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On the cover:
Doctors and staff at Dareda Hospital in Tanzania perform
an emergency laparotomy for bowel obstruction
secondary to sigmoid volvulous.

Cover photo courtesy of Jerry Chao, M.D.
President’s Message

Back From New Orleans

LAWRENCE J. EPSTEIN, M.D.

Your NYSSA leadership recently returned from a successful ASA annual meeting. The NYSSA’s ASA delegation is made up of officers and the Board of Directors. Your delegates were very active and visible at this year’s annual meeting in New Orleans. Our delegates were vocal leaders at the Mid-Atlantic Caucus, reference committees, and at the House of Delegates. We had a very strong presence on the Professional Affairs Reference Committee (me) as well as the Finance Reference Committee (Immediate Past President Michael Simon, M.D.). In addition, our ASA director, Scott Groudine, M.D., serves as the chair of the Section on Clinical Care. Essentially, we have members serving on virtually every committee of the ASA. I am also excited to report that our PGA general chair and ASA alternate director, David Wlody, M.D., was selected to chair the ASA’s annual meeting in 2017. I want to thank everyone who participated in all delegation activities. I would especially like to thank two of our alternate delegates, Drs. Salvatore Vitale (NYSSA past president) and Elizabeth Mahoney, both of whom were “seated” as voting members at various points during the House of Delegates.

Your leadership continues to work hard at the ASA annual meeting to forge stronger ties and build our relationships. For many years, the NYSSA officers have held a joint networking event with the California Society of Anesthesiologists. This was our year to host the event and it was well attended by members from both states. In an effort to build on this annual event and strengthen our relationships with other components, we held similar events with the Florida and Illinois societies this year. These three events were great opportunities for the delegations to get to know one another. Hopefully, these bonds will become mutually beneficial as our members run for ASA office in the coming years.

The NYSSA’s October Board of Directors meeting was held in New Orleans. At the meeting, I nominated and the Board approved the next Board of Directors of the Anesthesiology Foundation of New York (AFNY). AFNY was created during the presidency of Dr. Paul Willoughby to further the mission of the NYSSA while providing a vehicle for people to make tax-deductible contributions. The current AFNY BOD now consists
of the following physicians: Paul Willoughby, Kathleen O’Leary, Salvatore Vitale, Lawrence Epstein, Elizabeth Frost, Vilma Joseph, Rose Ber kun, Andrew Rosenberg, Michael Duffy, Alan Curle, Rebecca Twersky, David Bronheim, David Wlody, Irene Osborn, Michael Simon, Cheryl Gooden, Ingrid Hollinger, Jason Lok and Richard Wissler. The new AFNY BOD met two times during the week to elect officers and approve bylaws revisions. These actions were taken in order to strengthen the oversight of the Foundation and help ensure that future donations are used in a manner consistent with the organization’s overall mission.

This time of year is always busy and filled with anticipation as we prepare for the upcoming PGA. As always, Drs. David Wlody (PGA general chair) and Richard Beers (PGA scientific chair) have worked tirelessly over the past year to make sure that we continue to stage one of the world’s finest anesthesiology meetings. Each year, our team works hard to refine our educational offerings in order to bring our attendees the most current information, presented by the world’s thought leaders, many of whom come from New York. I am happy to report that the featured speaker at this year’s Current Issues Forum will be New York State Commissioner of Health Dr. Howard Zucker. Dr. Zucker is one of our own, an anesthesiologist and a long-time member of the NYSSA. This will be an excellent opportunity to hear the “state of the state” (health system) from a familiar perspective. New for this year, the PGA will open with the Thoracic Anesthesia Symposium, chaired by Dr. Eddie Cohen, which will be held on Thursday and Friday. These sessions will provide a comprehensive syllabus, focusing on anesthesia for thoracic surgery.

By the time you read this article, we will have newly constituted federal, state and local governments. Whatever their compositions, we need to continue to strengthen alliances and forge new relationships. We must work hard to ensure that the vital work done by ASA and NYSSA members every day in operating rooms, ambulatory surgery centers, offices, pain management practices, and an expanding list of anesthetizing locations is well understood and respected in Albany and Washington, D.C. We continue to face challenges relating to issues such as scope of practice and reimbursement, as well as the subjective mechanisms used to create and modify the value of our services. It is imperative that we have a voice in Albany and Washington; in order for that voice to be heard, we must have strong political action committees. Simply put, NYAPAC and ASAPAC are only as strong as the sum of our contributions. While New York had a record year with ASAPAC contributions just under $100,000, we still only came in fifth in the
nation, with Florida winning the coveted “Alabama Cup.” In fact, states with just 10 percent of our membership numbers raised almost twice as much money! We set a record in New York with only 20 percent of our members contributing to ASAPAC. If we could double our participation, we could bring the Alabama Cup to a new home in New York. There is no reasonable excuse for any anesthesiologist not to contribute to both NYAPAC and ASAPAC. To those members who have already donated, thank you! I ask that you aggressively solicit your colleagues who have not yet contributed (the ASAPAC list is available in the “Members Only” section of the ASA website). As Benjamin Franklin said, “We must all hang together, or most assuredly we will all hang separately.”

I want to take this opportunity to wish all of you a happy and healthy holiday season and a very happy New Year. It has truly been an honor and a privilege to serve my colleagues and the members of the NYSSA. I will always look back on the year I spent as president of our organization with humble gratitude.

You Can Make a Difference

In keeping with its mission, AFNY provides PGA-related scholarships to the most enthusiastic and dedicated anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. During the past 20 years, more than 320 anesthesiologists representing 58 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

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

Visit http://nyanesthesiologyfoundation.org and make your donation today.
Join ASA® and Advocate for Your Specialty and Patient-Centered, Physician-Led Care

Alert policymakers, the media and the public that

WHEN SECONDS COUNT...PHYSICIAN ANESTHESIOLOGISTS SAVE LIVES.™

We ensure safe, high-quality care. Our patients deserve no less. Let's make sure everyone knows it.
Mark your calendar for January 11-17, 2015, the ASA's inaugural Physician Anesthesiologists Week. This event was announced during the annual ASA meeting in New Orleans. The goal of the campaign is to educate policymakers, the media, and the public about the fact that “when seconds count, physician anesthesiologists save lives.” During this week, we are encouraged to advocate for our specialty and for patient-centered, physician-led care. More details can be found in the ASA’s article in this issue of Sphere.

ASA members who visit asahq.org/WhenSecondsCount will find a comprehensive toolkit created to help you make the most of this advocacy and public outreach opportunity. The When Seconds Count™ advocacy toolkit includes background on this campaign and members can access downloadable advocacy materials such as message maps, a policymaker brochure, frequently asked questions, and fact sheets detailing the education and training differences between physician anesthesiologists and nurse anesthetists, as well as the potential cost savings when patients receive physician-led anesthesia care. The ASA will also host a webinar in early December to further our efforts.

Personally, I recommend focusing each day of the week on different aspects of anesthesiology: general, pediatric, obstetric, geriatric, critical care, pain medicine, regional, etc.

On a different note, kudos to Drs. Kiri Mackersey and Alexander Nacht for their recent feature article on Bellevue Hospital. Their article caught the eye of the editorial director of Anesthesiology News and will be reprinted in that publication. This is a great opportunity to expand our readership to the non-NYSSA anesthesia community as Sphere, the NYSSA, Bellevue Hospital, and our well-deserving authors get national attention.

In this issue of Sphere you will find a new “Resident and Fellow Section,” with an introduction by our resident editor, Dr. Vanessa Hoy. Two NYSSA residents have started a resident-focused career/political newsletter and we wanted to share their first three editions with all NYSSA members.
We think you will be impressed by this grassroots effort by our upcoming leaders.

New ideas for *Sphere* will be discussed at the Communications Committee meeting that will be held during the 2014 PGA. One potential new idea involves showcasing prominent past or present NYSSA members. Other ideas previously considered include highlighting the pros and cons of anesthesia-related issues, current technology for practicing anesthesiologists, pearls of wisdom or practice tips, and puzzles. We continue to encourage submissions of case reports, clinical reviews, and book reviews. At present, we have not yet received any personal interest stories. Please consider sharing your experiences with your fellow members. While the Communications Committee will be discussing the future of *Sphere* by brainstorming new ideas to make the publication more relevant, informative and enjoyable to our membership, your additional suggestions and assistance are always welcome. Please contact me at jlokmd@yahoo.com or Stuart Hayman at stuart@nyssa-pga.org. Thank you in advance for your interest and consideration.

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**CME corner**

**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](http://www.nyssa-pga.org) to learn more.
As I have often done during my six-year tenure at the NYSSA, I am utilizing this issue of Sphere to provide the membership with an abbreviated synopsis of my annual report. We have accomplished a great deal these last six years, including the purchase of our new headquarters, the profitable sale of our previous office space, and success in a variety of socioeconomic and legislative campaigns. I sincerely appreciate the confidence and support I have received from the NYSSA leadership and members during my tenure.

The NYSSA’s legislative efforts continue to be extremely well organized and effective. This past year we put forth one of our more proactive efforts. Clearly, teamwork is an essential component of success; this is especially true with regard to our legislative work in Albany. This year, the dedicated, coordinated efforts of the NYSSA’s physician volunteers, staff and consultants were exceptional. I want to thank all of you for staying engaged and resolute.

Over the course of the last 12 months the NYSSA’s reserve funds continued to grow, providing the organization with a stronger balance sheet. Clearly, this is a testament to the strong fiscal leadership of the volunteers and staff. I am very proud of our sustained financial success.

The staff and I are committed to maintaining the NYSSA’s place as the foremost component society of the American Society of Anesthesiologists. I consider myself extremely fortunate to work with so many dedicated volunteers who have trusted and supported me in carrying out the NYSSA’s initiatives. I am honored and proud to serve as your executive director.

