Past presidents of the New York State Society of Anesthesiologists were recognized during PGA 64.
65th Annual
PostGraduate Assembly in Anesthesiology

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On the cover: Present at NYSSA’s Past Presidents’ Luncheon, held during PGA 64, were: (standing, left to right) Drs. Robert S. Lagasse, Richard A. Beers, Michael H. Mendeszoohn, Scott B. Groudine, Phillip N. Fyman, Mark J. Lema, and Peter B. Kane; and (seated, left to right) Drs. Alan E. Curle, Jared C. Barlow, Alexander W. Gotta, Gerald S. Weinberger, Michael S. Jakubowski, and Paul L. Goldiner.
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Paul M. Wood, M.D.
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Thomas F. McDermott, M.D.
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This has been a terrific year for the NYSSA. It is my pleasure to highlight a few of our accomplishments during the past 12 months.

We sold the building that housed our headquarters for a sizable profit. Our Land Use Subcommittee has located a new property for our headquarters, and we are in the process of negotiating with the owners.

As of this report, our attendance for the PGA has increased, as have our revenues from the technical exhibits. Overall, our margin improved over last year’s, which was one of our best years to date.

Our office has become more automated. The Web site now provides better services. We listened to our membership and, to better meet our members’ needs, we have put legal services online. In addition, we worked with New York state officials, obtained grant money, and now have an online infectious disease course as a member benefit as well.

In order to provide more legal support for our members, we diversified our legal consultants. Our expanded legal team can provide information and assistance concerning practice management, insurance issues, hospital disciplinary measures, and other hospital conflicts.

The Board of Directors created a permanent Finance Committee to protect our investments and assets. The investment policy was subsequently reviewed and improved. We also changed our indemnification policy to better protect our volunteer leaders and enhance our coverage.

The NYSSA always faces political challenges. We made progress with the Workers’ Compensation Board and met to improve reimbursement for those cases. We fought back a strong effort for CRNA practice without supervision. Efforts to bring the CRNA independent practice bill to the floor of the Assembly were stifled by our strong lobbying efforts.

We responded to the CRNA media campaign with letters to the editor of The Wall Street Journal and The New York Times. Now it is our turn to go on the offensive. I appointed an ad-hoc committee to develop a marketing plan designed to educate the public about the important role anesthesiologists play in the care of our patients. In addition, our
educational efforts at the New York State Fair were vastly improved over last year.

Challenges abound across the country: “Obamacare”; New Jersey’s anesthesiologists are facing an assault by CRNAs who wish to practice independently; California’s anesthesiologists have lost their lawsuit against CRNA independent practice; the governor of Colorado has opted out of physician supervision of anesthesia for select hospitals; and now the Federal Trade Commission has voiced its opinion that not allowing nurses to do interventional pain management procedures in Alabama is a restraint of trade. Fortunately, in New York we have developed strong relationships with the current and future governors and other state leaders. We hope that these relationships will help us keep the practice of anesthesia safe from the continuous aggression by non-physicians.
This year, our Board members volunteered their time to attend an educational retreat aimed at improving our organization and developing our leaders, both present and future. We held breakout sessions in three areas: to develop a Board handbook; to create an ongoing leadership educational process; and, most importantly, to improve our organizational structure to create learning opportunities for our future leaders. We are also conducting a complete review of, and modernizing, our administrative procedures.

The Anesthesia Foundation of New York, our not-for-profit organization created to educate anesthesiologists from poor countries and to develop grants for young investigators in New York, was recently incorporated and the first meeting of the Board of Directors was held. We expect to be granted not-for-profit status from the IRS sometime next year.

When I became president of the NYSSA, I acknowledged being part of a team of incredibly knowledgeable, hard-working, and caring Board members. Today, as I conclude my term as your president, I want to extend my heartfelt thanks to this team. Without these individuals, the numerous successes of the past year would not have been possible. ■

Outgoing President Dr. Paul Willoughby celebrates the end of his presidency with incoming President Dr. Kathleen O’Leary (left) and his wife, Dr. Katiuschka Willoughby.
It is difficult to know what motivates people. I often see news reports of the extraordinary actions of others — actions both good and bad — and try to put myself in their shoes to determine what would motivate them to do such things. As you might expect, more often than not, I find it impossible to do so.

When I look at the varied members of the House of Delegates, the NYSSA committees and the committees of the PGA, I find it easier to guess at the motivation of our members. We all have demanding professional lives and often juggle very busy personal lives and civic commitments. Yet we find the time to be involved. I personally believe that many of us are motivated by a desire to make a difference. It could also be a desire to “give back.” And yes, for some, it’s a desire to be in the limelight. Regardless, it’s a personal commitment of one of our most valuable commodities — time.

So, from one volunteer to another, I’d like to say, “Thank you.” And I’d also like to ask each of you to do two things in this coming year. One is to continue with your involvement in the NYSSA, and perhaps to branch out into an additional area. By that I mean become more involved in your home district, join a committee, or attend or join one of the Reference Committees (which meet today after lunch and are open to all NYSSA members to attend). Additionally, consider attending Legislative Day in Albany on May 10. We would welcome additional involvement as we speak to our legislators. And what an education it is for those who have never done it before! The first time I attended Legislative Day, I thought I would be in awe of the whole legislative process. Indeed, I was in awe, but more because I believe we made such an impression on the legislators we visited. They were very open to hearing what we said and were obviously impressed by the fact that we had taken the time to come to Albany to speak about issues of importance to us and our patients. The repeated visits on Legislative Day allow each of us to develop relationships with our own lawmakers. This is of critical importance.

The second thing I’d like to ask each of you to do is to make a serious effort this year to get at least one more person involved in the NYSSA.
I am sure each of you has at least one colleague who is not a member, yet who reaps the rewards of anything beneficial that we accomplish (e.g., increases in Workers' Compensation reimbursement). When the NYSSA speaks as an organization, it is the collective voice of all of the anesthesiologists in New York state. Those colleagues who are not members are riding on the backs of all of us who are members. The additional benefits of membership can be found on our Web site: there are CME opportunities related to this meeting, practice management links, and numerous legislative issue links for members. We also have tremendous legal support available to our members. All your nonmember colleagues need to do is to join.

I'd like to take this opportunity to recognize two volunteers in our midst who are stepping down from their positions as chairs of committees. Both Drs. Audrée Bendo and James Szalados have demonstrated tremendous dedication to our society in their respective roles. Dr. Bendo has served as chair of the Academic Anesthesiology Committee for several years. She has been able to bridge the perceived gap that many of the chairs of academic departments have noted in the past. As such, she has provided leadership within this group and they have become an excellent resource within our society. Additionally, she was instrumental in providing the support necessary for the Residents Section as it transitioned from an independent group within our society to one under the auspices of the Academic Anesthesiology Committee. This has been critical to the success of the Residents Section. I thank her for her leadership and dedication. I have asked Dr. Mark Lema to assume the role of chair of this committee. It was under his leadership as president of the NYSSA that this committee was established. So it is fitting that he steer it through the next few years.

Dr. James Szalados has led the Communications Committee for several years. It was under his leadership that this newly formed committee — a combination of the former Public Education and Information Committee and the former Communications Committee — established itself and redirected its focus. The NYSSA’s quarterly journal, Sphere, is now published at a significantly cheaper cost, with continued quality and excellence of content. I must admit that I look forward to Dr. Szalados’ editorials. His vantage point as an anesthesiologist, intensivist, attorney and businessman provide him with the right tools to provide insight into our roles. I sincerely thank Dr. Szalados, a friend since our days on the Residents Committee, for his continued dedication to this committee and his wonderful role as editor of Sphere.
I have asked Dr. Jason Lok to assume the role of chair of this committee. And I have asked Dr. Donna-Ann Thomas to partner with him in refocusing our attention on public education. While the New York State Fair has been one venue for this, it is surely not the most effective venue for getting the message out to the public about patient safety under anesthesia. I have also charged this committee with reevaluating the means of communicating with our members. While Sphere is one mechanism, in this electronic age there are many other opportunities open to us. I look forward to the recommendations that emerge from this committee.

