SPHERE
Quarterly Publication

The New York State Society of Anesthesiologists, Inc.

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2017

New York City

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Inaugural Address to the NYSSA House of Delegates

ROSE BERKUN, M.D.

“Do not go where the path may lead, go instead where there is no path and leave a trail.”

This quote by Ralph Waldo Emerson is a perfect description of our specialty. Anesthesiology has come a long way since the days of Humphry Davy and William Morton. In fact, anesthesiology is arguably the safest medical specialty today. The tremendous improvement in patient safety did not happen on its own, however. It was achieved through deliberate efforts by progressive thinkers in the field, people like E. C. Pierce, Jr., M.D., the 1984 president of the American Society of Anesthesiologists (ASA). Dr. Pierce was responsible for the creation of the ASA’s Committee on Patient Safety and Risk Management, which promoted the term “patient safety” for the first time. During Dr. Pierce’s tenure, the ASA also established the Anesthesia Patient Safety Foundation, which marked the first time an organization was created explicitly for the purpose of improving patient safety. ASA standards and guidelines followed and, later, the ASA developed evidence-based practice parameters, including the widely respected “difficult airway” guideline.

Nurse anesthetists are aggressively seeking independent practice, taking credit for the advances in anesthesia safety that have been achieved over the last several decades through rigorous research, evidence-based medicine and closed claims studies. The dissolution of the Anesthesia Care Team led by a physician anesthesiologist will lower the highest standard of anesthesia care and put our patients at unnecessary risk. Despite the recent mandate by the U.S. Department of Veterans Affairs Office of Nursing Services that excluded nurse anesthetists from independent practice, AANA continues to aggressively seek inclusion in the pool of independent advanced registered nurse practitioners. Many states have already opted out of physician supervision, allowing nurse anesthetists to practice medicine without proper education. During the last legislative session in New York we narrowly avoided the passage of a
nurse anesthetist “title” bill, which would have opened the door to nurse anesthetist independent practice in New York state. I would like to thank Dr. Malcolm Reid, the president of the Medical Society of the State of New York, and MSSNY leadership for their strong opposition to the title bill. MSSNY members sent more than 3,000 emails opposing this bill to New York state legislators. Under the strong leadership of Dr. Andrew Rosenberg — and thanks to the enormous efforts of NYSSA members, our legislative representative Charles Assini, Esq., our lobbyists Bob Reed, Shauneen McNally and Marcy Savage, and MSSNY — we were able to defeat the title bill and maintain the current standard of care requiring physician supervision of nurse anesthetists. At the start of the 2017 legislative session the title bill was reintroduced in both the Senate and the Assembly, promising another contentious year.

One of the obstacles that makes it difficult for us to lobby on behalf of our patients and our specialty is the fact that 40 percent of legislators and 60 percent of the general public do not know that anesthesiologists are physicians. When I first started practicing as an anesthesiologist, I was surprised to hear comments such as “so you are like a doctor” when asked about what I did for a living. I chalked it up to my being young and a woman, but those questions continued for the next 20 years of my
practice. The sad truth is that the majority of the public sees anesthesiology as a medical profession that does not require a doctor of medicine degree. We are allowing other people’s perceptions to define our specialty. So how do we convey our message that the practice of anesthesiology is safer when led by a physician when the majority of the population and our legislators do not see the difference between a physician anesthesiologist and a nurse anesthetist. Well, if perception is everything, let’s change that perception to benefit our specialty, our society and our patients. We need to clearly state who we are and to identify our organization as an association of physicians. Just like it took a man with a vision, Dr. Pierce, to change the future of our profession by making it safer, it will take a bold step to change the perception of who we are in order for us to keep anesthesia safe for our patients. I strongly believe that by adding the word “Physician” to the name of our society, we will define ourselves as physicians, clarify that anesthesiology is the practice of medicine, and distinguish our specialty from nurse anesthetists in the eyes of the public and our legislators.

When evaluating the state of women in medicine, it is important to appreciate the progress while also to understand the need for continued growth. Women have made significant inroads in medical education,
training, residency opportunities, hiring practices and overall composition of the physician workforce, particularly over the last half century. All data indicate the impact of female physicians on medicine will continue to expand. According to a report by Staff Care, as of 2014, more than one-third of the physician workforce in the United States was comprised of women. Forty-eight percent of medical school graduates and 46 percent of residents are female. In New York state, 40 percent of all physicians are women. Among anesthesiologists in New York state, 25 percent are female and almost 40 percent of anesthesia residents are now women.

In 2013, the American Medical Association established a Women Physicians Section in order to address gender differences as they apply to salaries, promotions, sponsorships, academic advancement and other issues unique to women physicians. The American Society of Anesthesiologists, under the leadership of Dr. Linda Hertzberg, is working toward creating a Women in Anesthesiology section. We should continue to build on this important initiative and establish a Women Physicians Section within the NYSSA. By establishing a Women Physicians Section we will be creating a membership group that will address issues that are important and unique to women anesthesiologists. The focus of the Women Physicians Section will be to develop leadership and negotiating skills, to promote work-life balance, and to provide guidance, mentorship and sponsorship within the academic anesthesiology community, the private sector and organized medicine. As of 2016, 26 percent of the NYSSA’s active members are women physicians. The member benefits that will be offered by the new section will attract more female members, potentially increase the delegate count to the ASA, and help develop future leaders of our society.

Last year I referred to our society as a family. I strongly believe that we are one and that by working together we will continue to excel and to protect our patients. I would like to thank each and every one of you for working hard on behalf of the NYSSA, our PAC, our members and our patients. I am honored and humbled by your trust and belief in me. It is an enormous privilege to be your president and I look forward to working with all of you in the upcoming year. Thank you and let’s blaze a trail together!
Help the NYSSA Maintain Patient Safety: Support Physician Supervision of Anesthesia

Patient-Centered, Physician-Led Care

Join your colleagues on May 2, 2017, for the annual NYSSA Legislative Day in Albany.
Letter to the Editor

Remembering Dr. Alexander Gotta

The In Memoriam notice for Alexander Gotta [winter 2017 Sphere] prompts me to write this letter. One Monday morning, while he and his wife, Colleen Sullivan, were still anesthesia residents, they told me a story of what happened to them on the weekend just past. They had been walking by Macy’s department store when an old man near them suddenly collapsed. They found that he had no pulse, but that his pupils were still small. Alex provided chest compressions and Colleen provided mouth-to-mouth artificial respiration. Pulse and consciousness returned, and the old man was taken away in an ambulance from Beekman-Downtown Hospital. They did not know anything more about him.

