fully laparoscopic colectomies than any other upstate surgeon. Independent outcome analysis confirms her patients have the shortest length of stay and the lowest infection rate.

Techniques have evolved significantly over the last 20 years to now include robotic colon surgery. Now in their third year of high definition, 3D robotic assisted surgery, RCRS surgeons have been offering robotic surgery to the majority of their patients with colorectal tumors, diverticular disease, IBD, prolapse and other conditions. Utilizing the da Vinci robotic platform, the program represents the first of its kind in New York State and is one of only five centers worldwide endorsed by Intuitive

Surgical, makers of the da Vinci robotic platform, to teach visiting surgeons their techniques. “The robotic-assisted technique is truly revolutionizing rectal and colon cancer treatments,” adds Dr. Asim Farid.

The robotic approach affords new levels of visualization as well as complex laparoscopic maneuvers, all done through small incisions. “The overwhelming success of our program is a tribute to our ongoing commitment to stay current with surgical care,” says Dr. Rauh.

### COMMUNICATIONS COMMITMENT

The practice’s commitment to innovation extends to supporting technologies. In 2003, RCRS was one of the first area practices to adopt an EMR system, allowing rapid distribution of documents, questions and concerns between providers at multiple locations. “The combination of EMR, e-mail, texting, faxing and basic phone calls helps facilitate a team approach to managing routine care or any emergent situation that may arise, often within minutes,” says Dr. Domajnko. “By using the EMR intranet for virtual discussions on patient management, we tap each other as resources all the time,” adds Dr. Farid.

Providers rotate among the offices to ensure regular face-to-face contact with colleagues and patients. Each month they participate in a two-hour city-wide conference with their GI, Oncology, Radiology and Pathology peers on how to better work together as a subspecialty within the medical community-at-large.

### COMPLEX CASES, HAPPY PATIENTS

RCRS surgeons agree, the more complicated the procedure, the more adept the care. Staff has fully embraced that each physician offers insightful perspective, particularly with more complicated robotics and abdominal surgeries. This team of experts consistently utilizes the vast clinical resources within to ensure the best care patient care. “I’ve committed to learning as much as possible,” says Dr. Ognibene, particularly as it relates to medical technology. “The learning curve associated with robotic surgery has definitely been an investment in my future with this practice.”

Dr. O’Neill finds daily reward in the treatment of her many long-suffering patients. “My colitis patients seem the most grateful,” she says. “Often their conditions have deeply affected them for years, but once they’ve had surgery, they experience such a relief from pain and dramatic improvement to lifestyle that they become very vocal in expressing their appreciation.”



NP Barbara Macey seen here helping a patient understand an upcoming test. Mid-level providers play a vital role in patient education, support and the coordination of care.

### KEEPING ITS PATIENT-CENTRIC FOCUS

Reflective of its commitment to patients’ long-term care, RCRS instituted a support group more than 20 years ago for patients undergoing procedures for ulcerative colitis and polyposis. Referred to as the J-Pouch Support Group, area participants meet regularly to discuss personal experiences, helpful remedies, websites, books and healthy recipes.

RCRS also relocated its Irondequoit office last month to a much larger, state-of-the-art facility on Portland Avenue, close to RGH for improved accessibility.

The practice anticipates continued growth as it remains at the vanguard of the specialty. RCRS is actively recruiting to fill its need for another board certified, fellowship trained surgeon. “We’re always looking for new talent, particularly those medical professionals with an interest in being trained being trained in robotic and colon surgery,” says Dr. Ognibene. “The tradition of our founders, to remain at the forefront of the specialty, must be carried on.”

#### ANTICIPATED ADVANTAGES OF ROBOTIC COLON SURGERY

- Reduced blood loss
- Genitourinary nerve sparing pelvic surgery
- Reduced use of permanent ostomies
- Shorter hospital stay / disability
- Decreased incidence of incisional hernias
- Less incisional pain
- Lessens frequency of conversion to open surgery
- Improved survival and recurrence rates

# Minimally Invasive Surgery for Carpal Tunnel Syndrome



Peter Ronchetti, MD

Peter Ronchetti, MD

**CARPAL TUNNEL SYNDROME** is a very common condition that affects a wide variety of individuals. The main symptom of carpal tunnel is numbness in the thumb, index, middle, and ring fingers. This may be accompanied by pain in the fingers, hand and wrist that extends up the forearm. Symptoms may occur at any time however they are most widely reported during sleep. In addition, activities that involve vibration such as riding a bicycle, motorcycle and even lawn mowing can evoke the symptoms. Weakness from muscle loss at the base of the thumb can also occur. Patients often complain that they drop objects and have difficulty picking up small items.

The cause of carpal tunnel is not entirely clear. The median nerve passes through a space bounded by the bones of the wrist and the transverse carpal ligament. When the pressure in the space increases, there are changes in the nerve that result in the sensory changes that are perceived. Prolonged exposure to this increased pressure can lead to permanent nerve dysfunction, loss of sensation and weakness.

Nonsurgical management primarily consists of splinting and cortisone injections. These usually provide temporary relief and when noninvasive methods fail surgery is often recommended. It is often helpful for a neurologist to consult, and assist in finding the location and severity of the nerve compression. A nerve conduction study is extremely useful in determining the location of compression be it at the carpal tunnel or in another location. This is particularly important to assess in order to avoid unnecessary and ineffectual surgery to be performed.

The timing of surgery varies depending on the duration and severity of symptoms. It is important to understand that ignor-

ing the symptoms for a prolonged period of time can result in permanent nerve damage. Unfortunately, the course of recovery in any nerve is unknown. A severely compressed nerve may not recover even after surgery. However, releasing the pressure will prevent further nerve damage.

