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President’s Message

Engaging the NYSSA’s Younger Members

LAWRENCE J. EPSTEIN, M.D.

Spring is finally here. As I write this article, it is the middle of the Passover/Easter holiday week, yet I awoke this morning to a snow-covered car!

Along with the arrival of spring, the governor has again delivered an on-time budget. Passage of the budget usually includes passage of seemingly unconnected legislation and this year was no different. The primary legislation that will impact NYSSA members relates to “surprise bills” (out-of-network charges). The “out-of-network” bill establishes a framework to deal with the situation where patients hold the “reasonable belief” that their care is “in network” with their insurance plans, only to find out later that it is not. (The example most commonly cited involves the anesthesiologist.) This legislation does not affect the situation where a patient knowingly obtains care from an out-of-network provider.

Simply put, if a patient has been led to believe that his/her care would be entirely “in network” and subsequently receives services from an out-of-network provider, the patient would be “held harmless” and the provider would bill (and receive payment from) the insurance company directly. The provider can determine the charge and the insurance company can determine the payment. If there is a dispute, it goes to arbitration, with the “loser” paying the arbitration costs. The standard for arbitration will be the 80th percentile of “usual and customary” fees for that area, “as determined by FAIR Health.” In other words, out-of-network providers, in this instance, should be able to collect a fee greater than that charged by approximately 80 percent of the practitioners (for the same service) in that region. In this era when insurance companies are offering fewer plans with out-of-network benefits, this legislation will incentivize the expansion of networks and motivate the insurance companies to negotiate more favorable in-network fees.

Payment models continue to evolve, along with just about every aspect of the practice of medicine, including anesthesiology. The experience and (hopefully) wisdom of your leadership are immensely valuable, but the rapid evolution brings an urgent need to integrate the perspectives of the younger generations of anesthesiologists. Those early in their careers face
new and different challenges and must work toward different goals. I now firmly believe that the recruitment and mentoring of our young members and future leaders are the most important functions of the current leadership. With this in mind, the NYSSA is sponsoring residents to attend the ASA Legislative Conference in Washington, D.C., as well as our Legislative Day in Albany.

We must also engage our new graduates immediately and integrate them into our NYSSA and PGA committees. Soon after the publication of this edition of Sphere, the annual survey of interest in NYSSA and PGA committees will arrive in your e-mail. Committees (and their members) are the “foot soldiers” of the NYSSA. Please “nominate” yourself for any committee that interests you. Come to the district meetings. Become a delegate to the NYSSA House of Delegates. Your president-elect, Dr. Michael Duffy, will be making NYSSA committee appointments in the fall, based on your (self) nominations.

Lastly, I implore you all to contribute to both the NYSSA (NYAPAC) and ASA (ASAPAC) political action committees. This is a “big” election year at both the state and national levels. At the state level, everyone is up for re-election. Our PAC money brings access to those making the decisions, which can potentially alter the very nature of our medical practices. Issues ranging from independent practice for nurse anesthetists to the “company model” to tort reform or even collective bargaining for physicians are all on the table in an election year. If we want to be heard, we must have the opportunity to speak.

I wish you all a great summer!
Editorial

Share Your Medical Mission and Personal Interest Stories
JASON LOK, M.D.

I hope you all enjoyed your well-deserved spring weather after undergoing the tough winter conditions this year.

If you have not checked out our Facebook page yet, please visit www.facebook.com/nyssapga. With 981 “likes,” you are sure to find fellow members with similar interests. In addition, you can check out the PGA 68 preliminary brochure, learn about the NYSSA’s official PGA 68 t-shirt design contest, and download a digital copy of the most recent issue of Sphere. You can also find information on how to follow the NYSSA-PGA on Instagram.

This issue features a medical mission article written by Dr. Francine Yudkowitz and two of her residents, Drs. Melissa Lee and Ilana Fromer. Unlike past mission articles, this article provides the residents’ perspectives as they experienced myriad challenges while helping children in La Romana, Dominican Republic. Hopefully, you will feel inspired by their stories about caring for children in need.

Dr. Michael Duffy has developed helpful guidelines for those who wish to submit feature articles on medical mission trips and personal interest stories. Here are a few excerpts:

“If you would like to share your story in a future issue of Sphere, we have some guidelines that will help. To assist us, please tell us who participated in your group from your district. How did you get involved? Please list the mission’s contact information so other interested members can also participate. Describe as best you can the location, with details and troubles of travel. Did you bring supplies or were they provided for you? Where did you stay, how was the food, what were the sleeping accommodations? What surprised you most about the delivery of care? How primitive were the conditions or what piece of equipment did you miss most? What types of cases did you see and what types of anesthesia were used? How were the people? Do you have any amusing anecdotes? What would you do differently if you were to participate again in the future?”
“We have more than 3,000 members, including many who live interesting lives outside the confines of providing anesthesia. Did you know we have several anesthesiologists who are pilots? Did you know we have one who built his own plane? We have a member who is also a caterer. We have some who play in bands, and others who have acted professionally. We have many members who have volunteered their services and time in a number of charitable capacities, both here and abroad. Perhaps you play or coach a sport you love. Perhaps you had a brush with the rich or famous, leaving you with an interesting or amusing anecdote to share.”

You can review the guidelines in their entirety in the summer 2012 issue of Sphere. If you no longer have this issue, just visit www.nyssa-pga.org and download a copy. In fact, a visit to the NYSSA website will now allow you to access past issues of Sphere dating back to 1983. Just click on “Publications” and then “NYSSA Sphere Newsletter Archives” to be directed to Issuu, a digital newsstand where you can view copies of the publication from 1983 to the most recent issue. Not every browser is compatible with Issuu, so be sure to try a different browser if you experience any difficulty viewing the publication.

We welcome your feedback, whether favorable or not, along with any additional ideas or suggestions for Sphere. Correspondence should be directed to me at jlokmd@yahoo.com or Stuart Hayman at stuart@nyssa-pga.org. Thanks in advance for your interest and consideration.

Check Out the NYSSA Website for News You Can Use

Click on “NYSSA News” from the “About” menu on our website for up-to-date information on current practice that will help you improve patient outcomes.

Help shape future PGAs by completing the survey question at the bottom left corner of the NYSSA Web page. This space is dedicated to important and controversial issues in anesthesiology. If you have experienced a unique dilemma in your practice, we want to hear from you. Send an e-mail to HQ@nyssa-pga.org.

Go to www.nyssa-pga.org to learn more.
I would guess that I am fairly typical of most people in that I selectively avoid “distractions” as I go through my daily ritual of commuting to and from New York City for work. Sometimes, however, I actually do become aware of something other than what’s on my iPhone or iPad. Early one morning recently, while standing on the MTA platform waiting for my New York City-bound train, I took notice of an advertisement on the platform across from me. In large print, it said, “Did you get your plan yet?” followed by, “A good, low-cost health plan is waiting for you.” My immediate reaction was, “WOW, I must have missed a great opportunity because I didn’t get my low-cost health plan!”

In New York, the state government has made a strong collaborative effort to be one of the first states to implement the Affordable Care Act (ACA). Having now lived through the early stages of the ACA transition from a
consumer perspective, I can’t help but wonder what the goal of this legislation really is. The government has been telling us that we needed this legislation in order to provide affordable healthcare to our entire population. This is a laudable goal, but is it really possible? Can we provide health insurance coverage to approximately 40 million more Americans and lower the costs for everyone?

At the NYSSA, we have experienced some of the negative consequences of the Affordable Care Act. I would like to take this opportunity to share our story about the impact this change has had on the organization, a small business that has long provided insurance to its employees.