I called Beekman-Downtown Hospital and, after considerable administrative shuffling, was connected to the nursing station of the floor where the old man was. “He’s doing fine,” the head nurse told me. I asked her if she knew what had happened. “Yes,” she said, “The chart says, ‘Fainted in front of Macy’s.’”

Just another story about our unsung heroes.

All good wishes and thanks for your excellent journal.

Alan Van Poznak, M.D.
Reflections

SAMIR KENDALE, M.D.

I can’t believe that it has already been one year since I first stepped into the role of Sphere editor. It has been a highly educational, enlightening, and, most importantly, enjoyable 12 months. While my involvement in the NYSSA as a resident afforded me the opportunity to learn more about the society at that time, being so intimately involved in some of the inner workings of the association these last 12 months has given me a strong appreciation for what the NYSSA truly does for us as a specialty. I want to share what I have learned in the past year.

I have learned that the leaders of the NYSSA are honestly passionate about what they do. Day in and day out, they are continuously thinking about how best to support New York’s anesthesiologists. They regularly communicate with our legislators, travel to Albany, write letters and emails, and make phone calls. They volunteer a tremendous amount of their time for us, solely because they love the specialty of anesthesiology.

I have learned that the NYSSA membership is equally passionate about engaging, from the wonderful contributions to this publication (which don’t just write themselves), to the brilliant and forward-thinking ideas pitched during the committee meetings. We have a great year ahead of us with Sphere. We had such a positive response to the article about physician wellness in the winter 2017 issue that we are planning to continue the wellness theme as a series. We are also planning a series on advice for residents transitioning to the workforce, reports from other NYSSA committees, and more case reports. There are also some big changes coming in terms of how you may be reading Sphere in the future, but I purposely will be vague and won’t spoil any surprises just yet.

Finally, I have learned that the NYSSA is particularly unique in how we welcome young physicians. Not every specialty society is so embracing of new people who wish to join the fold of experienced physicians who have been part of the society for 10 or 15 (or even 20 or 30) years.
I would not have had this unique opportunity were that not the case, and I am always thankful for the numerous chances to interact with other physicians and non-physicians, young and old, who are part of the NYSSA team. I encourage all New York’s anesthesiologists to find a way to get involved, whether it is by attending district meetings, joining committees, or writing articles for this publication.

71st PGA Resident Research Contest

If you are interested in submitting an abstract for the upcoming 71st PostGraduate Assembly in Anesthesiology — December 8-12, 2017, please email the abstract to Dr. Charles Emala at pgaresidentresearch@emala.net, with the subject line: “Resident Research Contest PGA71”

The final deadline for abstract submission is May 1, 2017.

71st PGA Scientific Exhibits, Poster Presentations, Medically Challenging Case Report Posters

If you are interested in submitting applications to exhibit your projects at the upcoming 71st PostGraduate Assembly in Anesthesiology — December 8-12, 2017, please visit www.pga.nyc for instructions to submit online (available in May).

Deadline for filing is August 15, 2017.

Submissions are only accepted electronically.
A member of the NYSSA recently brought to our attention a troubling new initiative undertaken by the New York state attorney general’s office. This member received a letter from the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) saying that an audit determined that the member had violated New York law by entering into a percentage-based compensation contract with his billing company (which they consider to be fee splitting). New York has had “fee-splitting” laws in place for more than 20 years, although they have never been strictly enforced. Why has the attorney general’s office suddenly decided to enforce them now? We don’t have the answer to that question.

The MFCU letter states:

Volume 16, Number 3, of the Medicaid Update March 2001, titled, “A Message for Providers Using Service Agents” (Service Bureaus/Billing Services) states in part:

Billing agents are prohibited from charging Medicaid providers a percentage of the amount claimed or collected. In addition, such payment arrangements, when entered into by a physician, may violate the Education Law and State Education Department’s regulations on unlawful fee-splitting.

In recent months, the Medicaid program has been made aware of violation of the regulations concerning the permissible payment arrangement with business agents. Although we understand that these practices are very common when it comes to billing other third-party health insurance programs, including the Medicare program, it is not an acceptable arrangement under the Medicaid program.

Please assure that your payment arrangements are in compliance with the regulations. If your billing agent is
charging you fees that are contrary to the official rules and regulations of the Department, you may be required to refund the resulting Medicaid payments made to you.

It is important to note that in March 2001, the Board of Professional Medical Conduct’s Committee on Fraud in Health Care authored a report on fee splitting. The State Education Department, along with other public and private stakeholders, participated in crafting this report. The report cited sections 6530 and 6531 of the education law and article II-D, sections 587-88 in Title VI of the public health law as statutes that prohibit fee splitting. Despite testimony by different stakeholders that a percentage of collection payments was the norm in the billing industry — not just in New York but around the country — this report concluded that New York should continue a prohibition against fee-splitting arrangements. It is also important to note that, as part of the 2001 report, the Department of Health was strongly urged to educate physicians and medical practices on the laws governing fee splitting. This education never took place.

It is difficult to explain why these laws and this report were ignored until now, or why the attorney general’s office has decided that enforcing these laws will be a focus going forward. In fact, they have demonstrated that they are willing to go back to 2010 to recoup the monies that were paid out of the Medicaid program to practice management companies for billing and collections.

We have just scratched the surface of this issue at this point. We have reached out to many different individuals (MSSNY legal, socioeconomic and legislative staff; David Adelson, Esq., the NYSSA’s legal counsel; Bob Reid, the NYSSA lobbyist; the NYSSA leadership; and members of the Socioeconomic Committee, etc.) in an effort to determine why Mr. Schneiderman’s office is suddenly pursuing this. Everyone is very surprised by this new initiative and the fact that no education or warning was provided in advance of this effort.

New York has a history of being one of the worst (as in lowest) reimbursement states for Medicaid services in the U.S. According to the Medicaid fee index (which measures each state’s physician fees relative to the national average), New York ranks in the bottom 10 for physician reimbursement. The state also has a long history of being unable to convince physicians to participate in the Medicaid program. It now
appears that the attorney general’s office is going to exacerbate this problem by arbitrarily enforcing fee-splitting laws that previously have gone unenforced.

What should you do? It is vital to reach out to your billing company/practice management company immediately to find out if they have already been contacted by the AG’s office regarding your billing records. That will be a clue as to whether or not you may be about to receive a similar letter from the AG. Next, it is recommended that you find an alternative method to reimburse your billing company for their services — one that is not based on fee splitting.

We do not know if there is any legal basis for fighting these audits or for challenging these laws in the legislative arena. The laws appear to be based on federal Stark anti-kickback fraud statutes. Going forward, we are going to dig deeper to see if we can determine why the attorney general’s office has made this a priority and what, if anything, can be done about it. Clearly, this does not bode well for the future of the Medicaid program in New York.