The tremendously dedicated volunteers who serve on the Executive Committee are well aware of my concerns about mentoring. I have often felt that in our professional practices, mentoring occurs more often by happenstance than anything else. I believe mentoring to be important in all aspects of our profession. However, when it comes to organized medicine, I believe we should make every effort to utilize mentoring for those who have the interest and ability to represent our societies in leadership positions. Within the NYSSA we are fortunate to have many who have served, or are currently serving, as leaders — in the NYSSA, the ASA, MSSNY, and other organizations. They have the expertise, connections and vision to guide those with an interest in serving in this and other societies. As such, I have asked Dr. Alan Curle to serve as chair of the new Mentoring Committee. I believe he possesses the necessary skill set to bring together those with experience to assist those with an interest in doing more.

My year as president-elect began with concerns about adequate representation within our society by those across the geographic expanse of this state. I have had the opportunity to discuss the concerns of representation with members and officers from both the upstate and downstate areas. I believe that we have come to an understanding that has resulted in a working document that can be utilized to assure seamless and appropriate representation within this society.

I must take this opportunity to thank Stuart Hayman, our executive director, for his able leadership of our organization. His business skills and decision-making capabilities have proven to be of great benefit to this society. We are on sound financial footing and look forward to stabilizing our organization financially as we move through the coming years. I must thank all of the office staff for their wonderful support and dedication. With my involvement in the PGA over the years, I have come to recognize
the tremendous workload that they shoulder in making this the stellar international educational event that it is. They put in long hours both prior to and during the PGA. At a time when many are enjoying the holiday season, they are hard at work to produce this wonderful event. Thank you one and all.

And as we move into a new leadership regime in Albany, it is reassuring to know that we have the excellent representation of our lead lobbyist and board counsel, Chuck Assini, and the expert lobbying firm of Weingarten, Reed and McNally. We are all anticipating tough legal battles in Albany this year with concerns about changes in scope of practice. These individuals have their fingers on the pulse of what is happening in the ever-changing Albany environment. I look forward to working closely with all of them in the coming year.
This concludes my second year on the Executive Committee and it has proved to be an amazing period of education and growth for me. The officers of the NYSSA with whom I am serving possess talent, dedication and many opinions. The opportunities for dialogue have been many and you should all rest assured that this group of dedicated volunteers has worked to keep the interests of the NYSSA as an absolute priority. I am honored to be part of such a wonderful group. I look forward to their support in the upcoming year.

And on a personal note, I’d like to thank my husband, Michael Collins, and our children, John and Nora. This has been a challenging year for me personally in several respects. Michael’s support of my role as president-elect has been the rock that I have needed to balance my roles as wife, mother, physician and officer in this society. For that, I am truly grateful.

I look forward to a challenging and rewarding year. I thank you for placing your confidence in me as president of this society.

Dr. Kathleen O'Leary receives the president's gavel from outgoing President Dr. Paul Willoughby.
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15th WFSA World Congress of Anaesthesiologists

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It's All About Time
JAMES E. SZALADOS, M.D., M.B.A., ESQ.

This issue will mark my farewell editorial for the NYSSA Sphere. How quickly four years have passed! In those years, four NYSSA presidents have held tenure, the NYSSA administrative leadership has turned over, the leadership of the state and federal governments has changed, and we as a profession and a medical society have successfully overcome a great many challenges. It has been a marvelous vantage point, as editor, to be able to share the news and the viewpoints of our members with you, the readership. For me, it has been time well spent. Thank you for the opportunity; it has been an honor to serve.

There is, however, no indication that the problems of the world have been solved. I am certain that future issues of Sphere, and any additional communications that the NYSSA will use to disseminate information to our peer members, will never be short on issues that will require our collective attention and our efforts.

Time marches on. Jason Lok, M.D., has kindly accepted the invitation to step into the shoes of editor and chair of the Communications Committee; he will bring renewed energy, as well as expertise in electronic (faster) communications, to his new leadership role within the NYSSA. Perhaps it really is about time.

What am I to do with all my newfound time? As I transform from editor to reader, I also commit to staying involved. I have never been one to spend my time idly. I am stepping into the role of president of the Monroe County Medical Society in 2011, where I hope both to gain new leadership experience and insight and also to increase my efforts as an advocate for the practice of medicine.

After all, anesthesiology represents the practice of medicine; we are all physicians first; and, perhaps most importantly, we should never forget that, “United we stand, divided we fall.” The issues that challenge us as anesthesiologists are similar to the issues faced by physicians of most specialties: reimbursement cuts, negotiations with third-party payers, scope of practice expansion by alternative care providers, and legislated administrative burdens.
Time is money. So, I will spend my time — budgeted carefully, of course — to continue with a balance of volunteerism, teaching, administration, and, of course, the practices of medicine and law. In the 1987 movie “Wall Street,” the protagonist, Gordon Gekko, remarked, “The most valuable commodity I know of is information.” By 2010, even Gekko had changed his mind, stating in the 2010 sequel “Wall Street 2: Money Never Sleeps” that, “If there’s one thing I learned … it’s that money is not the primary commodity in our lives, time is.”

Finally, I am reminded of the inspiration that a friend and mentor, Dr. Robert W. Vaughn, former chair at the University of North Carolina, once shared with me a long time ago:

“This is the beginning of a new day. I have been given this day to use as I will. I can waste it or use it for good. What I do today is important because I am exchanging a day of my life for it. When tomorrow comes, this day will be gone forever, leaving in its place whatever I have traded for it. I want it to be gain, not loss; good, not evil; success, not failure; in order that I shall not regret the price I paid for it.”

— author unknown

So, until next time ...
As we begin a new year and a new decade, many Americans admit to a feeling of great uncertainty. We face so many questions about the future. One of this country's biggest unresolved issues is that of healthcare reform: How will the Patient Protection and Affordable Care Act impact the future of medical care? Will we see adjustments to the legislation prior to its full implementation? Will the healthcare reform bill be repealed outright?

Beyond healthcare, we face questions regarding the state of the economy, unemployment, the future of our military, and so much more. Amid all of this uncertainty, I want to reassure you that the NYSSA will continue to be a constant in our support of you, your practice, and your profession. Your staff and leadership have worked hard to communicate to, advocate for, and educate anesthesiologists across the state, and we will continue to do so.

Personally, I am excited to begin a new decade and to celebrate my third “New Year” as your executive director. Although I’m still fairly new in my position, especially considering the more than 30-year tenure of your previous executive director, I feel we have accomplished much together already. This past December I directed my third PGA since joining the NYSSA staff — and my first without our longtime staff member Mrs. Patricia Burdett, who recently retired. Fortunately for me, I continue to be surrounded by a team of extremely hard working and conscientious staff members.

I would be remiss if I didn’t take this opportunity to recognize the outstanding effort your NYSSA staff put forth to make PGA 64 such a wonderful success. I would like to recognize and thank Mrs. Kathy Felicies-Rojas, Mrs. MaryAnn Peck, Ms. Lisa O'Neill, Mr. Will Burdett, Mr. Bill Peck, and Ms. Maria Vita. I know you join me in thanking them for their commitment and effort on behalf of the NYSSA. I would also like to recognize Ms. Debbie DiRago, the NYSSA special assistant to the executive director and our new meetings manager. Debbie joined us in April 2010 and she has been a great addition to our small staff, bringing with her an arsenal of skills and a terrific work ethic. I would like to take this opportunity to reflect on what a great year 2010 was for me and for the NYSSA. While the final numbers are not yet in, we fully anticipate that the NYSSA will experience similar financial success to my previous two years as your executive director.
There were also some significant changes in 2010. Last September we sold the NYSSA headquarters on Fifth Avenue. The sale was quite successful and allowed us to get out from underneath a sizable mortgage and significant property-related overhead. Moving forward, we anticipate closing on the purchase of the new office space in midtown before this article goes to print. The new NYSSA headquarters will be purchased outright (no mortgage), and this space will also enable the organization to reduce our space-related overhead by approximately 75 percent. Additionally, the new location will allow the NYSSA to retain its entire staff. If all goes well, we will be moving in late August 2011.

One thing that did not change in 2010, and will remain unchanged in 2011, is the amount of dues that the NYSSA charges its members. Your leadership is committed to keeping your dues at their current level. This year marks the fourth consecutive year that the NYSSA leadership has made the decision not to increase dues. One of my goals as executive director is to continue this trend as long as I am here at the NYSSA. I am proud to say that during my previous 10-year tenure as a medical society executive director, we never raised the annual dues. By exercising fiscal responsibility, I hope to look back 10 years from now and boast that my record is unbroken.