Traditionally the open carpal tunnel release provides excellent relief of symptoms however the recovery can be prolonged because of scar sensitivity and pain. Newer endoscopic methods afford the same results as the open technique with a much shorter recovery time.

The minimally invasive endoscopic technique is a short outpatient procedure. The transverse carpal ligament is seen directly with the endoscope on a monitor. This allows the complete decompression of the median nerve. A single stitch closes the incision and immediate finger motion is initiated. The dressing is small and early use of the wrist and hand are encouraged. (Figure 1) Patients can drive and type the next day, the use of pain relievers is minimal following surgery and reentry into ath-



*Fig. 1 Post-Surgery dressing*

letic endeavors is encouraged at 2 weeks post-surgery. Often patients with desk type jobs can return to work in 3-5 days and those in heavy manual labor return in 3 weeks.

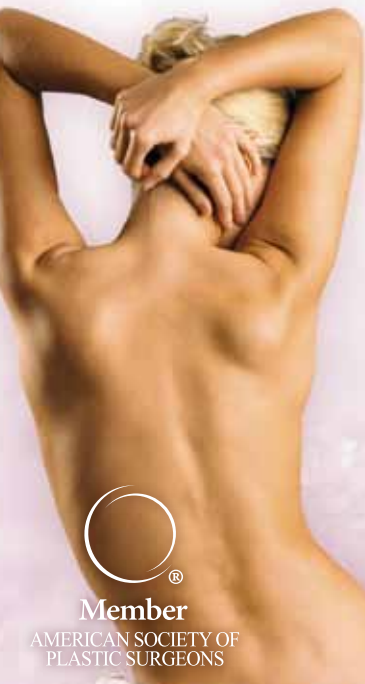
Endoscopic carpal tunnel release is a safe and effective treatment for carpal tunnel syndrome. The main advantages over open carpal tunnel release are the early return to work, and athletic activities. In addition, patients can stay on all their normal

medications prior to surgery, including coumadin if needed. In my experience, the endoscopic method has an excellent track record with over 99% of patients experiencing relief of some or all of their symptoms.

For patients wishing to quickly return to an active lifestyle, the endoscopic carpal tunnel release is an excellent choice. It is important however to find a surgeon comfortable with this newer technique. Special training in this method is recommended and patients should seek a provider that has performed a large volume of cases using this technique.

*Dr. Ronchetti is a board certified Orthopaedic surgeon with subspecialty training in hand and upper extremity surgery. He has been performing arthroscopic and endoscopic surgery for the past eight years. He resides in Brighton with his wife and three children. His practice is Hand Surgery Associates with offices in Penfield and Brockport.*

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# Cardiac CT Enters Mainstream Practice

Nathan Ritter, MD



Nathan Ritter, MD

For several years, the cardiology community has referred to Cardiac CT Angiography as an up-and-coming technology. It has been a frequent subject of medical journal and lay press articles. Memorably, Oprah Winfrey touted the Scans throughout an hour-long episode of her show in 2005. Now, 5 years later, Cardiac CT is entering mainstream medical practice. President Obama's personal physician recently had a Calcium Score done on the First Patient, as a means of screening for the presence of coronary disease. No longer a rarity, the sophisticated 64 slice CT scanners needed to obtain the high quality images have been installed in numerous hospitals and Radiology offices here in Western New York. Although far less commonly employed than the mainstays of Non-Invasive Cardiac Imaging, Nuclear Stress Testing and Stress Echocardiography, the test is now readily available, and is being used to diagnose heart disease on a routine basis in some centers.

There are two basic types of Cardiac CT scans, the Cardiac CT Angiogram and the Coronary Calcium Scoring Exam. While they are very different tests with different purposes, both tests have been made possible by the advent of EKG-Gating of the CT images, which allows stop-motion pictures of cardiac structures.

The Cardiac CT Angiogram reveals the coronary artery lumen, providing the ability to determine whether or not coronary disease is present, and if so, the degree of stenosis. It requires iodine contrast administration. We use 100 to 120 ml of contrast given intravenously, the same as what is used for a Pulmonary CT Angiogram done to rule out a pulmonary embolus. The radiation dose for the scan is currently 10 to 15 millisieverts (mSv), comparing favorably to the 10 to 30 mSv used for nuclear stress

tests. For a frame of reference, a chest x-ray uses about 0.1 mSv, and the average American receives 3-5 mSv in background radiation annually. And while the current degree of radiation is reasonable, important advances have been made in scanning technique, with a reduction in dosage down to 5 mSv or even less. These advances will be implemented throughout the country over the next few years.

The Coronary Calcium Scoring exam is a non-contrast CT of the heart. The sole purpose of the test is to quantify the amount of calcium present in the coronary arteries. The "score" is a number from 0 to 1000 or more, with 0 indicating there is no calcification of the coronaries, and higher numbers reflecting increasing degree of calcification. The computer workstation generates the score by counting the number of pixels demonstrating calcium. Because most coronary atherosclerosis is accompanied by calcification of plaques, and because coronary calcium is not present unless there is atherosclerosis, the score is used as a determinant of whether or not coronary disease is present. Unlike the Cardiac CT Angiogram, the Calcium Score does not give any quantification of the severity of stenosis.