In keeping with its mission, AFNY provides PGA-related scholarships to the most enthusiastic and dedicated anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. During the past 24 years, more than 374 anesthesiologists representing 62 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

You can help AFNY fund the education and research that will improve patient care. Contributions are tax deductible and 100 percent of every donation will be used to fund the programs that fulfill AFNY’s mission.

Visit http://nyanesthesiologyfoundation.org and make your donation today.
New York State Society of Anesthesiologists

32nd Annual Legislative Day in Albany

Tuesday, May 2, 2017

Location: Fort Orange Club
110 Washington Ave | Albany, NY 12210

8 am Breakfast Meeting
To include a discussion regarding legislative issues potentially impacting anesthesiologists in the state of New York

10 am Legislative Appointments
(which will be scheduled for members)

Conference call Monday, May 1 • 7 pm
Review key legislative developments

Speakers:
- Rose Berkun, M.D., President, NYSSA
- David J. Wlody, M.D., Chair, Government & Legal Affairs Committee, NYSSA
- Lee H. Winter, M.D., Chair, Economic Affairs Committee, NYSSA
- Robert Reid, Partner, Reid, McNally & Savage
- Shauneen McNally, Partner, Reid, McNally & Savage
- Charles Assini, Legislative Counsel to the NYSSA, Higgins, Roberts & Suprunowicz, P.C.

RSVP
Go to surveymonkey.com/r/NYSSALeg2017 and fill out the required information. Questions? Contact Grace Carter at GKCarmer@HRSLaw.us.com.

All NYSSA members are invited — you must RSVP.

Travel expenses will be reimbursed at IRS rates. Overnight accommodations must be preapproved.
A Look at the 70th PostGraduate Assembly in Anesthesiology Opening Session and R.W. Robertazzi Memorial Panel

Dr. Andrew Rosenberg (left) presents the Distinguished Service Award to Dr. Michael Jakubowski.

Dr. Jerrold Lerman at the podium
E.A. Rovenstine Memorial Lecture

Dr. Richard Beers (right) presents Dr. Robert Sladen with the Rovenstine plaque.

Dr. Robert Sladen presents his lecture.
Poster Presentations and Scientific Awards
Workshops
House of Delegates Meeting

Dr. Andrew Rosenberg

Dr. Michael Simon addresses the House of Delegates.

The NYSSA delegates stand for the Pledge of Allegiance.

(Left to right) Jason Berkun, Benjamin Khechen, and Robert Berkun
Drs. Michael Duffy and Andrew Rosenberg present Sen. John DeFrancisco (center) with the NYSSA Public Servant of the Year award.

ASA President-elect Dr. James Grant

ASA President Dr. Jeffrey Plagenhoef
The House applauds Dr. Ingrid Hollinger for her dedicated service as NYSSA District 2 director.
Mini-workshop: Active Shooter in the Hospital
International Scholars Reception

Dr. David Bronheim and Executive Director Stuart Hayman

Drs. Elizabeth A. M. Frost and Richard Beers
Scenes From the Speaker’s Reception

Drs. Jonathan Gal and Gregory Fischer with Dr. Lawrence Epstein and Erica Epstein

Drs. Lance Wagner and Robert Lagasse

Drs. James Philip and David Bronheim

Drs. Rose Berkun and Edmond Cohen

Drs. Lynn Bichajian and Eugene Viscusi

Ritchie and Jen Assini, Jason and Stuart Hayman, and NYSSA Legislative Counsel Charles Assini, Jr., Esq.
Resident Section
Happy Hour
Technical Exhibits
Scenes From the President’s Reception

Drs. Maris and Andrew Rosenberg

Leo Freire and his band perform.

NYSSA lobbyist Robert Reid and Dr. Andrew Rosenberg
Plans are already underway for the 71st PostGraduate Assembly in Anesthesiology.

Don’t miss PGA 71: Dec. 8-12, 2017. Register at: www.pga.nyc
Improper Patient Screening for Office-Based Surgery: A Case Study

JAMES ROBB

The importance of appropriate patient screening prior to performing office-based surgery is illustrated in the following case study.

The patient, a 48-year-old married father of five, was morbidly obese, weighing 270 pounds with a BMI of 43.8. He had diabetes, high cholesterol, and hypertension. He underwent an anal/rectal fistulectomy in the office of his proctologist. An anesthesiologist administered general anesthesia to him for the procedure. Despite his classification as an ASA III risk, the patient had no preoperative medical clearance, no preoperative electrocardiogram, and no preoperative blood work. The electrocardiogram, which was performed prior to the start of surgery, showed sinus tachycardia. Further, the patient was hypertensive. Despite these abnormal preoperative findings, surgery proceeded.

The procedure was performed with the patient in a prone jackknife position. He was monitored by an electrocardiogram, a blood pressure monitor, and an O2 analyzer. The patient was not intubated. He received intravenous Propofol and Versed, although the dosage of Versed given was not recorded in the operative record. The surgeon also gave the patient local anesthesia; however, the concentration and total dose of Marcaine and Lidocaine 1% also were not recorded.

The procedure took 25 minutes. After it was completed, the surgeon left the room, leaving the patient in the care of the anesthesiologist. When the patient was returned to the supine position, he was in cardiac arrest and had no pulse or blood pressure. Office staff was instructed to notify emergency medical services (EMS) immediately, resuscitation measures were started, and the patient was defibrillated. His blood pressure and heart rate were restored after 20 minutes of resuscitation. When EMS responded, they intubated the patient and transported him to a local hospital, where he died several days later.

The surgeon had dictated his operative note before the event, which made it appear that he was present at the time of the patient’s cardiac arrest. The
anesthesiologist also had documented before the occurrence that the patient was awake and alert and had fully recovered from anesthesia. Because this had to be crossed out in the records, it clearly proved to be very embarrassing to both physicians and made it very difficult to defend them.

The patient’s estate then commenced a wrongful death lawsuit, alleging negligent treatment resulting in a cardiac arrest while undergoing the office-based surgical procedure in the proctologist’s office. The estate sued both the proctologist and the anesthesiologist. The review by surgical and anesthesiology consultants for MLMIC concluded that the case could not be successfully defended for the following reasons:

- This patient’s excessive weight, diabetes, and hypertension clearly required preoperative medical clearance.
- The patient was not intubated to provide a safe airway. This was of particular importance since he was placed in the prone position.
- The record lacked any documentation of medication doses. For instance, the doses of Versed given pre- and intraoperatively were not documented, nor was the dose of the local anesthetic.
- Despite EKG changes indicating both tachycardia and hypertension preoperatively, the physicians still proceeded to perform this elective surgery.
- Finally, the consultants also were concerned about how effectively the patient was being monitored, since he was not found to be in acute respiratory failure and cardiac arrest without a recordable blood pressure until he was turned supine.