Finally, please know that if there is ever anything that we can do for you, we hope you won’t hesitate to call on us. We are here to serve you. On behalf of the entire NYSSA staff, I wish all of you a happy and healthy 2011.
A New Online CME Course FREE for NYSSA Members: Anesthesia Care and Infection Control: Keeping Your Patients Safe

In the past decade in the United States there have been 33 reported outbreaks of patient-to-patient transmission of hepatitis B and C virus in healthcare settings due to breaches in infection control. Seven of these outbreaks involved anesthesia care, putting 55,000 patients at risk and infecting 144.

Because the serious outbreaks outlined above were associated with injection practices of anesthesia professionals, it is vital that anesthesia professionals be informed of infection prevention principles that decrease the risk of healthcare-associated transmission of pathogens. This new online CME program - created by and for anesthesiologists - is specifically designed to provide anesthesia professionals with the information they need to decrease the risk of healthcare-associated transmission of pathogens. The course features streaming video, illustrations and links to important infection control reference materials.

Topics covered in this program include:

- Safe injection practices designed to prevent transmission of bloodborne pathogens, including the safe use of multidose medication containers
- A review of the basic principles of infection control including work practice and engineering strategies designed to prevent pathogen transmission
- Principles regarding the cleaning, disinfection and sterilization of reused anesthesia devices and the anesthesia workspace
- Practices shown to reduce the incidence of infectious complications associated with neuraxial anesthetic techniques, such as spinal and epidural blocks, and central venous catheters
- Prevention and post-exposure management of infectious diseases of interest to anesthesia professionals

Created in response to an infection control problem noticed by the New York Department of Health, this new course was developed by Medcom, Inc. in association with Elliott S. Greene, MD, Professor of Anesthesiology Department of Anesthesiology Albany Medical College, and Richard A. Beers, MD Professor, Anesthesiology SUNY Upstate Medical University who served as subject matter experts in review of the content, and performed a content validation review, and NYSSA, with an unrestricted educational grant from New York State.

Credit Designation
Medcom, Inc. designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The course is approved by New York state to meet the NY infection control requirement.

To complete this online course go to nyssa-pga.org

Then simply scroll to the bottom of the home page where the course is listed and click on MEMBERS graphic.

Accreditation
Medcom, Inc. is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
A Look at the 64th PostGraduate Assembly in Anesthesiology
Opening Session

Dr. Miles Dinner and Dr. Simon Tom provide a little music prior to the start of the opening session of the PGA.

Dr. Edward Miller speaks as part of the 26th annual Robertazzi Memorial Panel.

Dr. Andrew Rosenberg, PGA general chair, welcomes everyone to the 64th annual PGA.

Dr. Vinod Malhotra, advisor to the PGA, addresses those in attendance.
Dr. Andrew Rosenberg (left) and Dr. David Wlody (right) recognize Dr. John Drummond, the 40th E.A. Rovenstine Lecturer.

Dr. Mark Warner, ASA president, speaks to the attendees at the PGA.

Dr. Dennis Mangano speaks as part of the 26th annual Robertazzi Memorial Panel.

Dr. Alexander Gotta (center) receives the NYSSA 2010 Distinguished Service Award from Dr. Paul Willoughby and Dr. Andrew Rosenberg.

Dr. Stephen Thomas, moderator of the Robertazzi Memorial Panel, speaks at the opening session.
The 64th Annual PGA Scientific Awards and Posters
The 64th Annual PGA Workshops
The 64th Annual PGA Technical Exhibits
The 64th Annual PGA President’s Reception

(Left to right) Dr. Scott Groudine and his wife, Susan, join Dr. Paul Willoughby and his wife, Dr. Katiuschka Willoughby, at the President’s Reception.

(Left to right) Mrs. Rene Gibbs and Dr. Charles Gibbs spend time with Drs. Paul and Katiuschka Willoughby.
(Left to right) Mrs. Gisela Jakubowski, Drs. Paul and Katiuschka Willoughby, and Dr. Michael Jakubowski take time out for a photo.

(Left to right) Mrs. Janie Lok, Dr. Donna-Ann Thomas, Dr. Jung Kim, Dr. Alex Bekker, and Dr. Jason Lok enjoy the evening.
Dr. Paul Willougby (center) presents Dr. Elliott Greene (left) and Dr. Richard Beers with awards for their outstanding work on the online infectious disease course.

Dr. Marilyn Resurreccion (right), speaker of the NYSSA House of Delegates, addresses the delegates.
Dr. Michael Duffy (left), a Reference Committee chair and District 5 director, presents his Reference Committee report while Vice-Speaker Dr. Charles Gibbs looks on.

Dr. Jerry Cohen (center), ASA president-elect, speaks to the House of Delegates while Dr. Charles Gibbs and Dr. Marilyn Resurreccion listen.

The Rev. Dr. Walter Smith, S.J. (left) addresses the House of Delegates while (left to right) Dr. Marilyn Resurreccion, Dr. Paul Willoughby, Dr. Salvatore Vitale, Dr. Lawrence Epstein, and NYSSA Executive Director Stuart Hayman look on.
Dr. Jung Kim (center) gives a Reference Committee report while Dr. Charles Gibbs and Dr. Marilyn Resurreccion listen closely.

Dr. Salvatore Vitale (left) joins Dr. Charles Gibbs at the podium.

(Left to right) Dr. Alan Curle, Dr. Ken Freese, Dr. David Bronheim, Dr. Kathleen O’Leary, and Dr. Charles Gibbs sit at the head table at the House of Delegates meeting.
Dr. Mark Warner, ASA president, presents outgoing NYSSA President Dr. Paul Willoughby with an ASA football to commemorate his presidency.

Dr. Audrée Bendo (left), outgoing chair of the Academic Anesthesiology Committee, is presented with a plaque by incoming President Dr. Kathleen O’Leary in recognition of her many years of service to the NYSSA.
Participants at the 64th annual PGA enjoyed the sights and sounds of Times Square and other famous New York City attractions.
During 2010, the resident membership of the NYSSA made many changes to the Residents Section. A few of the most pivotal include adopting a new leadership format, electing resident committee members, and implementing new policies and new ideas. Importantly, the resident membership organized the NYSSA Residents and Fellows Section (RFS) meeting during the 64th annual PGA. The RFS meeting took place on Saturday, December 11, 2010, at the glorious Marriott Marquis. The theme was the future of anesthesiology, and the itinerary featured a host of prominent speakers. A large group of medical students, residents and fellows attended the meeting.

Our first speaker, Dr. Mark A. Warner, is the current president of the American Society of Anesthesiologists and professor of anesthesiology at the Mayo Clinic in Rochester, Minn. His talk was titled “The future of anesthesiology: If I were beginning to look for a place to practice.” Dr. Warner discussed the future of our medical specialty and our role in shaping that future.

The next speaker, Dr. Jerry Cohen, the current president-elect of the American Society of Anesthesiologists and professor of anesthesiology at the University of Florida in Gainesville, Fla., addressed the potential impact of healthcare reform on our specialty. His talk was titled “Healthcare reform and anesthesia: How will it affect us?” His talk enabled residents, fellows, and medical students to learn the truth regarding healthcare reform and its implications. Too often, as physicians-in-training we remain passive, believing that either we will not be taken seriously or we lack the knowledge to take action. Both of the above-mentioned speakers discussed the impact that various policies, laws and outside interest groups will have on our profession, and emphasized advocacy and active involvement to direct the future of our profession.

Our third speaker, Dr. Keith J. Ruskin, a professor of anesthesiology and neurosurgery at Yale University, provided a delightful and entertaining review of the training and the role of a physician involved in aviation medicine. His talk was titled “In-flight Emergencies.” Upon speaking to some of the residents and fellows who attended the annual meeting, it was clear that his talk was well-received. Many of us have been on a flight when our assistance was requested to help out an ill passenger.
For the first time, the Residents and Fellows Section hosted the Resident Research Contest presentations, with Dr. Cynthia A. Lien serving as moderator. Following the Resident Research Contest, Dr. Ken Newman, a senior partner at Cross River Anesthesiology Services in Mount Kisco, discussed the distinction between academic and private practice. Charles J. Assini, Jr., Esq., spoke on contract negotiations and legal pitfalls. He provided sound advice for residents and fellows who will soon be entering the job market.