Caveat emptor: Let the buyer beware. The sign on the train platform read like a government sales pitch, letting all of us know that, thanks to the ACA, we can now get “a good, low-cost health plan.” Whether or not one views this statement as true depends on how one would define “good” and/or “low cost.” As a small employer in New York City, this organization and its staff began feeling the impact of the ACA in January 2013. That is when we first heard that our insurer would no longer offer certain health plans (our health plan being one of them), because they have specific old-style benefits. The language the insurance companies are using to justify these changes has become a recurring theme: “The health plan is not ACA compliant.”

Going into 2013, the NYSSA offered a Blue Cross Blue Shield health insurance plan with generous prescription and vision benefits. The cost for each employee was approximately $600 per individual per month. The insurance plan didn’t require referrals and had a huge network of physicians and hospitals in and around New York City. Additionally, it was a fairly comprehensive health insurance product with low co-payments and minimal out-of-pocket costs. In January 2013, we were notified by our insurance provider that our current plan was not ACA compliant and, therefore, that particular plan would no longer be offered to us. Instead, we were offered a “similar” plan with a monthly premium of more than $840 per person (a roughly 40 percent premium increase). After reviewing the expensive replacement policy, we discovered the plan had fewer benefits, higher co-payments, and an annual $1,000 out-of-pocket per-person deductible (in addition to the 40 percent higher premium) — not necessarily what I would call a “similar” product.

After a careful review of the handful of insurance alternatives that were offered in our geographic area, the NYSSA settled on a different large
insurer with per-person premium rates of approximately $640 per month (more than a 6 percent increase). Disappointingly, the plan had very restrictive health benefits, less liberal prescription benefits, higher co-payments, and no vision coverage. However, it was the best alternative available at the time and allowed us to avoid an unacceptable premium increase. This was the first rude awakening that we received from the Affordable Care Act, but not the last.

In late 2013, less than one year after our previous ACA-related health insurance experience, we were again contacted by our health insurance carrier. We were informed that the company would not be reissuing our health insurance plan because the current plan was not ACA compliant. I immediately thought of the famous quote by Yogi Berra, “It’s déjà vu all over again.”

This time around, the health insurance company offered to move us into what they termed a “mapped renewal plan.” In our case, this was classified as the New York State Gold EPO plan. According to the carrier, it was the plan that was most similar to our existing plan. After comparing and contrasting the options from other health insurance companies, we concluded there were no better options in the price range being offered. Unfortunately, the new individual policy premium rate increased to more than $700 per month (a 9-plus percent increase). Additionally, the new policy includes deductibles of $750 per person and $1,500 per family, with out-of-pocket limits of $4,000 and $8,000 respectively (on top of the premiums). Add up all the additional out-of-pocket costs and NYSSA employees could pay as much as 72 percent more for health insurance coverage than we were paying just 15 months ago.

The NYSSA’s experience, which is not unique, clearly demonstrates that this new healthcare paradigm is not beneficial for everyone. While more Americans may be gaining access to basic insurance coverage — a commendable goal, to be sure — the fact is that this coverage is being subsidized by the very businesses and employees who have been dutifully paying into the system for years. To add insult to injury, these individuals are being forced to pay far more for what amounts to far less insurance coverage and benefits. I guess the answer to the question in the advertisement on the train platform is: “Yes, we have our plan, but it sure isn’t as good or as cost effective as what we had prior to the Affordable Care Act.”

The New York State Society of Anesthesiologists, Inc.

Distinguished Service Award

Each year the House of Delegates of the New York State Society of Anesthesiologists bestows The Distinguished Service Award on an outstanding member of our Society. The award recognizes significant contributions to anesthesiology and the NYSSA and is the highest honor that our Society can give to any member.

As outlined in the NYSSA Bylaws:

1. The recipient must be an anesthesiologist who has been an active member in good standing of the NYSSA for a minimum of 10 years.

2. The recipient must have provided significant service to the NYSSA by playing an active role in anesthesia education and/or an active leadership role in the NYSSA.

3. The award cannot be given posthumously.

4. Serving members of the Judicial and Awards Committee and officers of the NYSSA are not eligible to receive the Distinguished Service Award.

Any member of the NYSSA may submit a nomination. There is no nomination form. We only request a letter indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. The candidate’s current curriculum vitae should also be included. Please send your nomination to Salvatore G. Vitale, M.D., at NYSSA headquarters before July 15, 2014.

Only by your active participation in the nominating process can we be assured that the most deserving will receive due consideration.

Salvatore G. Vitale, M.D., Chair
NYSSA Judicial and Awards Committee
Caring for Children Around the World

FRANCINE S. YUDKOWITZ, M.D., FAAP

I went on my first medical mission in the year 2000 with Healing the Children® New Jersey, Inc. (HTC). Established in 1981, the organization’s mission is to “provide access to medical care and related services for children in need in New Jersey and worldwide” and to “create a world where every child has access to medical care.” They are certainly fulfilling this mission by caring for approximately 1,000 children per year, either in the United States or abroad. Children in need in New Jersey are provided with medications, equipment, treatment, eyeglasses, hearing aids, and orthotics. Medical teams (consisting of physicians, nurses, supportive healthcare personnel, and administrators) travel abroad to provide pro bono care in several areas (e.g., plastic surgery, urology, ophthalmology, general surgery, and ENT [ear, nose and throat] surgery). HTC teams have traveled to the Dominican Republic, Ecuador, Bolivia,
Peru, Thailand, Vietnam, and Kenya. Children whose medical conditions require care not available in their countries are brought to the United States to live with host families while pro bono care, arranged by HTC, is provided at U.S. hospitals. Once their medical care is complete and they have recovered, they return to their families in their native countries. Finally, aid is provided abroad through the donation of medications and medical equipment to families, as well as surgical and anesthesia equipment to hospitals.

My first mission with HTC was a pediatric urology trip to San Pedro de Macoris in the Dominican Republic. I was hooked. This was the first of 11 trips that I participated in with HTC. I have also gone to China four times, most recently in April 2014, with an organization originating in New York City, Children of China Pediatrics Foundation. The long hours, working with equipment I was unfamiliar with, traveling sometimes for 24 hours to get to our final destination, and making do with what was available did not detract from the personally rewarding experience of caring for children who would not otherwise have access to medical care, whether it was because of lack of expertise in the host country or lack of money on the part of the families.

But that’s not all. The one thing that continues to amaze me on every mission is the trust of the parents. Can anyone imagine surrendering their child to undergo anesthesia and surgery at the hands of strangers from another country? Anyone who takes care of pediatric patients in the U.S. is familiar with the conflicted feelings that parents experience when they want treatment for

The medical team works at Centro Medico Hospital in La Romana.
their children but they are anxious and reluctant to release those children into our hands. Parents in the U.S. get to choose their children’s physicians, speak the same language as the physicians, and in many circumstances have had conversations with the physicians about their children’s care well before the day of surgery. Parents in the U.S. can also access the Internet to learn all about their children’s conditions and what to expect. The parents we meet abroad do not have the same access or the same option to “choose” the physicians caring for their children. What they see is what they get and they can only hope that they made the right decision to allow us the privilege of taking care of their children. They hand over their children willingly, with grace and trust. To top it all off, they are extremely grateful for our care. I have received blessings from many different gods!

As an added bonus, I have met other volunteers from across the U.S. In a matter of hours, 20 some strangers manage to work together as a team, as if they have been doing it for years.