Therefore, the case was settled before trial for $2 million, with the anesthesiologist contributing $500,000.

*James Robb is a retired senior vice president, MLMIC Services Claims.*
Improper Patient Screening for Office-Based Surgery: A Legal and Risk Management Perspective

DONNALINE RICHMAN, ESQ.

New York state law requires that medical practitioners who perform surgery in their offices under general anesthesia or deep or moderate sedation be fully accredited by nationally recognized accrediting agencies determined by the New York state commissioner of health.¹

Even so, one of the keys to safely performing office-based surgery (OBS) is appropriate patient selection. There are serious consequences for physicians who fail to appropriately select patients. All deaths and serious adverse events arising from OBS must be reported to the New York State Department of Health within prescribed time periods.² The Department of Health demands prompt notification of such events, and is therefore able to take swift action. In serious cases, the New York State Department of Health Office of Professional Medical Conduct (OPMC) will most likely launch a prompt investigation that could result in licensure actions ranging from censure and reprimand to revocation of a physician’s license. Another consequence of inappropriate patient selection is the commencement of a medical malpractice lawsuit. A skilled plaintiff’s attorney would likely focus not only on inappropriate patient selection but also on other very obvious deficits in the care of this patient.

Performing an OBS procedure under general anesthesia on a morbidly obese patient with high cholesterol, diabetes, and hypertension is high risk and would likely be considered inappropriate patient selection. Any patient who has been determined to be an ASA III risk clearly must have preoperative medical clearance. When selecting patients for OBS, an assessment of both procedural complexity and risk is required, in conjunction with appropriate pre-procedure screening. Yet, despite all of this patient’s serious pre-surgical co-morbidities, the surgeon in this case failed to obtain medical clearance. The patient was both hypertensive and had experienced sinus tachycardia in the office immediately prior to commencing surgery. These symptoms should have prompted one or both physicians to cancel the surgery and reschedule it in a hospital setting. By failing to do so, both physicians provided the plaintiff’s attorney with substantial evidence of multiple serious deviations in the standard of care.

An anesthesia expert for the plaintiff would likely focus on the anesthesiologist’s failure to intubate this patient for the procedure. This
failure contributed to the patient’s cardiac arrest and the outcome of the patient’s resuscitation. The anesthesiologist’s attempts to intubate the patient after the arrest were unsuccessful. Only after EMS arrived was the patient successfully intubated, which was more than 20 minutes after the cardiac arrest was identified. It is unclear how long the patient had been in cardiac arrest before the anesthesiologist became aware of this. Thus, the plaintiff’s attorney could have argued that the anesthesiologist deprived the plaintiff of a last clear chance for survival.

Since the patient was already in cardiac arrest when he was returned to the supine position from the prone jackknife position, the plaintiff’s attorney could further reasonably allege that, since none of the alarms sounded on the equipment monitoring the patient’s vital signs, the alarms were either non-functional, had been turned off, or were perhaps ignored by the staff. Thus, if the patient had been properly monitored, the staff should have been aware of any changes in his vital signs before the cardiac arrest occurred or was recognized.

Another significant point of weakness in the defense was whether the physicians and staff of this office were properly equipped and trained to provide the necessary emergency care and resuscitation in the event of a code. A jury would likely believe they were not prepared to do so. The availability of appropriate emergency equipment and properly trained staff is a requirement of OBS accreditation. The plaintiff’s attorney would thus likely investigate the office’s accreditation status and potentially use the accrediting agency’s standards to prosecute the lawsuit. Failure to comply with accreditation standards could result in an OPMC investigation and possible licensure actions against the physician members of the practice, since noncompliance with accreditation requirements may be deemed professional misconduct.

One of the most obvious and substantial problems from a defense perspective was the physicians’ sparse, incredible and inaccurate documentation of this patient’s surgical procedure. The anesthesiologist failed to record the doses of Versed, Marcaine and Lidocaine given to the patient, which may have caused difficulties in the patient’s resuscitation. Further, it is extremely difficult, if not impossible, to defend a physician who completes an operative or anesthesia record before a procedure.

Finally, the fact that both physicians later crossed out their pre-written operative and anesthesia notes permits the plaintiff’s attorney to depict both physicians as uncaring and cavalier, and characterize this patient as just one
person in an assembly line of patients. A jury is likely to judge the physicians harshly under such circumstances.

It is almost impossible for the defense to rebut these presumptions and justify the pre-written documentation indicating that the patient did well both during surgery and postoperatively, when, in actuality, he was in cardiac arrest for an undetermined amount of time. The plaintiff’s attorney can legitimately question the credibility of the documentation of both physicians. A well-prepared plaintiff’s attorney would have been able to urge the jury only to depend on the sparse documentation available. The plaintiff’s counsel could have argued quite convincingly that the sparse documentation was consistent with, and equivalent to, the very obvious lack of attention both physicians paid to the patient’s preoperative and intraoperative condition. Neither physician had created an “accurate” record of the patient’s care, which put both physicians at serious risk of further allegations of professional misconduct and negligence in an OPMC investigation of professional misconduct.4

In sum, any defense of this case would have been extraordinarily difficult due to improper selection of this patient for OBS, failure to obtain medical clearance when faced with an obvious medically high-risk patient, the inadequate response to the emergency that occurred, and the creation of inaccurate documentation before, during, and after the procedure. Since the patient was 48 years old and provided support for a wife and five children, the likelihood of a substantial verdict at trial was inevitable. Therefore, settlement of this case was clearly indicated. ■

Donnaline Richman, Esq., is with Fager Amsler Keller & Schoppmann, LLP, counsel to Medical Liability Mutual Insurance Company.

REFERENCES
3. Education Law § 6530(47).
4. Education Law § 6530(32).

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With so much at stake, shouldn’t you be represented by Kern Augustine?

The sad truth is, everything you’ve worked for can all disappear if you’re not prepared for a government inquiry. Which is why if you or your practice is being investigated, you need counsel experienced and thoroughly knowledgeable in health law. At Kern Augustine, our goal is always to help you reach your goals by advising you on managed care, risk prevention, business planning, contracting and today’s growing maze of regulations. Yet, should you ever face career-threatening litigation, rest assured that our expertise can help you feel as if your problems have disappeared. For more reassuring details, please call.