We completed our section meeting with a fellowship panel and our section’s business meeting. The fellowship panel included fellows in the pediatric, regional and cardiac subspecialties and afforded opportunities for residents interested in these subspecialties to ask questions. Our business meeting was productive, as we were able to brainstorm new ideas to ensure a smooth transition of leadership with fair elections and to improve upon the present structure of our leadership to eliminate redundancies.

After serving for five years as chair of the Academic Anesthesiology Committee, Dr. Audrée Bendo is stepping down. We express our gratitude to her for all of her efforts and sound direction; she will be missed. Dr. Mark Lema, former ASA president and current chairman of the University of Buffalo Anesthesiology Program, will replace Dr. Bendo as chair of the Academic Anesthesiology Committee. We look forward to working with Dr. Lema and Dr. Richard Beers, former NYSSA president and chair of the Residents Section Advisory Subcommittee. Dr. Beers has been instrumental in advising our committee for many years.

I would like to express many thanks to my fellow resident section leaders who organized and directed this event. In particular, Dr. Ram P. Yogendra, our current Residents and Fellows Section president, deserves our gratitude for all of the hard work and enthusiasm that went into making this meeting a success.

We have had a busy but productive year and we look forward to another as we continue to improve upon our NYSSA Residents and Fellows Section.

Jodi-Ann Oliver, M.D.
Secretary and Treasurer, RFS
Ambulatory surgery centers ("ASCs"), particularly those whose physicians specialize in gastroenterology and endoscopy ("GI"), have been placing increasing pressure on anesthesiologists to enter into various financial arrangements that would allow the ASC or its owners to share in the income received by the anesthesiologists who provide anesthesiology services at the ASC. These arrangements take a variety of forms; however, they all have one element in common: the ASC and/or the surgeons who own the ASC, who are in a position to refer business to the anesthesiologists, are seeking to share in the revenue generated by the anesthesiologists, who are the beneficiaries of such referrals. Therefore, any arrangement must be analyzed in the context of the general prohibitions in both New York and federal law against kickbacks and fee-splitting, sometimes referred to herein as the “anti-kickback laws,” particularly given the severe consequences of violating these laws.

I. **Summary of Anti-Kickback Laws**

A. **Federal Anti-Kickback Statute**

The federal anti-kickback statute provides, in pertinent part:

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind —

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program …

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.¹

In addition to the criminal penalties described above, violation of the federal anti-kickback statute can result in civil penalties and exclusion from participation in Medicare and Medicaid.²
B. Third-Party Payor Agreements

Furthermore, many private third-party payor contracts contain provisions that allow the third-party payor to deny payment for any service rendered at a time when the provider was not in compliance with all applicable laws. Thus, violation of the federal anti-kickback law can result in significant loss of reimbursement, or claims for recovery of reimbursements previously paid, not only with respect to Medicare and Medicaid but also with respect to private third-party payors.

C. New York Anti-Kickback and Fee-Splitting Laws

In addition to the federal prohibitions and penalties described above, New York state law prohibits (i) “Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services,” and fee-splitting other than with a partner, employee, associate or subcontractor. The fee-splitting prohibition specifically includes arrangements for furnishing space, facilities, equipment or personnel services where the payment is based on a percentage of income or receipts.

D. Federal Safe Harbor Regulations

Applicable regulations of the Department of Health and Human Services include a series of “safe harbors,” which describe certain financial arrangements that will not be treated as a criminal offense or serve as the basis for exclusion from Medicare and Medicaid. In general, arrangements that satisfy a safe harbor will also be acceptable under the New York laws cited above. Although arrangements that do not satisfy a safe harbor do not automatically constitute a violation of the anti-kickback laws, such arrangements will be subject to scrutiny by the Office of Inspector General (“OIG”) and other regulatory authorities to determine whether, in fact, at least one purpose of the arrangement was to provide remuneration to induce referrals.

In light of the significant criminal and civil penalties that may be assessed for violation of the anti-kickback laws, every effort should be made to structure an arrangement to satisfy the requirements of a safe harbor. If the safe harbor cannot be satisfied, each arrangement must be carefully analyzed on a case-by-case basis to assess the risk that the arrangement will be found to violate the anti-kickback laws.
E. OIG Special Advisory Bulletin on Contractual Joint Ventures

The OIG issued a Special Advisory Bulletin in April 2003 concerning Contractual Joint Ventures (the “Advisory Bulletin”), in which the OIG identifies suspect features of contractual joint ventures that would lead it to view them as violating the anti-kickback law. For purposes of the Advisory Bulletin, “joint ventures” are defined very broadly to include “any common enterprise with mutual economic benefit.” The Advisory Bulletin also cautions that even where particular contractual arrangements meet the technical requirements of a safe harbor, the overall joint venture may still violate the anti-kickback law. Given this broad definition, any analysis of any of the business arrangements discussed in this article must take the OIG's joint venture analysis into account.

Among the characteristics that could indicate a prohibited arrangement, as described in the Advisory Bulletin, are the following:

- **New Line of Business.** One party is seeking to expand into a new line of business that can be provided to the first party's existing patient base.

- **Captive Referral Base.** The new venture is serving the owner's existing patient base, rather than expanding into an area that would allow it to serve an additional patient base.

- **Little or No Bona Fide Business Risk.** The main contribution of the owner of the joint venture is referrals. The owner is not taking on significant financial risk in exchange for the income it will receive.

- **Remuneration for Referrals.** The practical effect of the arrangement, viewed in its entirety, is to allow one party (the GI physician or ASC) to bill for services that were previously being provided and billed by another party (the anesthesiologists) and to be compensated in a manner that takes into account the volume and value of business generated between the parties.

The principals enunciated in the Advisory Bulletin were reiterated by the OIG in the “OIG Supplemental Compliance Program for Hospitals” (the “SCP”).

With this backdrop, we will now look at a few business models that have been considered, bearing in mind that each of these models is susceptible to numerous variations in details.
II. Business Models

While there are an infinite variety of arrangements that can be created, the possible structures can be divided into five basic types, each of which entails risks and benefits. This article attempts to highlight some of the relative risks and benefits of each type of arrangement. However, it is merely an introductory article for purposes of drawing attention to the issues involved and does not constitute an endorsement or condemnation of any particular transaction.

A. Service Agreement Model

Under the “Service Agreement Model,” an ASC will enter into an agreement with an anesthesiologist or anesthesiology group whereby the ASC will provide office space, equipment, and/or administrative support services to the anesthesiology group in exchange for a fee. As noted above, to satisfy New York law, the fee paid to the ASC cannot be determined as a percentage of revenues. This model implicates three safe harbor rules: space rental, equipment rental, and personal services and management contracts. The primary requirements common to each of these safe harbor regulations are:

1. The agreement must be in writing.
2. The written agreement must cover all of the space, equipment, and/or services involved.
3. If the arrangement is less than full time, the intervals of use or periods of service must be specified in advance in the agreement.
4. The term of the agreement must be at least one year.
5. The aggregate compensation must be set in advance, be consistent with fair market value in an arms-length transaction, and not be determined in a manner that takes into account the volume or value of referrals or other business generated between the parties.
6. The aggregate services, space or equipment contracted for do not exceed what is reasonably necessary to accomplish the commercially reasonable business purpose of the contracting party.

While it is possible to satisfy all of the above safe harbor requirements in the context of the Service Agreement Model, GI practitioners and ASCs
have become dissatisfied with this model because of the relatively low amount of compensation that the anesthesiologists can pay if all of the above conditions are to be strictly adhered to.

B. **Endoscopy Suite Model**

The Endoscopy Suite Model builds upon the basic contractual structure of the Service Agreement Model but attempts to increase the profitability of the enterprise by replacing the ambulatory surgery center with an office-based surgical practice (an “OBS”). The GI physicians lease the space, obtain the necessary accreditation for the facility,\(^\text{10}\) hire all the necessary support staff, and purchase all of the endoscopy equipment. The OBS then subleases space to the anesthesiologists (either directly or through their professional entity), and provides all services to the anesthesiologists, including administrative and billing services. The contractual elements — a real estate lease, an equipment lease, and a personal services contract — are the same elements present in the Service Agreement Model and are subject to the same analysis in determining whether each element satisfies an applicable safe harbor.

