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Like many NYSSA presidents before me, my presidential year was influenced by multiple legislative bills introduced by those attempting to expand the scope of practice for nurse anesthetists. The NYSSA leadership, consultants and staff, along with MSSNY and other specialty societies, have worked to combat these bills and to coordinate our efforts with regard to other proposed legislation.

Assemblywoman Rodneyse Bichotte and Sen. James Gaughran introduced legislation that would codify the current New York state health code regulations. As part of that legislation, the use of the term anesthesiologist would be restricted to those who practice medicine. This would help patients ascertain when a physician anesthesiologist is providing their anesthesia care versus other non-physician members of the anesthesia care team. I would like to thank all the NYSSA members who personally visited, corresponded with, or used social media to reach out to legislators. New York is not an opt-out state, and scope of practice under the New York state health code prevails.

The NYSSA was also significantly involved with public health issues this year. We participated in a campaign with several organizations to prevent flavored tobacco from being sold in New York. Historically, flavored tobacco has been known to entice our youth to enter into the habit of smoking tobacco. As physician anesthesiologists, we see the negative ramifications of tobacco use and know that it can have a devastating impact in the perioperative setting. The result of this initiative has been for Gov. Andrew Cuomo to ban flavored tobacco in New York state. At first this ban excluded menthol-flavored tobacco, but after vigorous campaigning the ban now includes this flavor as well.

The NYSSA has also been involved in socioeconomic issues impacting the specialty. The NYSSA leadership sent letters to smaller health insurance companies regarding policy changes they implemented that limit coverage for anesthesia care for gastrointestinal procedures. We argued that while these proposals might reduce costs, they would
deprive patients of medically necessary and important services during
endoscopic procedures. We explained that these changes will negatively
impact the quality and effectiveness of endoscopic procedures. Letters
were also sent to the New York State Department of Financial Services,
the New York State Department of Health, and the Medical Society of
the State of New York. We have had meetings with legislators to discuss
this issue, and upstate members met with a newspaper’s editorial board.
We hope that this practice will be reversed with the help of legislators
or through regulatory change.

The NYSSA has been involved on a national level in efforts to promote
New York’s method for dealing with surprise billing and out-of-network
legislation. During the ASA Legislative Conference and throughout the
year we have worked to educate legislators on the benefits of using New
York’s baseball-style arbitration for billing disputes between insurance
companies, patients and physicians. We have highlighted that multiple
years of data from the implementation of New York’s regulations
demonstrates that insurance costs have not notably increased while
patient and physician problems have been all but eliminated. Dr.
Michael Simon authored an op-ed explaining this issue to the public.

On the education front, the PGA has undergone a makeover thanks
to the energized and proactive leadership team of Drs. Audrée Bendo,
Meg Rosenblatt, Linda Shore-Lesserson and Rose Berkun. Changes for
PGA73 include the lecture format, the session structure, and the curb
appeal of the meeting. The leadership team is working to ensure that
the PGA remains a premier educational opportunity for New York’s
physician anesthesiologists as well as for national and international
participants.

Several ideas for enhancing membership have been discussed and are
being evaluated. We are in the process of determining if unified billing
would be a mechanism for increasing our membership numbers. This
change would put the control of membership billing in the hands of the
ASA, which would bill for New York state as well as ASA dues. We have
also discussed reaching out to the diverse anesthesiology community,
including the Chinese American Society of Anesthesiology and the
National Medical Association Anesthesiology Section. I urge all NYSSA
members to encourage your colleagues to join the NYSSA.
Finally, I am pleased to announce that the Ad Hoc Committee on Mentoring is working on enhancing networking opportunities within the organization as well as educating the public about our specialty. Committee members have visited schools and promoted the work we do for our patients. In addition, at various NYSSA meetings, these committee members are providing the framework for effective networking. I believe this is only the beginning for this mentoring effort, and I look forward to what the future holds as we promote our specialty to the public and elevate the careers of anesthesiologists in our state society.
5 Important Reasons to Renew Today!

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5. Your membership expires at midnight on December 31. Don’t miss a thing in 2020!
It Has Been an Exciting Ride

SAMIR KENDALE, M.D.

I am sad to say that after five terrific years, this issue will be my last as editor of Sphere. It has been an exciting ride navigating the ins and outs of the editorial process, interacting closely with the NYSSA Board of Directors, and having the unique opportunity to communicate with the entire NYSSA membership. I want to use this forum, my final editorial, to thank some of the people who have made these past few years so great, if only to reiterate how many dedicated people it takes to make this publication, and the NYSSA, a success.

I want to thank the amazing staff at the NYSSA for all that they do to keep this organization moving, especially with helping us to maintain our ever-growing and increasingly important online presence. Sandy Rogers, who works behind the scenes on every issue of Sphere, is absolutely irreplaceable. Thanks for helping me stick to deadlines (or at least trying to!), for your valuable opinions on the publication, and, of course, for your unparalleled editing work on each and every part of Sphere.

I want to thank my predecessor, Dr. Jason Lok, who handed me the reins with a gentle and guiding hand. I hope to follow your example with my successor. To the Executive Committee that offered me this position five years ago: Thank you for giving me this fantastic opportunity to dive right into the inner workings of the NYSSA. To Stuart Hayman, who has been supremely supportive of me since day one: There is no better person I can think of to do the tireless job that you do for this state’s anesthesiologists.

The members of the Communications Committee, without whom there would be no Communications Committee, are the essential piece to generating new and forward-thinking ideas about how we can communicate to the rest of the membership and the general public the tremendous things that New York’s anesthesiologists are doing for the specialty and for our patients. I’m not leaving for good, so please say hello if you see me in the hallways at future PGAs.
Physician Anesthesiologists Week
JANUARY 26 – FEBRUARY 1, 2020

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Explore all resources
From the Executive Director

The Year in Review

STUART A. HAYMAN, M.S.

As I begin my 12th year as the NYSSA’s executive director, I find myself reflecting on my time with the association. It has truly been my pleasure to serve the members, the association and the specialty.