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You’ve worked hard.
Done well.
Now the Government is investigating.
**Overtime Pay Salary Level Test Revised: New Rule Effective December 31, 2016**

**DONALD R. MOY, ESQ.**

On September 22, 2016, a U.S. District Court judge in Texas granted an Emergency Motion for Preliminary Injunction and enjoined the U.S. Department of Labor from implementing and enforcing the Federal Overtime Final Rule that was scheduled to go into effect on December 1, 2016. In general, the Fair Labor Standards Act (FLSA) requires payment of a minimum wage for all hours worked during the workweek plus overtime pay of not less than 1½ times the employee’s regular rate of pay for hours worked more than 40 hours in a workweek. The FLSA provides a number of exemptions from the overtime pay requirement for executive, administrative, professional and computer employees (the “white collar” or “EAP” exemption). In order to be exempt from the overtime payment requirement, generally, three tests must be satisfied: (1) the Salary Level Test, (2) the Salary Basis Test, and (3) the Duties Test.*

The Federal Overtime Final Rule would have increased the salary threshold under the Salary Level Test from $455 per week ($23,600/year) to $913 per week ($47,476/year). The U.S. Department of Labor estimated that the increase in the Salary Level Test would have extended overtime payment eligibility to millions more workers nationwide. While the federal court ruling blocks implementation of the Federal Overtime Final Rule for now, employers in New York state need to be aware that the New York State Department of Labor has adopted a rule that will increase the Salary Level Test in the state. New York State Department of Labor regulations, in general, incorporate the FLSA requirements for overtime pay, including the FLSA exemptions based upon the Salary Level, Salary Basis and Duties tests (NY Codes Rules and Regulations, 12 N.Y.C.R.R. section 142-2.2).

On December 28, 2016, the New York State Department of Labor adopted a rule that raises the Salary Level Test for executive and administrative employees. The new requirements went into effect on December 31, 2016. The revised salary threshold in New York state varies by geographical area and size of employer, as follows:

1. **Large employers of 11 or more employees (New York City)**
   $825.00 per week ($42,900/year) on and after 12/31/16
$975.00 per week ($50,700/year) on and after 12/31/17
$1,125.00 per week ($58,500/year) on and after 12/31/18

**Small employers of 10 or fewer employees (New York City)**
$787.50 per week ($40,950/year) on and after 12/31/16
$900 per week ($46,800/year) on and after 12/31/17
$1,012.50 per week ($52,650/year) on and after 12/31/18
$1,125.00 per week ($58,500/year) on and after 12/31/19

2. **Remainder of downstate — Nassau, Suffolk and Westchester counties**
$750.00 per week ($39,000/year) on and after 12/31/16
$825.00 per week ($42,900/year) on and after 12/31/17
$900.00 per week ($46,800/year) on and after 12/31/18
$975.00 per week ($50,700/year) on and after 12/31/19
$1,050.00 per week ($54,600/year) on and after 12/31/20
$1,125.00 per week ($58,500/year) on and after 12/31/21

3. **Remainder of New York state (outside of New York City, Nassau, Suffolk and Westchester)**
$727.50 per week ($37,830/year) on and after 12/31/16
$780.00 per week ($40,560/year) on and after 12/31/17
$832.00 per week ($43,264/year) on and after 12/31/18
$885.00 per week ($46,020/year) on and after 12/31/19
$937.50 per week ($48,750/year) on and after 12/31/20

**Lessons Learned**
While New York state employers currently are not required to increase exempt employees’ salaries to the $913 per week salary threshold as required under the Federal Overtime Final Rule, employers are required to meet the salary threshold as required under the New York State Department of Labor regulations. Thus, the salary threshold under the Salary Level Test in New York state is higher than the current salary threshold under the federal regulations. Employers with workplaces in multiple locations in the state must be aware of the different salary thresholds depending upon the employees’ location within the state. Employers are reminded that the Salary Level Test is only one of the three tests that must be satisfied. In order for an employee to be exempt from overtime payment requirements, the Salary Basis Test and the Duties Test must be satisfied in addition to the Salary Level Test.
Reminder: Minimum Wage Payment Requirement in New York State

Legislation was enacted as part of the 2016-17 state budget that will phase in a $15 per hour minimum wage, as follows:

New York City (employers with at least 11 employees): The minimum wage increased to $11 per hour on December 31, 2016, and will increase an additional $2 per hour each year, reaching $15 per hour on 12/31/18.

New York City (employers with 10 or fewer employees): The minimum wage increased to $10.50 per hour on December 31, 2016, and will increase an additional $1.50 per hour each year, reaching $15 per hour on 12/31/19.

Nassau, Suffolk and Westchester counties: The minimum wage increased to $10 per hour on December 31, 2016, and will increase an additional $1 per hour each year, reaching $15 per hour on 12/31/21.

Rest of New York state: The minimum wage increased to $9.70 per hour on December 31, 2016, and will increase an additional 70 cents per hour each year, reaching $12.50 per hour on 12/31/20. After that date, the minimum wage will continue to increase to $15 per hour on an indexed schedule to be set by the director of the division of the budget in consultation with the New York State Department of Labor.

*For a discussion of the Salary Level, Salary Basis and Duties tests, see the article titled “Overtime Pay Final Rule” by Donald R. Moy by visiting DrLaw.com and clicking on Mr. Moy’s attorney profile.

Kern Augustine, P.C., is general counsel to the NYSSA and is solely devoted to the representation of healthcare professionals. The firm has offices in New York, New Jersey and Pennsylvania and can be found on the Web at www.drlaw.com. Mr. Moy may be contacted at 800-445-0954 or via email at DMoy@DrLaw.com.
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With International Faculty and Complimentary Workshops

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January 14-19, 2018

Final program and hotel information will be available in September 2017. Interesting cases and research abstracts will be accepted for oral presentation. For abstract form, contact: menachem.weiner@mountsinai.org
(Deadline: October 30, 2017)

For information: george.silvay@mountsinai.org
Informed the NYSSA Membership

The leadership of the NYSSA (President Dr. Rose Burken and the entire Executive Committee) worked closely with Government and Legal Affairs Committee (GLAC) Chair Dr. David Wlody; GLAC Vice Chairs Dr. Scott Plotkin and Dr. Jonathan Gal; Executive Director Stuart Hayman; Reid, McNally & Savage (our Albany lobbyists Bob Reid, Shauneen McNally, and Marcy Savage); and me to implement strategies aimed at keeping NYSSA members informed about critical New York state legislative and budget developments and, when needed, to ask you to reach out to your local legislative representatives to voice your views on these important developments. The purpose of this article, similar to last year's article at this time, is to alert you to the existing resources as well as some new resources that are available and how we plan to keep you informed throughout the legislative session.