The advantage of the Endoscopy Suite Model is that, if it is done properly, it can reduce overall overhead while increasing the services and facilities available to be provided and paid for by the anesthesiologists, without taking on significant additional risk with respect to the anti-kickback laws.

However, the other business models considered herein assume that there is an existing ASC that is seeking to restructure its relationship with its anesthesiologists. Assuming that to be the case, the obvious downside to the Endoscopy Suite Model is that it requires a more comprehensive overhaul of the entire practice structure and the creation of a new OBS facility, with its attendant time and expense.

C. **Company Model**

A model commonly referred to as the “Company Model” is described in a June 16, 2010, letter from the American Society of Anesthesiologists to the Office of Inspector General of the United States Department of Health and Human Services (the “ASA Letter”). Under this model, a separate group or company is formed, which is owned by some or all of the same individuals who own the ASC (the “Anesthesiology Company”). The Anesthesiology Company contracts to provide anesthesiology services to the ASC, and the Anesthesiology Company hires the anesthesiologists as
employees or independent contractors. Income received by the Anesthesiology Company in excess of the compensation paid to the anesthesiologists is distributed to the GI physician owners of the Anesthesiology Company.

It should be noted at the outset that, in order to satisfy the corporate practice of medicine requirements under New York law, all of the owners of the Anesthesiology Company must be physicians. Assuming this requirement is satisfied, New York, as noted above, permits the sharing of fees between a practice and its employees or independent contractors.

Under the safe harbor regulations, payments by the Anesthesiology Company to the anesthesiologists, whether as employees or independent contractors, can be structured to fall within the bona fide employee safe harbor or the personal services safe harbor described above. However, the payments from the Anesthesiology Company to its owners would not satisfy any applicable safe harbor. Since the owners of the Anesthesiology Company do not provide services to it, payments to the owners constitute a return on investment in the Anesthesiology Company. Therefore, the payments to the owners would have to qualify either under the safe harbor for investment interests or for investments in group practices.

The investment safe harbor requires, among other things, that no more than 40 percent of the equity interests in the entity be held by investors who are in a position to make referrals. Under the Company Model, all of the investment interests in the Anesthesiology Company are held by physicians who are in a position to make referrals to the Anesthesiology Company.

The group practice safe harbor includes a requirement that “the equity interests in the practice or group must be held by licensed health care professionals who practice in the practice or group.” However, as described in the ASA Letter, this requirement would not be satisfied because the Anesthesiology Company only provides anesthesiology services, while its owners are GI physicians who practice through other practice entities.

Since the model would not comply with a safe harbor, it would be subject to scrutiny. Furthermore, there are several factors that appear to fall squarely within those factors specifically outlined in the Advisory Bulletin and the SCP. All the owners of the Anesthesiology Company are in a position to make referrals, and the owners who make the referrals have a more favorable investment interest than the anesthesiologists, who have
no investment interest. Therefore, any attempt to structure an arrangement in accordance with the Company Model must be subjected to careful risk analysis with respect to potential anti-kickback violations.

Some of these concerns might be ameliorated by allowing the anesthesiologists to acquire equity interests in the Anesthesiology Company. However, the basic problem of having GI physicians share in the profits of a group practice through which they do not practice would remain.

D. Employer/Employee Model

In the Employer/Employee Model, the GI practice entity hires the anesthesiologists as direct employees. This differs from the Company Model by having the anesthesiology services and the GI services performed and billed through the same entity. As with the Company Model, the employment agreement between the practice entity and the anesthesiologist(s) can be structured so as to comply with the bona fide employee safe harbor regulations, as well as the New York law permitting “fee-splitting” with employees. It also has the ability, not present in the Company Model, to be structured to comply with the requirements of the group practice investment safe harbor. As noted above, in order for profits distributed to owners to be covered by that safe harbor, the owners must practice through the group practice entity.

However, there are several legal and practical concerns raised by this structure that would need to be addressed in order for it to succeed in any given situation.

First, the business motive for entering into an arrangement is to permit the members of the ASC to benefit from the income generated by the anesthesiologists. Unless all of the members of the ASC are also members of the same GI group practice, having one GI group practice employ the anesthesiologists would not permit all of the members of the ASC to benefit from the arrangement.

Second, anesthesiologists are often out-of-network providers, while the GI physicians are in-network providers. Having both services provided through the same group practice could therefore create problems with third-party payors. Either the anesthesiologists would have to become in-network providers, thus reducing their reimbursement rates, or they would have to bill for their services under a separate billing number, which could result in their not being considered to be practicing in the same group for purposes of the safe harbor rules. As noted above, if the
GI physicians are not practicing through the same group as the anesthesiologists, the safe harbor for investment interests in a group practice is no longer available. The same concerns would apply if the anesthesiologists were made equity owners or independent contractors of the GI practice.

E. Independent Contractor Agreement Model

A variation on the Employer/Employee Model is the Independent Contractor Model, in which a GI practice retains the services of anesthesiologists, either directly or through their separate professional entity, to provide anesthesiology services to the GI physician patients. As with the Employer/Employee Model, it does not violate the New York prohibition against fee-splitting. It also has the advantage of keeping the anesthesiology practice independent and allowing its anesthesiologists, directly or through their entity, to contract with more than one GI practice entity. However, it does not address concerns raised by in-network vs. out-of-network participation status. It also creates additional hurdles to compliance with an anti-kickback safe harbor.

The agreement would have to comply with the safe harbor for personal services and management contracts. In particular, the agreement would have to specify the aggregate compensation paid to the anesthesiologists over the term of the agreement.15 Any arrangement that compensated the anesthesiologists on a per-case basis (without specifying the number of cases to be performed) or based on a percentage of revenue collected for anesthesiology services would not satisfy this requirement. Furthermore, if the agreement was for less than full-time services, the agreement must specify “exactly the schedule of such intervals, their precise length and the exact charge for such intervals.”16 Given these constraints, it is not likely that such an arrangement could be structured so as to comply with a safe harbor.

III. Conclusion

All of the models described above share one feature in common: They each seek to allow physicians who are in a position to make referrals (i.e., GI physicians) to share in the income generated by the providers to whom the referrals are made (i.e., the anesthesiologists). However, any of these arrangements is subject to being considered a “joint venture” under the Advisory Bulletin and will therefore be subject to close scrutiny. Furthermore, each model poses significant hurdles (in varying degrees) to satisfying a safe harbor; and even where a particular arrangement appears
to satisfy a safe harbor, there may be aspects of the arrangement that the safe harbor does not cover. (For example, an employment contract that satisfies the safe harbor for bona fide employment relationships protects the payments made by the employer to the employee, but does not address the payments made by the practice entity to its owners.) Given the difficulty of meeting safe harbor requirements and the potentially devastating consequences, both civil and criminal, of violating state and federal anti-kickback laws, it is imperative that any proposed arrangement be closely and carefully analyzed in light of all the facts and circumstances before being acted upon.

Kern Augustine Conroy & Schoppmann, P.C., is general counsel to the NYSSA. The firm has offices in New York, New Jersey, Pennsylvania and Illinois. The firm’s practice is solely devoted to the representation of healthcare professionals. The Web site is www.drlaw.com. The authors may be contacted at 800-445-0954 or via e-mail at cnewman@drlaw.com or mlevy@drlaw.com.

REFERENCES
1. 42 USCA §1320a-7b(1)
2. 42 USCA §1320a-7a
3. NY Ed Law §6530(18)
4. NY Ed Law §6530(19)
5. 42 C.F.R. §1001.952
6. 70 FR. 4858
7. 42 C.F.R. §1001.952(b)
8. 42 C.F.R. §1001.952(c)
9. 42 C.F.R. §1001.952(d)
10. See NY Pub Health Law §230-d
11. NY BCL §1501 et seq.
12. 42 C.F.R. §1001.952(i)
13. 42 C.F.R. §1001.952(a)
14. 42 C.F.R. §1001.952(p)
15. 42 C.F.R. §1001.952(d)(5)
16. 42 C.F.R. §1001.952(d)(3)
The Department of Anesthesiology of the Mount Sinai School of Medicine, New York, NY presents the

30th Annual Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine

With International Faculty and Industrial Exhibits
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For information and abstract forms contact: marc.stone@mountsinai.org
The development of the Government and Legal Affairs Committee (“GLAC”) and the Economic Affairs Committee (“EAC”) agendas for 2011 involves a multi-step process that included conducting telephone conferences with the GLAC and EAC members, NYSSA Executive Director Stuart Hayman, the NYSSA leadership, and Weingarten, Reid & McNally, LLC (our Albany lobbyists). The GLAC and EAC committees convened during the PostGraduate Assembly (“PGA”) to review, discuss, and strategize about implementation of the agendas as we enter into a new political era in Albany with Gov. Andrew Cuomo assuming the executive role and the Republican Party assuming the majority role in the New York State Senate.