My annual report is an opportunity to tout our small but diverse staff. Our seven staff members work as an effective team to produce a wonderful quarterly publication, employ social media tools, skillfully manage a challenging legislative agenda both in Albany and in Washington, D.C., and orchestrate one of the largest and most successful annual anesthesiology educational conferences in the world. Working behind the scenes are a few independent contractors who contribute their expertise to Sphere, NYSSA marketing and other materials for the PGA, legislative messaging for Albany, and our social media campaigns. Staff members also work with third parties for legal, regulatory and legislative support as needed.

Since beginning my tenure at the NYSSA in September 2008, the association has been continually evolving in positive ways. As the staff leader, I strive to promote a culture that welcomes suggestions for productive change while eliminating redundancies and impractical activities.

It has been my privilege to work with the NYSSA’s volunteer leaders, all of whom share new ideas and embrace positive change. We benefit from the work of so many enthusiastic members who give their time and expertise for the betterment of the profession and this association. The NYSSA is truly volunteer driven. Please know that the staff and I appreciate your continued support.

The association continues to be financially strong and debt free. We have established sound fiscal policies that are reviewed annually. The NYSSA is one of the strongest medical associations in New York and one of the most successful component societies within the ASA.
Below are just a few of our activities this past year:

**Advocating for Our Members**

By tapping into my long-standing relationships at county, state and national medical associations, and by working with NYSSA leaders, we have forged strong alliances with numerous other specialty societies and associations. These relationships make the NYSSA stronger and better positioned to serve our members.

The NYSSA leadership, consultants and staff, along with representatives of the Medical Society of the State of New York (MSSNY) and other specialty societies, have worked to combat aggressive scope expansion bills and to coordinate efforts with regard to other legislation. I would like to thank Charles Assini, Esq., the association’s legislative counsel, and Albany-based lobbyist Bob Reid and his firm, Reid, McNally & Savage. They do an outstanding job working with staff to safeguard the practice of anesthesiology and fight for safe patient care.

I would also like to thank the NYSSA’s core group of physician volunteers, all of whom dedicate an enormous amount of time and effort to the organization’s mission as well as to the pursuit of our legislative and regulatory goals: NYSSA President Dr. Vilma Joseph, Immediate Past President Dr. David Bronheim, Government and Legal Affairs Committee (GLAC) Chairman Dr. Jonathan Gal, NYAPAC Chair Dr. Rose Berkun, and ASA director and former GLAC Chairman Dr. David Wlody. Additional thanks is also owed to the members of the NYSSA’s Executive Committee and the Board of Directors for the significant amount of time they give to work on behalf of their fellow members, the association and the profession.

**Nurse Anesthetists:** We are thankful that in 2019 the New York State Department of Health did not attempt another assault on patient safety and the specialty of anesthesiology by hiding nurse anesthetist collaborative practice in the governor’s budget. This ill-conceived proposal would put an end to the anesthesia care team as we know it in New York. This past year the NYSSA received multiple invitations from representatives of the New York State Association of Nurse Anesthetists (NYSANA) asking to meet to discuss expanding nurse anesthetists’ scope of practice in New York. While they were soliciting the NYSSA leadership under the guise of “friendly talks,” they were also sending out notices to their entire membership publicizing their
goal of independent/unsupervised practice. Their correspondence to their membership included language that vilified NYSSA leaders as liars who were using scare tactics to promote the status quo. Regrettably, NYSANA’s leaders continue to demonstrate that their offers to negotiate with the NYSSA in good faith are disingenuous.

**Surprise/Out-of-Network Billing:** The NYSSA has been assisting the ASA and MSSNY in the ongoing battle in Congress relating to federal legislation on surprise/out-of-network billing. The goal is to remove patients from the middle of disputes between physicians and health insurers. The NYSSA supports legislation such as H.R. 3502, which would address this issue in a way that’s similar to the balanced approach adopted in New York in 2014.

**Socioeconomic Issues:** NYSSA leaders sent letters to Oscar Health and Independent Health Association expressing their outrage that these insurers have adopted policies that deprive patients of medically necessary and important services during endoscopic procedures. The NYSSA argued that the policies threaten patients’ rights, safety and comfort while compromising the quality and effectiveness of endoscopic procedures. Letters were also sent to the New York State Department of Financial Services, the New York State Department of Health, the Medical Society of the State of New York, and area newspapers.

With the 2020 elections around the corner, it is imperative that NYSSA members stay vigilant and engaged. Remember, you are vital stakeholders in the healthcare system. You must monitor any potential changes to healthcare that are being driven by legislators and special interest groups. Their tendency is to focus on cost, quantity and profits. We must ensure that they do not sacrifice quality and safety. It is vital that you educate your colleagues young and old and inspire them to make their voices heard. Together we can improve patient care and practice safety, advance fair reimbursement, provide quality medical education, and work toward sensible regulations and legislation.

**Providing for the Educational Needs of Our Members**

The PGA is one of the oldest, largest and most successful anesthesiology meetings in the world. The PGA’s continued success is directly attributable to the leadership of General Chair Dr. Audrée Bendo,
Scientific Programs Chair Dr. Meg Rosenblatt, Scientific Programs First Vice Chair Dr. Linda Shore-Lesserson, and Scientific Programs Second Vice Chair Dr. Rose Berkun. This year, PGA leaders worked to overhaul and reform the PGA.

The PGA MOCA offerings this year will include credits for multiple educational programs. As in the past, attendees will be eligible for some credits for patient safety, MOCA part 2, and MOCA part 4.

Dr. Edmond Cohen will again spearhead the thoracic symposium, and we continue to offer the state-mandated infection control CME course on our website.

Educating the Public
Members of the NYSSA continued the joint New York State Fair effort with the Medical Society of the State of New York and the Onondaga County Medical Society. In addition, Dr. Joseph created the Ad Hoc Committee on Mentoring as a more organized way for members to get involved in community outreach.