1. Dr. Rose Berkun will be presenting a newsletter to the membership that will provide updates on topics and initiatives of interest to members, including governmental affairs updates.

2. GLAC Chair Dr. David Wlody provides an annual report to the House of Delegates (HOD) summarizing GLAC activities during the year and the outcome of key legislative initiatives.

3. The NYSSA website contains legislative position papers and memorandums setting forth information that summarizes critical pieces of legislation of interest to anesthesiologists as well as other documents of interest. (Please note: most position papers, memorandums, and other documents require a member login.) We strive to provide timely updates to the information posted on this site throughout the legislative session. On the NYSSA website, go to the “Professional & Practice Issues” tab and then click on “Legislative/Regulatory Issues,” or go directly to http://members.nyssa-pga.org/Scripts/4Disapi.dll/4D CGI/m em bers/legislative.htm l.
4. Information with respect to seeking an exemption from the mandatory three-hour CME on pain management training will be posted as soon as information is available from the New York State Department of Health. The pain management CME requirement was included in a package of bills enacted in 2016 to address the state’s serious opioid/heroin epidemic.

5. The NYSSA’s 32nd annual Legislative Day in Albany will be held this year on Tuesday, May 2, 2017. We will hold a pre-Legislative Day webinar on Monday, May 1, 2017, to provide an overview of the NYSSA legislative agenda as well as an update on critical bills. All members are welcome to attend the annual Legislative Day in Albany. Appointments with your legislators will be scheduled by our Albany lobbyists, Reid, McNally & Savage. All participants will receive our legislative position papers and background resource materials. NYSSA President Dr. Rose Berkun and GLAC Chair Dr. David Wlody will provide participants with additional information during a breakfast meeting held on Legislative Day. Contact NYSSA headquarters if you are interested in participating.

6. The American Society of Anesthesiologists (ASA) Office of Governmental Affairs legislative meeting will be held May 15-16, 2017, in Washington, D.C. An update of important federal issues will be presented, such as the plan to replace the Affordable Care Act.

7. “CapWiz” is an important means to: (i) update you on legislative initiatives that require your immediate attention, (ii) provide you with a template letter to allow you to communicate with your legislative representatives, and (iii) help you locate your legislative representatives. CapWiz can be found on the NYSSA website. Click on the “Professional & Practice Issues” tab, then the “Legislative Action Center” tab, or go directly to www.capwiz.com/nyssa-pga/home/.

8. The NYSSA leadership is encouraging our members to reach out to their district directors to schedule meetings with lawmakers at their local/district offices. Bob Reid and Shauneen McNally, of NYSSA’s Albany lobbyist Reid, McNally & Savage, and I stand ready to assist you in planning for these sessions. At the NYSSA leadership’s request, Bob Reid, Shauneen McNally, and I will be preparing a PowerPoint presentation (which will be made available on the NYSSA website) as a
tutorial for you on the NYSANA-backed nurse anesthetist title bill (which has been introduced for the 2017-2018 legislative session) and general advice when meeting with your lawmaker.

9. Bob Reid, Shauneen McNally, and I stand ready to attend district meetings to provide you with an overview of legislative developments. Your district director will likely be presenting updates throughout the year on important developments both at the state and national levels.

In sum, it is a priority for the NYSSA leadership to keep members informed on critical New York state legislation and budget initiatives. It is our hope that the methods outlined above will provide you with timely and comprehensive information to allow you to become proactively involved in the NYSSA’s advocacy process.

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Have You Visited the NYSSA Website Lately?

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Since 1998, breaches in infection control have resulted in 77 reported outbreaks of patient-to-patient transmission of hepatitis B or C virus in healthcare settings. Ten of these outbreaks involved anesthesia care, putting more than 70,000 patients at risk and infecting 153.

Anesthesia Care and Infection Control: Keeping Your Patients Safe

Created by and for anesthesiologists, this CME program provides the information you need to decrease the risk of healthcare-associated transmission of pathogens.

Course Topics Include:

- Safe injection practices designed to prevent transmission of bloodborne pathogens
- 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

To complete this online course, go to nyssa-pga.org. Scroll down to the course listing and click on the NYSSA MEMBERS graphic.

Infection control training is mandatory for anesthesiologists and other healthcare providers in the state of New York.

This course was developed by Medcom, Inc., in association with Elliott S. Greene, M.D., professor of anesthesiology, Department of Anesthesiology, Albany Medical College, and Richard A. Beers, M.D., professor of anesthesiology, SUNY Upstate Medical University, and the NYSSA, thanks to an unrestricted educational grant from New York state.

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Addressing the Opioid Epidemic

MARK W. SAWERIS, M.D.

As resident editor of Sphere, I want to convey my thoughts on the role of anesthesiologists in combating the widespread abuse of opioids. Physicians are facing a new public health threat; as just one example, JAMA Pediatrics reported that the number of cases of neonatal abstinence syndrome increased fivefold between 2000 and 2012.1 Based on a 2013 National Survey on Drug Use and Health (NSDUH), it is estimated that 29.7 million people in the U.S. (or 9.4 percent of Americans) aged 12 and older were illicit drug users, creating an escalation of adverse complications in the population as well as complicating pain management strategies for the anesthesiologist.2 The question remains how anesthesiologists can address this growing problem.

Opioids are vital to the adequate provision of anesthesia; however, a responsible clinician must balance their use with their potential adverse effects across multiple organ systems. Complicating the issue is the question of whether or not anesthesiologists can curtail treatment to individuals in a selective nociceptive state (such as the operating room). Although any sort of connection between our clinical obligations and the global epidemic may seem far-fetched, we as an institution have already had to adapt our practices, with many new models focusing on non-opioid analgesic regimens. This is especially the case in the expanding morbidly obese patient population and those at risk for adverse respiratory complications common to morbidly obese patients. Many institutions, including SUNY Upstate Medical University, are beginning to implement protocols to limit overzealous opioid administration in these patient populations. Furthermore, in the schema of the perioperative surgical home model for anesthesiology practice, we must adhere to the management guidelines as they pertain to possible opioid abuse and establish a collaborative relationship with other perioperative practitioners to address the problem.

As it stands, several steps have been taken to address the opioid epidemic at the primary care level and in chronic pain clinics. CDC guidelines were recently released that emphasize the non-opioid management of chronic pain. The approved Risk Evaluation and Mitigation Strategies (REMS)
program was instituted by the FDA in an effort to guide practitioners on the appropriate use of long-acting opioids. Exit strategies are emphasized to help with the opioid weaning process in appropriate patients. Several states, including New York, have implemented prescription monitoring systems (PMP) such as I-STOP to prevent the overprescribing of narcotics. All of these programs have direct implications for anesthesiologists managing opioid-tolerant patients during major surgical procedures. It is evident that we must broaden our focus from the pharmacological knowledge of opioid bioavailability, elimination half-lives, toxic metabolites, and potential adverse reactions to include epidemiological principles and public health as we implement medical decision making for opioid dependent patients.