It is my pleasure to provide a brief synopsis of the NYSSA’s activities this past year. For a complete copy of my annual report, please e-mail me at stuart@nyssa-pga.org.

Planning for the Future

The NYSSA staff has been working in the new headquarters for more than three years now. This facility is centrally located in New York City and the office is equipped with modern technology, allowing for more
operational efficiency. Since the purchase of the new NYSSA office space, the raw property value has increased by approximately 52 percent. The NYSSA owns the headquarters space outright (no debt).

Here are just a few examples of the new and enhanced technology and member services we have implemented this past year:

- We continually update legal and political resources on the NYSSA website and via the Capwiz online advocacy program.
- In 2014, we held the second annual pre-Legislative Day video conference to educate new and veteran members on priority legislative and socioeconomic issues.
- We utilize software and websites to provide information to members and the public (e.g., Hip Chat, Survey Monkey and Constant Contact, Facebook, Twitter, Pinterest, Foursquare and YouTube).

Advocating for Members
During my tenure, we have enhanced the communication and coordination between legislative consultants, lobbyists, physician volunteers and staff. The NYSSA is fortunate to have a team of specialized veteran consultants and a core group of well-informed and seasoned physician volunteers. Together with staff, we have worked carefully to promote NYSSA issues for the organization and its members. While the issues themselves have not changed substantially year-to-year, your adversaries have recently been intensifying their efforts. In response, the NYSSA has utilized additional resources to enable us to preserve patient safety and the quality of healthcare in New York.

I would like to thank our superlative consultants, who provide members and staff with expert advice and assistance: Kern Augustine Conroy & Schoppmann, P.C., the NYSSA’s general counsel; Higgins, Roberts & Suprunowicz, P.C., the NYSSA’s legislative counsel; and Reid, McNally & Savage, LLC, the Albany-based lobbying firm. I would also like to thank our core group of volunteer members who give extensive time to the NYSSA’s legislative and socioeconomic issues: NYSSA President Lawrence Epstein, M.D.; President-elect Michael Duffy, M.D.; Immediate Past President Michael Simon, M.D.; Government Relations Committee Chairman David Wlody, M.D.; Economics Committee Chairman Alan Strobel, M.D.; and NYAPAC Chair Bruce Hammerschlag, M.D. In addition, every one of the individuals on the Executive Committee and the Board of Directors gives a sizeable amount of time to work on behalf of the members, the association, and the profession.
This year, the NYSSA leaders hired a former legislator and consultant to analyze a study on CRNA barriers to practice in New York and to prepare an independent “third-party” position paper. The leadership also hired an opinion research firm to poll New York voters about their views regarding basic anesthesia. Respondents confirmed what NYSSA leaders believed: Ninety-two percent of those polled wanted a physician to respond to anesthesia emergencies (not a nurse) during surgery. Eighty-four percent of respondents said it was either extremely or very important to have nurses supervised by physicians. More than 51 percent of those polled said they would vote to remove their legislators if those legislators voted to remove the current physician supervision requirement with regard to anesthesia. The NYSSA culminated these efforts with a timely end-of-session media campaign in Albany. We utilized strategically placed radio and newspaper advertisements to educate the public and legislators about the opinion research results.

**Educating Members and the Public**

The PGA is one of the largest anesthesiology meetings in the world and accounts for 61 percent of the staff’s time annually. The PGA continues to be successful thanks to the leadership of Chair David Wlody, M.D., Scientific Programs Chair Richard Beers, M.D., and Scientific Programs Vice Chair Audrée Bendo, M.D.

The NYSSA’s accreditation is essential to the ongoing PGA program. In 2012, the NYSSA received accreditation with commendation from the ACCME. Staff members continue to work closely with Dr. Francine Yudkowitz to ensure that we maintain ACCME compliance.

In addition to the ongoing efforts to maintain the NYSSA’s accreditation, Dr. Audrée Bendo successfully applied for MOCA credits for 10 PGA scientific panels. Staff members also have been working with Dr. Edmond Cohen and the PGA leadership to create a day-plus thoracic symposium to run before and during the PGA.

**Educating the public about the specialty of anesthesia and the issues that impact our members and their patients:**

- With the assistance of the ASA, we utilized public polling and a media campaign to educate the public about anesthesiology and patient safety issues.
- We continued the distribution of physician identification badges.
- We continued the joint New York State Fair effort with MSSNY.
• We continued to work with the New York City Department of Health and Mental Hygiene on data collection and education relating to safe injection practices.

**Advancing anesthesiology and medicine by affiliating with and supporting organizations that share our mission:**

• During the ASA meeting in New Orleans, I hosted a meeting of state component executives to share information and ideas.

• I attended the AMA’s interim meeting in Maryland with current and future physician anesthesiologist leaders.

• I participated in meetings with my colleagues from around the world while at the ASA and ESA annual meetings. We discussed educational issues as well as other issues impacting our memberships.

• We continue to collaborate with the European Society of Anaesthesiology (ESA), the World Congress of Anesthesiologists, and the American Society of Anesthesiologists (ASA) on educational and marketing efforts.

• We formed alliances and promoted the PGA by sending a NYSSA representative to the following meetings: SAMBA’s annual meeting in Baltimore, AACA/ASURA (New Zealand/Australian societies) in New Zealand, and the 23rd International Congress of the Israel Society of Anesthesiologists (ICISA) in Israel.

• We continued our collaborative arrangements with the *British Journal of Anaesthesia* (BJA), the Anesthesia Patient Safety Foundation (APSF), the American Association of Clinical Directors (AACD), the World Institute of Pain (WIP), and the Foundation for Anesthesia Education and Research (FAER).

• We continued our relationships with the New Jersey State Society of Anesthesiologists (NJSSA) and the Pennsylvania Society of Anesthesiologists (PSA) and are now sharing our publications via one another’s websites.

In conclusion, this summary is intended to provide you with a quick snapshot of the noteworthy initiatives we have undertaken on behalf of all NYSSA members and the specialty of anesthesiology. It gives me great pleasure to report that this has been a successful and productive year. I believe the future is very promising, both for the NYSSA as well as the specialty. I thank you for your continued support and for the opportunity to represent the NYSSA as your staff leader.
Providing Care in Tanzania: A Medical Mission to Dareda Hospital

JERRY CHAO, M.D., SHERIF MECKAEL, M.D., YOLANDA RIVAS, M.D., AND ANDREA MONTALVO, RN

On August 11, 2013, a team of physicians and staff from the Children’s Hospital at Montefiore/Montefiore Medical Center departed for Dareda Hospital in Tanzania on a medical mission to establish a gastroenterology service and provide anesthesia care. The physicians and staff included Dr. Yolanda Rivas from the Department of Pediatric Gastroenterology; Dr. Jerry Chao and Dr. Sherif Meckael from the Department of Anesthesiology, Pediatric Division; Ms. Andrea Montalvo, RN, from Pediatric Gastroenterology; and Mr. Waldemar Montalvo, who provided technical support.
The United Republic of Tanzania is located just south of the equator on the
eastern coast of Africa and borders Kenya, Uganda, Rwanda, Burundi, the
Democratic Republic of Congo, Zambia, Malawi, Mozambique, and the Indian
Ocean. The country has an area of approximately 900,000 square kilometers,
which is larger than the states of Texas and New York combined. The country
has a population of nearly 40 million people, approximately the same number
as the state of California. According to the Human Development Index of
2014, a summary measure of average achievement in key dimensions of
human development created by the United Nations Development Programme,
Tanzania ranks 159th out of 177 countries in the world. More than one-third
of the population lives below the poverty line. Agriculture is the main source
of income for 80 percent of the population. Compared to the United States,
people in Tanzania are 11 times more likely to die in infancy. The Tanzanian
life expectancy is, on average, 25.75 years less than Americans and income
earned is 96.98 percent less.
Dareda Hospital is a 200-bed hospital located in Babati District of Manyara Region, 206 km south of the city of Arusha. In 2011, the hospital had more than 48,000 outpatients, 9,000 inpatient admissions, and 2,700 deliveries. More than 1,200 interventions were performed in the operating theatre, which consists of two operating rooms. The hospital is nestled at the foot of the escarpment of the East African Rift Valley and is one of the institutions run by the health department of the Catholic Diocese of Mbulu. The hospital was founded by the Medical Missionaries of Mary in 1948. In 2011, the top diagnoses among outpatients under 5 years of age were pneumonia, acute respiratory infection, diarrhea, malaria, eye infections, intestinal worms, and skin infections. Outpatient diagnoses among patients older than 5 years were similar, with eye infections ranking first and dental diseases higher than pneumonia. An important risk factor accounting for the high prevalence of eye infections and diarrheal disease is the scarcity of clean water. A water
pump constructed in 2009 broke down and in the interim the hospital depended on bringing in water from a nearby river more than 5 km away. The top inpatient diseases for 2011 among patients younger than 5 years old were pneumonia, diarrhea, malaria, acute respiratory infection, skin infections, kwashiorkor, intestinal worms, dysentery, anemia, and fracture. Kwashiorkor is a form of severe protein-energy malnutrition consisting of edema, irritability, anorexia, ulcerating dermatoses, and an enlarged liver and fatty infiltrates. It occurs in the setting of sufficient global caloric intake but insufficient protein consumption, distinguishing it from marasmus, which is a state of global starvation and caloric insufficiency. The name is derived from the Ga language of coastal Ghana and means “the sickness the baby gets when the new baby comes,” which explains the presentation of the condition in an older child weaned from protein-rich breast milk. At-risk populations have a high-carbohydrate, protein-deficient diet. Among patients older than 5 years of age, the top inpatient diagnoses were malaria, pneumonia, non-infectious gastroenteritis, diarrhea, complications of pregnancy, anemia, and tuberculosis.
Our team arrived in Kilimanjaro, Tanzania, on August 13, 2013, and traveled by jeep to Dareda Hospital via the city of Arusha, a total distance of 252 kilometers. Upon arrival, our first day consisted of seeing patients in the clinic while also setting up the endoscopy room. Once procedures started, clinic patients were seen during and between procedures by various physician members of the team. We saw more than 70 patients in the clinic over the next six days and did approximately 45 procedures requiring 40 discrete anesthetics. The majority of procedures consisted of upper endoscopies with some colonoscopies. Our youngest patient was 11 years old and our oldest was 64. The average weight of our patients was approximately 52 kg. Among the many challenges we faced, the most significant was barriers to successful communication between our team and the Tanzanian patients. Our Tanzanian medical colleagues were highly clinically skilled and accustomed to making diagnoses without the aid of advanced workups or imaging modalities. It was a privilege and joy to work with them delivering care. Other challenges included limited resources as well as the creation of a new endoscopy room in a hospital with limited infrastructure. In general, the majority of patients were lean and did not suffer from cardiovascular disease. Our main anesthetic technique consisted of sedation using a propofol infusion (we brought a syringe pump) and bolus ketamine.

