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The New York State Society of Anesthesiologists, Inc.
Inside This Issue:

3 President’s Message
Ensuring a Bright Future
MICHAEL P. DUFFY, M.D.

7 Editorial
Senate Rejects AANA Effort to Mandate VA ‘Independent’ Nurse-Only Anesthesia
JASON LOK, M.D.

9 The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai: A Long History in the Specialty of Anesthesiology
INGRID HOLLINGER, M.D.

25 App Review
Double Lumen Simulator: An iPad App Review
DIVYA CHERUKPALLI, M.D.

28 Euroanaesthesia 2014 and the Canadian Anesthesiologists’ Society Annual Meeting

30 Supporting New York Legislators

32 2015 New York State Fair

33 Albany Report
Legislative Update
CHARLES J. ASSINI, JR., ESQ.

45 Case Report
Spontaneous Cerebral Spinal Fluid Leak and Intracranial Hypotension During Pregnancy
JOHN K. AIDONIS, M.D., M.S., AND SANFORD MILLER, M.D.

53 Resident and Fellow Section
Be Successful in a Pay-for-Performance Era
CHRIS J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

54 Ensuring Access to Vital Anesthesia Services
CHRIS J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

58 Membership Update

On the cover:
An evening view of the campus of The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai, bordered by Central Park on Manhattan's Upper East Side.
SPHERE
Editors

Paul M. Wood, M.D.
1948                                   Vol. 1
 (Newsletter)

Morris Bien, M.D.
 (Bulletin)

Thomas F. McDermott, M.D.
1950-1952                                Vol. 2-4

Louis R. Orkin, M.D.
1953-1955                                Vol. 5-7

William S. Howland, M.D.
1956-1960                                Vol. 8-12

Robert G. Hicks, M.D.

Berthold Zoffer, M.D. (Emeritus)
1964-1978                                Vol. 16-30
 (Sphere ’72)

Erwin Lear, M.D. (Emeritus)
1978-1984                                Vol. 30-36

Elizabeth A.M. Frost, M.D.

Alexander W. Gotta, M.D.
1989-1990                                Vol. 41-42

Mark J. Lema, M.D., Ph.D.
1991-1996                                Vol. 43-48

Douglas R. Bacon, M.D., M.A.
1997-2000                                Vol. 49-52

Margaret G. Pratila, M.D.
2000-2006                                Vol. 52-58

James E. Szalados, M.D., M.B.A., Esq.
2007-2011                                Vol. 59-63

Jason Lok, M.D.
2011-                                    Vol. 63-

SPHERE
Editorial Board

Editor:                                     District
Jason Lok, M.D.                             5

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Sanford M. Miller, M.D.                    2

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Christopher Campese, M.D.                  8
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Kevin Glassman, M.D.                       8
Michael Jakubowski, M.D.                   4
Jung Kim, M.D.                              2
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Francis Stellaccio, M.D.                   8
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Kurt Weissend, M.D.                         6

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Vanessa Hoy, M.D.                           5

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Based upon the immense popularity of various books about our Founding Fathers, I must be but one of many NYSSA members who have enjoyed reading the fascinating personal histories of America’s founders. They were quixotic individuals who voiced extraordinary humanistic compassion but often failed to live up to their own ideals. Certainly it is well known that Benjamin Franklin, George Washington, Thomas Jefferson and James Madison were all deeply committed to personal freedom while owning slaves. Our third and fourth presidents, Thomas Jefferson and James Madison, were particularly close friends; however, they differed on one’s obligation to future generations. In response to Jefferson’s “The Earth Belongs to the Living,” Madison offers a rare criticism of Jefferson: “… There is instead a seamless web of obligatory connections between past and present generations.” I tend to agree with Madison: we have an obligation to future generations for the wonderful profession we inherited. Through mentorship, education, and advocacy we can pay this debt forward.