The Healing the Children 2013 ENT team included: (Front row, left to right) George Brewer, Joe Charleman, LPN, Gregg Lobel, M.D., Robin Brody, M.D., Lee Eisenberg, M.D., and (back row, left to right) Debby Dunn, RN, Francine Yudkowitz, M.D., Mike Yaker, M.D., Janet Trinidad, CRNA, Judy Padula, RN, Heather Kewley, RN, Lou Winkler, M.D., Laurie Didyk, RN, Teri Kelly, RN, Ilana Fromer, M.D., Cindy Bischoff, RN, Elissa Dunn, and Pam Wiest, CRNA.
My relationship with HTC started in 2000 and has continued to the present. Even after 11 missions, I still get excited about going. When I return from a mission, I am already looking forward to the next one. From almost the beginning and with the support of my chair, I was able to include a CA-3 resident from my program on these trips. It is usually someone who performs at the top of his or her class and is planning to do a fellowship in pediatric anesthesiology. This has become such a rewarding experience for the residents that I am constantly asked by other residents when I am going on another trip and if they could accompany me. Every resident who has participated in a mission has found the experience rewarding and eye opening. They not only learn about healthcare in countries where access is not always guaranteed, they learn how to evaluate a patient whose medical history is not always clear and to administer a “standard of care” anesthetic with limited resources. Many of these residents have gone on to volunteer on other medical missions when they have completed their training.

Dr. Melissa Lee distracts a child with a video game while inducing general anesthesia prior to surgery.
The following summaries are by two residents who describe their experiences on the annual ENT trip HTC makes to La Romana, Dominican Republic.

**Long but Rewarding Days**

**MELISSA LEE, M.D.**

In October 2012, I participated in a one-week medical mission trip to La Romana in the Dominican Republic. I went as part of a group of 17 volunteers, organized by Healing the Children (HTC) New Jersey, to provide ENT care to children in the community who would otherwise not have access to such care. We worked at the Centro Medico Hospital, which was built in 1916 with a new addition recently completed. The clinic provides medical care to people in the area as well as to employees of the Central Romana Corporation. Our medical team consisted of pediatric physician anesthesiologists, CRNAs, pediatric otolaryngologists, a pediatrician, operating room and PACU nurses, and administrators. As an anesthesiology resident, I worked with an attending to provide anesthesia to children undergoing ENT procedures.

The first day was spent as a preoperative screening day where children with ENT problems waited in the clinic for evaluation. Prior to our arrival, various communities and the local orphanage were informed of our visit and provided with a list of medical problems that we would be addressing during this trip. Each child was seen by one of our pediatric or ENT doctors; if surgery was necessary, the anesthesia team then assessed the child. I took part in the preoperative evaluation of patients who were scheduled to receive surgery that week. With the help of translators — students volunteering from an international high school — and a team member who was originally from the Dominican Republic and spoke fluent Spanish, we were able to communicate with the children and their families. We obtained their medical histories, performed physical examinations, and explained our plan for anesthesia (informed consent). The ages of the patients ranged from 2 to 21 years old. Approximately 200 children were screened that day for surgery. Although gathering information was challenging at times, particularly with the orphanage children, who were unsure of even how old they were, interacting with the children and families made it an amazing experience. With the long lines, many were required to wait several hours to be seen, yet each person I met waited patiently, never complained, and was grateful for our help.
That same day, we also set up two operating rooms in preparation for surgery the next day. We unpacked suitcases prepared by HTC containing all the equipment and medications we needed, except for controlled substances and fluids. There were three operating rooms, a holding area, and a recovery area in the newly built section of the medical center. The operating rooms were clean and spacious; it was an impressive area. However, it was also evident that the resources and technology in the hospital were somewhat limited. For example, we discovered that nitrous oxide was not available in all of the operating rooms and scavenging capability was lacking in both of the rooms we worked in. Therefore, on days of the surgeries, it was not unusual for the anesthesia team to be sleepy by the afternoon. We also found an anesthesia machine donated by Englewood Hospital that was kept in storage for two years but was unusable due to a lack of parts (no oxygen sensor) and incompatible gas pipeline connections. Instead, we used the hospital’s own anesthesia machines, one of which was fairly new but programmed in Spanish. This required us to learn the various controls and what each of the alarms meant. It was challenging to adjust to the unfamiliar machines and to utilize the resources that we had, but it also made for a great learning experience. We also met some of the hospital’s nurses and anesthesiologists, who were all very welcoming and eager to offer their assistance and to observe us.

On the day of their scheduled surgery, the children were met in the holding area and re-evaluated. We were greeted with smiles, but we also sensed their nervousness. To help ease their anxiety, some of our team members played
games with them in the holding area. They also played interactive games on an iPad, brought by one of the team members, as they walked into the operating room. This was a great way to distract them as they entered an unfamiliar environment. We performed 50 surgeries over four days. These cases consisted of myringotomy tube placements, tonsillectomies, adenoidectomies, mastoidectomies, and tympanoplasties. The days were long but extremely rewarding. The wonderful feeling of helping others and seeing their appreciative faces made the long days worthwhile.

Our team of volunteers worked extremely well together and I learned that many of them had known each other from previous mission trips. It was evident how much all of the volunteers enjoyed taking time out of their lives to provide medical care to these children. The time I spent in La Romana confirmed my decision to pursue a fellowship in pediatric anesthesiology and reinforced my desire to take part in future medical missions. It was a truly wonderful and rewarding experience and one that will influence my future in pediatric anesthesiology. I hope to remember this mission as the first of many.

A Meaningful Experience

ILANA FROMER, M.D.

Healing the Children (HTC) conducts a yearly pediatric ENT mission to Centro Medico Hospital in La Romana, Dominican Republic. I participated in this mission trip in October 2013. Our team consisted of two pediatric ENT surgeons, one pediatrician, two physician anesthesiologists, one anesthesiology resident, two CRNAs, two PACU nurses, four OR nurses, and two administrators. Local high school students, as part of their community service requirement, acted as translators for members of the team who did not speak Spanish.

The first night we arrived in La Romana, I remember how anxious the team was about how many patients would be waiting in the clinic the next morning. “What if no one shows up?” people kept saying. Prior to our arrival, our host distributed fliers and information about the upcoming mission, but we had no idea what to expect.

On the first morning of our trip, those fears were quickly allayed, as there were so many families and children waiting to be seen there was not enough space for us to walk in through the normal entrance. The waiting room, among other rooms, was packed and the line of children and parents was so long that it went outside the hospital doors. More than 300 children
were waiting at the clinic to be seen. Most had arrived early in the morning, knowing they might have to wait all day. Everyone was unbelievably patient and, despite waiting several hours for their turn, thanked us profusely. These children have no regular access to care and this mission was their chance to have a doctor evaluate them and, if need be, to have surgery to correct their problems for free. The parents were grateful for the opportunity to have their children’s problems addressed despite the long wait.

In the clinic, the pediatrician and ENT doctors addressed medical as well as surgical problems. I was told that the number of children seen in the clinic that day broke all records from previous missions. Everyone on the team was excited and felt such a sense of accomplishment, and we hadn’t even started surgery yet! Either one of the ENT surgeons or the pediatrician saw all 300+ children, 50 of whom were scheduled for surgery during this mission. Due to the limited time and space for the mission, 40 children who were identified as needing surgery will have first priority for next year’s mission.

Once a child was identified as needing surgery, I performed an anesthesia preoperative evaluation along with the other anesthesia team members. After the child was deemed OK for surgery, a surgical date was assigned and instructions, written in Spanish, were given to the parents. These

The hospital’s anesthesia machines were programmed in Spanish.
instructions included NPO guidelines, medications the child needed to take, and when to come back for follow up. All the children scheduled for surgery were also required to undergo an evaluation by the hospital’s pediatric cardiologist and blood testing (CBC, electrolytes, HIV, HBV), an ECG, and a chest x-ray. The tests were done the same day as the clinic visit, but families had to return another day for the cardiologist appointment. None of the families complained about the multiple visits necessary or the waiting time inherent in all those visits. They were just grateful that their children were going to get much-needed surgery that they would not have received without our help.