Current ACC/AHA guidelines support the use of the Cardiac CT Angiogram in symptomatic patients or patients who, although asymptomatic, have had an abnormal stress test. Further, these patients should have a low to intermediate likelihood of having obstructive coronary disease. It is important to note that patients with typical angina symptoms who have a high likelihood of having severe disease are better served by having a traditional angiogram, because Cardiac CT Angiography is unlikely to affect management. To date, most scans are ordered by Cardiologists and ER providers, although in some locales with



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## EDITORIAL OUTLOOK

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a significant history of experience with the test, Primary Care Physicians have gained sufficient fluency with the indications and results and feel comfortable ordering it. Some physicians use the Cardiac CT Angiogram as the initial imaging test in patients with chest pain, but I usually obtain the scan in patients with atypical chest pain who have had an equivocal or mildly positive stress EKG, stress echocardiogram or nuclear study. I can then determine whether or not the patient has any coronary disease at all, and if so, the degree of severity. In patients with a moderate or greater stenosis by CT, I arrange traditional angiography. In patients without disease, I do not perform further workup for coronary disease, nor do I treat the patient medically for presumed disease, in spite of an abnormal stress test. A negative Cardiac CT Angiogram rules out significant disease, given the very high sensitivity of the technique, which is far greater than in nuclear stress testing or stress echocardiography. In this setting, insurance companies provide coverage for the test.

In contrast to Cardiac CT Angiography, ACC/AHA guidelines support use of Coronary Calcium Scoring in asymptomatic patients, who have low to moderate risk Framingham scores.

In patients who have abnormal calcium scores, I typically initiate statin therapy. In those with normal scores, I recommend lifestyle modifications as indicated. In many centers, Calcium Scores are done without a physician order, as it is purely a screening test. I, however, do not advocate this. Patients need to be able to discuss the results of the test with a knowledgeable provider. Insurance has not covered the Calcium Score at all in New York so patients invariably pay out-of-pocket. Cost varies widely from center to center, from \$200 to \$800. Insurance coverage will likely remain absent, although Calcium Scoring will very likely be addressed in the ATP IV cholesterol treatment guidelines due for release in the Fall of 2011.

While there is certainly some controversy about the use of Cardiac CT, numerous recent studies have demonstrated accuracy, usefulness in prognosis, and, perhaps most importantly, cost effectiveness, with the modality reducing expense compared to traditional assessment. Given these characteristics, use of Cardiac CT will continue to expand in the future.

*Dr. Ritter is a Cardiologist with University Cardiovascular Associates, which has offices in Brighton, Greece, Geneseo and Dansville. He specializes in Non-Invasive Cardiology and Cardiac Imaging. Please contact him at (585) 442-5320 with any questions or comments.*

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### JANUARY

#### **Clinical Focus: ENDOCRINOLOGY**

#### **Special Focus: Cervical Cancer**

*Glaucoma*

*Obesity*

## UR Discovers New Way to Boost Vaccines—Seeks Patent

*As the medical community searches for better vaccines and ways to deliver them, a University of Rochester scientist believes he has discovered a new approach to boosting the body's response to vaccinations.*



Richard P. Phipps, Ph.D.

### **Richard P. Phipps, Ph.D.**

found that the same molecules used in drugs that treat diabetes also stimulate B cells in the immune system, pushing them to make antibodies for protection against invading microorganisms.

The **University of Rochester Medical Center** has applied for international patent protection for this discovery.

Phipps believes further research will show that low doses of insulin-sensitizing drugs might be useful as vaccine adjuvants, particularly for people with weakened immune systems who cannot produce a proper antibody response. This would include some infants, the elderly, and patients with chronic health problems that lower immunity.

Currently the only widely approved vaccine adjuvant in the United States is alum. A vaccine adjuvant is a substance added to a vaccine to improve the body's immune response. Various forms of aluminum salts have been used for 70 years. (Adjuvants are added to some vaccines but not all. For example, live viral vaccines given during childhood and seasonal flu vaccines do not contain adjuvants.)

"The search is always on for new adjuvants and safe adjuvants," said Phipps, a Dean's professor of Environmental Medicine and professor of Medicine, Oncology, Ophthalmology, Microbiology and Immunology, Pediatrics and Pathology and Laboratory Medicine. "We are excited that we've identified a potentially important new and effective adjuvant."

## Patient-centered Care Requires Communication and Relationships

*Investment in infrastructure and technology can support care*



Ronald M. Epstein, M.D.

Research has demonstrated that patient-centered health care improves patient satisfaction, quality of care and health outcomes while reducing health care costs and disparities in care.

**"But what exactly is patient-centered care and how can it be achieved?"**

In an article published today in the August issue of *Health Affairs*, lead author **Ronald M. Epstein, M.D.**, professor of Family Medicine, Psychiatry and of Oncology at the **University of Rochester Medical Center**, and his colleagues define patient-centered care, detail the steps to a patient-centered health care system and explain how progress can be measured.

"Patient-centeredness is not just giving patients what they want, when they want it, regardless of value or cost," the article states. "Although the use of health information technology and similar infrastructure supports are important enablers of patient-centered care, the concept, at its core, encapsulates healing relationships grounded in strong communication and trust."

The article, which is titled "*Why the Nation Needs a Policy Push on Patient-Centered Health Care*," says "patient-centered care depends on three factors: an informed and involved patient and family; receptive and responsive health professionals who can focus on disease and knowing the patient; and a well-coordinated and well-integrated health care environment that supports the efforts of patients, families, and their clinicians."

# URMC Lands \$15M to Expand Bioterrorism Research

*The University of Rochester Medical Center once again has received federal bioterrorism funding, allowing investigators to build on several new discoveries made during the past five years to improve our ability to treat radiation injury, especially from an act of terrorism.*

The URMC was awarded an initial grant of \$21 million in 2005 to become part of a national research network, **Centers for Medical Countermeasures Against Radiation**. The Centers were charged with researching how best to respond to a possible dirty bomb or other radiological or nuclear attack. A second, \$15 million, five-year award, received August 1, 2010, from the **National Institutes of Health/National Institute of Allergy and Infectious Disease**, will allow URMC researchers to focus on testing known drugs and experimental agents – particular antibiotics, antioxidants, and anti-inflammatories including the Asian and Indian folk medicine, curcumin – and their ability to ward off systemic radiation injury that affects the lungs, brain, skin, and bone marrow.