The American Society of Anesthesiologists has taken this approach by publishing practice guidelines for the perioperative management of patients with obstructive sleep apnea secondary to obesity. It focuses on increasing monitoring, limiting use of IV narcotics, and emphasizing multimodal pain management techniques to include regional anesthesia as the mainstay of treatment whenever applicable. To date, however, there are no direct, evidenced-based recommendations for restricting an optimal or appropriate opioid analgesic regimen intraoperatively because of the risks for long-term abuse, and the American Society of Anesthesiologists has yet to address this issue. While the current attention of the CDC and other agencies is on limiting prescriptions for narcotics, the true answer to the epidemic will require extensive research into alternatives for adequate analgesia in the postoperative period. Continuous regional anesthesia techniques such as peripheral nerve catheters seem to have a promising role in controlling pain in the immediate postoperative period. In addition to an expansion of acute pain regional anesthetic techniques, attention also has turned to potent non-opioids for analgesia.

The most popular alternatives thus far include selective NMDA receptor antagonists like ketamine that bind phencyclidine sites on receptors (through calcium ion channels), as well as the alpha-2 agonist dexmedetomidine. Both medications mimic opioid analgesia through sleep pathways originating in the locus ceruleus that mimic non-REM sleep. This is in sharp contrast to opioids that inhibit the ascending transmission of nociceptive pain through the rostral ventromedial
medulla to the midbrain and from the dorsal horn of the spinal cord. Research also focuses on norepinephrine transmission and pathways in the basal forebrain. Recent studies presented at the 44th annual meeting of the Society for Neuroscience in Anesthesiology and Critical Care point to the potential usefulness of methylphenidate in emergence of over-narcotized patients from general anesthesia. However, these studies focus on arousal pathways in animal models only, and they are limited to isoflurane maintenance anesthesia. Despite these limitations in the operating room setting, research suggests promise in methylphenidate in improving symptoms of fatigue in cancer patients on chronic opioids in the outpatient setting. It remains to be seen whether these alternatives have potential for abuse, although, if so, it is likely on a much smaller scale than the mu-receptor agents.

Outside of these common alternatives, preliminary studies suggest that a new class of medications may remedy the current epidemic crisis. I recently had the opportunity to speak with Dr. Charles Serhan, the Simon Geiman professor of anesthesia, perioperative and pain medicine and director of the Center for Experimental Therapeutics and Reperfusion Injury (CETRI) for the Harvard Medical School at Brigham and Women’s Hospital, regarding the promise of pro-resolving lipid mediators in wound healing and pain resolution physiology. Dr. Serhan narrowed his focus on omega-3 acids, eicosapentaenoic acid (EPA) and their precursors — a new genus of mediators, the lipoxin, resolvins, protectin, and maresin families collectively coined SPMs, or specialized pro-resolving mediators. These mediators were initially discovered at the CETRI through marine organisms including scallops, organisms known to be better producers of EPA and docosahexaenoic acid (DHA) than humans. EPA specifically modulates the conversion of arachidonic acid to proinflammatory eicosanoids, serving as new models for pain counter-regulation via endogenous novel pro-resolving mediators.

These EPA-derived mediators are known not only to enhance microbial clearance in inflammatory pathways, but also to function in host defense, organ protection, tissue remodeling, and, most importantly, pain. DHA is also a known protector against oxidative damage, particularly in the brain. Since their discovery through liquid chromatography and mass spectrometry in 1989, new interest in these resolution pathways may provide an alternative to managing pain. The limiting factor in advancing
these directives is not funding (as the National Institutes of Health is known to be generous in this regard), but in the inherent limitation of structuring clinical trials, according to Dr. Serhan. Research has mostly been limited to nutritional precursors of omega-3 fatty acids taken orally in relation to predisposed pain scores conveyed by the patient. The clinical trials must take into account oral bioavailability with respect to these studies, which is vastly different than for intravenous narcotics. Other modalities for research include topical omega-3 derivatives in treating inflammation with periodontal disease secondary to bone loss (note no pain is associated with periodontal disease), which is currently in phase 1 and phase 2 clinical trials. Although still far from replacing narcotics in clinical practice, Dr. Serhan felt optimistic that despite research being only in its preliminary stage, non-opioid remedies, including oral omega-3 analgesics, may become more prominent in therapy, if not in our lifetimes then likely for future generations. To date, the role of these drugs is limited to chronic pain conditions; however, with additional research this may change and include the intraoperative management of acute pain.

As is often the case in evidence-based medicine, exploring one specific challenge often opens the door for other endeavors. Specifically, pro-resolving mediators may not only prove efficacious in addressing the opioid epidemic. As surgical site infections become an increasingly hot topic, there is promise that these mediators may decrease antimicrobial resistance that occurs secondary to the over-prescription of antibiotics for inflammatory pain. It has also been theorized that diets containing EPA can improve outcomes in pro-inflammatory lung injury secondary to acute respiratory distress syndrome (ARDS). Three small clinical trials (Gadek et al., Pontes-Aruda et al., and Singer et al.) support Oxepe (enteral nutrition composed of eicosapentaenoic acid from marine oils and gamma-linolenic acids from borage oil) in improving outcomes such as ICU stay and rate of cardiorespiratory complications in mechanical ventilated patients with systemic inflammatory response syndrome (SIRS), acute lung injury (ALI), and ARDS. This was again shown in 2011 with Rice et al., a larger randomized, double-blinded, placebo controlled, and multicenter study, which was eventually discontinued due to lack of scientific futility.

There may be a connection between research in prevention of neurodegenerative disorders such as Alzheimer’s disease and the
physiologic reward pathways in opioid pharmacology. As it relates to inflammatory pathways, there may also be promise in these modulators as it relates to neurological outcomes in Alzheimer’s patients. As the progression of neurodegenerative disease becomes an urgent public health issue, therapeutic adjuncts in limiting cognitive impairment are of increasing interest. In 2006, Freund-Levi et al. showed that omega-3 fatty acids aided in memory loss and mild cognitive dysfunction after six months of therapy. Resolvins have been shown to aid in limiting the progression of cognitive dysfunction through increasing phagocytosis of amyloid-B molecules, although it is not currently known if this would be more beneficial in the setting of prophylaxis or acute onset and management of progressing disease. Resolvins and protectins have also been shown to aid in preventing memory loss in traumatic brain injury through neuroprotective signaling pathways in murine experimental model systems. It remains to be seen if they can be used prophylactically in PTSD and other psychological disorders, particularly with patients in VA institutions, as veterans are known to have a higher prevalence of these physiological impairments.