Moreover, in 2010, we initiated a discussion between Dr. Steven Schwalbe (a past president of the NYSSA), NYSSA’s Carrier Advisory Committee representative and the Medical Society of the State of New York (“MSSNY”) Multispecialty chair; Jason Byrd, J.D., ASA director of practice management, quality, and regulatory affairs; and Lisa Albany, J.D., ASA state component legislative coordinator. The goal of this dialogue was, first of all, to tap into the expertise of the aforementioned individuals and to coordinate our agendas with the ASA and MSSNY.

I am appreciative of the hard work and dedication of Dr. David Wlody, chair of GLAC; Dr. Scott Plotkin, vice-chair of GLAC; Dr. Alan Strobel, chair of EAC; Dr. Steven Schwalbe, vice-chair of EAC; and the NYSSA members who serve on GLAC and EAC in developing, refining, and improving the agendas and in strategizing to achieve implementation of our goals and objectives. The dialogue among and between the committees’ members can be characterized as very lively since all involved in the committees have great passion and interest in addressing the challenges of the specialty of anesthesiology.

The GLAC agenda and the EAC report summarizing goals for 2011 can be found on the NYSSA Web site (for members only). You will see that preserving safe anesthesia care for New York state remains our key legislative priority. However, there are a number of additional initiatives
that have been identified, including lobbying for an increase in the
Workers’ Compensation anesthesia conversion factor; monitoring and
meeting with New York State Insurance Department officials with respect
to out-of-network physician regulations; clarifying issues relating to the
new Medicaid CPT-4 Anesthesia administration procedure codes; and
working with ACOG on the Neurologically Impaired Infant bill.

**Opt-Out**

1. **Concept of “Opting Out”**
   The concept of “opting out” of the long-standing federal
requirement for there to be physician supervision of nurse anesthetists
caring for Medicare patients was first promulgated in the last days of the
Clinton administration, when the president (whose mother was a nurse
anesthetist) opted every state out. President Bush, as a compromise,
modified this regulation to permit, under certain conditions, each individual
state to “opt-out.” In June 2009, California became the 15th state to make
this declaration and very recently Colorado became the 16th state.

2. **List of States That Have Opted Out**
   Iowa, Idaho, Nebraska, Minnesota, New Hampshire, New
Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana,
South Dakota, Wisconsin, California, and Colorado.

3. **State Societies Filed Suit**
   Both the California Society of Anesthesiologists and the Colorado
Society of Anesthesiologists filed suit against their respective governors
upon learning of the opt-out. These suits challenged the legality of the
opt-out. For background information on both court cases, please note that
Lisa Albany, J.D., of the ASA Office of Governmental Affairs, has prepared
articles published in the ASA NEWSLETTER that are available to review if
you have not done so already.

   Article regarding the California lawsuit; April 2010, Volume 74,
   Number 4, pages 48-49:
   Article regarding the Colorado lawsuit, also includes an update of
   the California ruling; December 2010, Volume 74, Number 12, pages 44-45:
   [http://viewer.zmags.com/publication/8de38f6e#/8de38f6e/46](http://viewer.zmags.com/publication/8de38f6e#/8de38f6e/46)

4. **Court Ruled Against California Society of Anesthesiologists (CSA)
and California Medical Association (CMA)**
   On October 21, 2010, in a preliminary ruling, a San Francisco
Superior Court judge ruled against CSA and CMA on their opt-out
challenge. The ruling was based on the judge’s opinion that given the
absence of a state statute requiring physician supervision of nurse
anesthetists who administer anesthesia, federal regulations allow the governor discretion to conclude that opting out of the Medicare supervision requirement is consistent with state law. The judge stated that with respect to the physician supervision issue, current California law does not directly refer to supervision, and that interjecting a supervision requirement into the law would create ambiguity. The judge went on to state that the Legislature has the ability to impose such a requirement into state law should it wish. Upon information and belief, CSA will be filing an appeal.

5. **New Jersey Paving Way to Opt-Out?**
   New Jersey health officials, according to a recent *Wall Street Journal* article, are reviewing state regulations requiring CRNAs to work under the direct supervision of an anesthesiologist. Without a modification of the requirement, it would appear that the New Jersey governor is restrained from pursuing an opt-out.

6. **Governors’ Justifications**
   The primary purported justification expressed by those governors electing to opt-out was access to care in rural areas. In fact, the Colorado opt-out letter seeks an exemption for all critical access hospitals and contains a list of rural hospitals.

7. **Legal Reality of Supervision**
   The California Society of Anesthesiologists recently published an analysis of California law when a surgeon supervises a nurse anesthetist — a/k/a the “captain of the ship” doctrine — and notes that an opt-out cannot change this legal reality. (This article is posted on the NYSSA Web site.)

8. **NYSSA’s Key Contact Initiative**
   If you are interested in becoming more actively involved, please consider becoming a Key Contact and/or reaching out to your district director to express your interest in attending our annual Legislative Day to be held in Albany on Tuesday, May 10, 2011. Your involvement is critical to carry our message to your lawmakers and your patients.

9. **Materials Available to NYSSA Members**
   The NYSSA annual Legislative Day materials can be obtained by members through the NYSSA Web site by going to http://nyssa-pga.org/ and clicking on the “Professional & Practice Issues” tab, then clicking on “Legislative/Regulatory Issues,” or at: http://members.nyssa-pga.org/Scripts/4Disapi.dll/4DCGI/members/legislative.html.
## 10. Majority Standing Committee Appointments 2011

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At the time this article was written, the Assembly Standing Committee appointments had not been released.

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MLMIC: Much More Than Just Underwriting and Claims

GARY P. ANDELORA, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY

After speaking to many Medical Liability Mutual Insurance Company (MLMIC) insureds and their staffs throughout the state, it became apparent to me that most policyholders do understand the basic services MLMIC provides in the areas of underwriting and claims management. Having been in the professional liability insurance business since 1975, MLMIC is known for having the most knowledgeable and experienced underwriting and claims staffs of all the professional liability insurers in the country. However, there are other valuable services MLMIC provides that may be overlooked by some policyholders. These additional services include those offered by the attorneys at Fager & Amsler (F&A), counsel to MLMIC, and the comprehensive risk management education offered by MLMIC’s Risk Management Department. This article will explore some of these services.

Legal Services
Fager & Amsler attorneys are available during normal business hours to assist policyholders with a wide range of legal services, including, but not limited to, advisory opinions concerning liability issues, liability litigation activities, lecture programs, consulting services, and legal audits and assessments. Below are some of the frequently discussed issues the attorneys address:

- Dealing with angry, threatening, or noncompliant patients and their families
- Discharging patients from a practice
- Discontinuing a medical practice
- Release and retention of medical records
- Peer review protection and concerns
- Release of records due to unusual situations – divorce, custody, deceased patients
- HIPAA, HIV, mental health issues, and alcohol and drug treatment confidentiality
- Law enforcement and confidentiality issues
- How to respond to patient complaints
- OPMC issues and the need to have an attorney present
- Patients who are seeking and/or abusing drugs
While this list is certainly not all inclusive, it should give MLMIC insureds an idea of some of the legal information to which they have access. In addition, F&A attorneys regularly review and update all risk management forms and legal templates, such as H1N1 consent forms and other informed consent forms. They also routinely review subpoenas, authorizations, and other legal documents seeking medical information from MLMIC insureds.

Policyholders who have legal issues and questions are encouraged to call Fager & Amsler to speak with one of the attorneys. They can be reached at: 212-889-2498 (Manhattan); 877-426-9555 (Syracuse); 516-794-7340 (Long Island); and 518-786-2880 (Albany area).

**Risk Management Services and Continuing Medical Education**

MLMIC’s risk management professionals also provide many services about which policyholders may be unaware. For example, the Risk Management Department offers educational programs that help improve patient care and, ultimately, reduce the frequency and severity of claims.