Principal Investigator **Jacqueline P. Williams, Ph.D.**, research professor in the **Department of Radiation Oncology**, said the new project places the URMC firmly in a leadership position in the counterterrorism effort.

“For decades we have built an expertise here in looking at the delayed effects of radiation exposure, mostly in the context of cancer treatment, and now we are able to apply that knowledge to the terrorism scenario,” Williams said. “The most exciting part of this project is that through these and other collaborative efforts, we believe we are at the brink of discovering ways to mitigate the damage caused by radiation and protect the body from the repercussions that can arise months or years after the exposure.”



Jacqueline P. Williams, Ph.D.

“Previous research has revealed that it’s not just the immediate effect of radiation that makes adults and children sick,” Williams said. Rather, the radiation damage can remain relatively undetected in key tissues and organs, but will trigger life-threatening illnesses after an injury that occurs later. The catalyst can be as benign as the flu or a small wound on the skin, she said, and this is particularly worrisome in children. The URMC is one of the only groups looking at this population.

“Previous research has revealed that it’s not just immediate effect of radiation that makes adults and children sick.”

Cancer patients will also benefit from the bioterrorism project, as researchers uncover new information about how to reduce side effects such as a loss of brain function that can result from chemo and radiation therapy, or how to protect the blood vessels and bone marrow from radiation injury. The URMC investigators will be working closely with industry partners such as **ImmuneRegen Biosciences** of Scottsdale, Arizona, and **Navigen**, of Salt Lake City, Utah, to test emerging drugs in this area. “Most of the known drugs and experimental agents that we are testing have the potential to reduce the side effects of cancer treatment without adding new toxicities,” Williams said.

# What is My Liability?

## Physician Liability for Nurse Practitioners

James E. Szalados, MD, MBA, Esq.



James E. Szalados, MD, MBA, Esq.

### Question:

You are served in connection with a bad outcome following care rendered by your nurse practitioner. You did not participate in the care of the patient.

**N**urse practitioners [NPs] represent one of many groups of ‘mid-level providers,’ also referred to as either ‘physician-extendenders’ and ‘non-physician providers’ which also include NPs, Physician Assistants, Nurse Anesthetists, and Midwives. In general, each category of practitioner is governed by distinct statutory rules and regulations, and as such, these providers cannot be treated interchangeably, either in contract or in practice. Importantly, although these providers may increase physicians’ ability to serve patients, it is important to realize that the physician may be ultimately legally responsible for any liabilities.

In NY, an NP is an RN who has earned a separate license as an NP through additional education and experience in a distinct and specialized area of practice and is certified by a national certifying body. The NP must also be certified in the state in which he or she is licensed and is governed by state-specific laws and regulations. Title VIII of the NYS Education Law, Article 139 (Nursing), Section 6902 delineates NPs’ scope of practice. NPs may diagnose, treat, and prescribe for conditions which fall within their designated specialty area of practice. NPs in NY must practice through a written collaborative practice agreement with a licensed physician who is quali-

fied in the same specialty, and NPs must practice in accordance with detailed clinical protocols and guidelines. Collaborative practice agreements will typically include provisions for referral and consultation, coverage for emergency absences, resolution of disagreements concerning diagnosis and treatment, and periodic review of patient records. NY law also requires that patient records be reviewed by the collaborating physician “in a timely fashion but in no event less than every three months.” Healthcare institutions may set even higher standards and stricter guidelines governing NP scope of practice. However, NPs are otherwise considered to be autonomous and need not practice under the direct supervision of the collaborating physician.

As is the case with all providers, National Practitioner Data Bank data suggests that malpractice litigation against NPs is on the rise, with more cases being filed and higher judgments being awarded.

A physician’s liability for an NP’s acts will heavily depend on whether a physician-patient relationship exists. If the physician meets with the patient and discusses treatment options, a duty of care is clearly established. Whereas, if the NP simply presents a case, or if the physician reviews an active chart and recommends or approves a treatment plan, those actions may be interpreted to result in an implied relationship and therefore a duty of care, causing the physician to be liable, - even if he or she never actually met the patient.

In the case scenario above, if you’ve never met the patient, never reviewed the chart, and the NP never consulted you about the treatment, you probably have no duty of care simply arising from the fact that you are the NP’s collaborating physician.

However, there is rarely a bright line that defines one's potential liability; the 2003 NY case of *Quirk v. Zuckerman*<sup>1</sup> exemplifies potential risks faced by physicians in collaborative practice. In *Quirk*, a patient was treated by an NP at a hospital ED for upper extremity pain which the NP diagnosed as epicondylitis or "tennis elbow" when in fact the patient actually had a compartment syndrome necessitating later amputation of the arm. Although the NP verbally consulted with the ED physician, the physician never examined or spoke with the patient. The court reasoned that "collaboration" implied a joint effort; the court also opined that an implied physician-patient relationship existed between Dr. Zuckerman and the patient, and that under the reasonably prudent physician standard, it was incumbent on the attending physician to examine the patient's arm himself.

**MALPRACTICE CLAIMS AGAINST NPs  
[AND ALL PHYSICIAN EXTENDERS] MAY BE GROUPED AS:**

- 1 inadequate examination
- 2 lack of adequate physician supervision
- 3 delayed referral to a consultant (the supervising physician); and failure to diagnose.

In these cases, root cause analyses suggest that failure or delay of diagnosis can be attributed to inadequate physician supervision of the NP. Many lawsuits against NPs and their supervising physicians cite the failure of the physician extender to contact the physician, which may be due to a failure to appreciate the significance of a clinical finding, or the unavailability of the physician. The more specific and comprehensive the practice protocols are ("always document neurovascular status before and after casting") the more they may help minimize legal risks. Another similar area of physician liability is in the improper delegation of authority to an NP where the issue of whether the NP had the requisite level of training and skill, an issue could become a legal issue for a jury to determine.