Advancing Our Mission
We have signed memorandums of understanding with the ASA, the European Society of Anaesthesiology, and the São Paulo State Society of Anesthesiology. These agreements promote the exchange of ideas with regard to innovation, education and marketing. These relationships produce benefits that go beyond what could be achieved working independently.

We continue to collaborate with our state, national and international colleagues. These organizations include: the ASA, the ESA, the WFSA, the Canadian Anesthesiologists’ Society, the Brazilian Society of Anesthesiology, and the São Paulo State Society of Anesthesiology.

We continue to build on collaborative efforts with other medical associations as well as other not-for-profits and local municipalities. Together we have discussed multiple scope of practice issues and other matters such as the measles outbreak and corresponding religious exemptions to immunizations. This year we also joined the group Flavors Hook Kids NYC to help reduce youth tobacco use by combating the sale of flavored e-cigarettes to kids.
Conclusion
This annual report provides a brief summary of the activities we have engaged in on behalf of all NYSSA members and the specialty of anesthesiology. The report is not intended to be all-inclusive but, rather, to highlight significant areas or initiatives from this past year. As we celebrate another productive and successful year for the organization, I wish to express my sincere appreciation to the entire membership for your continued support.
Mark your calendar and plan to attend

Keynote Speaker: Francis Collins, M.D., Ph.D.

2020
October 3 – 7 | Washington, D.C.

2021
October 9 – 13 | San Diego, CA

2022
October 22 – 26 | New Orleans, LA

2023
October 14 – 18 | San Francisco, CA

American Society of Anesthesiologists

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The NYSSA's Continuing Medical Education and Remediation (CME&R) Committee serves in an advisory role to the PostGraduate Assembly in Anesthesiology (PGA) planners, whose mission is to provide a comprehensive, integrated continuing medical education program designed to address the full spectrum of perioperative medicine, anesthetic management, pain management, critical care, and anesthesia practice management. The committee is composed of PGA planners and representatives from each NYSSA district.

The CME&R Committee is primarily responsible for ensuring that the NYSSA maintains its accreditation status from the Accreditation Council for Continuing Medical Education (ACCME) and completes the required ACCME self-study report and documentation of our activities at each term renewal. ACCME accreditation is essential to our goal to provide our members with the continuing medical education credits they require for Maintenance of Certification in Anesthesiology™ (MOCA®), medical licensure, and hospital privileges. This is also important in order to fulfill our stated mission to provide continuing medical education to both national and international meeting attendees. To accomplish this, the CME&R Committee members maintain intimate knowledge of the ACCME criteria. There are 13 criteria required to achieve basic accreditation (four years). Recently, the ACCME completely revised the criteria for achieving accreditation with commendation (six years). There are 16 criteria for commendation to choose from, of which we have to show compliance in eight criteria to obtain commendation. It is crucial that the CME&R Committee and PGA planners remain abreast of these changes. Currently, we are working with the PGA planners to evaluate which of the new ACCME criteria for commendation will be pursued and to implement changes to the PGA program accordingly.
The CME&R Committee assists the PGA planners in implementing a program designed to change competence, performance and patient outcomes, one of the ACCME requirements. This process begins with identifying professional knowledge gaps in our target audience. One mechanism coordinated by the CME&R Committee is the annual district survey that is reviewed and updated every year. The survey is emailed to all NYSSA members and distributed at district meetings. Information gathered from the survey helps identify the knowledge gaps of our membership as well as ongoing areas of need. It also informs us when topics no longer need to be addressed.

We are also collaborating with the American Board of Anesthesiology (ABA) to identify professional knowledge gaps in ABA diplomats.
An ad hoc group of CME&R Committee members developed MOCA Minute® questions covering topics from several subspecialties and these have been submitted to the ABA. The NYSSA will be given recognition for any questions utilized and the ABA will share the results of MOCA Minute® question performance with the NYSSA to further assist our efforts to guide the educational content of the PGA meeting.

The CME&R Committee also provides oversight with regard to reviewing PGA planners’ and presenters’ disclosures of relevant financial relationships, including identifying and resolving potential conflicts of interest. This is essential to ensuring that the PGA content is independent from the influence of ACCME-defined commercial interests, another requirement of the ACCME for maintenance of accreditation.

Another role of the CME&R Committee is to consult with the state Department of Health’s Office of Professional Medical Conduct (OPMC). A New York anesthesiologist who is reported to OPMC for misconduct may be referred to our committee for evaluation and to provide recommendations for remediation, if deficiencies are identified. An individualized evaluation program is formulated based on the anesthesiologist’s misconduct. This has only happened once since the inception of this committee. The anesthesiologist who was referred by OPMC was evaluated for cognitive deficiencies (written examination) and clinical acumen (simulation). In addition, a review of the events that led to the referral was conducted. Based on our findings, a focused remediation program was recommended.

The CME&R Committee appreciates the opportunity to serve the NYSSA membership and is proud to support the PGA planners in developing an outstanding ACCME-accredited educational activity each year.

Francine S. Yudkowitz, M.D., FAAP, FASA, is a professor of anesthesiology, perioperative and pain medicine and pediatrics at the Icahn School of Medicine at Mount Sinai and the director of pediatric anesthesia and coordinator of global health initiatives at the Mount Sinai Hospital. Jaime Hyman, M.D., is an assistant professor of anesthesiology, perioperative and pain medicine at the Icahn School of Medicine at Mount Sinai.
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This activity contributes to the patient safety CME requirement for Part II Lifelong Learning and Self-Assessment of the American Board of Anesthesiology’s QI/CEP. For information on the Maintenance of Certification in Anesthesiology Program (MOCA®), known as MOCA 2.0. Please consult the ABA website, for a list of all MOCA 2.0 Part II requirements and their associated points values.

Accreditation and Designation Statement
The American Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates this enduring material for a maximum of 5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in this activity.
Understanding the Issues Related to Concierge Medicine

MATHEW J. LEVY, ESQ.