MLMIC is accredited by the Medical Society of the State of New York (MSSNY) to provide continuing medical education (CME) for physicians. MLMIC’s Risk Management Department utilizes conventional formats and new technologies, including an Internet-based format, to provide and deliver its CME programs. Physicians who complete these programs satisfactorily are able to earn CME credits and the applicable premium credit; they also qualify for participation in the medical malpractice excess insurance program.

MLMIC’s risk management personnel also offer policyholders a number of additional services, including advisory opinions, a resource lending library, a speakers’ bureau, educational lectures and seminars. Like those lectures provided by F&A attorneys, the educational lectures and seminars presented by the risk management staff are frequently presented at MLMIC-insured facilities and office practices. The programs are individually tailored to meet the needs of the target audience. Frequently addressed topics include basic risk management procedures and malpractice prevention measures.

MLMIC’s Risk Management Department also offers Regional Network Meetings, which are held twice a year at convenient times and locations for MLMIC insureds. The topics presented at these regional meetings are based on feedback received by policyholders as well as timely subject matter that needs to be addressed.

Working closely with F&A attorneys, the Risk Management Department will provide to policyholders, upon request, consent forms, form letters, legal
memos, bulletins and guidelines, all of which cover a wide variety of issues, such as Authorization for Release of Information and Informed Consent forms. It has also published and distributed collateral materials pertaining to current healthcare, legal, risk management, and insurance issues in an effort to keep policyholders apprised of current news and updated information. MLMIC’s biannual newsletter, Dateline, is one such publication.

A complete list of materials appears on MLMIC’s Web site. To contact the Risk Management Department by telephone regarding any of the services it provides, please call 800-275-6564 (Manhattan); 877-777-3560 (Long Island); 800-356-4056 (Syracuse); or 800-635-0666 (Albany).

**Resource Lending Library**

MLMIC's Lending Library is available to all policyholders at no charge and may be accessed via MLMIC's Web site at www.mlmic.com/portal/lib_home.aspx. To date, thousands of policyholders have borrowed materials from the library, which consists of more than 2,000 books and audiovisual materials on topics such as risk management, patient safety, and quality improvement. Policyholders may also submit library and research requests (library searches, literature services, and cyber-searches) by contacting Judi Kroft, library services administrator, at 800-635-0666, ext. 2786, or by e-mail at jkroft@mlmic.com.

Providing excellent service to its policyholders has always been one of MLMIC’s major goals. MLMIC is *not just about* underwriting and claims. Hopefully, the information presented in this article will help policyholders understand the magnitude of the many services MLMIC provides.

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**65th PGA Resident Research Contest**

If you are interested in submitting an abstract at the upcoming 65th PostGraduate Assembly in Anesthesiology — December 9-13, 2011, please contact NYSSA headquarters for information:

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Case Report

Diabetes Insipidus During Anesthesia

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Abstract

Diabetes insipidus (DI) is an uncommon disorder that develops in patients with hypothalamic, pituitary or adjacent structural lesions. Typically, neurosurgical patients present with either a preoperative diagnosis of DI or develop DI postoperatively. This case report describes the onset of DI shortly after the induction of anesthesia but prior to any surgical intervention.

Introduction

Central DI results from a deficiency of antidiuretic hormone (ADH, arginine vasopressin (AVP)), which acts directly on the distal tubules and collecting ducts of the kidneys to promote water reabsorption. The usual clinical presentation of DI involves excessive urinary loss of solute-poor water and, in awake patients, polydipsia. DI is diagnosed if polyuria is associated with a urine osmolality of less than 200 mOsm/kg, urine specific gravity less than 1.010, and serum sodium greater than 145 mEq/L.1-3

Case Description

The patient was a 17-year-old, 70 kg male who presented to the hospital with a six-week history of generalized malaise, intermittent left hand and leg weakness, a left facial droop, nausea, vomiting and headaches. The remainder of his medical history and review of systems was unremarkable. A magnetic resonance image (MRI) of the brain showed a right temporal 5 cm by 4 cm by 3 cm heterogeneous mass with central necrosis, associated with vasogenic edema and right uncal herniation. Due to symptoms of increased intracranial pressure, the patient was treated with dexamethasone for four days; by the time the patient presented to the operating room, his symptoms were alleviated.

On the day of surgery, all of the serum electrolyte levels were within normal limits (see Table). The patient was premedicated with intravenous
midazolam (2 mg) for anxiety. Standard anesthesia monitors (electrocardiogram, pulse oximetry and noninvasive blood pressure) were applied. Blood pressure was 110/80 mmHg, pulse, 72, and respiratory rate, 12. The pulse oxygen saturation was 99% on room air. After preoxygenation, general anesthesia was induced with a combination of thiopental (375 mg), fentanyl (100 mcg), lidocaine (100 mg) and vecuronium (10 mg). A left radial arterial catheter was placed before endotracheal intubation. Following an uneventful intubation, anesthesia was maintained with propofol (150-300 mcg/kg/min) and fentanyl (2 mcg/kg/hr) infusions, while ventilation was controlled at an end-tidal carbon dioxide level of 30 mmHg, which correlated to a PaCO₂ of 32 mmHg. Following induction, the patient was placed in 15 degrees Trendelenberg position and simultaneously a urinary catheter and a left internal jugular central venous catheter were placed without change in hemodynamic parameters.

Immediately after placement of the urinary catheter, the urine output was noted to be 1100 ml. A head-holder was placed and the patient positioned supine with his head rotated toward the left. The urine output recorded 15 minutes after the initial measurement was an additional 400 ml and appeared colorless. Up to this point, 1 liter of normal saline had been administered intravenously.

Due to polyuria and concerns of possible DI, serum and urine specimens were obtained. Laboratory analysis showed an increase in serum sodium levels of 14 mmol/L to 147 mmol/L, an increase in serum osmolarity from 302 mOsm/kg to 364 mOsm/kg and urine specific gravity was 1.0030 compared to 1.078 preoperatively (see Table).

The diagnosis of DI was discussed with the surgeon. A continuous vasopressin infusion was started at 0.02 units/hr and increased to 0.04 units/hr after 15 minutes. The surgeon opted to delay the operation until the DI resolved. An external ventricular drain was placed to monitor intracranial pressure. An opening pressure of 40 cmH₂O was recorded. It was not clear why the pressure was high, but this reinforced the decision to delay the surgery. Within six hours of instituting the vasopressin infusion, the polyuria dissipated. The patient was kept sedated, intubated, and mechanically ventilated until he returned to the operating room 48 hours later. The tumor was successfully resected using isoflurane, oxygen, fentanyl infusion, and neuromuscular blockade. No evidence of DI was present at the second operation.
Central DI results from a deficiency of antidiuretic hormone (ADH, arginine vasopressin (AVP)), which acts directly on the distal tubules and collecting ducts of the kidneys to promote water reabsorption. This can be caused by damage to the hypothalamus or pituitary stalk by tumor, anoxic encephalopathy, surgical or accidental trauma, or infection.\(^1, 4\) Normally, an intact circumventricular organ (CVO) assesses plasma osmolarity via fenestrations in the blood-brain barrier. Triggering of the osmoreceptors propagates neural stimuli via magnocellular neurons to the vasopressin synthesis-paraventricular nulei (PVN) and the supraoptic nucleus (SON). From here, neural projections extend to the posterior pituitary, where vasopressin is stored and secreted into the bloodstream.\(^1\)

The usual clinical presentation of DI involves polyuria with urinary excretion of essentially solute-free water and, in awake patients, polydipsia.\(^1\) Polyuria is defined as urine volume of more than 3 liters in 24 hours or a urine output of >4 cc/kg/hr. Typical laboratory findings include a urine osmolality <200 mOsm/kg, urine specific gravity <1.010, and serum sodium >145 mEq/L.\(^1, 3, 5\)

Additionally, it is possible to assess the difference between central and nephrogenic DI by measuring the urine osmolality in response to exogenous AVP. A 50% or greater rise in urine osmolality is seen in central DI. Nephrogenic DI is much less responsive to exogenous AVP administration.\(^1, 6, 7\) Our patient's response to exogenous vasopressin is an indicator of central DI.