We reviewed all the reports prior to the start of each surgery and the pediatrician reassessed each patient on the morning of surgery. Because of this extensive workup, we identified three children who were HIV positive and we had to inform the families of these findings. However, they were all healthy and we still were able to provide their much-needed surgeries by taking extra precautions. One child with Down syndrome had to be postponed because of an underlying cardiac defect that needed to be addressed prior to surgery.

Surgeries performed included, but were not limited to, mastoidectomies, adenoidectomies, reduction tonsillectomies, turbinate reductions, and frenulectomies. Every single patient showed up on his or her day of surgery and every single one was on time. There was not a single “no show” and there was not a single patient who did not follow the preoperative instructions!

Some members of the team had come on this ENT mission many times before and some members were new (like me). In a very short period of
time, everyone on the team worked efficiently together as if we worked together all the time. Everyone was eager to take care of as many children as possible, no matter how long it took; and we were extremely helpful to one another, making it a great working environment and a very positive experience for the patients and their families.

The week flew by way too fast and the 50 surgeries were completed without any complications. On a personal note, the mission was an especially meaningful experience for me. Not only was I able to visit a foreign country and help so many children, I also learned to broaden my own scope of practice by stepping outside of my comfort zone. I learned how to set up an OR in a completely foreign environment, including checking out an anesthesia machine that not only had I never seen or worked with before but also had all the instructions in Spanish. The first day was especially challenging, trying to get all the different monitors and equipment to function properly before we could safely start our cases for the day. I also learned how to gather information and evaluate patients with little or no medical history, medical knowledge, or previous access to healthcare. I can’t wait until I will be able to participate in another medical mission, which will have to wait until I finish my pediatric fellowship at Children’s National Medical Center in Washington, D.C. ■

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Melissa Lee, M.D., is a pediatric anesthesiology fellow at Columbia University Medical Center in New York.

Ilana Fromer, M.D., is a CA-3 resident at the Icahn School of Medicine at Mount Sinai in New York. As of July 2014, she will be starting a pediatric anesthesiology fellowship at Children’s National Medical Center in Washington, D.C.

To learn more about Healing the Children® New Jersey, Inc., go to www.htcnj.org.
Why Every Physician Should Learn From the Estate of James Gandolfini

MICHAEL J. SCHOPPMANN, ESQ.

Many of you know of James Gandolfini, who played Tony Soprano on HBO’s hit series “The Sopranos.” Mr. Gandolfini died unexpectedly of a heart attack at the age of 51 on June 19, 2013, leaving behind his second wife, Deborah; his 13-year-old son, Michael (from his first marriage); and his 9-month-old daughter, Liliana. Although he died with a Last Will and Testament dated December 19, 2012, Mr. Gandolfini, whose estate was estimated at $70 million at the time of his death, could have benefited from careful estate planning.

As physicians, it is unlikely that you will have an opportunity to play the role of a mob boss, as Mr. Gandolfini did, but it is highly likely that you own or may own valuable assets (e.g., medical practice(s), commercial real estate, domestic and/or foreign residential real estate, investment accounts, etc.), as Mr. Gandolfini did, and in light of your sizeable estate:

1. If you currently do not have an estate plan, it would be imprudent to assume you will have time during the twilight of your professional career (or even during retirement) to establish an estate plan; or

2. If you currently have an estate plan, the documents may be outdated or may not provide the appropriate estate tax savings as you may have hoped.

1. Brief Overview of Federal and State Estate Tax

Under current federal estate tax laws, if you die in 2014 with a gross estate in excess of $5.34 million, your estate may be subject to federal estate tax.

The New York state estate tax exemption for 2014 is $1 million, while the New Jersey state estate tax exemption for 2014 is $675,000.00. Thus, if you die in 2014 a resident of New York or New Jersey and your gross estate exceeds $1 million or $675,000.00, respectively, then your estate may be subject to state estate tax.

2. Consider a Revocable Living Trust to Ensure the Privacy of Your Testamentary Intentions

Mr. Gandolfini died with a Last Will and Testament (the “Will”), which, in New York state, was subject to probate (the judicial procedure by which a
testamentary document is established to be a valid Will) and open to public inspection. Once Mr. Gandolfini’s Will was probated by the New York County Surrogate’s Court on July 2, 2013, it was readily available to the public at no cost. Generally, Mr. Gandolfini’s Will had fairly simple provisions:

After giving $1.6 million to various friends and relatives and making provisions for his personal property and his house and land in Italy, Mr. Gandolfini split the remainder of his estate (the “estate residue”) among four beneficiaries:

- 30 percent to Sister #1
- 30 percent to Sister #2
- 20 percent to his wife, Deborah
- 20 percent to his daughter, Liliana

Mr. Gandolfini could have avoided publicizing his testamentary intentions by expressing such intentions under a Revocable Living Trust, which would have kept his affairs private and out of the court’s jurisdiction. Had Mr. Gandolfini used a Revocable Living Trust, no one would have known the intimate details of his financial affairs, the identity of the beneficiaries of his estate, or, most importantly, the nature and size of his estate assets.

3. Your Surviving Spouse Is Your Best Estate Tax Savings Tool

With respect to his wife, Deborah, Mr. Gandolfini failed to take advantage of the unlimited marital deduction, which is an estate preservation tool where assets can be distributed to a surviving spouse without incurring an estate or gift tax. Under the unlimited marital deduction, any and all assets distributed to a surviving spouse pass free of estate tax. In addition, any and all assets in an amount not exceeding the federal or state estate tax exemptions’ that pass to a non-spousal beneficiary/entity are exempt from federal and/or state estate tax, as the case may be, but any amount in excess of the said exemptions will trigger federal and/or state estate tax.

As mentioned above, Mr. Gandolfini bequeathed only 20 percent of the estate residue to Deborah. As a result, only 20 percent of the estate residue was shielded from estate tax liability by virtue of the unlimited marital deduction, while the remaining 80 percent of the estate residue plus the value of the tangible personal property and specifically devised real estate were subject to federal and New York state estate tax.

Taking into account the unlimited marital deduction, consider the following alternatives that Mr. Gandolfini could have incorporated into
his Will to avoid a high estate tax liability:

1. Name Deborah as the sole beneficiary of the Estate of James Gandolfini, of which the entire inheritance would then pass free of federal and New York state estate tax. 

2. Name Deborah as the sole beneficiary of the Estate but create a credit shelter trust (the “CST”) for the lifetime benefit of Deborah. The CST would hold an amount not to exceed either the federal or state estate tax exemption amount ($5.34 million or $1 million, respectively) so as to escape federal and/or New York state estate tax, as the case may be, and then the remaining balance of the estate would be distributed to Deborah outright, free of trust and free of estate tax.

3. Divide $5.34 million or $1 million of Mr. Gandolfini’s estate into four (4) shares, thereby escaping federal and/or state estate tax, as the case may be, to be distributed to his sisters and children, and then distribute the remaining balance of the estate to Deborah outright, free of trust and free of estate tax.

It should be noted that under the first two alternative methods above, the original beneficiaries would no longer directly share in the proceeds of the estate. Careful analysis should be conducted to ensure the sole beneficiary's prospective compliance with the wishes and desires of the deceased.