Since its introduction in the mid-1990s in Seattle, Washington, a growing number of medical practitioners have converted their medical practices into “concierge” practices, or they have joined concierge practice networks. These practitioners have found fulfillment, flexibility, and financial gain; they can once again enjoy practicing medicine and reduce or eliminate completely the hassle of dealing with managed care companies. In a concierge practice, also known as boutique medicine or retainer medicine, the physician’s patients pay an annual retainer fee, typically between $1,500 and $1,800 above and beyond any health insurance co-payments or deductibles. In exchange, the patient receives enhanced services from the provider. Concierge medicine is now being considered by a broader spectrum of providers, undoubtedly triggered by the financial strain that physicians are experiencing simply to keep their medical practices viable in an economic environment where reimbursement for services provided is falling and medical malpractice insurance rates are increasing.

In theory and in practice, if structured correctly, both the physician and the patient benefit from this arrangement. In exchange for the retainer fee, patients often have access to their physicians or a member of the group 24 hours a day, seven days a week, as well as highly personalized services such as health and wellness plans, extended appointment times, minimal wait times, luxury robes, internet access, shower facilities, and house calls.1

Models of Practice

The first model of concierge practice is the standard retainer model: The provider requests an annual or other periodic installment retainer and, in exchange, provides enhanced or premium care to the patient. In the second model of concierge care, in exchange for the retainer fee (which is often greater than the fee in model one practices), the patient receives the services provided to model one concierge patients as well as primary care from the physician. Model two patients often must still retain their own health insurance to cover hospital visits, tests and
specialist care. The third type of concierge practice model is the fee-for-service model. Practitioners utilizing this model may choose whether or not to participate with insurance companies. Regardless, the physician charges a flat fee per visit in addition to the fee for the consultation and other medical services or treatments rendered to the patient.

Federal Law, State Law and Contractual Considerations

Concierge medicine has triggered heated ethical and legal debates at the state and federal levels. Contractual issues with HMOs and other third-party payors also arise. The focus of the debate is whether collecting a retainer (1) violates state and federal public health laws and (2) constitutes the practice of insurance, which would subject the provider’s practice to more stringent regulations.  

Federal: For providers who only participate in the Medicare program, the good news is that in 2002, a favorable opinion letter was issued by the secretary of the Department of Health and Human Services. This letter explained that the Medicare rules that governed how much a physician could charge for services are not determinative of how much a physician can charge for non-covered services. Thus, as long as the retainer fee paid for services that were truly not covered by Medicare, then these fees were not in violation of Medicare law or the False Claims Act. The HHS Office of the Inspector General, in an alert dated March 31, 2004, affirmed this analysis, stating that “Medicare participating providers can charge Medicare beneficiaries extra for items that are not covered by Medicare.” However, this alert cautioned that retainer fees for providing a service such as “extra time” with a Medicare beneficiary constituted a violation of the Medicare regulations.

State: Few states have clearly analyzed the issues that arise in concierge practices, but among the states that have are New York and New Jersey. The New York State Department of Health, in an opinion letter dated April 16, 2004, stated that it was the interpretation of the department that many of the services that are claimed to be included in the cost of retainers (24-hour care, coordination of necessary benefits, and case management) are already required services under state law. Therefore, charging a retainer fee constitutes double-billing. Using similar reasoning, the New Jersey Department of Health and
Senior Services rendered an opinion in 2003 that insurance, network and provider agreements involving concierge practices were inherently suspect, “not acceptable and should be terminated immediately.”

**Contractual:** A concierge physician’s provider agreements with managed care companies must be reviewed for potential conflicts. For example, if a provider represents that the retainer fee buys the patient an enhancement of healthcare services already covered by an insurance company, the insurer will view the treatment of concierge patients who are enrollees of their plan as discriminatory as compared to the services provided to patients who are enrollees of said plan but not paying the retainer. Further, discrimination between insured individuals is typically addressed in state insurance statutes and regulations. In New York state, providing better waiting rooms and expedited appointments to retainer patients constitutes discrimination under state law.

Concierge practitioners can be found in many states, including Florida, New York, Massachusetts, New Jersey, California, Oregon and Washington. Even in these states it is unclear as to exactly how a concierge practitioner can satisfy state laws and regulations pertaining to the practice of medicine and insurance. Overall, there are more unanswered questions than answers with regard to how a respective state’s department of health or department of insurance will treat a concierge practitioner. As such, before a practitioner whose entrance into the concierge market is otherwise attainable begins the transition, he or she would be well advised to seek competent counsel as well as the guidance of a mentor or consultant.

Mathew J. Levy, Esq., is a partner at Weiss Zarett Brofman Sonnenklar & Levy, P.C., the NYSSA’s general counsel. Mr. Levy has extensive experience representing healthcare clients in transactional and regulatory matters. He can be reached at 516-926-3320 or mlevy@weisszarett.com. The firm can be found on the Web at weisszarett.com.

**NOTES**

2. Insurers are required by the law of every state to meet various solvency and licensing requirements, which is why determining whether retainer medicine constitutes insurance is such a critical question.


Supporting Our Legislators

Assemblywoman Rodneyse Bichotte and Dr. Lance Wagner

Dr. Vilma Joseph, state Sen. Andrea Stewart-Cousins, state Sen. Alessandra Biaggi, and Dr. Realba Rodriguez

Dr. Vilma Joseph and Assemblyman David Weprin

Bronx County Medical Society President Dr. Realba Rodriguez, state Sen. Alessandra Biaggi, and Dr. Vilma Joseph

Dr. Michael Simon with U.S. Rep. Raul Ruiz

Drs. Anthony Schwagerl, Christopher Campese, Vilma Joseph, and Daniel Sajewski with state Sen. James Gaughran
Scenes From the 2019 ASA Annual Meeting
Dr. Berend Mets presents Dr. Elizabeth A. M. Frost with the 2019 Nicholas Greene, M.D., Humanitarian Award
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Patient-Centered, Physician-Led Care
The Changing Anesthesia Marketplace and Corporate Investors
At the 2018 American Medical Association (AMA) Annual Meeting, the House of Delegates adopted a policy titled “Corporate Investors.” According to the AMA report, the AMA would study, and report at the 2019 AMA Annual Meeting, the effects on the marketplace of corporate investors (public companies, venture capital/private equity firms, insurance companies, and health systems acquiring a majority and/or majority interest in entities that manage physician practices). At the 2018 AMA Annual Meeting, the American Society of Anesthesiologists (ASA) supported the adoption of this policy.