Several patterns of DI due to manipulation of the hypothalamic-pituitary area have been described. The most common pattern presents two to six hours postoperatively as a result of local edema or from manipulation of the pituitary stalk. DI in such cases resolves in one to seven days as the edema dissipates.\(^8\) However, this cannot be an explanation for our case since DI was noted after induction of anesthesia but prior to any surgical manipulation.

In our case, preoperative magnetic resonance imaging (MRI) showed vasogenic edema in the region of the hypothalamus. Edema in this area is probably the most common cause of postoperative DI.\(^8, 9\) It is plausible that our patient had some destruction of AVP secreting neurons, but did not exhibit polyuria preoperatively because greater than 80% of these neurons must be destroyed for clinically apparent effects to be noted.\(^2, 10\) It is also possible that the increase in AVP known to occur at the induction of anesthesia did not occur. Propofol enhances the endogenous
gamma-aminobutyric acid mediated inhibition of AVP release as well as the inhibition of voltage-gated Ca\textsuperscript{2+} currents that would normally cause AVP release.\textsuperscript{9, 11, 12} This effectively results in AVP insufficiency and polyuria. Hence, we postulate that the likely cause of DI in our patient was a combination of an already compromised hypothalamic-pituitary axis and diminishing AVP levels during the induction of anesthesia. The short course of the DI further supports this explanation.

Once diagnosed, central diabetes insipidus is treated with desmopressin (DDAVP, 1-deamino-8-D-arginine vasopressin) or AVP, although overzealous treatment may lead to symptomatic hypotonicity.\textsuperscript{8, 10, 13, 14} Vasopressin infusion may also be considered first-line therapy but requires vigilance because of potential hypertension and hypervolemia, although these are unlikely during low-dose continuous infusions, which should be titrated to achieve a urine output of less than 2 ml/kg/hr.\textsuperscript{10}

### Table

<table>
<thead>
<tr>
<th>LABORATORY TEST</th>
<th>PREOPERATIVE</th>
<th>DURING POLYURIA</th>
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</thead>
<tbody>
<tr>
<td>Sodium (mmol/L)</td>
<td>133</td>
<td>147</td>
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<tr>
<td>Glucose (mg/dl)</td>
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<td>119</td>
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<tr>
<td>Serum Osmolarity (mOsm/kg)</td>
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<tr>
<td>Urine Specific Gravity</td>
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<tr>
<td>Urine Sodium (mmol/l)</td>
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<td></td>
</tr>
<tr>
<td>Urine Osmolarity (mOsm/l)</td>
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<td></td>
</tr>
<tr>
<td>Hemaglobin</td>
<td></td>
<td>15.3</td>
</tr>
</tbody>
</table>

### REFERENCES


George Mashour has deftly brought together 24 leading experts from around the world as contributors to a 262-page, 13-chapter multidisciplinary review of the key issues surrounding consciousness and awareness under anesthesia. Mashour’s text spans the spectrum of fundamental anesthetic neuroscience — from the neurobiology and psychopharmacology of sleep, consciousness, memory formation, and dreaming to the highly relevant practical issues regarding monitoring of anesthetic depth, the current controversies regarding intraoperative awareness and the psychological consequences thereof, as well as the inherent medical-legal consequences.

Overall, once I navigated the relatively intense opening chapter, I found the textbook to be remarkably easy to read and highly engaging. Chapter 1, “Relevance of sleep neurobiology for cognitive neuroscience and anesthesiology” by Vanini, Baghdoyan and Lydic from the University of Michigan, succinctly and systemically reviews the neuronal and chemical substrates as well as the relevant neuroanatomy involved in sleep, wakefulness, and anesthesia. The authors do an excellent job of distilling a tremendous amount of basic science into a relatively brief chapter that is well-referenced, well-illustrated, and clearly represents the state-of-the-art knowledge regarding the neurochemistry of consciousness. Chapter 2, “The neurobiology of consciousness,” makes for significantly more fascinating reading, not unlike reading Stephen Hawking or Michio Kaku, wherein very complex concepts are made readable and understandable to those of us who are not neuroscientists. The final foundational chapter, Chapter 3, “Memory formation during general anesthesia,” begins to utilize the basic concepts developed in the earlier chapters and explores the effect of anesthetic drugs on memory formation as quantified using available technologies such as auditory evoked response and bispectral index compared with PET scan neuroimaging technology using anesthetic MAC as a basis for defining relationships.
The majority of the remaining text is directed at the issue of intraoperative awareness. Chapter 5, authored by Ghoneim, summarizes the etiology and risk factors for intraoperative awareness. Chapters 7 and 8, authored by Sebel and Garcia, and Palanca, Searleman and Avidan, respectively, divide up the current controversies related to intraoperative awareness in a highly clinically relevant fashion, which, in my opinion, is mandatory reading for anyone with an interest in the issue of intraoperative awareness. Chapter 10 explores the “Psychological consequences of intraoperative awareness,” including the psychologic impact of the psychiatric diagnosis of posttraumatic stress disorder and its treatment options. Chapter 11, “Medicolegal consequences of intraoperative awareness,” authored by Domino and Kent, represents an exceptionally cogent overview of the legal process, closed claims data regarding the assignment of liability, and typical historic consequent dollar-amount damages. Although well-written, Domino’s chapter falls short regarding strategies for risk minimization and a discussion of historically successful defensive litigation strategies, which would be of extreme practical importance to anyone involved in defending an awareness lawsuit. Finally, Esaki, in Chapter 12, uses a case-based discussion to explore the management of expectations and complaints of awareness after sedation and regional anesthesia.

Overall, I found the textbook to be highly engaging as well as extremely informative and thought provoking. Although I will confess that I would not have chosen this textbook off a library shelf, I will also confess that my knowledge and understanding have been greatly enriched by it. As an anesthesiologist, the issue of intraoperative awareness remains a clinical concern — perhaps even more so as data questioning the safety of benzodiazepines becomes increasingly convincing, especially in populations at risk for delirium/postoperative cognitive dysfunction. Based on the evolving literature, it may become important for us all to balance the question, “Does one size fit all?” for benzodiazepine dosage versus the risk/benefit of using benzodiazepines at all as the foundation for each routine or standard anesthetic and sedation regimen. As an attorney, I submit that this textbook represents required reading for both plaintiff and defense counsel involved in awareness cases since it underscores the persistent uncertainty and controversies regarding intraoperative awareness. The textbook should be made available to residents and should be explored as part of the anesthesia residency curriculum; I highly recommend this text and look forward to future editions as more information — hopefully pharmacogenetic data — becomes available.
Mount Sinai School of Medicine Department of Anesthesiology Celebrates 60 Years

GEORGE SILVAY, M.D., PH.D.

The Department of Anesthesiology of the Mount Sinai School of Medicine celebrated its 60th anniversary on Saturday, December 11, 2010, with a reception at the Renaissance New York Hotel overlooking Times Square. The event was attended by more than 140 alumni, friends, and members of the department.

Dr. George Silvay opened the short program. Dr. Arthur Aufses, Jr., professor and chairman emeritus of the Department of Surgery, provided an overview of the history of Mount Sinai and highlighted the many departmental contributions to research and clinical advancement. He reviewed the history of anesthesia leadership at Mount Sinai and the events leading to the founding of the Department of Anesthesiology under Dr. Bernard Eliasberg. Dr. James Cottrell, professor and chair of the Department of Anesthesiology, SUNY Health Sciences Center, Brooklyn, and past president of the ASA, presented the evolution of anesthesia and its subspecialties since the founding of the department at Mount Sinai. Dr. David L. Reich, professor and chair of anesthesiology, MSSM, updated the audience on recent clinical, research, administrative, and service accomplishments of the department.

(Left to right) Drs. David Reich, Paul Goldiner, Arthur Aufses, George Silvay, and James Cottrell enjoy the reception.
Dr. Prithi Pal Singh (left) and Dr. Kenneth Abrams.

Dr. Paul Goldiner (left), Mary Goldiner, and Dr. James Cottrell.

Dr. David Reich (far right) poses with a new generation of anesthesiologists.
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- Mini-Workshops
- Case Discussions
- Medically Challenging Case Reports
- Problem-Based Learning Discussions
- Scientific Exhibits
- Poster Presentations
- Technical Exhibits
- Resident Research Contest
- Pre-PGA Hospital Visits
- 3,500 Anesthesiologists in Attendance
- More than 6,000 Registrants
- Broadway Shows
- Opera
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