It is unknown whether opioid use in clinical practice will ever be replaced by these alternatives. More often than not, the use of intravenous narcotics in the perioperative period does not lead to addiction. The mechanisms regarding the alterations in mood, particularly feelings of reward and pleasure, are mostly unknown despite knowledge of potential links to pathways in the nucleus accumbens, amygdala, and hippocampus. Mu-knockout mice studies have shown a close correlation between the mu receptor and a broad spectrum of anesthetic agents, including morphine, ketamine, and even sevoflurane. Therefore, some argue it may be a futile endeavor to find substantive alternatives to these potent agents. There is also a wide variability in the analgesic effects of narcotics, and it is not uncommon for individuals to avoid them, despite deep discomfort and pain, due to adverse reactions. It is my hope that anesthesiologists will continue to engage the medical community on the opioid epidemic, and that we take a leadership role in addressing this serious problem for future generations.

Mark W. Saweris, M.D., is a CA2 resident at SUNY Upstate Medical University with a special interest in pain management. He is also Sphere’s resident editor.
Inequality in Anesthesiology

MEERA KIRPEKAR, M.D.

For the first time in the history of the ASA, the topic of female leadership in anesthesiology was discussed during the first official meeting of the Ad Hoc Committee on Women in Anesthesia, held during the ASA’s annual meeting in Chicago. Currently, only 4 percent of ASA directors, 12 percent of alternate directors, and 26 percent of committee chairs are women. This discrepancy in leadership is part of a larger problem, however, as highlighted by a 2015 article in Anesthesiology that brought to light a study of gender inequality in the anesthesiology workforce.

The RAND Corp., a non-partisan research institute, studied the demographics and salaries of anesthesiologists across the country to determine how gender affects pay and promotions. The researchers found that in 2007, 22 percent of anesthesiologists were female, compared with 25 percent in 2012. (Thirty percent of all physicians in 2012 were female.) Additionally, of the anesthesiologists younger than 36, 40 percent were female compared with 26 percent in 2007. While these numbers clearly show a closing of the gender gap and more interest in entering the field of anesthesiology among younger generations of female medical students, the salaries that women earned were sizably different.

In 2012, women anesthesiologists earned approximately $313,000 while their male colleagues earned $404,000. When these numbers were further broken down to control for hours worked, experience, type of employer and age, women still earned 7 percent less than men — an average of $114 per hour compared with $122. Per the researchers, “Our results for gender
gaps in compensation for anesthesiologists were similar to those found in other studies of all physicians. However, we found a slightly larger gap in compensation …” in 2012 compared with 2011, indicating that the pay gap increased slightly in one year.

When analyzing why the pay gap exists, it seems that female anesthesiologists “are significantly more likely to work for an individual hospital and to be paid a flat salary … differences that account for much of the earnings gap between men and women.” Additionally, “women are three times as likely to work part-time, compared with men, and work on average six fewer hours per week.” Lastly, married female anesthesiologists also worked less on average, “but having children — something often cited in explaining differences in hours worked across genders — “didn’t seem to influence how much women worked.” At this point it remains unclear whether these differences exist because of women choosing lower-paying jobs with fewer leadership positions out of personal preference or whether gender biases exist within anesthesiology. And while we are making strides to close the gender gap, clearly more research needs to be done to better understand the reasons behind the gap and to promote equality within anesthesiology. Additionally, hospitals need to work toward understanding and better accommodating the needs of women in the workplace.

To that end, at Mount Sinai Hospital we recently formed a “women in anesthesiology” group and held our first panel discussion of female attendings, with residents and department heads present, in order to begin a dialogue on the issues that affect female anesthesiologists today. We plan to continue these panels in the future and encourage other women anesthesiologists to hold similar discussions at their respective institutions. Our profession is heading in the right direction, but work still needs to be done in order to help close the gender gap in anesthesiology.

Meera Kirpekar, M.D., is a CA3 resident at Icahn School of Medicine at Mount Sinai and the RFS secretary and treasurer.

REFERENCES
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Membership Update

New or Reinstated Members
October 1 – December 31, 2016

Active Members

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Lola Balogun, M.D.
David Derdzinski, M.D.
Pei-Lee Ee, M.D.
John Hsih, M.D.
Shibrah Jamil, M.D.
Ronita Mukherjee Mori, M.D.
Vahe Naljian, M.D.
Avishai Neuman, M.D.
Igor Ostrovsky, M.D.
Jose Pena, M.D.
Usman Saleem, M.D.
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Erica Ash, M.D.
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Vikram Saxena, M.D.
Krish Sekar, M.D.
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Jacob Tieg, M.D.
Jing Wang, M.D.
Elaine Yang, M.D.
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Raghubar Badola, M.D.
Mani Hamedi, M.D.
Sudheera Kokkada
Sathyanarayana, M.B.B.S, M.D.
Bhupendra Modi, M.D.
Armand Wilhelm, M.D.
Membership Update

New or Reinstated Members
October 1 – December 31, 2016

Active Members continued

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Jennifer Hayes, M.D.
Sujatha Nigam, M.D.

DISTRICT 5
Luis Velez-Pestana, M.D.

DISTRICT 6
William Ambrosini, M.D.

DISTRICT 7
Andrea Esch, D.O.

DISTRICT 8
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Daniel Feldman, M.D.
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Jonathan Feldstein, M.D.
Samiawit Goshu, M.D.
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Guensley Delva, M.D.
Jasmeet Easwar, D.O.
Abigail Meigh, D.O.
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Sam Nia, M.D.
Gregory Pivarunas, M.D.
Tolga Suvar, M.D.
Edward Yang, M.D.
Membership Update

New or Reinstated Members
October 1 – December 31, 2016

Resident Members (continued)

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Dale DiSalvo, M.D.
Laura Fornarola, M.D.
Peter Gajdek, M.D.
Michael Goettelman, M.D.
Brett Harmon, M.D.
Nika Karimi, M.D.

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Nasim Nourmohammadi, D.O.
Meghan Park, M.D.
Marissa Rubin, M.D.
Michael Rubin, M.D.
Amit Singal, M.D.
Yang Zhang, M.D.

Medical Students

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Jonathan Korets

DISTRICT 2
Trung Pham

DISTRICT 8
Jonathan Guenoun

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Thiagarajan Meyappan, M.B.B.S.

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