4. It Is Best to Assume the Worst of Your Children

Mr. Gandolfini considered the welfare of his children when he signed his Will. Although he devised his real estate to his son, Michael, and bequeathed 20 percent of the estate residue to his daughter, Liliana, his estate plan went one step further by placing these assets into trust for their respective benefit until they reached the responsible age of 21. While there are some children mature enough to manage money at the age of 21, given the size of Mr. Gandolfini’s estate, it might have been more prudent to place those assets in trust until they were older. For example, such a trust could have been drafted so that:

1. The trust income would be paid out to the children upon attaining the age of 21;

2. The trust principal would be available to the children immediately for their health, education, maintenance and support; and
3. The children would have the right to demand distribution of the trust principal in stages: for example, 10 percent of the trust principal at age 25, 25 percent of the then-balance at age 30, and the distribution of the remaining balance at age 35.6

Furthermore, in conjunction with establishing a trust for his children, Mr. Gandolfini could have used the trust as a training tool to teach his children how to be responsible with the trust assets, as each child could have been named a co-trustee of his/her trust at a particular age (25 years) and then ultimately become the sole trustee of the trust (30 years).

5. Be the Insured of Your Life Insurance Policy, Just Don’t Own It

It was discovered that Mr. Gandolfini had established an irrevocable life insurance trust (“ILIT”) for the benefit of his son, Michael. The ILIT was the owner of an insurance policy on Mr. Gandolfini’s life in the amount of $7 million, but the life insurance proceeds were not subject to federal and New York state estate tax. Whether or not an asset is subject to estate tax depends on whether such asset is in the name of the decedent, jointly or individually, at the time of the decedent’s death. In Mr. Gandolfini’s case, he was the insured of the $7 million life insurance policy, but the ILIT was the owner. As a result, $7 million of the Gross Estate of James Gandolfini escaped estate tax.

If you currently own a life insurance policy, consider creating an ILIT and transferring the policy to the ILIT. This will accomplish the following:

1. The owner of the life insurance policy will be the ILIT (not you), which means that on your death, the proceeds of the life insurance policy will not be included in your gross estate.

However, it should be noted that if you transfer a life insurance policy into an ILIT, such transfer is subject to a three-year look-back rule, which requires you to survive the transfer of the life insurance policy to the ILIT for three years; otherwise the proceeds of the life insurance policy are pulled back into your gross estate. One estate planning strategy to avoid being subject to the three-year look-back rule is to first create an ILIT and then have the ILIT purchase a life insurance policy on your life. In this case, since you would never have been the owner of the life insurance policy, the policy could never be subject to the three-year look-back rule.
2. The ILIT can be drafted to create trusts for the named beneficiaries (surviving spouse, children, etc.). In the case of your children, the life insurance policy proceeds can be held in trust up until a certain age (35 years or longer) or for the child’s lifetime.

Examine Your Plan

In reviewing the landscape of your estate plan, or possibly the lack thereof, we encourage you to consider the following issues:

1. **Make sure you have a Will or Revocable Living Trust.** This ensures that your assets are distributed to the beneficiaries of your intention (as opposed to distribution under the laws of intestacy). Furthermore, if you have minor children, the Will ensures that you have named someone as guardian to care for them should they be minors at the time of your and your surviving spouse’s deaths.

2. **The Will or Revocable Trust is not the only estate planning document to have in place.** The Will is virtually a useless document until you die. While you are alive, it is critical that you have the following documents in place:
   
   a. **Durable Power of Attorney:** This document names an agent who is authorized to take financial action on your behalf if you’re incapacitated.
   
   b. **Health Care Proxy:** This document names an agent who is authorized to make medical decisions on your behalf in the event you are unable to do so yourself.
   
   c. **Living Will:** This document names an agent who is authorized to enforce your wishes with respect to life-preserving treatment.

The failure to have these documents in place may result in long and expensive court battles necessary to appoint an agent and, more ominously, the potential for irreparable damage to family relationships.

Kern Augustine Conroy & Schoppmann, 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, Florida, Pennsylvania and Illinois and can be found on the Web at www.drlaw.com. Mr. Schoppmann may be contacted at 800-445-0954 or via email at mschoppmann@drlaw.com.

(See Notes on page 26.)
NOTES

1. $5.25 million (adjusted for inflation).

2. Gov. Andrew Cuomo has introduced a proposed change to the New York state’s 2014-2015 budget, calling for the increase of the New York state estate tax exemption over a four-year period from $1 million to $5.25 million (adjusted for inflation), where by 2019, the New York state estate tax exemption is to be in conformity with the federal estate tax exemption (currently $5.34 million). In conjunction with this, the top New York state estate tax rate will be gradually reduced from 16 percent to 10 percent over the same four-year period. In addition, the New York generation skipping transfer tax enacted in 1999 will be repealed. More significantly, the 2014-2015 budget proposal calls for the adding back into the New York gross estate the value of any lifetime taxable gifts made by a New York resident decedent after March 31, 2014. The addition to the gross estate of taxable gifts made during the lifetime of a New York resident decedent will increase the state estate tax due.

3. In addition to the New Jersey state estate tax, it should be noted that New Jersey also imposes an inheritance tax, a tax which is based upon the relationship of the beneficiary to the decedent. Thus, even if a decedent of New Jersey dies with a gross estate not exceeding $675,000.00, the decedent’s estate may nevertheless be subject to inheritance tax if a beneficiary of the estate is either a Class “B,” Class “C” or Class “D” beneficiary. See N.J.A.C. Sec. 18:26-2.1 et seq.

4. Federal estate tax exemption: $5.34 million; New York state estate tax exemption: $1 million; New Jersey estate tax exemption: $675,000.00.

5. It should be noted that any and all assets Deborah inherits under any variation of Mr. Gandolfini’s Will, and thereafter owns upon her death, would then be subject to federal and state estate tax.

6. Such distributions may be delayed, at the discretion of the trustee, if the child has marital issues, drug/alcohol abuse issues, creditor issues, and overall immaturity. In such cases, you may consider drafting the trust so that your child’s inheritance is held in trust for the child’s lifetime.
On March 23, 2010, President Barack Obama signed the Affordable Care Act. This legislation mandates reforms aimed at improving medical quality and lowering costs by integrating health systems to reduce administrative costs and paperwork. Some of these reforms went into effect on October 1, 2012, with plans for full implementation of electronic medical record (EMR) technology by 2015.

I remember the first time an EMR system was implemented at my hospital. I was a fourth-year medical student. The first day was quite chaotic and I remember my resident being frustrated that his orders were lost in the EMR system.

Flash forward two years, and the hospital where I am now in residency is implementing an EMR system. There was so much to do prior to the electronic system going live. Physicians, nurses, and all staff involved in patient care were required to be trained months in advance. Support systems, both over the phone and in-house “tech” help, were made available. Each week prior to the system going live we received a countdown on what to expect. Finally, when March 1, 2014, arrived, going to work seemed different. I thought to myself, “I don’t have to run around for the patient’s chart anymore.” However, a little anxiety started to settle in as I recalled what happened as a fourth-year medical student. I wondered, “What happens if the nurses don’t get my orders, or the orders somehow disappear?” To my surprise, there was a tremendous amount of support and teamwork. Yes, there were some grumblings about schedule changes for our EMR training, but in the end it was worth it. We are now two months into the new EMR system and I am starting to appreciate it. Patient information is centralized and communication between specialties is more efficient and streamlined. Of course, there are inherent issues with this new system that still must be addressed at our hospital, including improvement of healthcare, patient satisfaction, provider efficiency and cost effectiveness.

So what is the next step? As an anesthesia resident, I am looking forward to the implementation of an anesthesia information management system
(AIMS) in the next few years. We have to take some time from our busy schedules to learn yet another system; however, it is estimated that by the end of 2014, 75 percent of academic anesthesia programs will implement AIMS.¹ Some of the features of AIMS that anesthesiologists require are integration with their current EMR and documentation of workflow through the various operative stages.² As we progress through our residency, new technology will inevitably be incorporated wherever we may work and will be a part of patient care. Instead of approaching a new system with trepidation and uncertainty, we should have an open yet critical mind to embracing it. ■

REFERENCES

68th PGA Scientific Exhibits Poster Presentations Medically Challenging Case Reports

If you are interested in submitting applications to exhibit your projects at the upcoming 68th PostGraduate Assembly in Anesthesiology — December 12-16, 2014, please visit the NYSSA website for instructions to submit online:

Go to www.nyssa-pga.org and click on PGA Meeting.