Vicarious liability is a legal concept whereby liability is imposed for the actions of that party's agent - employers can be held liable for the actions of their employees. Although there may not be an actual agency, it may appear as though one party is acting on behalf of the other - under the theory of "apparent

agency" causing a patient believe that the an NP is in fact directly supervised - liability can still be imposed even if the physician was not aware of the encounter. Patients should always be informed whether they are being seen by an NP or a physician. NPs who are Doctorates of Nursing should be careful not to misrepresent themselves, and name badges should be clear to avoid confusion. In a similar fashion, physicians may also be liable under the doctrine of failure to obtain informed consent when patients who anticipated receiving treatment from a physician instead receive treatment from an NP.

In conclusion, NPs typically practice independently, even though they practice under a collaborative agreement. However, collaborating and supervising physicians may be inadvertently exposed to liability under many legal theories.

**STRATEGIES TO MINIMIZE PHYSICIAN RISK INCLUDE**

- 1 due diligence in hiring
- 2 requiring NPs to carry adequate malpractice insurance [if the NP is uninsured or under-insured, and is jointly sued with the physician, the physician will likely face the majority of the liability burden]
- 3 ascertain that the medical malpractice carrier has updated information about the collaborative practice [or insurance coverage may be denied on the basis of failure to disclose]
- 4 facilitate and encourage communication
- 5 be as specific as possible with respect to policies and protocols to be followed when acting independently
- 6 educate liberally and assess performance through documented periodic reviews.

The information contained herein is presented for educational purposes only. The material presented here is not, and must not be in any way considered to be, legal advice.

*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.*

<sup>1</sup> *Quirk v. Zuckerman*, 196 Misc. 2d 466 (N.Y. App. Div. 2002).

# Navigating the Great Retirement Shift

## Boosting Contributions to Your Qualified Retirement Plans

James M. Sperry, MBA



James M. Sperry, MBA

As a result of losses suffered in 2008 and the heightened volatility that ensued, many investors are earnestly re-examining their prospects for retirement. Physicians are not immune. Frankly, the prospects can be quite unpleasant. For some, this means postponing retirement and working several years more than originally planned. For others, it means dialing down their expected retirement lifestyle, which in practice is even more painful than it sounds. To my shock and dismay, I have even heard of cases where investors have been advised to take more risk

to achieve the gains necessary to accumulate the desired level of retirement assets – at exactly the time that they should be reducing their risk! Fortunately, there may be more palatable strategies, especially for those with higher incomes. These involve maximizing the contributions you are making to your qualified retirement plans. Implementing such strategies can make all the difference in enabling you to retire comfortably, and rely less on investment gains in getting there.

The vast majority of workers in the US today build their retirement assets by making pre-tax contributions from their

paychecks into their qualified retirement accounts, such as their 401(k) or 403(b). Unfortunately, the IRS limits what one can contribute to one's pension or qualified retirement plan. The idea is to encourage us to save for retirement but not make it so attractive as to create a tax loophole for those whose purpose goes beyond funding their retirement. The limits on allowable annual contributions set by the IRS are summarized below:

The consequence of these limits is that it is very challenging to accumulate a level of assets over the course of one's career that

Current Annual Contribution Limits to Qualified Retirement Plans (IRS) <sup>1</sup>			
Age	401(k); 403(b) elective deferral limit	Defined Contribution Plan Limit	Defined Benefit Plans
< 50	\$16,500	\$49,000	\$195,000
50 and over	\$22,000	\$54,500	\$195,000

will fund a desired retirement lifestyle. Combine this with the two historic market corrections in this past decade and you have the makings of a retirement funding nightmare for those nearing retirement, even if they are the most diligent savers. Because of these limits, many physicians believe that their capacity to save in their qualified retirement plan is capped at a total of \$54,500 per year. This may or may not be true, depending on a number of factors, including employment status. So, how can one save more than \$54,500 in their qualified plan to maximize their hopes for a comfortable retirement when they want to retire?

*“For others, it means dialing down their expected retirement lifestyle, which in practice is even more painful than it sounds.”*

<sup>1</sup>2010 limits reflect issuance of IRS Notice 2009-94, 2009-50 I.R.B. 848 (December 14, 2009): [http://www.irs.gov/irb/2009-50\\_IRB/aro6.html](http://www.irs.gov/irb/2009-50_IRB/aro6.html).

## DEFINED CONTRIBUTION VS DEFINED BENEFIT

First, recall that there are two basic types of pension or qualified retirement plans: defined contribution plans (i.e., 401(k), 403(b), profit sharing, etc.) and defined benefit plans. In a defined contribution (DC) plan, the retirement benefit is based on the participant's account balance, which is determined by the employee's (and employer's, where applicable) contributions (less withdrawals), investment gains/losses, and fees. As with any other saving account, the benefit in retirement lasts only as long as the account balance remains positive. In contrast, a defined benefit (DB) plan is one in which an employer promises a specified monthly lifetime retirement benefit to the employee that is based on a predetermined formula including the employee's earnings history, age, and tenure. It is 'defined' in the sense that the formula is established in advance, and the benefit lasts at least for the life of the employee.