In 1847, the AMA was created “to promote the science and art of medicine and the betterment of public health.” In 1905, nine physicians organized the Long Island Society of Anesthesia, the first professional anesthesia society. In 1911, the Society expanded geographically into Manhattan and increased its numbers to 23 members, and thus became the New York Society of Anesthetists. Over the next 25 years, involvement in anesthesia-related issues grew, attracting other interested physicians nationwide. In 1936, the Society changed its name to the American Society of Anesthetists, then the American Society of Anesthesiologists. With this history in mind, I hope that each of our members will pick out a junior member to mentor, inspire and support to become a future leader. Work with that individual and leave your own legacy for our collective future. Be generous with your time, your patience, and your praise. We need to be advisors for future anesthesiologists and assure them that the profession of anesthesiology has not only a long history but also a bright future.
Patient safety has always been our number one priority. Over the past several years, the “patient experience” has become a major metric but its value and relationship to outcome has been hard to quantify. The NYSSA has been fortunate that a patient has reached out to us to advocate for change. Ms. Carol Ann Rinzler is an author and activist who has offered us a patient-based perspective on the anesthesia experience. Ms. Rinzler shared her insight that to influence patient outcomes, a shared accountability and partnering will be needed. The value of the patient as teacher was brought home to those of us who followed her communications. The Executive Committee, with full support of the Board of Directors, will present the NYSSA inaugural “Patient Safety Advocate Award” to Ms. Rinzler at this year’s PGA, with the hope that this will be the first of many such awards. Similarly the “Committee on Continuous Quality Improvement and Peer Review” will be renamed the “Committee for Patient Safety” to reflect this emphasis. Lastly, in the future an effort will be made to include patient advocates within this committee’s deliberations.

Another legacy we hope to improve upon is the Anesthesiology Foundation of New York (AFNY). AFNY is a 501(c)(3) non-profit that I hope can be developed to support the NYSSA’s future educational endeavors. One of the goals has been to support the participation of anesthesiologists from emerging nations at the PGA. With your contributions and under the leadership of Dr. Elizabeth Frost, the PGA has one of the most successful programs bridging the educational divide between the U.S. and emerging nations. However, this is just but one possible mission of a foundation supporting anesthesia education. We hope that we might build upon this success to establish a protected principal so that our AFNY can supplement and assure a bright future for the PGA. Visit http://nyanesthesiologyfoundation.org and consider making a donation today.

This year we experienced a difficult legislative session in New York. However, thanks to the tireless efforts of many individuals, including our lobbyists, headed by Mr. Reid; our attorney, Mr. Assini; our executive director, Mr. Hayman; the Executive Committee; and the Government and Legal Affairs Committee, we were able to galvanize our members into action. More than half of you responded using the CapWiz to contact legislators. This is a highly efficient advocacy tool; with each use, I received a response from each of my legislators. For those who did not participate, this process takes less than
three minutes to use, even with my “caveman” level Internet skills. We cannot refuse to learn this new technology; that is not in our social DNA. I fully understand the many members who are frustrated by legislators of questionable integrity as well as by endlessly recurring practice issues, but I am mystified by members who neither engage nor donate yet continue to complain. Perhaps it was best said by Thomas Jefferson: “We in America do not have government by the majority. We have government by the majority who participate.” Donation forms for NYAPAC can be found at www.nyssa-pga.org/wp-content/uploads/2014/02/NYAPAC-form-for-PGA.pdf.

As I look forward to my last few months as president, I want to thank all our members for allowing me to lead this wonderful organization. I also wish to thank the past NYSSA presidents, especially Drs. Lawrence Epstein and Michael Simon, for their shared wisdom and insights. I wish to thank our future presidents, Drs. Andrew Rosenberg and Rose Berkun, for their advice and enthusiasm. Lastly, I would be remiss if I did not thank Drs. David Wlody, David Bronheim, Vilma Joseph, and Scott Groudine, who, along with Mr. Stuart Hayman and his staff, have made this an enjoyable experience.

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 22 years, more than 325 anesthesiologists representing 59 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](http://nyanesthesiologyfoundation.org) and make your donation today.
ESA Focus Meeting on Perioperative Medicine:
The Cardiac Patient

13-14 November 2015
Nice, France
The U.S. Senate recently rejected efforts by the American Association of Nurse Anesthetists (AANA) to remove physician anesthesiologists from veterans’ care teams. The AANA had sought to promote the “independent” practice of nurse anesthetists within the VA health system. The good news is that the organization’s most recent efforts toward that goal were unsuccessful.