Dr. Rivas demonstrates how to use the gastroscope.
Features of drawover apparatus:
1. Robust, compact and portable
2. Low purchase price and running costs
3. Straightforward maintenance
4. Not dependent on compressed gases

The EMO drawover apparatus. This drawover system is designed to provide anesthesia without the need for compressed gases. Atmospheric air is used as the main carrier gas and is breathed in during the patient's inspiratory effort through the vaporizer. Ether or halothane is typically used. In this case, an oxygen halothane mixture was delivered via a non-rebreathing valve.⁸⁹

Oxford inflating bellows used to deliver positive pressure ventilation manually.
Water gutters made patient transport via stretcher challenging.

A patient ward with balled-up mosquito nets hung over patient beds ready for use. Malaria and mosquito-borne illnesses are a major source of morbidity in Tanzania.
We used a 3 lead EKG, pulse oximetry, and manual blood pressure for monitoring. We did not have continuous end-tidal CO₂ monitoring and reserved use of supplemental oxygen via nasal cannula only in cases of sustained significant hypoxemia because of the scarcity of compressed oxygen gas. Fortunately, we did not have to provide advanced airway support in any of our procedures.

Common diagnoses included gastritis, peptic ulcer disease, and polyp disease. One patient was suspected to have inflammatory bowel disease. Two patients were diagnosed with hiatal hernias. Two patients were diagnosed with esophageal masses that likely represented malignancy. We are grateful that we encountered no significant complications during the care of our patients. All patients tolerated their interventions and recovered well from their anesthetics. In some cases, patients stayed overnight because they lived too far away to make it home by sundown. A patient with an esophageal mass bled during upper endoscopy and had to be observed overnight. While we delivered clinical care, our team simultaneously trained the physicians and staff at Dareda Hospital to carry on their GI service independently.

At the conclusion of the medical mission, we donated all GI and anesthetic equipment as well as medications to Dareda Hospital to help them sustain their GI service into the future. We intend to return annually to provide continued support and donations of resources. We made many new friends and are grateful for the privilege of taking care of patients and working alongside the Tanzanian physicians and staff. We wish to thank our colleagues...

Drs. Rivas, Meckael, and Chao in the operating theatre.
and staff in the departments of anesthesiology and pediatric gastroenterology at Montefiore Medical Center, as well as the larger institution, for their support, insight, and suggestions — in particular, Dr. Ellise Delphin and Dr. Andrew Racine. The team returned to Tanzania in July 2014 and we look forward to reporting to the anesthesia community about this most recent trip in an upcoming issue of Sphere.

Jerry Chao, M.D., and Sherif Meckael, M.D., are attending pediatric anesthesiologists at the Children’s Hospital at Montefiore. Yolanda Rivas, M.D., is an attending pediatric gastroenterologist and director of endoscopy and Andrea Montalvo, RN, is a pediatric gastroenterology nurse at the Children’s Hospital at Montefiore.

REFERENCES

Empower your practice by participating in PRACTICE MANAGEMENT 2015. Join us as we bring together anesthesiology leaders to share insights and strategies for strengthening practice performance.

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- Risk management
- Best practices and trends
- Value proposition development
- Bundled payment negotiations

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- **Advanced Strategies in Chronic Pain Practice Management**
  - Acquire critical skills needed to ensure your chronic pain services are run efficiently, cost-effectively and in compliance with federal and state regulations.

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American Society of Anesthesiologists®

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Advocate for Our Specialty During Inaugural Physician Anesthesiologists Week: January 11-17, 2015

KENNETH ELMASSIAN, D.O.

There has never been a more important time to advocate for our specialty and our patients as potential federal and state issues related to scope of practice threaten patient-centered, physician-led care. To help showcase the role physician anesthesiologists play in providing the safe, high-quality care all patients deserve, the American Society of Anesthesiologists® is launching Physician Anesthesiologists Week January 11-17, 2015.

The inaugural event provides an opportunity to alert policymakers, the media and the public that when seconds count, physician anesthesiologists save lives. In order to make our voices heard on critical issues that affect our specialty, we need to mobilize all New York State Society of Anesthesiologists (NYSSA) members as well as ASA members to take action.

During the week, the NYSSA and ASA are asking physician anesthesiologists to showcase the role you and every one of our members play in protecting patient safety and to schedule meetings with legislators, talk to local press, engage in social media, and connect with colleagues and the community.

Planning for these activities can start this month. The ASA has developed materials and resources to help you, including a Physician Anesthesiologists Week member engagement webinar in December that will provide specific instructions on how to make the event a success. The webinar will highlight the materials contained in the comprehensive support toolkit developed for
the week’s activities. The toolkit will provide instructions and materials to help you:

- **Set up meetings at the state capital or at your lawmakers’ district offices.** Advocate for your patients and your NYSSA and ASA colleagues in one-on-one meetings with influential elected officials and staff with tips for scheduling face time — and staying on point — with legislators.

- **Showcase your expertise.** Invite policymakers and the media to tour your hospital to see your specialty in action. A sample tour agenda and key messages to convey when speaking to the media and policymakers will be provided.

- **Engage the media.** Increase awareness of the importance of physician-led care in ensuring patient safety by conducting outreach, sending materials, and offering interviews with local media. Instructions, sample materials, and talking points will be included to help you with your efforts.

- **Spread the word online.** Use the #PhysAnesWk15 hashtag as well as the NYSSA’s and ASA’s social media messages to sound off in January about the physician anesthesiologist specialty. You can also post a specially designed ASA physician anesthesiologist banner on your website.

- **Connect with colleagues and the community.** Make this week an occasion to gather physician anesthesiologists, patient advocates, and others from the community in “lunch and learns,” networking events, health fairs, and other events to raise awareness of the specialty.

- **Share your patient stories.** Visit asahq.org/WhenSecondsCount to share your “When Seconds Count” stories.

The key messages for the week are based on the research developed for the ASA’s When Seconds Count™ educational endeavor. The research looked at perceptions the public and policymakers have of physician anesthesiologists and found that the majority are unaware that anesthesiologists are physicians. Even fewer know how we save lives when emergencies occur in surgery or other procedures.

To help increase awareness of the critical role we play before, during and after surgery, we are asking ASA members to share key messages on their comprehensive medical education, training and experience, along with stories of lives they saved. Whether diagnosing an underlying health condition during pre-surgical screenings or stepping in when a routine procedure becomes an emergency, these stories support our key messages and highlight how our involvement can mean the difference between life and death. Tips for effective storytelling will be included in the support kit as well.
As you make your voice heard locally, the ASA will spread the word nationally through media outreach to generate coverage about the work you, your ASA member colleagues, and all physician anesthesiologists do to advance patient safety.

We will also be reaching out to our state component societies to encourage everyone to get involved. Additional information will be available in ASAP, the ASA’s weekly e-newsletter, and on our social media sites.

I personally challenge all ASA members to play a role, whether it’s just one activity or several. You can help us make a difference. Physician Anesthesiologists Week 2015 is our time to say loud and clear that “When Seconds Count, Physician Anesthesiologists Save Lives.” Visit asahq.org/WhenSecondsCount to learn more.

Kenneth Elmassian, D.O., is chair of the ASA Committee on Communications.

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

Anesthesia Care and Infection Control: Keeping Your Patients Safe
This online CME program — created by and for anesthesiologists — is specifically designed to provide anesthesia professionals with the information they need to decrease the risk of healthcare-associated transmission of pathogens.

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

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Abstract submission from
1 November - 15 December 2014
New York Law Bans “Surprise Bills” by Out-of-Network Providers

MICHAEL J. SCHOPPMANN, ESQ.

Background
New York has enacted the “Emergency Medical Services and Surprise Bills” law in response to consumer complaints about inadequate reimbursement from health plans for medical services rendered by out-of-network providers. Issues revolving around out-of-network reimbursement often lead to frustration for both consumers and providers. Consumers do not understand why they are receiving bills when they have insurance and providers are left in a relentless battle with health plans over fees. When health plans will not reimburse their services in a reasonable manner (or at all), providers are left with no choice but to bill consumers for the services, which can be damaging to physician/patient relationships. Previously, the law offered little to no assistance in resolving these issues, but New York has taken an important step in creating a mechanism for both consumers and providers to resolve these issues effectively.

Emergency Medical Services and the Surprise Bills Law
The law covers bills received for emergency services and surprise bills. Emergency services are defined as, with respect to an emergency condition: (i) a medical screening examination, which is within the capability of the emergency department of a hospital, including routine ancillary services, to evaluate such condition, and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment required to stabilize the patient. Surprise bills are defined as bills that a patient receives for out-of-network services: (i) received at an in-network hospital or surgery center without the consumer’s knowledge, (ii) received based on a referral by an in-network provider with the patient’s written consent, and (iii) received by a patient who was not insured for the services and who did not receive proper disclosures required under the law.

The law will go into effect on March 31, 2015, and creates a number of consumer protections, including those detailed below. The law does not apply to workers’ compensation claims.