This article will highlight: (i) the findings of the AMA study, including recommended guidelines that should be considered by physicians who are contemplating corporate investor partnerships; (ii) the Medical Society of the State of New York (MSSNY) position on the corporate practice of medicine; and (iii) the AMA resources to assist physicians who are contemplating corporate investor partnerships.

Background With Respect to the Changing Anesthesia Marketplace

Despite the substantial number of transactions that have taken place over the past ten years, the specialty of anesthesiology still remains highly fragmented and ripe for consolidation. Haverford estimates that over 80% of anesthesiologists in the U.S. are still practicing independently in private practices. Considering that private equity firms continue to exhibit significant interest in investing in the consolidation of the specialty, Haverford Healthcare Advisors anticipates that anesthesiology practice acquisitions will continue to occur at a rapid pace throughout 2018.
As the healthcare services market continues to experience changing payment models, mandated infrastructure investments, and broader competitive dynamics, many anesthesia practices have begun to seek partnership opportunities with private equity groups and larger practice consolidators to take advantage of growth opportunities and mitigate risk. From an investment perspective, an aging US population coupled with a rise of surgeries, in both outpatient and inpatient settings, will continue to drive market volumes and influence consolidation.

Florida, New Jersey and New York are among the most active states for anesthesiology acquisition activity. The map below shows acquisitions by state from 2009 through 2016.

Critics argue that private equity firms have an intense incentive to increase profitability — perhaps at the expense of patient care — whereas private equity firms argue that they provide practices with more autonomy than they would have if acquired by a hospital or insurer; capital to improve care; and expertise in financial discipline, business operations, and acquisitions of other practices.

The current environment is accelerating the disappearance of independent practices and the corporatization of medicine. Many of the largest practices have already been acquired by a hospital, insurer, or private equity firm. No peer-reviewed evidence examines the effect of private equity acquisitions on the quality and cost of patient care; physician professionalism; or the experience of patients, physicians, or staff; little evidence examines the effect of hospital or insurer acquisitions.

REFERENCES

1. Herschman GW. Physician groups should consider strategic options as mergers, acquisitions boom. MGMA Connection 2018; (May):26-8.


American Medical Association (AMA) Study

The AMA study of the effects of corporate investors on the healthcare marketplace considered the following.
... the degree of corporate investor penetration and investment in the health care marketplace; the impact on physician practice and independence; patient access; resultant trends in the use of non-physician extenders; long-term financial viability of practices; effects of ownership turnovers and bankruptcies on patients and practice patterns; effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces; and the relative impact corporate investor transactions have on the paths and durations of junior, mid-career and senior physicians.


Executive Summary
While the extent of corporate investment in physician practices is not precisely known, growing numbers of physicians are employed by corporations including hospitals, health systems and insurers. Increasingly, private equity firms have also acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician experiences and opinions vary.

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues; loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians’ financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources.
Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.

Longstanding AMA policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. This report recommends a series of guidelines that should be considered by physicians who are contemplating corporate investor partnerships; supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; and encourages further study by affected national medical specialty societies.

**Medical Society of the State of New York (MSSNY) Statement**

95.980 **Use of Percentage-of-Fee Based Compensation Arrangements:**

The Medical Society reaffirms its support for the underlying principle that a physician’s dedication to providing competent medical service for his or her patient is paramount. Moreover, we also support the opinion that the physician’s control over clinical decision-making must remain unencumbered and independent from non-clinical influence. The Medical Society recognizes that the continuation of the corporate practice of medicine doctrine’s prohibition against an unlicensed person or entity’s influence in the practice of medicine is necessary to uphold these principles and to protect against potential abuses and fraudulent activity. Physicians must remain knowledgeable of and in control of the business aspects of their practice and should not relinquish such authority to non-physician business entities. In our opinion, the following “business” decisions and activities involving control over the physician’s individual practice of medicine should be made by a physician and not by a non-physician or entity:

- ownership and control of a patient’s medical records, including determining the contents thereof;
- selection (hiring/firing as it relates to clinical competency or proficiency) of professional, physician extender and allied health staff;
- set the parameters under which the physician will enter into contractual relationships with third-party payors;
• decisions regarding coding and billing procedures for patient care services; and
• approval of the selection of medical equipment.

Moreover, the following health care decisions should be made by a physician only and would constitute the unlicensed practice of medicine if performed by an unlicensed person:
• determining what diagnostic tests are appropriate for a particular condition;
• determining the need for referrals to or consultation with another physician/specialist;
• responsibility for the ultimate overall care of the patient including treatment options available to the patient; and
• determining how much attention to devote to address a patient’s needs.

As a result of the foregoing, the Medical Society supports the continuation of the corporate practice of medicine doctrine.

American Medical Association Resources

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Annual Anesthesiology Residents’ Night at the New York Academy of Medicine

ELIZABETH A. M. FROST, M.D.

The annual Anesthesiology Residents’ Night at the New York Academy of Medicine, organized through the Section on Anesthesiology, was held on October 3, 2019. Of the 29 submissions, 21 were selected for poster demonstrations and eight for oral presentations, representing seven departments in New York and New Jersey. Some 70 registrants enjoyed a cocktail reception as well as a plentiful array of food.

The entries were judged by a panel of senior anesthesiologists. Winners received monetary prizes and all participants were presented with certificates from the Academy.

Judging was coordinated and the winners announced by Dr. Farida Gadalla, vice chair of the Section on Anesthesiology.

Three winners were selected for their poster presentations:

First prize: Dr. Varun Channagiri representing Rutgers University New Jersey for “Adaptation of Transient Receptor Potential Vanilloid 1 in the Lateral Habencula During Alcohol Withdrawal.”

Second prize: Dr. Emily Wang representing Mount Sinai West for “Early Improvement in Patient Reported Disability Following Bariatric Surgery.”