Unfortunately, the AANA will continue to seek ways to expand nurse anesthetists’ scope of practice through legislation rather than medical school education and the experience gained during residency and/or fellowship training. This foray now extends beyond the delivery of anesthesia to include pain medicine as well. I hope that our members will be proactive by investing time and/or money in response to this ongoing threat. For example, we can participate in the NYSSA’s annual Legislative Day in Albany. We can solicit our colleagues who have not yet joined the NYSSA or the ASA. Finally, we can contribute to NYAPAC and ASAPAC. Our joint efforts will help to safeguard our practices and, more importantly, our patients’ quality of care.

If you have not checked out our Facebook page yet, please visit www.facebook.com/nyssapga. We have 1,424 likes as of July 2015. Our Facebook page has information on our headquarters and our upcoming 69th annual PGA, links to Sphere archives dating back to 1983, and a collection of photos and videos of our NYSSA officers at work representing us and advocating for our patients.

With this issue of Sphere, we proudly showcase the fascinating history and prominent leaders of The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai. Many impressive details were provided by Sphere’s associate editor, Dr. Ingrid Hollinger. I personally was fascinated by the hospital’s humble beginnings. This feature
article follows the profile of SUNY Downstate, written by Dr. Mark Jensen, that was published in our summer issue. If you don’t have a copy of the summer issue, you can download it, along with other past issues dating as far back as 1983, at www.nyssa-pga.org.

Dr. Srinivasa Thota organized the NYSSA presence at this year’s annual New York State Fair in Syracuse, New York. The fair was held August 27 to September 7. I wish to extend many thanks to those who volunteered their time to educate New Yorkers about who we are and how we make a difference in their healthcare.

As we enjoy fall, I hope to meet many of you at the ASA annual meeting in San Diego or at the NYSSA’s 69th annual PGA. If you have any suggestions for future articles, please do not hesitate to discuss them with me at one of these events, or contact me at jlokmd@yahoo.com or Stuart Hayman at stuart@nyssa-pga.org.

Participate in the Democratic Process

You have an opportunity to voice your opinions on positions and policies of the New York State Society of Anesthesiologists at the annual Reference Committee Hearing, which is open to the membership at large.

REFERENCE COMMITTEE
Saturday, December 12, 1:45 p.m., Marquis Ballroom (9th floor)
Reviewing: Officers and Directors reports; Bylaws & Rules; Communications; Government & Legal Affairs; Economic Affairs; Continuous Quality Improvement & Peer Review; Pain Management; Critical Care Medicine; Judicial & Awards; Annual Sessions; Continuing Medical Education & Remediation; Academic Anesthesiology; and Retirement committee reports.

LOCATION: The New York Marriott Marquis
1535 Broadway (between 45th and 46th Streets)
New York, New York

All Officer, Director, Standing Committee, and Board of Directors’ reports are subject to review by a panel of your peers and are discussed at this open forum.

Please come to listen, learn, and, if you wish, to speak. Here’s your chance to have a direct impact on the decision-making processes that will steer the New York State Society of Anesthesiologists into the future.

For additional information, contact Stuart A. Hayman, executive director, at NYSSA headquarters.
The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai: A Long History in the Specialty of Anesthesiology

INGRID HOLLINGER, M.D.

The mission of The Mount Sinai Hospital is to pursue excellence in patient care, education, research, and community service. This is also the mission of the Department of Anesthesiology

The roots of the current hospital go back to 1852, when nine altruistic men established the “Jews’ Hospital” to care for “indigent Hebrews” and others. The original hospital building opened in 1855, was located in lower Manhattan, and accommodated 45 patients. It was a completely charitable enterprise. In the 1860s, the hospital cared for Union Army soldiers and draft rioters and was clearly no longer a sectarian hospital. In 1866, its name was changed by the New York state Legislature to “The Mount Sinai Hospital.”
When the hospital outgrew its original location, it moved in 1872 to Lexington Avenue between 66th and 67th streets. The institution would remain at this location until 1904. This period was marked by the creation of an outpatient department (1875), a school of nursing (1881), and the establishment of a formal house staff in 1872 (although teaching was not an official mission of the institution at that time).