New Protections for Consumers and Tools for Providers
When a consumer receives emergency out-of-network services, the health plan shall ensure that the consumer does not incur out-of-pocket expenses greater than he or she would have incurred for the services if rendered by an in-network provider. This will help relieve providers’ collection efforts.
Consumers who receive surprise bills may elect to assign benefits for these bills to the providers and the consumers will only be liable for their in-network cost sharing. Each bill will be negotiated directly between the health plan and the provider through a dispute resolution process. If the consumer elects not to assign, the consumer may dispute the payment through the dispute resolution process.

The law creates an independent review process for providers to dispute charges with the health plans. The dispute resolution entities shall use licensed physicians in active practice with a similar specialty as the claims at issue. Uninsured patients may also use the independent review process. The costs for the review process will be paid by the losing party, or, if the matter is settled between the parties, they shall split the costs. For example, if it is found that the physician’s fee was reasonable, the health plan shall pay the costs.

The law requires that health plans that are based on comprehensive provider networks be certified as having “network adequacy” (provider networks that meet the health needs of their membership without having to rely on out-of-network providers). If the health plan does not have network adequacy, patients may seek services from out-of-network providers without additional out-of-network costs.

Health plans must meet the following disclosure requirements regarding out-of-pocket expenses:

- they must disclose provider status, reimbursement, and how the reimbursement compares to the usual, customary and reasonable fee when patients seek authorization for a particular service; and
- patients who have access to out-of-network care must be given examples about their costs for common medical procedures at out-of-network rates and how those costs compare to typical charges.

Provider disclosure requirements include:

- disclosure to patients prior to a non-emergency procedure on their right to know the costs;
- disclosure of the costs if requested and a warning to the patient that costs could rise if unexpected complications occur;
- written consent from a patient when a referral is made to an out-of-network provider;
- disclosure of network and hospital affiliations in writing or online;
- disclosure of network participation at the time the appointment is made and prior to rendering services; and
- advising patients of other physicians involved in their care and how to learn about the costs for those physicians.
Hospitals also face numerous disclosure requirements, such as:

- publicly posting fee schedules for various services on their websites;
- listing health plans they participate with, warning patients that providers may be out-of-network, and instructing patients on how to check network status;
- posting information on practice groups the hospital has contracted with for radiology, anesthesiology and pathology, along with information on how patients may determine the network status of those groups; and
- posting information on hospital employee physicians, including network participation, and giving this information directly to patients when they register or are admitted.

The law also created an out-of-network reimbursement rate working group that will include health plan, physician and consumer members. The working group will study and make recommendations on out-of-network coverage and levels of reimbursement and issue a report by January 1, 2016.

**Conclusion**

While there are still steps to be taken with respect to out-of-network reimbursement, this law has taken an important first step in addressing this issue. The law will make consumers more aware of their benefits under their respective health plans as well as alleviate the stress of receiving surprise bills for medical services. Providers are required to provide additional disclosures to patients; however, the dispute resolution process should be an effective tool for receiving reimbursement from health plans. We expect that regulations will be issued to further clarify the dispute resolution process.

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.

**NOTES**


2. The review process contains exclusions for certain bills and services, such as a dollar amount threshold for certain CPT codes.
Scenes From the ASA Annual Meeting
New York Caucus

Drs. Michael Duffy and Lawrence Epstein lead the New York caucus meeting.
President’s Reception

Dr. Lawrence Epstein (left) with Dr. John Dombrowski

Dr. Mark Lema (left) and Dr. Lance Wagner

(Left to right) Drs. David Wlody, Jung Kim, Jason Lok and Andrew Rosenberg

ASA CEO Paul Pomerantz (left) and Dr. Scott Groudine

(Back row, left to right) Drs. Paul Willoughby, Rose Berkun, Michael Duffy and Gregory Fischer with (front row, left to right) Drs. Vilma Joseph, Meg Rosenblatt, Linda Shore-Lesserson, Lawrence Epstein and Salvatore Vitale.
NYSSA’s Delegation to the ASA

Drs. Cynthia Lien, Vilma Joseph, Charles Gibbs and Michael Duffy

Drs. Lance Wagner, Steven Schulman and Ingrid Hollinger

Drs. Lawrence Epstein, Michael Duffy and Michael Simon attend the NYSSA Board of Directors meeting in New Orleans.
ASA Reference Committees

(Standing, left to right) Drs. Melinda Aquino, Donna-Ann Thomas, Richard Beers, Jung Kim, Jesus Calimlim, Salvatore Vitale, Richard Wissler, Michael Simon, Rose Berkun, Scott Groudine, Scott Plotkin, Elizabeth Mahoney, David Wlody, Lawrence Epstein, Christopher Campese, Steven Schulman and Lance Wagner, and Mr. Stuart Hayman with (seated, left to right) Drs. Ingrid Hollinger, Tracey Straker, Charles Gibbs, Vilma Joseph, Gregory Fischer, Paul Willoughby, Jason Lok, Lawrence Routenberg and Michael Duffy
NYSSA Members Meet With Legislators

U.S. Rep. Louise Slaughter with Dr. Richard Wissler

U.S. Rep. Chris Gibson and Dr. Scott Grounide

(Left to right) Dr. Dave Reubuck, Mr. Bob Reid, Dr. Cyriac Joseph and Dr. Sebastian Thomas
Vargo Anesthesia Case Tips

MARK JENSEN, M.D.

Application Name: Anesthesia Case Tips

Cost: $19.99

Developer: Vargo Anesthesia

Review: One of the things that makes anesthesia fun is the wide variety of patients and procedures that we get to see. I recently helped with a robotic prostatectomy at University Hospital for a 70-year-old man with severe sleep apnea, then I went across the street to King’s County Hospital for call where my patient was a 7-year-old who needed a craniotomy after getting hit in the head with a baseball bat.

Knowing the nuts and bolts of each procedure takes time and experience, and too often it is bad experience. If you choose to learn the easy way, there is a new iPhone app with tips for more than 400 cases. Anesthesia Case Tips provides a summary of each procedure and outlines the preparation needed, the surgical position you should plan for, the expected procedure duration, estimated blood loss, possible complications, and even the IV access the patient should have. This app even reviews the physiology that is relevant for each procedure and anticipates unpleasant surprises. Armed with this app, actually doing the case is a breeze.

But don’t think of Anesthesia Case Tips as an anesthesiaology cookbook; it is definitely not that. Depending on the circumstances of the case, Vargo Anesthesia weighs the pros and cons for style decisions such as conservative versus aggressive fluid management or the anesthetic agent that is used.

Bottom Line: Anesthesia Case Tips is a valuable tool for anyone hopping from case to case because it has useful information that is easy to access. The tips are clinical, practical and helpful with new situations. One negative is that all of this practicality lacks a basic science foundation that makes an anesthesiologist more complete and
competent. The app also costs $20, which is a lot for an iPhone app. Still, in practice environments like Brooklyn with high volume and diverse patients and procedures, it is — quite literally — a lifesaver.

Anesthesia Case Tips, by Vargo Anesthesia, can be downloaded from the iTunes store.

Mark Jensen, M.D., is a CA-2 resident at SUNY Downstate.
Scientific Research Is the Surest Way Forward

DENHAM S. WARD, M.D., PH.D.
FOUNDATION FOR ANESTHESIA EDUCATION AND RESEARCH (FAER)

As physicians, we have the unique responsibility not only to provide the safest and most effective care for our patients, but also to identify new treatments, innovate new technologies, and implement new procedures that improve quality and outcomes. We fulfill these responsibilities by generating new knowledge through the process of scientific discovery and research.

One of the very best ways to advocate for anesthesiology is to invest in research and innovation. Scientific research is an investment that helps us create a better tomorrow for our patients, who expect no less than the safest, most compassionate, and most advanced treatment. They care that we are on the cutting edge. What fuels their support for medicine is the promise that the future will bring even safer, more effective care. It’s the new discoveries that make the news, not the good routine care that we give our patients.

Although we can agree on the merits of scientific research, the specialty of anesthesiology faces many challenges in this area. Federal research and development funding has declined (in real dollars) continuously over the past decade while growing more competitive in recent years. In constant 2003 dollars, which show NIH funding adjusted for inflation, the level of NIH funding in 2013 was 22 percent less than the level of NIH funding in 2003. Last year, the success rate for funding requests to the NIH was only 17 percent, the lowest level in 15 years. In addition to these facts, anesthesiology ranks near the bottom of all medical specialties in the amount of NIH funding per faculty member.

Scientific discovery requires experience and often federal funding; to obtain funding as an independent investigator, training and data are required. Thus, it is important that, as a specialty, we do everything we can collectively to provide our trainees and young faculty members with the experience and data they need to become independent investigators capable of obtaining funding from the NIH or other sources. FAER grants accomplish this. Our mentored research grants and fellowship opportunities are a starting point on the pathway to knowledge acquisition.
I encourage you to support scientific discovery in anesthesiology by supporting FAER. The donations we receive directly support new anesthesiologists and trainees, many of whom are based in New York.

Research Funding Supports New York Anesthesiologists

In 2014, anesthesiologists in New York received $250,000 in FAER research grant funding to be awarded over two years. This follows the $350,000 they received in 2013. In fact, over the past six years, anesthesiologists and their departments in New York have received a total of $1.05 million in research grant funding from FAER. Receiving this level of FAER funding is a great accomplishment and should be celebrated!

Congratulations to the recent FAER grant recipients from New York:

Jennifer Danielsson, M.D.
Columbia University
Mentored Research Training Grant – Basic Science (2014)
Antagonism of the calcium-activated chloride channel TMEM16A: A novel target to treat bronchospasm
Mentor: Charles W. Emala, M.D., M.S.