Two winners were identified in the oral category:

First prize: Dr. Sofia Gilels representing Rutgers University New Jersey for “Reactive Oxygen Species Play a Role in P2x7 Receptor-Mediated IL-6 Production in Spinal Astrocytes.”

Second prize: Dr. Jane Gui representing Mount Sinai West for “Effect of Cardiac Surgery on Post-Operative Sleep Patterns: A Prospective Observational Study.”

The Section on Anesthesiology gratefully acknowledges financial support for this event from anesthesiology departments at Columbia University, Icahn School of Medicine, Rutgers Medical School and SUNY Downstate Medical School, as well as private donations, including from Dr. A. Elisabeth Abramowicz. Thanks also to the Academy and Donna Fingerhut for providing logistical and practical help and for the use of the library once more.

The next event will be the Jeopardy contest in the spring, date to be announced.

Elizabeth A. M. Frost, M.D., is chair of the New York Academy of Medicine Section on Anesthesiology.

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Drive-by Induction: An Appreciative Inquiry
Case Report

VICTORIA SOKOLIUK, D.O., ARUP DE, M.D., MBA, AND LINDSAY GENNARI, M.D.

The Appreciative Inquiry case reports are meant to facilitate alternative methods of examining patient care and outcomes. We hope that this series will encourage other medical systems to consider reevaluation of their focus in the QA process.

Appreciative Inquiry (AI) is an established method of change management that has been utilized in the business world.¹,² We have highlighted an AI approach to challenging cases in previous issues of Sphere.³,⁴ Instead of internalizing blame for bad outcomes, the fundamental belief in AI is that work systems (organizations, personnel, anesthesia care teams) are inherently good and are driven to become better. AI recognizes that there is enormous talent, energy and drive within the core of a care team, and through selective recognition and focus on the “good,” the team can become even better. Recent articles in the surgical literature highlight the extent to which cooperation within the perioperative care team can improve team morale and anesthesia provider performance.⁵ The quest to elevate care delivery and the perioperative patient experience moves from the Morbidity and Mortality conference perspective — “What have we done wrong?” — to the AI view — “What can we do even better and how can we do that as a high-functioning team?” It is a positive, energizing process, a shift from the traditional Morbidity and Mortality approach to one of “Positivity and Praise.” We present the following case from the AI perspective.

Case Report

An 8-year-old boy with severe autism and a history of brain tumor was scheduled for a repeat MRI and occipital cranioplasty. The patient had known difficulties with the process of obtaining medical care. On previous physician appointments, he had become combative and refused to leave the car. For routine pediatrician visits he required special preparation with a regimen of medications: In addition to receiving his several daily maintenance antipsychotics he would also be given oral anxiolytics. Even with adequate planning and preparation, the patient...
would refuse to enter the clinic. He was usually examined by the pediatrician while still in the family car. Any change in his daily routine elicited aggressive, self-harming behavior that was difficult to manage.

A multidisciplinary meeting involving neurosurgery, anesthesiology, oncology and the parents took place to discuss how to best care for this patient. Normally, the MRI would precede the surgery by a period of several weeks; however, given the complexities of bringing the patient into the hospital, everyone agreed that the MRI and surgery should take place on the same day. The team then looked to the parents for suggestions as to how they would physically get him into the hospital. The patient’s mother was concerned because any small change in her son’s daily routine, such as not going to school for the day, was often met with resistance, agitation and behavior that was difficult to control. She was worried that he would become combative and refuse to leave the car at the hospital, canceling all planned interventions for the day. At the parent’s suggestion, it was decided that the patient would go to school and then be picked up at his usual dismissal time, thereby maintaining most elements of his normal daily routine. After school, he would be driven to the hospital where the anesthesia team would be waiting for him at a convenient alternate entry (thereby avoiding the main hospital entrance, which triggered anxiety in the patient). They would then give him an intramuscular injection of ketamine while the patient was still in the car and then transfer him to the MRI suite. The use of ketamine was discussed with the neurosurgeons, who confirmed that the patient did not have evidence of raised intracranial pressure.

On the day of the scheduled procedure, the family informed the anesthesia team of their estimated time of arrival. The patient had eaten an early, light lunch to maximize the period of fasting. Emergency equipment, portable monitors, and oxygen were available at the alternate hospital entrance. A hospital security team ensured that no cars blocked the entrance and that no one interfered with the plan. As soon as the patient arrived, he was approached while in the car with his parents and sedated with an intramuscular injection of ketamine (5 mg/kg) in combination with glycopyrrolate. Once appropriately sedated, he was placed onto a stretcher and transported directly to the MRI suite. Spontaneous ventilation was monitored with continuous pulse oximetry and capnography during transport. Once in the MRI suite, he remained adequately sedated and intravenous access was obtained. Intravenous
induction agents, including propofol and rocuronium, were given and the patient was intubated.

Following the MRI scan, the patient remained intubated and continuously monitored. He was then transferred to the operating room for his cranioplasty. The surgical procedure was uneventful. The patient became extremely uncooperative and combative after extubation despite the continuation of his intraoperative dexmedetomidine infusion. Further sedation was attempted; however, his agitation worsened. Due to a concern about the patient harming himself, he was reintubated and admitted to the pediatric intensive care unit (PICU).

He was stable throughout his PICU course except for continued severe agitation. He was extubated in the PICU on the first postoperative day only to be reintubated again due to combative behavior and continued concern for self-harm. He was successfully extubated on the second postoperative day and was discharged home the following day.