Deadline for filing is August 15, 2014.

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www.anesthesiology2014.org
Out-of-Network Hearing in Albany

(Back, left to right) Dr. Michael Duffy, Pat Clancy (MSSNY) and Bob Reid

Sens. James Seward, Kemp Hannon and Greg Ball listen to testimony at the out-of-network hearing.
(Back) Drs. David Wlody and Lawrence Epstein

Drs. Michael Simon and Lawrence Epstein meet with staff members from state Sen. Catharine Young’s office.

(Left to right) Drs. David Wlody, Jana Janco, Scott Plotkin, Rose Berkun and Scott Groudine, Assemblyman Phil Steck, and Dr. Michael Simon
The California Society of Anesthesiologists (CSA) Annual Meeting

Dr. Lawrence Epstein with CSA’s Drs. Adrian Gelb (left), Mark Rollins, and Peter Sybert

Dr. Lawrence Epstein with CSA’s Drs. Adrian Gelb (left), Mark Rollins, and Peter Sybert
NYSSA Around the World

The PGA was promoted at the 14th Asian Australasian Congress of Anaesthesiologists combined with the 4th Australasian Symposium on Ultrasound and Regional Anaesthesia in Auckland, New Zealand.

The PGA was promoted at the SAMBA 29th Annual Meeting in Baltimore, Maryland.
Medical Society of the State of New York (MSSNY) House of Delegates Meeting

Dr. Rose Berkun and Stuart Hayman

Drs. Michael Duffy and Lawrence Epstein

Drs. Lawrence Routenberg and Rose Berkun
AAA Legislative Day in Albany

Jet Toney, executive director of AAAA (left), shakes hands with Franklin Esson from state Sen. Kenneth LaValle’s office.

Physicians and anesthesia assistants meet with Assemblywoman Ellen Jaffee.

MSSNY Legislative Day in Albany

Dr. Michael Duffy, Sen. Catharine Young, Dr. Lawrence Epstein and Dr. Michael Simon
Highlights of the ASA Legislative Conference

Drs. Andrew Rosenberg, Bruce Hammerschlag, Alan Strobel, Lawrence Epstein, Salvatore Vitale, Jonathan Gal and David Bronheim meet with Colleen Ramsey Nguyen from Congressman Steve Israel’s office.

Drs. Michael Duffy and Michael Nayshtut

Dr. Scott Plotkin and Stuart Hayman

Drs. Chris Curatolo, Bruce Hammerschlag and Alan Strobel

Drs. Paul Willoughby, Lawrence Epstein, Steven Hattamer and Salvatore Vitale
(Left to right) Drs. Iyabo Muse, Vilma Joseph, Chris Curatolo and Jonathan Gal meet with Carl Nicholas from Congressman Charles Rangel’s office.

Drs. Chris Curatolo, Lawrence Epstein and Jonathan Gal meet with Catherine Barnao from Congressman Eliot Engel’s office.

Drs. Tripti Kataria, Michael Simon and Rose Berkun

Andrew Tantillo (second from left) from Congressman Brian Higgins’ office meets with Drs. Michael Duffy, Rose Berkun and Scott Plotkin.

(From left) Drs. Lawrence Epstein, Andrew Rosenberg, Jonathan Gal, Michael Duffy, David Bronheim, Chris Curatolo, and Salvatore Vitale meet with Elizabeth Darnall from Congresswoman Carolyn Maloney’s office.

Drs. Michael Simon, Lawrence Epstein, Michael Duffy, David Bronheim and Andrew Rosenberg meet with Morgan Brand from Sen. Charles Schumer’s office.
NYSSA’s Annual Legislative Day in Albany

(Left to right) Drs. Richard Dunn and Michael Duffy, Sen. John DeFrancisco, and Drs. Lawrence Epstein and Jesus Calimlim

Dr. Lawrence Epstein with Sen. George Latimer (center) and Dr. Roland Rizzi

Drs. Michael Duffy (left) and David Wlody (right) meet with a member of Assemblywoman Deborah Glick’s staff.
Dr. Lawrence Epstein speaks about the medical I.D. bill at a press conference.

(Left to right) Dr. Salvatore Vitale, Sen. Dean Skelos, and Drs. Lawrence Epstein and Alan Curle

(Left to right) Drs. Michael Nguyen, Joshua Heller, Jonathan Gal, Christopher Curatolo, and Shawn Sikka
The New York State Society of Anesthesiologists, Inc.

Joseph P. Giffin

Wall of Distinction Award

The House of Delegates of the New York State Society of Anesthesiologists will bestow The Joseph P. Giffin Wall of Distinction Award on an outstanding member of our Society. The award recognizes significant contributions to anesthesiology and the NYSSA.

As outlined in the NYSSA Bylaws:
1. The recipient must be an anesthesiologist who had been an active member in good standing of the NYSSA for a minimum of 10 years.
2. The recipient must have provided significant service to the NYSSA by playing an active role in anesthesia education and/or an active leadership role in the NYSSA.
3. The Wall of Distinction award can only be conferred posthumously and is not required to be awarded annually.

Any member of the NYSSA may submit a nomination. There is no nominating form. We request only a letter from you indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. If available, the candidate’s current curriculum vitae should also be included. Please send your nomination to Salvatore G. Vitale, M.D., at NYSSA headquarters before July 15, 2014.

Only by your active participation in the nominating process can we be assured that the most deserving will receive their due consideration.

Salvatore G. Vitale, M.D., Chair
NYSSA Judicial and Awards Committee
Virtual Practice With Regional Anesthesia: An iPad App Review

MARK JENSEN, M.D.

Application Name: GuRU – Guidance for Regional Anaesthesia using Ultrasound

Cost: $9.99

Developer: University Hospitals Birmingham NHS Foundation Trust

Review: While there are many apps that try to teach regional anesthesia, this one is by far the best, and it is worth the $10 investment. Learning could not be easier than watching the videos about each of the 11 standard blocks. These clips narrate how to perform each block in a step-by-step style that is easy to follow. They start with the proper positioning of the patient, progress into how to identify the relevant anatomy with the ultrasound probe, and then describe where to inject the local anesthetic.

The video clips are valuable because they divide the screen into three sections. The first is the ultrasound image, the second is a 3D construction of the anatomy, and the third is the skin level of the person performing the block. The three screens run together, so it is easy to see the needle advance in the skin, the anatomical view, and the ultrasound image all at the same time.

The app also has a didactics section with tips for each block as well as important things to avoid.

Bottom Line: This app is a quick way to develop a deeper understanding of the process underlying regional anesthesia. It could be improved with videos of failed blocks or maybe by being more interactive and having
the user identify the anatomy and then decide where to put the local anesthetic. Nevertheless, this app is a great guide for residents and a smart supplement to clinical instruction.

GuRU can be downloaded from the iTunes store.

*Mark Jensen, M.D., is a CA-1 resident at SUNY Downstate.*

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**Have You Visited the NYSSA Website Lately?**

The NYSSA has launched a more user-friendly website that contains easy-to-access links to the information and resources you need.

Check it out at [www.nyssa-pga.org](http://www.nyssa-pga.org).
Legislative Update

CHARLES J. ASSINI, JR., ESQ.