May Hua, M.D.
Columbia University
Mentored Research Training Grant – Health Services Research (2013)
Assessing end-of-life care needs among critically ill surgical patients
Mentor(s): Guohua Li, M.D., DrPH; Hannah Wunsch, M.D., MSc

Kingsley Storer, M.B.B.S., Ph.D.
Weill Cornell Medical College
Mentored Research Training Grant – Basic Science (2013)
Network mechanisms underlying propofol-induced loss of consciousness and amnesia
Mentor(s): George Reeke, Ph.D.; Hugh C. Hemmings, M.D., Ph.D.

Marcin Karcz, M.D.
University of Rochester
Research Fellowship Grant (2014)
The role of antihistamines and nicotine metabolites in cardioprotection
Mentors: Paul S. Brookes, Ph.D.; Laurent G. Glance, M.D.

Support Scientific Research, the Campaign for New Knowledge

A FAER award is a catalyst for a successful academic career. Let FAER be your gateway to supporting the research that differentiates anesthesiologists and
moves medicine forward. The NYSSA, academic departments in New York state, and individual members have been strong supporters of FAER. We gratefully appreciate your support.

Ways to Support FAER
1. Make a gift today. Donate online at FAER.org/donate. Donations made online have an immediate effect on FAER’s ability to provide ongoing support in the form of research grants. You can make an online donation to FAER using any major credit card. Visit our secure gift form at FAER.org/donate.

2. Set up a monthly or quarterly recurring donation. Becoming a regular donor to FAER is an excellent way to provide sustained support for anesthesia research and education. You can set up a recurring gift to FAER via our online donation form at FAER.org/donate.

Remember: Make your gift by December 31 to receive potential tax benefits for 2014!

Denham S. Ward, M.D., Ph.D., is the president and CEO of the Foundation for Anesthesia Education and Research.

NYSSA Members: Apply for FAER Research Grant Funding and Fellowships – February 15 Deadline
FAER is now accepting applications for research grant funding to begin July 1, 2015, or January 1, 2016. The application website is open, and the submission deadline is February 15, 2015. Current opportunities include the following:

- Mentored Research Training Grants in Basic Science, Clinical, Translational or Health Services Research ($175,000, two years, 75 percent research)
- Research Fellowship Grant ($75,000, one year, 80 percent research)
- Research in Education Grant ($100,000, two years, 40 percent research)

For more information and to apply, visit FAER.org/research-grants.

Second Grant Cycle Announced
The FAER Board of Directors will be opening a second grant cycle in 2015, for grant funding to begin January 1, 2016, or July 1, 2016. The application deadline for this cycle will be August 15. For more information, visit FAER.org/research-grants.
SAVE THE DATE

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St. Kitts Marriott Resort
St. Kitts, West Indies
January 18-23, 2015

For information, contact: george.silvay@moundsinai.org
The NYSSA’s Governmental “TEAM”

During the American Society of Anesthesiologists (ASA) House of Delegates opening session in October 2014, the ASA officers addressed the delegates and offered a summary of ASA accomplishments and their vision for the coming year. Each year, I find the officers’ presentations impressive, informative, and oftentimes inspirational. I am not certain whether the ASA communications office publishes these speeches, but it is clear that each ASA officer spends considerable time and effort on them. Jane Fitch, M.D., president of the ASA this past year, made an excellent presentation. One theme that she promoted was the concept of TEAM. Dr. Fitch defined TEAM this way: “Together Everyone Achieves More.” She set forth how the ASA TEAM accomplished objectives during her tenure. As we embark upon the 2015 New York state legislative session and the challenges that will confront us, I thought it would be helpful to highlight the NYSSA’s governmental, legal, and economic affairs TEAM; to outline my very positive impressions about the members of our TEAM; and to illustrate how we work together to achieve more on behalf of the NYSSA membership.

Stuart Hayman, M.S., Executive Director

Stuart performs a multitude of tasks on behalf of the NYSSA. With respect to governmental affairs matters, he provides strong, effective leadership to the Government and Legal Affairs Committee (GLAC), including, for example, reviewing and critiquing legislative memorandums that I prepare and the strategies and meetings that our Albany-based lobbyists (Reid, McNally & Savage, LLC) propose. Stuart has a broad range of skills and experience and offers invaluable guidance in the promotion of NYSSA’s governmental agenda.

NYSSA Officers

The NYSSA officers, including Dr. Lawrence Epstein (president), Dr. Michael Duffy (president-elect), Dr. Michael Simon (immediate past president), Dr. David Wlody (GLAC chair), Dr. Scott Plotkin (GLAC vice chair), Dr. Alan Strobel (EAC chair), Dr. Steven Schwalbe (EAC vice chair), Dr. Bruce Hammerschlag (NYAPAC chair), and the remaining
members of the NYSSA Executive Committee (Dr. Andrew Rosenberg, Dr. Vilma Joseph, Dr. David Bronheim, and Dr. Scott Groudine) represent NYSSA’s voice in Albany professionally and effectively. Two examples come to mind that illustrate the effectiveness of their representation on behalf of the NYSSA membership on matters of significance.

Approximately one year ago, Sen. Catharine Young requested that NYSSA’s leadership meet with the New York State Association of Nurse Anesthetists (NYSANA) leadership to discuss and attempt to agree on scope of practice legislation. Drs. Epstein, Simon, and Wlody met with NYSANA representatives and did a fabulous job of presenting the NYSSA position at the meeting. They persuaded the NYSANA leadership that preservation of the anesthesia care team as embodied in the New York State Health Code was the standard for scope of practice legislation to allow for the safe delivery of anesthesia care in New York state. Unfortunately the NYSANA leadership apparently was unable to achieve consensus with their board on the advantages of this approach. As a result, no agreement was reached between the NYSSA and NYSANA.

A second example involved a critical meeting with the governor’s staff and high-ranking Department of Health officials about NYSANA’s initiative to promote their title bill. Once again, Dr. Epstein and Dr. Simon presented the NYSSA position in a forceful and articulate manner. A title bill was not advanced this past legislative session. Our NYSSA leadership has been, and will continue to be, the NYSSA’s voice in Albany.

Reid, McNally & Savage, LLC
For those of you who have worked with Bob Reid, Shauneen McNally, and Marcy Savage, you immediately appreciate the effectiveness of their representation of the NYSSA in Albany, the respect that they have earned from Albany lawmakers and other state governmental officials, and their broad knowledge of the inner workings of Albany government. Bob, Shauneen, and Marcy are NYSSA’s eyes and ears in Albany and work diligently on behalf of the organization.

NYSSA District Directors
The NYSSA district directors play a critical role in promoting our governmental agenda by participating in our annual Legislative Day in Albany, recruiting district members to attend the annual Legislative Day, serving as key legislative contacts, hosting district meetings to promote the NYSSA’s governmental agenda, and encouraging contributions to
political action groups. For the past two years, based on the efforts of
the NYSSA’s district directors and Executive Committee, we have had
38 participants at our annual Legislative Day. This year we were able to
schedule appointments with 65 lawmakers to present the NYSSA’s
position on critical legislative initiatives and to refute the NYSANA-
sponsored hospital survey prepared by the Center for Health Workforce
Studies. As noted above, the NYSANA-sponsored title bill did not move
from committee in either the Senate or Assembly and NYSSA members’
face-to-face meetings on Legislative Day played a key role in achieving
this result.

**Government and Legal Affairs Committee (GLAC) and
Economic Affairs Committee (EAC)**

The GLAC and EAC members play an important role by attending the
PGA in December; reviewing the proposed agendas for their committees;
and offering suggestions, additions, and strategies to promote the
NYSSA’s governmental agenda. Dr. David Wlody, as part of his role as
chair of GLAC, facilitates the Current Issues Panel at the PGA. This year,
Dr. Wlody’s invitation to Acting Commissioner of Health for New York
State Howard A. Zucker, M.D., J.D., to the PGA was accepted. Dr. Zucker
is an anesthesiologist and obviously a critical leader in promoting
healthcare policies for New York state. Dr. Alan Strobel (EAC Chair)
provides an excellent update on Medicare, coding, and related
compliance developments. The dedication of our chairs and committee
members allows the promotion of governmental, legal, and economic
agendas that address NYSSA members’ concerns.

**ASA Office of Governmental Affairs (OGA) Staff**

Jason Hansen, ASA state director, provides the NYSSA with helpful
updates from other state component members. For example, Jason
alerted the NYSSA to the FTC’s involvement in promoting independent
practice for nurse anesthetist legislation in Massachusetts. This allowed
me to discuss strategies implemented by the Massachusetts Society of
Anesthesiologists (MSA) to combat the federal government’s
inappropriate intrusion into this state’s professional licensing of
healthcare providers.

Additionally, we have received updates from the ASA OGA and the ASA
leadership on the initiative advanced by the Department of Veterans
Affairs to eliminate physician supervision of nurse anesthetists in all VA
hospitals through the adoption of the VA Nursing Handbook. Should this
initiative be successful, it will create a duel standard of anesthesia care in
New York; namely, the anesthesia care team will be the standard for all patients except veterans. We also understand that this initiative will be used by NYSANA to promote their independent practice legislation.

**Medical Society of the State of New York (MSSNY) and New York State Medical Specialty Societies**

The NYSSA leadership has a strong working relationship with these organizations. There are at least three areas where the NYSSA will need to continue to secure the support of MSSNY and the specialty societies: (i) promoting legislation that will decouple the no-fault reimbursement fee schedule from the workers’ compensation fee schedule; (ii) monitoring, commenting on, and addressing the out-of-network proposed rules and regulations that will implement the recently enacted out-of-network law; and (iii) promoting the healthcare provider badge bill to ensure uniformity by requiring New York state healthcare providers to use their licensed titles on their badges (not their academic degrees).

I believe that our governmental TEAM, as illustrated above, is extensive and diverse, and that by working together we will continue to achieve more on behalf of the NYSSA membership. The upcoming 2015-2016 legislative session will present new challenges. It is my goal to continue to play a proactive role.