**Discussion**

Autism spectrum disorder (ASD) is a biologically based neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction, and restricted, repetitive patterns of behavior, interests, and activities. Insistence on sameness (cognitive rigidity) is another behavioral feature of ASD. It interferes with functional activities (e.g., eating, communicating, and socializing). Patients who insist on sameness may exhibit distress, temper tantrums, or anxiety at small changes in routines and difficulty with transitions — as was made manifest in this case.6

The pathogenesis of ASD is incompletely understood. The current belief is that ASD is caused by genetic factors that alter brain development, specifically neural connectivity.7-9 Given the complexity of ASD and the diversity of clinical manifestations, it is likely that interactions between multiple genes or gene combinations are responsible in addition to epigenetic factors and exposure to environmental modifiers.10-12 Estimates of the prevalence of ASD vary with study methodology and the population that is evaluated. In a 2010 systematic review of epidemiologic studies, the global prevalence of ASD was 7.6 per 1,000 (1 in 132).13 The overall prevalence of ASD in Europe, Asia, and the United States ranges from two to 25 per 1,000, or approximately one in 40 to one in 500.14
Patients with severe autism and comorbidities who require complex medical care present a particular challenge to all care providers. In these patients, even a seemingly insignificant change in their normal daily activities can cause major behavioral problems. Remaining flexible and being open to creative approaches improves patient care and fosters growth for medical innovation.

From an AI perspective, by actively soliciting input from the parents, the care teams of the anesthesiologists, radiologists and surgeons were able to collaborate to achieve excellent patient care. The normal time frame of MRI scan, evaluation and operative intervention was compressed from several weeks to several hours. Multiple visits were reduced to one. Instead of a morning scan, the teams agreed to start later in the day to minimize disruption to the patient’s established routine. Inducing the child in the car outside the physical borders of the hospital was a unique solution to attempting to coax him out of the car. Although a drive-by induction is unlikely to ever become the standard of care, it was a key component in a multi-disciplinary approach that allowed the safe and compassionate care of a severely autistic child.

Victoria Sokoliuk, D.O., is an associate professor of anesthesiology and a member of the pediatric cardiac anesthesia division at Albany Medical Center. Arup De, M.D., MBA, is vice chair of anesthesia systems integration and an associate professor of anesthesiology at Albany Medical Center. Lindsay Gennari, M.D., is an assistant professor of anesthesiology and a member of the division of obstetrical anesthesiology at Albany Medical Center.

REFERENCES

40 NYSSA — The New York State Society of Anesthesiologists, Inc.


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Resident and Fellow Section Hosts Activities for Members

AMREEN RAHMAN, M.D.

In anticipation of ASA 2019 in Orlando, Florida, the NYSSA Resident and Fellow Section (RFS) board hosted a meet and greet for residents and fellows in the New York City area on October 4. More than 40 residents from a variety of anesthesiology programs gathered for happy hour at Tonic East in Midtown East. The event marks the first of many more such gatherings to come this academic year.

At the ASA’s House of Delegates meeting, 16 members of the NYSSA’s Resident and Fellow Section had the opportunity to participate in the annual meeting of the ASA’s primary legislative body. The RFS board also hosted the Resident and Fellow Section at this year’s PGA.

Follow the NYSSA’s Resident and Fellow Section on Instagram for our most recent updates on activities @nyssa_rfs, and email rfs.nyssa@gmail.com if you are interested in participating in future events.

Amreen Rahman, M.D., is an anesthesiology resident (PGY-3) at Mount Sinai.
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July 1 – September 30, 2019

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July 1 – September 30, 2019

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New or Reinstated Members
July 1 – September 30, 2019

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A CASE REVIEW BY MLMIC INSURANCE COMPANY

GERALD J. GLUM

A 58-year-old male patient with unrelenting pain in the left arm following left rotator cuff repair surgery was seen by a MLMIC-insured anesthesiologist for pain management. This patient had a chronic regional nerve pain syndrome allegedly due to the infiltration of an IV during surgery performed six weeks earlier. Treatment with Neurontin 300 mg BID was unsuccessful. The patient rated the pain in his entire left upper extremity as 10/10. He had pain with even the slightest shoulder movement. His left hand and wrist were edematous and very warm. Following his examination, the insured anesthesiologist recommended a series of stellate ganglion blocks, in coordination with aggressive physical and occupational therapy. The patient’s past medical history revealed that he underwent cardiac testing prior to the shoulder surgery because of complaints of intermittent chest pain and shortness of breath on exertion. An EKG, exercise stress testing, and chemical stress testing ruled out ischemia and thus the patient was cleared for the shoulder surgery. The patient initially underwent a series of left stellate ganglion blocks at the C-6 level on the left side for eight weeks. He had no complications and seemed to benefit from these injections. The procedures were performed on an outpatient basis in the pain management suite of the local hospital.