The hospital developed specialty wards, including surgery, pediatric eye and ear, neurology, genitourinary, and dermatology. Early giants in American medicine practiced at the Lexington location. These included Bernard Sachs, who described the first American case of Tay-Sachs disease, and Arpad Gester, who wrote the first American textbook on aseptic and antiseptic surgery. The pediatric service was created in 1864 by Abraham Jacobi — the father of American pediatrics. His wife was the first woman to graduate from a formal house staff program when she received her Mount Sinai diploma in 1882.

Sculpture and sunlight permeate the soaring lobby of the Leon and Norma Hess Center for Science and Medicine on the campus of the Mount Sinai Health System.
On March 15, 1904, The Mount Sinai Hospital moved to a new campus at 5th Avenue and 100th Street, where it resides to this day, extending from 98th Street to 102nd Street between Madison and 5th avenues. At the new location, the hospital added research and medical education as important adjuncts to its patient care mission. During this expansion era, Mount Sinai contributed important new discoveries, including the use of citrate to store blood for transfusion and the first clinical description of regional ileitis by Ginzburg, Oppenheimer, and Crohn.

As Mount Sinai’s commitment to teaching grew over the first half of the 20th century, the hospital entered into a formal agreement with Columbia University to integrate the post-graduate training of interns and residents into the Columbia program.

In 1963, the Mount Sinai School of Medicine was chartered. The school admitted its first class of medical students in 1968 in affiliation with the City University of New York. In 1999, the School of Medicine changed its affiliation to New York University without merging with its medical school. This affiliation was terminated in 2007. In 2010, the Middle States Commission on Higher Education accredited the Mount Sinai School of Medicine as an independent degree-granting institution. In 2012, the school was renamed the Icahn School of Medicine at Mount Sinai. The school offers postgraduate training programs at its Mount Sinai Health System hospitals and the Graduate School of Biological Sciences.

In September 2013, Mount Sinai and Continuum Health Partners joined to form the Mount Sinai Health System. It includes seven hospitals: The Mount Sinai Hospital, Mount Sinai Queens, Mount Sinai Beth Israel, Mount Sinai Brooklyn, Mount Sinai New York Eye and Ear Infirmary, Mount Sinai Roosevelt Hospital, and Mount Sinai St. Luke’s Hospital. The system comprises 3,571 beds, 138 operating rooms, 12 freestanding ambulatory surgical centers, and 31 community health centers. There are more than 5,000 faculty members at the school and more than 2,000 students, residents and fellows. More than 6,500 physicians practice at the system’s hospitals, which employ 35,000 people.

The Department of Anesthesiology in the Icahn School of Medicine at Mount Sinai has a long and illustrious history. In March 1902, the position of anesthetist was created by the board of the hospital following concerns about the quality of anesthesia services in the surgical service.
Dr. M. L. Maduro and Dr. C.P. Denton shared this position. Their goal was to instruct incoming house staff in the safe administration of anesthetics. Dr. Carl Koller, the discoverer of cocaine as a local anesthetic, joined the Mount Sinai faculty in 1890, and local anesthesia with cocaine became popular on the surgical service. In February 1910, Dr. Charles Elsberg demonstrated the first intratracheal insufflation of anesthesia in humans and developed the first positive pressure anesthesia machine, which allowed surgery in the thorax.

Drs. William Branower and Bernard Eliasberg developed a cadre of trained anesthetists that, by 1940, consisted of more than 10 physicians and nurses. Dr. Eliasberg was one of the anesthesiologists involved in the incorporation of the New York State Society of Anesthesiologists and an original member of the American Board of Anesthesiologists. The first resident in anesthesiology graduated in 1943. Dr. Eliasberg retired in 1950 and was succeeded by chairs including Drs. Milton Adelman, Leslie Rendell-Baker, David Stark, Joel Kaplan, Paul Goldiner, David Reich and, since 2014, Andrew Leibowitz. The department integrated practices at Mount Sinai St. Luke’s and Mount Sinai Roosevelt Hospital in November 2014. The department is comprised of 150 faculty members and 150 trainees (residents and fellows) and employs a staff of more than 60 administrative, technical and clinical professionals at these hospitals. There are plans to integrate practices at Mount Sinai Beth Israel in January 2016 and Mount Sinai New York Eye and Ear in the future.