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Case Report

Acute, Sudden Hypoxemia Due to Intraoperative Lung Collapse From a Mucus Plug After Intubation

JOHN K. AIDONIS, M.D., M.S., AND SANFORD MILLER, M.D.
NEW YORK UNIVERSITY LANGONE MEDICAL CENTER, NEW YORK, NEW YORK

Abstract

We present a case of intraoperative right lung collapse due to a mucus plug in a patient undergoing repair of a cleft lip. The patient is an 8-month-old infant with trisomy 20, born via cesarean section at 31 weeks with cleft lip/palate, scheduled for elective repair. Approximately five minutes after intubation, the patient was noted to have decreased right chest motion, decreased breath sounds, and possible subcutaneous emphysema during ventilation, followed by hypoxia, tachycardia, hypercapnea, and hypotension. Thoracic surgeons were consulted because of the possibility of pneumothorax. At this time, the patient's right chest was not moving symmetrically and there was a significant decrease in breath sounds. Endotracheal suctioning improved both the chest expansion and the lung sounds. A chest X-ray revealed white-out of the right lung field and no evidence of pneumothorax. After suctioning, saline lavage and hand ventilation, the breath sounds improved. A repeat chest X-ray showed complete re-expansion of the right lung.

Introduction

Desaturation from atelectasis caused by a mucus plug is a rare event after induction of anesthesia. General anesthesia is associated with decreased oxygen tension from increased alveolar-arterial oxygen gradient and occasionally from oxygen desaturation. These changes are magnified when the patient is in the prone or lateral position. Other mechanical causes of hypoxemia are equipment failure, blockage of the endotracheal tube, and endobronchial or esophageal intubation, while the clinical causes are aspiration, hypoventilation, or pulmonary embolism, particularly in trauma patients. Intraoperative atelectasis as a cause of hypoxemia due to mucous plugging of a bronchopulmonary segment, a lobe, or an entire lung is uncommon, but may be fatal.
Case Report
An 8-month-old infant with trisomy 20, born via cesarean section at 31 weeks, was scheduled for an elective cleft lip and palate repair. There were no unusual findings in the preoperative period or on physical examination, except that the infant had had bronchiolitis three weeks previously, which was treated and resolved completely. The lungs were noted to be clear to auscultation prior to induction. A smooth inhalation induction with sevoflurane was performed, followed by an uneventful intubation with a 3.5 mm cuffed ETT after fentanyl, propofol and rocuronium were administered. After intubation, capnographic monitoring was established and bilateral air entry was confirmed by chest auscultation. The ETT was fixed at 11 cm. An air leak was noted at 25 cmH₂O and mechanical ventilation was instituted. Approximately five minutes after intubation, hypoxemia (PO₂ in the low 90s) was noted. There were decreased motion of the right chest, decreased breath sounds, and possible subcutaneous emphysema during ventilation, which raised the concern for pneumothorax. Hemodynamic changes included a sudden increase of the heart rate to >200 (baseline 120), a decrease in the systolic BP to the 50s, and a progressive increase of PₐCO₂ from the 30s to the 50s.

The ETT was pulled out to a depth of 9 cm without improvement in the ventilation of the right lung. Furthermore, two minutes later, no movement of the right chest was seen. The surgical team was notified of these findings and the procedure was interrupted. Albuterol was administered by inhaler without improvement. A chest X-ray (CXR) was ordered, and the surgeon marked the right 2nd interspace at the mid-clavicular line for needle decompression if there was a pneumothorax.
Just prior to the examination, suctioning of the ETT revealed thick mucus with some return of chest wall movement on the right side. The CXR showed complete opacity of the right hemithorax with some air bronchograms compatible with diffuse atelectasis [Figure 1]. There was a possible mild mediastinal shift. Normal saline in 1 ml doses was used for flushing the ETT, which was suctioned several times with an 8 F catheter. A significant quantity of thick secretions was obtained. Ventilation of the right chest improved. There was no wheezing on auscultation and equal air entry with bilateral chest movement resumed after suctioning. The vital signs returned to baseline after 30 minutes. A repeat CXR showed re-expansion of the right lung with improved positioning of endotracheal tube. Both lungs appeared well aerated, with complete resolution of the opacity [Figure 2]. After discussion with the surgical team we concluded that it was safe to proceed with the surgery.

**Discussion**

Acute pulmonary collapse is common in the postoperative and intensive care unit (ICU) setting but is a rare event after induction of anesthesia. The most common causes are endobronchial intubation or blockage of the tube by secretions, blood, or a herniated cuff. This report highlights the precipitous onset of hypoxemia associated with severe pulmonary collapse due to a mucus plug.¹

Airway occlusion may result from inspissation of mucus and other secretions within the airway and can cause partial or even complete airway obstruction. It often occurs in the bronchi or bronchioles, but may also appear in the ETT. It is reported that in the pediatric ICU, partial ETT obstruction by mucoid impaction occurs in about 20 percent of children who are intubated for a long period of time.¹,²
In children who undergo general anesthesia and endotracheal intubation, several factors can increase the risk of developing thick secretions within the trachea. Dehydration from fasting and low inspired humidity, and clinical doses of atropine and inhalational anesthetics, may increase the viscosity of secretions, leading to inspissation and reduction in mucociliary flow. In addition, inflation of the ETT cuff may not only decrease mucus transport in the trachea, but also can prevent normal effluence of secretions within the trachea and result in their accumulation in the upper trachea. Because of the continuous flow of dry inspired gases during anesthesia, secretions that flow initially into the proximal part of the ETT may form a thin layer of dried mucus on its inner wall. With gradual accumulation, a mucus plug is formed within the ETT. When this plug becomes large enough to obstruct most of the lumen, signs of airway obstruction emerge. In an anesthetized pediatric patient, moreover, infrequent airway suctioning, use of the non-rebreathing circuit, and intubation with a small ETT can facilitate the occurrence of this adverse airway event.

General anesthesia may be associated with decreased oxygen tension due to increased alveolar-arterial gradient and occasionally oxygen desaturation leading to hypoxemia. Other mechanisms of hypoxemia include ventilation/perfusion (V/Q) mismatch, hypoventilation, diffusion impairment, and physiologic or anatomic shunt.

During anesthesia and neuromuscular relaxation, ventilation is redistributed to the nondependent regions of the lungs because of atelectasis and airway closure in the dependent lung areas, resulting in increased alveolar-arterial oxygen gradient and possibly hypoxemia. In the lateral position, gravity-related preferential perfusion to the dependent lung worsens this V/Q mismatch and thus the hypoxemia. In our patient, this was not the cause, as hypoxemia developed acutely with rapid onset of physical findings.

In our patient, the initial clinical presentation included sudden onset of hypoxemia, decreased right lung expansion, and hypotension associated with increased PaCO₂ on beginning mechanical ventilation post-intubation. Coupled with possible subcutaneous emphysema, the initial differential diagnosis was pneumothorax, mucus plug, or endobronchial intubation, as there was reduction or absence of breath sounds over the right lung. Endobronchial intubation was ruled out by withdrawing the ETT. Pneumothorax was ruled out by CXR. Therefore,
blockage of the ETT by a mucus plug was diagnosed by aspiration of moderate thick secretions and subsequent improvement in the patient’s condition. The first X-ray confirmed right upper lobe collapse. At the same time, the thoracic surgeons were consulted about the possible need for a chest tube if there was a pneumothorax. A repeat chest film demonstrated complete re-expansion of the collapsed lung and the patient’s hemodynamic status improved. Significant lung collapse is usually associated with hemodynamic instability due to mediastinal shift and decreased venous return, as occurred in our patient. While lung collapse and intraoperative hypoxemia have been reported previously, few of the cases involve mucous plugging and atelectasis. In the literature, there are five reports describing mucous plugging, all associated with orthopedic surgery following trauma and all diagnosed with chest radiographs. In these patients, the combination of recent trauma and surgery was the contributing factor to intraoperative atelectasis and lung collapse from mucous obstruction.

It is well known that airway obstruction during surgery may occur from many causes. When difficulty in ventilation occurs in an intubated patient, therefore, a rapid, well-formulated systematic approach to differential diagnosis is necessary. In this case, early detection of the airway obstruction was aided by increased peak airway pressure and $P_{A}CO_2$, a change in the capnograph waveform, and difficulty in manual ventilation. According to the algorithm for management of airway obstruction in anesthetized patients, we first inspected the anesthesia machine, the breathing circuit and the placement of the ETT. Subsequently, auscultation of the lungs revealed diminished breath sounds and no chest movement on the right side. In addition, deflation of the cuff did not result in improved ventilation or a significant leak around the ETT, excluding ETT obstruction secondary to cuff herniation and compression of the lumen by cuff overinflation. Then we attempted to pass a suction catheter down the ETT to differentiate between occlusion and other causes of increased inspiratory pressure. This proved to be both diagnostic and therapeutic. The presence of the mucus plug was shown by a CXR that confirmed complete whiteout of the right lung.

After an ETT obstruction is diagnosed, it is necessary to reopen the airway. Although different methods are available to remove the obstructing materials from the ETT — such as suction, forceps extraction, balloon embolectomy, and fiberoptic bronchoscopy — we feel that reintubation is the most appropriate way to establish a patent airway if direct
laryngoscopy is not difficult. If the initial laryngoscopy and intubation are difficult, however, ETT exchange using a fiberoptic bronchoscope should be the first option. Briefly, a new ETT is threaded over the FOB. After the FOB has passed the glottis into the middle of the trachea alongside the obstructed ETT, the obstructed ETT is carefully withdrawn and the new ETT advanced into the trachea.

In summary, we have presented an unusual case of ETT obstruction from mucous impaction in a healthy child undergoing general anesthesia. Based on our experience successfully managing this case, we emphasize that when difficulty in ventilation occurs during anesthesia, a quick differential diagnosis must be performed, followed by appropriate and prompt treatment to prevent further morbidity.