The patient arrived for his ninth injection at 4:40 p.m. He was assessed by the admitting nurse. His vital signs were: BP 128/74, pulse 76, respirations 16 and oxygen saturation 98%. The patient’s procedure began at 5:07 p.m. The insured anesthesiologist administered IV propofol 100 mg for sedation. He gave additional doses of propofol 50 mg at 5:12 p.m. and 5:15 p.m. The patient’s
vital signs at that time were: BP 109/70, pulse 73, and 96% oxygen saturation. Lidocaine was injected by the anesthesiologist at the C-6 level and an anesthetic catheter was inserted under fluoroscopic guidance. To confirm proper placement, 2 cc of contrast was injected through the catheter. Aspiration was then performed to confirm that the catheter was not placed intravascularly. He then administered 10 cc of bupivacaine with 0.5% lidocaine without complication. At 5:17 p.m., the patient’s vital signs were: BP 109/70, respirations 18 and oxygen saturation 95%. The procedure was completed at 5:19 p.m. At 5:30 p.m., the patient was taken to the recovery room. His vital signs were: BP 111/74, pulse 71, respirations 16, and oxygen saturation 97%. Because patients undergoing this procedure do not usually require continuous monitoring, they are typically evaluated by registered nurses every five to ten minutes. At 5:45 p.m., the nurse documented that the patient was drowsy, but responsive, and could swallow without difficulty. His vital signs were: BP 107/68, respirations 16, and oxygen saturation 97%. The patient’s 13-year-old son was present with him in the recovery room. After 5:00 p.m., there were only two nurses on duty in the pain management suite. The receptionist and admitting nurse for this area regularly left at 5:00 p.m. The nurse monitoring this patient left him to assist the physician with his next case. The remaining nurse was responsible not only for monitoring the patient in the recovery room, but also for admitting other patients scheduled after 5:00 p.m., as well as answering the telephone. While this nurse was in another room preparing the next patient for a procedure, she heard a commotion at the front desk. The patient’s son was requesting immediate assistance for his father because a monitor alarm was ringing. When the nurse reached the recovery room, the patient was apneic, cool, dusky and pulseless. At 5:55 p.m., she called a code blue and summoned the anesthesiologist, who had not yet begun his next procedure. He and numerous hospital staff responded promptly to the code. Resuscitation efforts included CPR, intubation, the administration of epinephrine and atropine, and defibrillation. Finally, at 6:14 p.m., the patient’s heart rate was reestablished. He was in asystole for at least 19 minutes and suffered an anoxic brain injury, secondary to his cardiac arrest. The patient’s condition did not improve in the hospital so he was transferred to a nursing home. He remains there today in a vegetative state. A lawsuit was commenced on behalf of the patient. The case was reviewed for
MLMIC Insurance Company by experts in anesthesiology. They found that the decision to proceed with a series of stellate ganglion blocks was appropriate. However, one expert expressed serious concern that the patient was given 200 mg of propofol over an eight-minute time frame. Giving such a high dosage clearly requires close monitoring of the patient in the recovery room. Further, the expert opined that more time should have been scheduled between cases to permit the staff to closely monitor patients in the recovery room. The expert reviewers were unanimously critical of the inadequate staffing of this hospital unit, which allowed this catastrophic complication to occur. Staffing of this unit after 5:00 p.m. had been inadequate for an extended time period. However, multiple requests to hospital administration to increase the nursing staff after 5:00 p.m. had been denied. Thus, the anesthesiologist would have had a difficult time convincing a jury that he was the only physician at the facility who was unaware of the inadequate staffing. Yet, despite this knowledge, he continued to perform procedures after 5:00 p.m. Following this event, the hospital promptly increased the number of registered nurses working in the unit after 5:00 p.m. Because of these issues, the experts recommended settlement of the lawsuit. The hospital settled the lawsuit for $1.5 million. However, the anesthesiologist did not have excess insurance. Thus, defending him in court without the co-defendant was problematic. Therefore, he consented to settle, and the case was resolved for $500,000 rather than continuing to defend the lawsuit in court. ■
Evolving Strategies in Anesthesia to Prevent Drug Diversion
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Drug diversion in the healthcare setting is a crisis involving patients, clinicians, and the society at large. Opioid abuse remains common, and perhaps more so among anesthesiologists than the general population of physicians. Fentanyl has been the most commonly abused medication among anesthesiologists presumably because of its rapid onset and potency. Other agents, such as Propofol, ketamine, midazolam, and nitrous oxide are less frequently abused but still have abuse potential. Why are anesthesia providers more prone to abusing controlled substances? The setting in which anesthesia providers work, easy access to drugs, increasingly stressful jobs, and expert knowledge on how to use the drugs are often suggested as reasons. In addition, anesthesiologists, often in isolation, both enter controlled substances prescription orders and administer opioids in their daily practice. This creates risks for not only anesthesiologists, but for others. Drug diversion has been deemed a multi-victim crime in that it places patients, coworkers, employees, and the society at risk. It is very likely that an addicted anesthesiologist could be impaired while administering drugs to a patient, creating the risk of inadequate vigilance, administration of the wrong drug or dose to a patient, or failure to use proper sterile technique.

Costs associated with drug diversion can be significant. In 2015, Massachusetts General Hospital (MGH) in Boston, the original and largest teaching hospital of Harvard Medical School, paid $2.3 million to settle drug diversion allegations with the Drug Enforcement Administration. MGH’s Chief Pharmacy Officer, Chris Fortier, spoke on the topic, stating “we wanted to be more transparent about a topic that most people don’t want to discuss.” More recently, the University of
Michigan’s Health System, a renowned academic medical center of the University of Michigan in Ann Arbor, paid $4.3 million to settle allegations that it violated provisions of the Controlled Substances Act, which contributed to two overdoses and one employee death.

Anesthesiology residency programs have relied on SUD education and efforts to detect and discourage substance abuse by anesthesiologists. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that primary care centers, hospital emergency departments, and trauma centers should adopt its Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices. Implementing SBIRT practices help to educate health care providers on how to identify patients and providers who are affected by substance use disorders at the earliest point of care, subsequently provide care, and apply drug use prevention initiatives or provide guidance to appropriate drug treatment facilities as needed.

MGH addresses drug diversion by implementing random urine testing in anesthesiology residents. Residents in their first clinical anesthesia year are subject to at least two random tests per year and residents in their second and third clinical anesthesia year are subject to at least one test a year, with testing performed in an outside facility.

Other ways that hospitals and healthcare companies are partnering to prevent and hopefully eliminate drug diversion from the workplace is by making drugs available in small unit dose preparations as well as providing tamper evident and tamper deterrent packaging. As stated in Anesthesiology News, tamper evident or resistant packaging, particularly tamper-resistant syringes with cap seals, may be helpful in preventing diversion. Systems such as MicroVault™, recently added to the market, includes a polypropylene shell that is rigid and transparent allowing for inspection of visible tampering. The outer shrink-wrapped label has no seam and cannot be peeled off. This enhanced piece of technology is one way that industry is supporting healthcare providers and innovating to mitigate drug diversion within the workplace.

Institutional protocols, tamper evident packaging, random urine testing, all are examples of different initiatives that can minimize or prevent drug diversion. Anesthesiologists are more predisposed to divert opioids and abuse these medications intravenously. It is thus incumbent upon hospitals to employ system wide protocols to increase both awareness...
and education and invest in diversion deterrent packaging. There are clear opportunities to mitigate drug diversion within the healthcare system. The rate of drug diversion continues to be high among healthcare workers, and it is critical that healthcare facilities implement strategies, protocols, and system-wide use of tamper evident products to deter controlled substance diversion and to best protect and serve our patients.

REFERENCES


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