On Saturday, March 29, 2014, Gov. Cuomo and legislative leaders announced a three-way state budget agreement for the 2014-15 fiscal year. Below is a summary by Reid, McNally & Savage, LLC (NYSSA’s Albany lobbyists) of two items of interest to anesthesiologists: insurance coverage of out-of-network (OON) services and the nurse practitioner (NP) law.

Insurance Coverage of Out-of-Network Services

The final state budget contained a provision to regulate out-of-network services, including billing, reimbursement and consumer disclosure for healthcare services provided to patients by “out-of-network” healthcare providers who do not participate in a patient’s health insurance plan. Key provisions of the bill are provided below.

New Consumer Protections

- The bill affords patients enrolled in all health insurance products the right to access out-of-network healthcare providers at no additional cost to the patient if the insurer does not have an in-network provider with the appropriate training and experience to meet the healthcare needs of the patient. (Currently, only those enrolled in HMOs have this right.)
- A new right is established for a patient to file an appeal through the independent external appeals process when an insurance company denies a patient request to receive services from an out-of-network provider.
- Insurance companies, healthcare professionals, hospitals and other healthcare facilities are required to disclose significant information to patients so that they can determine how insurance companies calculate rates, whether a healthcare provider is in their insurance company’s network and, if not, what the patient will be billed for the services. Disclosures to consumers are covered in more detail below.

Out-of-Network Rates and Adequacy

- Usual and customary cost (UCR) is defined as the 80th percentile of all charges for health services performed by a provider in the same or similar specialty and provided in the same geographic area as reported by a benchmarking database maintained by a nonprofit organization specified by the Department of Financial Services (DFS) superintendent. (This is understood to mean FAIR Health).
• Insurers that issue a comprehensive group or group remittance policy for out-of-network coverage must “make available” at least one policy that provides coverage of at least 80 percent of the UCR.

• All insurance products, not just HMOs, are required to have adequate networks.

Disclosures by Insurers

Insurers are required to:

• Provide to enrollees a listing of languages spoken and affiliation with participating hospitals on the insurance plan’s website.

• When a policy offers out-of-network coverage, provide patients with a clear description of the methodology used to determine reimbursement for out-of-network healthcare services, a description of the amount that the insurer will reimburse under the methodology, information on patient out-of-pocket costs, and whether a healthcare provider scheduled to provide services is an in-network provider.

Disclosures by Healthcare Professionals, Group Practices, Diagnostic & Treatment Centers (D&TC) and Health Centers

• Healthcare professionals (any licensed, registered or certified professional under Title VIII of the Education Law), group practices, D&TCs and health centers are required to disclose to patients or prospective patients in writing or via a website the healthcare plans and hospitals which the entity participates in or is affiliated with.

• If a healthcare professional, group practice, D&TC, or health center does not participate in the network of a patient or prospective patient’s plan, they must, prior to the provision of non-emergency care, inform the patient or prospective patient that the amount or estimated amount to be billed is available upon request. If the patient or prospective patient makes a request, the healthcare practitioner, group or facility must provide the information in writing.

• Physicians are required to provide the name, practice name, address and phone number of any providers of anesthesia, laboratory, pathology, radiology or assistant surgeon services for services performed in the physician’s office or coordinated or referred by the physician.

• Physicians are required, for a patient’s scheduled hospital admission or scheduled outpatient services, to provide a patient and the hospital with the name, practice name, address and phone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or
admission, and information as to how to determine the healthcare plans in which the physician participates.

**Disclosures by Hospitals**

**Hospitals are required to:**

- Post on their websites the healthcare plans in which the hospital is a participating provider;
- Post a statement that: physician services provided in the hospital are not included in the hospital's charges; physicians who provide services in the hospital may or may not participate with the same healthcare plans as the hospital; and the prospective patient should check with the physician arranging for the hospital services to determine the healthcare plans in which the physician participates.
- As applicable, provide the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions on how to contact these groups to determine the healthcare plans in which they participate.
- As applicable, provide the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the healthcare plans in which they participate.

**Independent Dispute Resolution for Emergency Services and Surprise Bills**

- Excluded from the independent dispute resolution process are specific emergency services CPT codes in which the amount billed is under $600 (annually adjusted for inflation) and the amount does not exceed 120 percent of UCR (the 80th percentile of Fair Health).
- A non-participating physician or healthcare plan may submit a dispute regarding a fee to an independent dispute resolution entity (IDRE) for emergency services and for “surprise bills” for non-emergency services provided in a hospital or ambulatory surgery center.
- An uninsured patient may submit a dispute if they have not received all of the required disclosures under the law in a timely fashion.
- The IDRE must select either the physician’s charges or the insurer’s payment based on the following criteria:
  - whether there is a gross disparity between the fee charged by the physician as compared to their usual charges for the same
services when the physician is not participating in a healthcare plan;

- whether there is a gross disparity between the fee paid by the healthcare plan to reimburse similarly qualified providers for the same services in the same geographical region who are not participating with the healthcare plan;
- individual patient characteristics;
- the level of training, education and experience of the physician;
- the circumstances and complexity of the case; and
- the usual and customary cost of the service (defined as 80th percentile of Fair Health).

- In instances where the IDRE disagrees with both the physician’s fee and the insurer’s payment, the reviewer would be permitted to ask the parties to negotiate a fee.
- All decisions by the IDRE are required within 30 days.
- The IDRE is required to use licensed physicians in active practice in the same or similar specialty as the physician subject to review. To the extent practicable, the physician must be licensed in this state.
- The losing party pays for the dispute resolution process, except in the case where a healthcare plan and a physician reach a settlement after being directed to negotiate by the IDRE, in which case responsibility for payment is evenly divided between the healthcare plan and the physician.
- When the IDRE rules in favor of a physician for a dispute brought by an uninsured patient, payment shall be the responsibility of the patient unless the superintendent determines that this would pose a hardship to the patient.

**Out-of-Network Work Group**

A nine-member work group is established and appointed by the governor with recommendations from the Legislature. The superintendent of the Department of Financial Services and the commissioner of the Department of Health will serve as co-chairpersons. The work group is charged with reviewing current out-of-network rates and coverage and making recommendations to the governor and the Legislature no later than January 1, 2016.

**Modification to Nurse Practitioner Law in New York State**

- Allows for nurse practitioners (NPs) practicing for more than 3,600
hours to have a collaborative “relationship,” versus a “written agreement,” with one or more physicians qualified to collaborate in the specialty involved, or with a hospital that provides services through licensed physicians in the specialty involved and having privileges at such institution.

- States that NPs electing to have such collaborative relationships would be required to complete and maintain a form created by the Education Department describing these relationships. Collaborative relationships shall mean that the NP shall communicate with a licensed physician to exchange information to provide comprehensive patient information and make referrals as necessary. The form shall also reflect the NP’s acknowledgment that if reasonable efforts are made to resolve any dispute that arises with the collaborating physician about a patient’s care and they are unsuccessful, the recommendation of the physician shall prevail. Failure to comply with all such requirements would subject the NP to a charge of professional misconduct.

- Rejects the executive budget proposal to allow an NP to collaborate with another NP with more than 3,600 hours of experience, under certain circumstances.

- States that as a condition of each triennial registration, the Education Department shall collect information from the NP as required to evaluate access to needed services, determine which NPs are practicing with a written agreement, which are practicing with a collaborative relationship, and other information deemed relevant. The commissioners are required to issue a report based on these findings and any recommendations by September 1, 2018.

- States that these changes shall take effect January 1, 2015, and shall expire June 30, 2021.