The department is proud of its faculty, many of whom are full professors and associate professors in the School of Medicine. The department was one of the early adopters of electronic recordkeeping and has developed a leading role in anesthesia informatics.

The department staffs the cardiothoracic surgical ICU and jointly staffs the surgical ICUs through its participation in and leadership of the Institute for Critical Care Medicine. The department is organized to include subspecialty groups with certified subspecialists devoted to critical care, cardiothoracic anesthesia, pediatric anesthesia, liver transplantation, obstetrical anesthesia, neurosurgical anesthesia, minimally invasive and bariatric surgery, regional anesthesia, office-based anesthesia, and a wide range of other subspecialties that reflect the diversity of the specialty. Members of the department also serve in administrative positions such as
medical director of the operating rooms, on multiple hospital quality committees, and in the office of excellence in patient care and patient safety initiatives.

The Pain Management Division includes several ambulatory practices, as well as acute and chronic inpatient pain practices. Our pain management and integrative medicine programs include an ACGME-approved fellowship program and AAAHC-accredited interventional pain facility.

The cardiothoracic anesthesia group has 13 members, and this entire faculty is certified by the National Board of Echocardiography. The cardiothoracic anesthesia fellowship was among the first in the nation to achieve ACGME certification. The research and clinical strengths of the division include transesophageal echocardiography, neurological outcomes following circulatory arrest, mitral valve repair procedures, complex aortic surgery, congenital heart disease, and complex thoracic surgery.

Another point of excellence in the department is our high fidelity patient simulation facility known as the HELPS (Human Emulation, Education, and Evaluation Lab for Patient Safety and Professional Study) Center. In 1994, under the leadership of Dr. Joel Kaplan, the HELPS Center became one of the first simulation centers.
programs in the world. It served as a beta test site for the University of Florida Gainesville Simulator, now known as the CAE-METI HPS simulator. Our original simulator facility (manufactured by Loral) was housed in an operating room at our affiliate site, the James J. Peters VA Medical Center in the Bronx. It was moved to the Mount Sinai campus in 1995 and settled in its permanent site within the department’s administrative suite in 2002. Although modest in space, at just over 1,500 square feet, the Center is prolific in terms of academic and educational activities. In addition to resident and medical student education, the facility is used extensively by the School of Medicine, other clinical departments, and other residency programs in the New York metropolitan area. It was one of the first programs to achieve ASA endorsement and is currently the busiest center providing MOCA simulation for ABA recertification. The Center also provides quality and patient safety initiatives for the Hospitals Insurance Company training faculty and CRNAs from five New York City hospitals. Its unique CARE (Clinical Anesthesia ReEntry) program provides simulation-based retraining and high-stakes assessments for anesthesiologists on clinical hiatus who are seeking re-entry into clinical activities. The HELPS Center also hosts community groups and colleagues from industry and the media. Center faculty participate in the AHRQ-funded MOCA Middle school students enrolled in a summer immersion program in medicine participate in a simulator session at the HELPS Center.
simulation research consortium investigating the use of simulation-based assessment and are senior editors of the “The Comprehensive Textbook of Healthcare Simulation.” They are actively investigating manipulatable parameters that make simulation a unique educational method.

Outstanding members of the department include:

Bernard H. Eliasberg, M.D., graduated from Cornell in 1906 and joined the Mount Sinai Hospital faculty. In 1910 he was appointed anesthetist and from 1943 to 1950 he served as chief anesthesiologist. He received Mount Sinai’s Jacobi award in 1958. Dr. Eliasberg trained hundreds of residents and is one of the anesthesiologists involved in incorporating the NYSSA, as well as an original board member of the ABA. He passed away in 1962 and a lecture was established in his memory starting in 1963.

The first lecturer was Dr. William W. Mushin. The Bernard H. Eliasberg medal has been awarded annually since 1977 to a distinguished individual who has made significant contributions to anesthesiology, critical care and pain management. From 1991 to 2005 the Eliasberg lecture was part of the New York Anesthesiology Review. Since 2006 the lecture and award have been presented at the Icahn School of Medicine at Mount Sinai.