REFERENCES

Mass Media: Using Ebola as a Prime Example

VANESSA HOY, M.D.

As all New Yorkers know by now, the Ebola outbreak in West Africa has sparked not just an international response, but a local one as well. From the first index patient confirmed by the CDC on September 30, 2014, to the recent case of the New York City physician, the American public has followed each U.S. case closely. There are currently eight hospitals designated to handle Ebola in the state of New York, with additional hospitals that have also agreed to care for these patients. There are strict protocols and guidelines on how a hospital must be prepared to handle Ebola patients. One particular area of concern is an infected patient who requires emergent intubation. Before entering the room, the healthcare provider must put on the personal protective equipment (PPE). I was curious as to how long it would take for an anesthesiologist to intubate an Ebola patient. According to the American Society of Anesthesiologists (ASA) website, “Recommendations From the ASA Ebola Workgroup,” presented by the Committee on Trauma and Emergency Preparedness (COTEP) Subcommittee on Ebola, intubating an Ebola patient can potentially take up to 90 minutes if one takes into account the donning and doffing procedures. Once the anesthesia provider has worn the PPE, he/she also must to take into account the intubation and suctioning procedure that can potentially aerosolize the pathogen. It is clear that Ebola has affected every part of the hospital environment, from the staff to the equipment used.

Transitioning to the general public, what is public opinion regarding Ebola? After scouring the mass media, it appears that the majority of the public believes that the government should take action to treat Ebola. There is controversy, however, on whether to quarantine healthcare workers who return from West Africa. At a local level, several children of African decent were either barred from returning to school or were bullied by their peers because of Ebola fears. From this one situation, it is clear that social media has a significant impact on the general public. Not only can it stir up emotions and cause fear if events are not portrayed in the correct manner, but it is a powerful tool for communicating pertinent information and views to the masses.

Keeping the idea of social media in mind, I am very happy to introduce a new feature in Sphere, the Resident and Fellow Section (RFS) newsletter, contributed by RFS members Christopher Curatolo, M.D., and Shawn Sikka, M.D.
Dr. Curatolo is a CA2 anesthesiology resident at Mount Sinai Hospital in New York and currently serves as RFS president-elect. Among his many accomplishments, he served as a U.S. Navy submarine officer and nuclear engineer for six years. As a resident physician, he is heavily involved in both quality and advocacy measures at the departmental, institutional, state, and national levels. He has served on several NYSSA committees: Government and Legal Affairs, Economic Affairs, and Continuous Quality Improvement and Peer Review. Dr. Curatolo is a resident ASA delegate and a member of the ASA’s Committee on Performance and Outcomes Measurement.

Dr. Sikka is also a CA2 anesthesiology resident at Mount Sinai Hospital in New York. He is currently serving as the secretary and treasurer of the NYSSA RFS, and has served as a resident delegate for two years in the Resident Component House of Delegates at the ASA annual meeting. He plans to pursue a fellowship in pain management and is currently involved in a research project regarding intrathecal morphine for obstetric patients. Dr. Sikka dedicates his time to educating residents and colleagues and protecting the current model of physician-led, team-based surgical anesthesia care.

Both Drs. Curatolo and Sikka are deeply passionate about increasing resident advocacy in the field of anesthesiology. After attending the ASA legislative conference in Washington, D.C., as well as the NYSSA Legislative Day in Albany, Drs. Curatolo and Sikka concluded that the biggest barrier to resident advocacy is education. Residents simply are unaware of the critical issues affecting our specialty. Even more alarming is the realization that anesthesia residents will be most affected by these issues, as we have our entire careers ahead of us. Their vision for these newsletters is twofold: Educate fellow residents about the current issues affecting our specialty and provide residents with the tools they need to get involved and to tackle the issues at hand.

To that end, Drs. Curatolo and Sikka have sent a number of e-newsletters to anesthesiology residents at Mount Sinai, and they plan to expand their newsletter distribution to Saint Luke’s Roosevelt program in New York. Eventually, they would like to distribute these newsletters to all anesthesiology residencies. As Dr. Curatolo notes, the more informed we are, the more effective we can be at coming up with solutions that both recognize our specialty as a leader in patient safety and improve patient outcomes in the perioperative period. I hope these newsletters will
inspire you and provide the tools you need to participate in advocacy for our specialty, whether it is at the local, state, or national level.

Vanessa Hoy, M.D., is a CA2 anesthesiology resident at SUNY Upstate University Hospital.

NOTES


A Message to the NYSSA’s Resident Members

CHRIS J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

This is the inaugural edition of a newsletter aimed at all anesthesiology residents that explores our future in anesthesiology. While it is of great importance that we learn how to deliver anesthetics safely, it is also of great importance that all of us understand the current political, legal, and economic state of our specialty. Don’t worry, we intend to explain why.

The following is a true story. In 2012, an anesthesiologist was elected to the state Senate in Michigan; he took his job very seriously. One day, a group of motorcyclists showed up at the state capital to lobby for the repeal of the state’s mandatory motorcycle helmet law. The anesthesiologist immediately knew this was an absolutely terrible public health decision that would lead to an increase in head injuries, hospital admissions and deaths. As a physician, he knew how important it was to speak up so he vehemently opposed any legislation that would repeal helmet laws for bikers. What followed, however, was a persistent and well-orchestrated campaign by a small group of bikers to explain why helmets were bad. Helmets, they explained, were dangerous, and the bikers even produced a study they had commissioned that proved that helmets reduced their
peripheral vision and blocked out important sounds. Many of the bikers were also veterans and they argued that they had earned the right to ride a motorcycle without a helmet. At the end of the day, the Michigan state Senate voted to **REPEAL A MANDATORY MOTORCYCLE HELMET LAW** and the governor signed the legislation into law.

The physician anesthesiologist in the Michigan state Senate felt extremely defeated, but learned a very important lesson: It is LESS important who is right and wrong when it comes to lobbying for a particular cause. What is MORE important is having a clear message and being persistent. The bikers campaigned for years. They commissioned studies. Despite being clearly wrong and completely at odds with common sense, they convinced Michigan lawmakers, including the governor, that this was a good idea.

The same exact thing is happening in medicine right now. There is legislation EVERY YEAR that is introduced both in New York as well as at the federal level that is completely wrong and at odds with what we would consider good medical care. Why do these bills keep getting introduced? Because there are groups that are persistent, well funded, and deliver a clear message.

In summary, all of us need to be informed about what is happening outside the walls of our hospitals. People are advocating against the care that your patients deserve, care by a physician anesthesiologist. It is, therefore, equally important that members of our specialty also have a clear message and demonstrate persistence at both the state and federal levels so that our voices and the voices of our patients are heard. If you can repeal a mandatory state helmet law for motorcycles, you can do pretty much anything.

What we envision as we write this article is a newsletter that describes current legislation and hot topics in our great specialty. We will also discuss potential solutions and ways that all residents can become involved.

Get excited and stay tuned!

*Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesiology residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.*
We Must Stay Informed and Active

CHRIS J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

In our last newsletter, we presented a factual case in which a small group of Michigan residents successfully lobbied to repeal a mandatory state helmet law despite cries from public health officials. The residents were able to accomplish this because they were persistent, passionate, and presented “studies” they had commissioned.

Efforts like these are not restricted to helmet laws, and have occurred this year in our own specialty. Earlier this year in New York state, the New York State Association of Nurse Anesthetists (NYSANA) paid the University at Albany’s Center for Health Workforce Studies (CHWS) to conduct a study titled “Anesthesia Services Provided in Hospitals in Upstate New York.” The study was highly skewed and used carefully selected language to create the impression that the inability of nurses to practice independently is a barrier to patient care. What’s more, both nurse anesthetists and lobbyists presented the “findings” of this very skewed study to New York lawmakers earlier this year. Sound familiar to the Michigan story?

The study polled 28 hospitals in upstate New York. This represented only 13 percent of New York hospitals. The study also used leading questions on a scale known to produce response bias (only negative or neutral answer choices with no option for a positive response). It presented a “set of problems and barriers” to nurse anesthetist independent practice; these so-called “barriers” are really a set of protections for patients. Finally, the study highlighted that 40 percent to 50 percent of anesthesia services associated with inpatient and ambulatory surgeries and deliveries are provided by nurse anesthetists and that 50 percent to 60 percent are provided by anesthesiologists. (This information creates the illusion that nurse anesthetists are already delivering anesthesia independently in nearly half of all cases.) The unwillingness of surgeons to supervise nurse anesthetists was also cited as a severe problem and a reason to support independent practice.

The following “findings” are taken directly from the CHWS study:

“Nurse anesthetists lack the ability to prescribe medications and to write patient treatment orders.”
YES, because they lack the proper medical training to perform this duty safely.

“Nurse anesthetists lack the ability to conduct patients’ physical assessments.”

YES, because they lack the medical training to properly evaluate suitability to withstand surgery.

“Nurse anesthetists are not permitted under existing New York state Medicaid rules to bill independently.”

YES, because state law and the health code mandate that a nurse anesthetist work under the direct supervision of a physician anesthesiologist.

We urge all residents to stay up to date on ACTIVE issues that will affect our future practice. Highly skewed studies such as this one are being commissioned by special interest groups and are being used in state legislative offices TODAY to lobby for practices that are not in the best interests of our patients.

Here’s the good news: Our state organization, the New York State Society of Anesthesiologists (NYSSA) immediately produced a response to this study that included an independent review by a third party. Armed with the results of this review, physician anesthesiologists from across the state (including Drs. Lawrence Epstein and Jonathan Gal as well as several of us residents) descended upon Albany and met with lawmakers from all the major districts in New York. We must continue to present a clear message and remain as persistent as the other groups so that our voice and the voice of our patients are heard.

Stay informed, stay active, and protect our patients!

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesia residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.
Finding Ways to Make a Difference

CHRIS J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

The purpose of these newsletters is to encourage discussions about current issues that will have the most impact on residents since we are just beginning our careers. If we choose not to keep ourselves informed or do anything about these issues, we may find ourselves in a specialty that is radically different from what we imagined.