If the DB plan sounds more like the plan under which your grandparents retired than the one you currently have, you are probably correct. Today, only 32% of employees of large- and medium-sized employers are covered under a DB pension plan, down from 84% in 1980. Except in the public sector (where 88% of employees still participate in a DB plan), the shift has been to DC plans, such as 401(k)s, where there is no guaranteed payout.<sup>2</sup>

### A HYPOTHETICAL CASE:

#### PRACTICE OWNER VS. HOSPITAL EMPLOYEE

What is the difference when it comes to the cumulative savings for retirement? Consider one physician who is employed by a hospital, which offers a 403(b) retirement plan and another who owns a business, perhaps as a partner in a practice. This practice is working with an advisor to evaluate the potential benefits to the owners of establishing a DB plan in addition to its 401(k) and profit sharing plans, and their objective is to maximize the amount the owners can contribute into their own plans. The allowable contribution under the DB plan is calculated by an actuary using methods that go beyond our purposes here. Suffice it to say that there is some degree of actuarial flexibility in determining how the plan is funded, but generally the allowable contribution scales with the owner's income (to a limit, of

course!). Below is a summary of hypothetical contributions allowable for different plans:

Since one can establish a DB plan in conjunction with a 401(k) and profit sharing plan, the total contribution is the sum of the contributions to each. So, for example, the practice owner today might be able to contribute over \$170,000 per year if age 52 (or over \$216,000 per year if age 60), more than three times what would be allowable using DC plans alone. And since the contributions can be made each year until retirement, the incremental savings can compound over time to yield a dramatic difference in one's retirement assets. In this case, a physician adding a DB plan to his 401(k) and profit sharing plan might accumulate over \$4,000,000 in retirement benefits (assuming a modest 5% net annual investment return) from contributions between age 52 and 67 alone. Under the same assumptions, the hospital-employed physician who could only take advantage

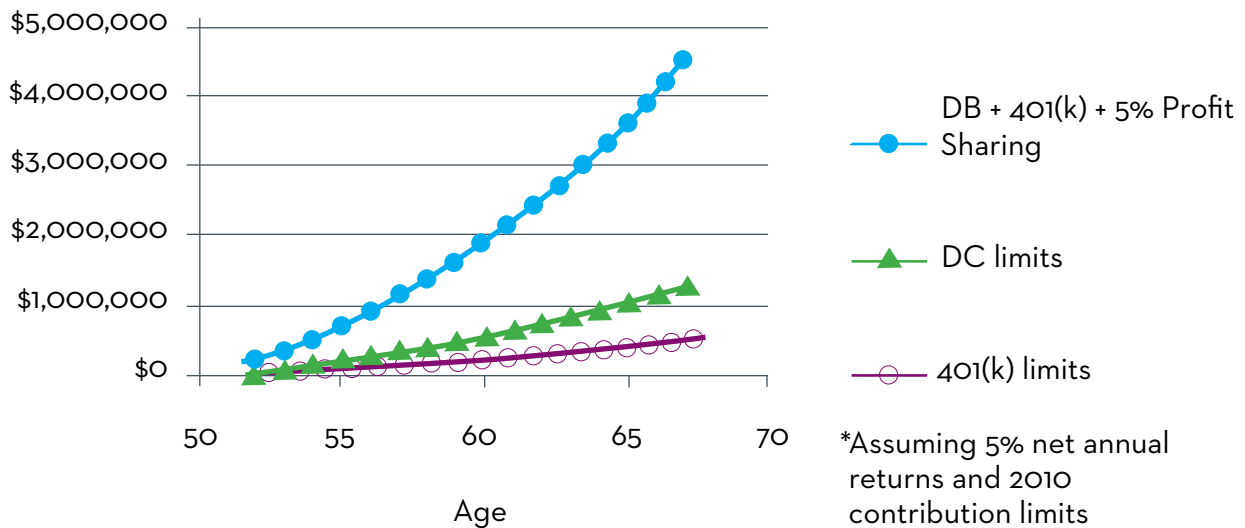
Age	401(k)	5% Profit Sharing	Defined Benefit (DB)	Total
52	\$22,000	\$12,500	\$137,000	\$171,250
60	\$22,000	\$12,500	\$182,000	\$216,250

of DC plans for purposes of retirement accumulations would accumulate only just over \$1,000,000 in retirement savings. For most, the difference between a retirement benefit base of \$4,000,000 and \$1,000,000 will have a profound impact on the lifestyle that will be sustainable in retirement.

*Today, only 32% of employees of large- and medium-sized employers are covered under a DB pension plan, down from 84% in 1980.*

<sup>2</sup> "City employees' golden years start too soon". Opinion: EDITORIAL. statesman.com. Thursday, May 07, 2009. [http://www.statesman.com/opinion/content/editorial/stories/05/07/0507pensions\\_edit.html](http://www.statesman.com/opinion/content/editorial/stories/05/07/0507pensions_edit.html).

# Cumulative Hypothetical Savings in Alternative Retirement Plans\*



Needless to say, there is more to consider in choosing which plan(s) to establish for you and your employees. Certainly, a DB plan can be more complex to set up and operate but also offers a great deal of flexibility, so it is imperative to find a qualified specialist to guide you in that assessment and design. If a DB plan fits your situation, however, it can help to dramatically accelerate your retirement savings in a tax-advantaged manner.

\*\*\*\*\*

*Jim develops individualized protection, growth and transfer strategies for clients in diverse lines of business, including medicine. He earned his MBA from the Simon Business School at the University of Rochester (2002) and his Ph.D. in engineering from Duke University (1997). He moved his practice to Tompkins Financial Advisors recently to offer his clients greater depth of expertise in investment management, estate planning and wealth transfer, tax planning, and specialized services for business owners. You may reach Jim by phone 585-721-0068 or by email [jsperry@ammfinancial.com](mailto:jsperry@ammfinancial.com)*

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**Lead paint** poisons more than 500 kids in Monroe County every year. The damage to their bones and brains is permanent. Make sure your children are tested at one and again at two years old. Have your home tested today. You can get the information you need to protect your children. Call **585-256-2267**. Or visit [www.leadsafeby2010.org](http://www.leadsafeby2010.org).