The U.S. Department of Health and Human Services OIG Work Plan for 2014 contains the following for the focus on anesthesia services (page 16):

**Anesthesia Services — Payments for Personally Performed Services**

Billing and Payments. We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesiologist services reported on a claim with the “AA” service code modifier met Medicare requirements. Context — Physicians report the appropriate anesthesia modifier code to denote whether
the service was personally performed or medically directed. (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, ch.12, § 50) Reporting an incorrect modifier on the claim as if services were personally performed when they were not will result in Medicare paying a higher amount. The service code “AA” modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the QK modifier limits payment to 50 percent of the Medicare-allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, §1833(e).) (OAS; W-00-13-35706; various reviews; expected issue date: FY 2014; new start)

If you receive any information that your claims may be under HHS OIG review, please contact: Sharon K. Merrick, M.S., CCS-P, director of payment and practice management, American Society of Anesthesiologists; s.merrick@asahq.org; phone 202-289-2222.

**New Interim New York State Commissioner of Health**

As of the writing of this article, Howard A. Zucker, M.D., first deputy commissioner of health, will be appointed as the new interim commissioner of health. Dr. Zucker is a professor of clinical anesthesiology at Albert Einstein College of Medicine of Yeshiva University and a pediatric cardiac anesthesiologist at Montefiore Medical Center in the Bronx; and he is a member of the NYSSA and the ASA.
Abstract
A 38-year-old male assault victim with extensive neck swelling and multiple head and facial fractures was intubated in the field by EMS. Further workup in the hospital revealed an aspirated large central incisor embedded in the right middle/lower lobe (RML/RLL) bifurcation. After medical stabilization, the cardiothoracic surgeons made several unsuccessful attempts to remove the tooth bronchoscopically at the patient’s bedside. It was then decided to proceed to the operating room to exchange his 7.5 mm ETT with a 9.0 mm ETT, which was performed without incident. Subsequent attempts at removal of the tooth with a fiberoptic bronchoscope remained unsuccessful, and resulted in breakage into two asymmetric fragments that migrated deeper into the lungs. We discuss the airway management considerations of foreign body aspiration in an intubated trauma patient.

Introduction
Foreign body aspiration, particularly of a tooth, is a rare but serious complication in trauma patients. More importantly, prompt diagnosis and treatment is crucial in the unconscious patient because delayed diagnosis could lead to acute respiratory failure and death. In cases where a patent and secure airway already exists, the clinical dilemma presented is, what degree of airway compromise is permissible in the presence of a large bronchial obstruction by a foreign body?

Case Report
A 38-year-old male was admitted to the hospital following an assault, with an unknown mechanism of injury. He was found lying supine in the street with severe facial trauma. Initial assessment by EMS revealed him to be unresponsive and smelling of alcohol and marijuana; the patient was intubated on site and transported to the nearest trauma center (Bellevue Hospital) for further management.
In the Emergency Department, examination revealed that the patient had active facial bleeding with significant periorbital, perioral, and neck ecchymosis/edema; initial FAST evaluation was negative. A chest x-ray revealed a 1.5 cm foreign body lodged in the right lower lobe. CT scans demonstrated a transverse fracture of the left mandibular angle, a comminuted depressed fracture of the mandibular symphysis, a fracture of the posterior wall of the left maxillary sinus, and a left nasal bone fracture. Scans also confirmed the foreign body at the RML/RLL carina, likely an aspirated tooth. The cardiothoracic (CT) surgeons were notified and, after medical stabilization, the patient was transferred to the SICU for close hemodynamic monitoring with a radial arterial line, Foley catheter, and orogastric tube in place.

In the SICU, several attempts at bronchoscopic tooth removal by the cardiothoracic surgeons were unsuccessful. The tooth was too large to pass through the 7.5 mm ETT lumen, and the decision was made to proceed to the operating room for exchange with a 9.0 mm ETT.

Preoperative airway evaluation demonstrated an intubated male with significant facial edema, a thick swollen neck with a Miami-J collar in place, bloody lips, some avulsed teeth, poor mouth opening (limited by mental status), and moderate dried blood in oropharynx. The case was reviewed among the anesthesiology staff, and several options were discussed.

Given the mandibular fracture, a Glidescope® was used to visualize the airway and verify ETT placement; a grade II view was obtained. A Cook® airway exchange catheter was then used to exchange the endotracheal tube without incident. Direct visualization was maintained throughout with the Glidescope. The surgeons then proceeded to flexible bronchoscopy for extraction of the tooth. Several attempts with rat-tooth grasping forceps were only partly successful (see image series). A wire basket also proved unsuccessful. Among the problems encountered were: 1) the tooth repeatedly caught on the Murphy hole; 2) the tooth was secured, but could not be pulled through the length of the tube as the lumen was barely large enough; 3) developing endobronchial secretions plus wearing away of the tooth enamel made grasping it difficult. Care was taken not to advance the specimen further into the bronchus; however, the tooth broke in two distinct pieces, and one piece migrated deeper. A final attempt at extraction using flexible bronchoscopy and a snare was ultimately successful, with no residual foreign body in the lung.
Discussion

From the very beginning, the approach determined which subsequent steps would be taken. Option A was to remove the ETT in order to perform a rigid bronchoscopy, with ventilation through the side port. Rigid bronchoscopy has been traditionally used for removal of foreign bodies (FB) from the trachea or bronchus, particularly in the pediatric population. In certain circumstances (i.e., severe maxillofacial trauma or cervical spine injury) use of a rigid bronchoscope may exacerbate the underlying injury and thus is contraindicated. In this case, given the possibility of tracheobronchial damage and the existing ETT, along with the presence of a cervical spine immobilization collar, this option was dismissed.

Alternatively, fiberoptic bronchoscopy (FOB) may be useful for retrieval of foreign bodies embedded within a bronchus. The fiberoptic retrieval technique, using a video display and intermittent ventilation during pauses in the extraction, poses several challenges. These include the inability to adequately grasp the FB, the FB being too large to pass through the endotracheal tube, and the depth at which the FB is lodged in the bronchial tree. Previous reports of fiberoptic FB retrieval include the use of a Fogarty catheter, endoscopic forceps, a basket, and dual FOB/endotracheal tubes. In the case of the Fogarty catheter, the balloon is advanced past the foreign body, then inflated and retracted along with the FB. This method incurs the risk of traumatizing the tracheobronchial tree. A basket can be too small to grasp and remove the foreign body. Furthermore, even after proper securing of the object there still may be considerable difficulty in removing it through the endotracheal tube. In our case, extraction attempts were unsuccessful because the tooth was caught in the tube; hence one option would have been to remove both the tooth and tube together, with subsequent direct laryngoscopy and ETT insertion. This obviously may compromise the airway, and the risks and benefits of this maneuver should be weighed. With the dual intubation method, two tracheal tubes are inserted with fiberoptic bronchoscopy, followed by FB removal with one tube while the other remains in place as a definitive airway.

A more extreme retrieval strategy employs tracheotomy and tube placement with or without orotracheal intubation. This method permits removal of the FB with basket or forceps either through or with the tracheal tube. This approach also poses several challenges, including difficulty in grasping a “slippery” object, poor visibility, and the chance of
losing the airway once the tracheal tube is removed. Nonetheless, combining a tracheotomy with proximal endotracheal intubation may provide the safest option for retrieval by ensuring a secure airway, minimizing tracheobronchial trauma, minimizing any leak during ventilation, and permitting use of a larger instrument than can be inserted through a fiberoptic scope.

A truly definitive approach would be placement of a double lumen tube with video-assisted thoracoscopic surgery (VATS)/open lung resection; this has been reported as a salvage measure in some situations, although it has been rarely used.7

Images

1.5 cm incisor lodged at RML/RLL carina

Attempted extraction – grasping

Splitting of tooth; 2nd fragment migration

Final specimen
REFERENCES


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