The VA’s new nursing handbook contains a very disturbing proposal to require all advanced practice nurse practitioners (NPs) and nurse anesthetists to practice independently. The VA would abandon the current consensus model of physician-led, team-based surgical anesthesia care and replace it with solo nursing care. Nearly 70 of the VA’s own surgical anesthesia experts, including the VA chiefs of anesthesiology, informed VA leadership that the new policy “would directly compromise patient safety and limit our ability to provide quality care to veterans.” Concerns to VA leadership were also voiced by prominent national veterans service organizations such as AMVETS and the Association of the United States Navy.

The ASA, via its political action committee, contacted lawmakers, educated them, and helped congressional members Ann Kirkpatrick (D-Ariz.) and Michael Grimm (R-N.Y.) co-author a letter to the VA director that was signed by more than 40 members of Congress.

Expanding the scope of practice of primary care NPs could ease the burden caused by a lack of primary care resources in the VA. In an outpatient clinic, however, mistakes or incomplete treatment regimens have a time scale of days to weeks or more. In an operating room, the time scale is on the order of seconds to minutes. Thus, it is completely inappropriate to apply the same potential policy to primary care clinics and operating rooms.

Given the fact that one of us is a veteran who was twice deployed overseas, we are horrified by this policy proposal. It should be noted that not all veterans can use the VA. A veteran often must demonstrate a service-related disability even to be eligible for VA healthcare. Retired veterans and active duty personnel use Department of Defense hospitals, not VA hospitals. What’s more, higher socioeconomic status (SES) VA-eligible veterans preferentially use other health insurance through their jobs.
instead of the VA. The veterans who use the VA are, therefore, usually of a lower SES, which correlates with more coexisting disease as well as an increased risk of morbidity and mortality during and after surgery. Additionally, the proposal would create a two-tier healthcare system in which the standard of care at a VA hospital would be different from that of all other hospitals in the state — a clear health justice concern.

What’s more, the VA is experiencing huge credibility issues, having recently been in the news because of forged records related to long wait times at clinics in Arizona. Some wait times were even linked to veteran deaths as they waited for appointments. As a result of these investigations, the secretary of the VA recently resigned. It is hardly a good time to consider reducing the level of care for our veterans.

While this is a scary issue with potentially huge ramifications not only for veteran healthcare but also the U.S. healthcare system in general, it is important to know that the ASA’s political action committee (ASAPAC) has been fighting this issue and others like it on a daily basis. With a fully staffed Washington office, the ASAPAC has relationships with lawmakers and policymakers across government. They are able to communicate our concerns and the concerns of our patients to those who need to hear the other side of the story.

Members of the NYSSA traveled to Washington, D.C., earlier this year to discuss such issues with members of Congress. Physicians have a lot of credibility in Washington. This is why it is so important to maintain an active PAC to discuss these issues with both state and federal lawmakers on a regular basis. The nurse anesthetist lobbyists were literally on Capitol Hill days before we got there. Imagine if we, as physician anesthesiologists, didn’t show up or have representation. If you are a lawmaker and only hear one side of a story, what would you think? We cannot assume that a lawmaker who lacks medical training and is supplied with incomplete information will act in the best interests of our specialty and patients.

If you want your voice and the voice of your patients heard, you have two options: Give your time by becoming an advocate and partnering with the ASA Grassroots Network to meet with local policymakers (http://grassroots.asahq.org). If you don’t have time to do that, as many physicians understandably do not, you can donate to physician anesthesiologist political action committees so that someone can represent you. These PACS fight every day to protect the current physician-led
anesthesia work model by making phone calls, sending letters and emails, meeting with members of Congress, and updating ASA members.

If you want to have a tangible impact on the course of this potential policy change at the VA, we urge you to donate to ASAPAC. The suggested contribution amount for residents is $20. Last year, there were 39 anesthesia residencies that had 100 percent participation in ASAPAC. We should all work hard to ensure that the names of our programs are on that list every year!

To donate to ASAPAC, visit www.asahq.org/asapac.aspx and sign in with your ASA member login.

Thanks for reading this and showing your interest in your own future, and the future of your specialty. Together, we really can make a difference! ■

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesiology residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.

From the NYSSA Resident and Fellow Section

Publish Your Case Report in Sphere

- If you have an interesting case
- If you are ready to share your experience
- If you are interested in building your CV

You can submit your case report for publication in Sphere. All cases will be reviewed and the most interesting published.

Submit your case report via e-mail to maryann@nyssa-pga.org. Subject: Article for Sphere

If you have questions, call MaryAnn Peck at NYSSA headquarters: 212-867-7140.
Membership Update

New or Reinstated Members
July 1 – September 30, 2014

Active Members

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Cyzar Arca, M.D.
Muhammad Iqbal, M.B., B.S.
Ni Khin, M.B., B.S.
Lijin Liang, M.D.
Roman Lorin, M.D.
Spencer Lubin, M.D.
Boris Tsemekhin, M.D.
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Joseph Hung, M.D.
Christopher Legga, M.D.
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Anna Ng-Pellegrino, M.D.
Raj Parekh, M.D.
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Robert Ross, M.D.
Anthony Saviri, M.D.
Neeta Singh, M.D.
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Jing Wang, M.D.
Cindy Wang, M.D.
Albert C. Yeung, M.D.

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Ashley Caggiano, M.D.
Eric M. Diana, M.D.
Jason Epstein, M.D.
Karina Gritsenko, M.D.
Christen-Jennifer Lee, M.D.
Ethan Leer, M.D.
Ananth Mothukuri, M.B., B.S.

**DISTRICT 4**
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Amar Parikh, M.D.

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Vandana Sharma, M.D.
Xi Yang, M.D.

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Luciana Curia, M.D.
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Jeremy McKay, M.D.
Jennifer Mogan, M.D.
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Helen Nazareth, M.D.
Carin Tauriello, M.D.

**DISTRICT 8**
Qiao Guo, M.D.
Emily Lin, M.D.
Robert Oldaker, M.D.
Neera Tewari, D.O.
Membership Update

New or Reinstated Members
July 1 – September 30, 2014

Medical Student

Daina Blitz

Affiliate

DISTRICT 3
Limei Cheng, Ph.D.

Resident Members

DISTRICT 1
Elio Beta, M.D.
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Edwin Chan, M.D.
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Annekay Forbes, M.D.
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David Williams, M.D.

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Devon Flaherty, M.D.
Kenneth Flax, M.D.
Scott Hayes, M.D.
Hannah Hsieh, M.D.
Samuel Hunter, M.D.
Brandon Kandarian, M.D.
Arif Khan, M.D.
Daniel Kohut, M.D.
Membership Update

New or Reinstated Members
July 1 – September 30, 2014

Resident Members continued

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Jacob LaSalle, M.D.
Matthew Lee, M.D.
Vicky Liu, M.D.
Robert Locke, M.D.
Sha Sha Lu, M.D.
Andrea Luncheon-Hilliman, M.D.
Olga Martins, M.D.
James McKeever, M.D.
Calvin Moh, M.D.
Quo-Sy Nguyen, M.D.
Anand Nogori, M.D.
Michael Oleyar, D.O.
Thomas Palaia, M.D.
Nandini Palaniappa, M.D.
Joseph Park, M.D.
Hersh Patel, M.D.
Manan Patel, M.D.
Nikita Patel, M.D.
Sunny Patel, M.D.
Joseph Poli, M.D.
Liliya Pospishil, M.D.
Saad Rasheed, M.D.
Nicolette Schlichting, M.D.
Samion Shabasher, M.D.
Marc Sherwin, M.D.
Patrick Smollen, M.D.
Tiffany Sou, M.D.
Elaine Spaeth, M.D.
Will Sun, M.D.
Corey Tong, M.D.
Kevin Turezyn, M.D.
Rishi Vashishta, M.D.
Justine Viola, M.D.
Ashley Wells, M.D.
Sunny Whisnant, M.D.
Boris Yaguola, M.D.
James Yeh, M.D.

DISTRICT 3
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Sara Aljohani, M.D.
Ratan Banik, M.D.
Adam Bromberg, M.D.
Marc Cohen, M.D.
Jacob Esquenazi, M.D.
Tracey Gibson, M.D.
Christine Hardeway, M.D.
Cindy Hernandez, M.D.
John Hui, M.D.
Faizan Kalwar, M.D.
Donguk Nam, M.D.
Sakina Nayaz, M.D.
Robyn Pallack, M.D.
Devina Persaud, M.D.
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Dmitry Rozin, M.D.
Suretti Singh, M.D.
Max Snyder, M.D.
Satish Vembu, M.D.
Elizabeth Vue, M.D.
Camari Wallace, M.D.
Membership Update

New or Reinstated Members
July 1 – September 30, 2014

Resident Members continued

DISTRICT 4
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Kareem Kassel, M.D.
Matthew Lawrence, M.D.
Chyong-Jy Liu, M.D.
Jazelle Mealing, M.D.
Jenny Woo, M.D.

DISTRICT 5
Michael DeCicca, M.D.
Indervir Grewal, M.D.
Matthew Lilien, M.D.

DISTRICT 7
Jane Arcadi, M.D.
Joseph Cerminara, M.D.
Francis Chang, M.D.
Ivan Cohen, M.D.
Jose Cruz, M.D.
Dili Dhanani, M.D.
Zain Hasan, M.D.
Krunal Patel, D.O.
Darius Sefidrou, M.D.
Subin Sharma, M.D.
Cyrus Tanhaee, M.D.
Vandana Vedanarayanan, M.D.

Recently Retired Members

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Paul Flangos, M.D.

DISTRICT 4
Ronaldo Gonzalez, M.D.

DISTRICT 5
Soon Park, M.D.

DISTRICT 8
Michael Meyers, M.D.
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