# WHAT'S NEW IN Area Healthcare

## ROCHESTER GENERAL HOSPITAL CHOSEN TO TEST AND EVALUATE FUTURE ROBOTIC SURGICAL SYSTEM

**Rochester General Hospital** has been selected by **Titan Medical Inc.** of Toronto, Canada to assist in the testing (development) of a new clinical-grade surgeon console for the **Amadeus Robotic Surgical Platform**.

A non-binding memorandum of understanding (MOU) has been executed by both parties. Under the terms of the MOU, Rochester General Hospital will assist Titan Medical in the testing and evaluation of the new robotic surgeon console and its component sub-systems, including the vision system, the telecommunication system, hand controllers, simulated instrumentation and ergonomic interface.

"We are pleased to be helping guide the development of Titan's next generation Robotic Surgical System," said **John Valvo MD**, head of the Robotic Program at Rochester General Health System. "Rochester General Hospital has been a leader in bringing robotic surgery to our community and ranks among the top 4% of U.S. hospitals in completed robotic surgery procedures."



John R. Valvo, MD, FACS

## SIME NAMED URMIC DIVISION CHIEF OF PULMONARY AND CRITICAL CARE MEDICINE

Pulmonary expert **Patricia J. Sime, M.D., FRCP**, has been named chief of the **Division of Pulmonary and Critical Care Medicine** at the University of Rochester Medical Center. The appointment is effective July 1.

Sime is a professor of Medicine, Environmental Medicine, Microbiology and Immunology, and Oncology, as well as director of Pulmonary Research Programs and associate chair of Medicine for Research.

An authority in the field of pulmonology best known for her basic and translational research of lung inflammation and scarring, Sime has been a URMIC faculty member for more than a decade. She is known as a highly productive physician-scientist who runs a vibrant translational lung-disease program considering mechanisms and therapeutic interventions in lung inflammation and scarring, with an additional focus on the study of the cellular and molecular mechanisms of chronic obstructive lung disease (COPD). She excels in combining care of patients with research and teaching missions.

"We are incredibly pleased Dr. Sime has accepted this position,"



Patricia J. Sime, MD, FRCP

## RGH INTRODUCES DIGITAL MAMMOGRAPHY WITH LOW DOSE RADIATION PATIENT SAFETY FEATURES AND SUPERB IMAGING COMBINED

**Rochester Diagnostic Imaging** at **Rochester General Hospital** has dedicated the latest breast imaging technology.

The Hologic Selenia Dimensions offers low patient dose radiation, superb image quality, better patient comfort, and Computer Aided Detection (CAD), which assists Radiologists in detecting areas of concern.

"Combining superior imaging with low dose radiation offers unparalleled patient safety," said **Jonathan Broder MD/Chief of Diagnostic Imaging** at Rochester General Hospital. "This state-of-the-art technology also provides our expert Radiologists with the highest quality images available for early detection."

Rochester General Hospital has been designated a **Breast Imaging Center of Excellence** by the **American College of Radiology**. This designation is awarded to breast imaging centers that have earned mandatory accreditation for their imaging equipment as well as voluntary accreditation in all available mammography modules and procedures.



said **Paul C. Levy, M.D.**, acting chair of the URMC Department of Medicine. “Her talents as a clinician, teacher, researcher and administrator have made a significant impact over the past 10 years, and those same attributes will allow her to expand research endeavors, as well as grow the clinical enterprise and further improve patient care.”

Sime earned her medical degree with honors from the **University of Edinburgh Medical School**, Scotland. She completed training at the **Royal Infirmary of Edinburgh** and the **University of Edinburgh**. She was then awarded a highly competitive traveling fellowship to **McMaster University** in Canada, followed by research and clinical fellowships also at McMaster.

### GERIATRIC ASSESSMENT PROGRAM OFFERED TO NORTHERN WAYNE COUNTY SENIORS WITH RECURRENT MEDICAL CONDITIONS

A new specialized medical program is available for Senior Citizens from rural Northern Wayne County who are 65 and older. **The Geriatric Assessment Program** is offered to seniors who are experiencing recurrent medical conditions impacting their quality of life. If your patients suffer from syndromes such as: urinary incontinence, chronic pain, functional decline, frequent falls, dementia, delirium or another recurrent medical problem, the Geriatric Assessment Program may be able to help.

A member of the **Geriatric Team** will contact patients to: set-up a home visit including a physical examination; evaluate clinical needs; and develop a care plan to manage the syndrome and pharmacology. This short term program offers non-emergency, specialized care with: **Dr. Mohamed Mohamed**, Geriatrician; **Cheryl Fontaine**, Geriatric Nurse Practitioner; and **Denise Washburn**, Care Manager. The program is provided at no charge to patients without insurance; for patients with insurance, co-pays apply. For patient convenience office visits may occur at the **Rochester General Medical Group** facility in Wolcott or at the state of the art **Newark-Wayne Community Hospital Telemedicine** office. Transportation to office visits may be arranged through the Geriatric Assessment Program team in partnership with the **Wayne County Department of Aging and Youth**.

In addition to the direct medical services provided, the Geriatric Assessment Program will subsidize educational efforts of health professionals and care-givers in Wayne County to elevate the skill set of those who work with the elderly. For more information on educational opportunities please contact, **Marya Vande-Doyle** at (315) 398-8201.

The Geriatric Assessment Program is funded by a federal outreach grant from the **Health Resources and Services Administration**. The three-year grant was awarded to the **Wayne County Rural Health Network (WCRHN)**, one of 35 networks in New York State working to increase access to health and human services for New York residents. WCRHN is sponsored by Newark-Wayne Community Hospital and several other county-wide non-profit organizations.



Mohamed Mohamed, MD

### RGH SIGNIFICANTLY REDUCES WAIT TIMES IN ITS EMERGENCY DEPARTMENT

Patients at **Rochester General Hospital's B. Thomas Golisano Emergency Pavilion** are being treated more efficiently than ever before. And, this improving trend at Rochester General is in stark contrast to the findings presented in a newly released report by **Press Ganey Associates, Inc**, a healthcare consulting and measurement company.

According to Press Ganey's 2010 **Emergency Department Pulse Report**; “From the moment patients walk into a hospital emergency room until the time they are discharged from the emergency department, the average time spent was four hours and seven minutes in 2009 – an increase of four minutes compared to 2008 and 31 minutes more than the nationwide average in 2002.” Press Ganey based its findings on more than 1.5 million patients treated at 1,893 hospitals in 2009.

“At Rochester General Hospital we continue to decrease, not increase, the amount of time a patient spends in the ED,” says **Keith Grams MD**, Chief of Emergency Services. “This year, though June, our patients are spending, on average, 3 hours and 42 minutes from door-to-discharge. That is a 15-percent decrease from a year earlier.”

Year to date, Rochester General Hospital is operating the busiest Emergency Department in Rochester. Volume is up almost 8%. “In addition to reducing the length of stay for treat-and-release patients, we have significantly reduced our door-to-provider wait time. Last month, the average wait time for patients to be seen was just 27 minutes, down from 90-minutes in 2009.”

Grams credits the positive improvement to “profound process changes” in the hospital, significant support from Senior Leaders within the System, and a newly designed facility, which opened in late 2009.

### BORG & IDE AT CLINTON CROSSINGS IS AWARDED BREAST IMAGING CENTER OF EXCELLENCE BY THE ACR

*Borg and Ide Imaging at Clinton Crossings has been designated a Breast Imaging Center of Excellence by the American College of Radiology (ACR).*

The breast imaging services at **Clinton Crossings** are fully accredited in mammography, stereotactic breast biopsy, breast ultrasound and ultrasound-guided breast biopsy. Peer-review evaluations, conducted in each breast imaging modality by board-certified physicians and medical physicists who are experts in the field, have determined that **Borg and Ide at Clinton Crossings** has achieved high practice standards in image quality, personnel qualifications, facility equipment, quality control procedures, and quality assurance programs.

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## UPDATE 2010

Late breaking news on  
medical-legal developments  
affecting physicians and  
health care providers.

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**Stipulation Holds Off Enforcement of Red Flags Rule Against Physicians:** Not long after delaying enforcement of the Red Flags Rule to December 31, 2010 (see *Statlaw* 6/20/10), the Federal Trade Commission (FTC) entered into a joint stipulation with several medical groups that had sued the FTC, agreeing that it would not enforce the Rule against physician members of the associations until after a federal court rules in a case brought by the American Bar Association (ABA) alleging the Rule should not be enforced against attorneys. If Congress does not act by January 1, 2011, to statutorily exempt physicians from the Rule's application, the stipulation will continue the exemption until the appeals process in the ABA case has concluded.

**New HIPAA/HITECH Rules Proposed; Data Breach Reports Increase:** The U.S. Dept of Health & Human Services has finally issued proposed rules to implement revisions to the HIPAA Privacy, Security and Enforcement Rules as required by the HITECH Act enacted early last year. The revisions include extending application of certain of the Privacy and Security Rules' requirements to a covered entity's business associates and their subcontractors, expanding restrictions on the use and disclosure of protected health information (PHI) for marketing and fundraising, prohibiting the sale of PHI without patient consent, expanding patients' rights to access their PHI and obtain restrictions on certain disclosures to health plans, and strengthening HIPAA's enforcement provisions. The proposed rules can be accessed at [www.drlaw.com](http://www.drlaw.com). While many of these rules will not be effective for some time, HITECH's Data Breach Notification Rule and reporting requirements already are effective and enforced. As of today, there have been over 100 reported breaches involving over 500 persons each. Several involve thousands of persons and all are listed on OCR's website. One of the most recent reported breaches occurred when a New York hospital's billing processor, Siemens, shipped to the hospital seven CDs containing sensitive health and personal information via FedEx. The CDs never arrived at the hospital. Although the CDs were password-protected, the data was unencrypted, requiring the hospital to report the breach. While many breaches involve lost laptops, mishandled paper records, or hackers, a significant percentage involve business associates, highlighting the need for protective provisions in a practice's vendor agreements.

**Obama Unveils Patients' Bill of Rights:** Issuing rules for already enacted health care reform measures, the Obama Administration has announced what it calls a Patients' Bill of Rights. In addition to restrictions on pre-existing conditions limitations, coverage rescission, annual dollar limits on coverage, and protecting a patient's choice of doctors and access to obstetrical and gynecologic care, the Patients' Bill of Rights also addresses emergency service coverage and out-of-network providers. The rules require plans to cover emergency services without the member having to obtain prior authorization, even if the provider is out-of-network. Plans cannot limit benefits for out-of-network emergency care beyond what is provided for in-network care and cannot charge customers more, in the form of coinsurance or copayments, for emergency out-of-network care than they do for in-network care. Out-of-network providers can charge patients the balance of a bill not collected from health plans for these emergency services, but only if the plan has paid a "reasonable amount" for the services. The rules include a formula requiring plans to pay a minimum amount to out-of-network providers, based on factors such as the negotiated in-network rate, the Medicare rate, and the out-of-network rate reduced only by the in-network cost-sharing amount. Grandfathered health plans—plans that meet certain benchmarks for maintaining coverage—are exempt from the emergency services coverage rules. Although subject to comment within the next 60 days, the rules are to become effective September 23, 2010. Yet to be seen is how the new rules will affect state laws and rulings regarding balance billing.

# Reach

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