Leslie Rendell-Baker, M.D., trained in Great Britain and Pittsburgh and, after a five-year stay at Case Western Reserve University Hospital, he became chairman of the newly created Department of Anesthesiology at Mount Sinai in 1962. The department became part of the medical school in 1968. He dedicated his career to improving patient safety and reducing anesthesia morbidity and mortality. Together with the chairman of surgery, he spearheaded the founding of one of the first surgical intensive care units staffed by full-time physicians from surgery and anesthesiology. He developed the Rendell-Baker Soucek mask for pediatric anesthesia, which is still the basis of all masks designed for pediatric resuscitation today. As
chairman of the Z-79 Anesthesia Standards Committee of the American National Standards Association, he was responsible for the development and adoption of the international standard for anesthesia circuit connections 15 mm male/22 mm female. He was also responsible for the adoption of the rabbit muscle implantation test for all endotracheal tubes, Z 79 I.T., which still is the standard today. He developed standard Z 79.8 in 1979, which required that the oxygen flowmeter was to be fluted for easy identification and located on the right side of the flow meters, downstream from all other gases. This ensured that in case of a leak, oxygen would still flow to the patient. The standard also required the use of an oxygen analyzer, complete with an audible alarm for low oxygen concentration, to monitor the gas mixture going to the patient. His committee also introduced the DISS fittings, which are specific to each gas and do not allow misconnections of gas hoses and outlets. In addition, this standard includes agent-specific filling systems. All these standards still apply today. In 1979, Dr. Rendell-Baker stepped down as chairman and moved to California, where he continued to practice at the VA hospital in Loma Linda until 1998. He died in 2008, having trained four generations of anesthesiologists and leaving us anesthesia equipment standards that formed the foundation of anesthesia equipment safety in the U.S. and the world.

Joel Kaplan, M.D., received his medical degree from Jefferson Medical College in Philadelphia. After starting his training in cardiology, he changed to anesthesiology and completed a residency at the University of Pennsylvania. After serving two years in the U.S. Army, he joined the faculty at Emory University as chief of cardiac anesthesia in 1974. In 1983 he was appointed chair of the Department of Anesthesiology at the Mount Sinai School of Medicine and became the first Horace Goldsmith Professor of Anesthesiology. In 1998 he left Mount Sinai to become vice president for health affairs, dean of the School of Medicine, and senior vice provost for academic affairs at the University of Louisville in Louisville, Kentucky. Subsequently, he moved to California and is presently on the cardiothoracic anesthesia faculty of the University of California San Diego. Dr. Kaplan is a prolific writer who has authored
or co-authored more than 200 manuscripts, textbooks and review articles. He is best known as editor of Kaplan’s Cardiac Anesthesia, presently in its 6th edition. He has been the editor-in-chief of the Journal of Cardiothoracic and Vascular Anesthesia since 1986, and previously served as editor-in-chief of Seminars in Cardiothoracic and Vascular Anesthesia and Cardiothoracic and Vascular Anesthesia Updates. He was the recipient of the Eliasberg Medal in 2004.

Paul Goldiner, M.D., started out as a dentist and worked for the U.S. Army in Germany. After his service, he returned to the U.S. to pursue training in medicine at New York University Medical School. He completed a residency in anesthesiology at New York Hospital, Cornell Medical School and joined the faculty at Memorial Sloan-Kettering Cancer Center (MSKCC). During his time at MSKCC, he developed their intensive care unit and ICU training program and set up their respiratory therapy program. He was chairman of the Department of Anesthesiology at MSKCC from 1979 to 1985. In 1985, he was appointed professor and chairman of the Department of Anesthesiology at Albert Einstein College of Medicine.

In 1992, Dr. Goldiner left Einstein to join the faculty at the Mount Sinai School of Medicine. In 1998, he was appointed interim chair and in 1999 chair of the Department of Anesthesiology at the Mount Sinai School of Medicine. He retired in 2004. Dr. Goldiner has the distinction of having been chairman of three outstanding departments of anesthesia in New York City. He also served the NYSSA in multiple offices: he was president in 1994 and was business manager of the PGA from 1997 until 2013. He continues as medical director and teaches at the Borough of Manhattan Community College Respiratory Therapy Program. He is also an examiner for the National Board for Respiratory Care. Dr. Goldiner served for many years as the ASA liaison to the American Dental Association and as a member of the ASA Committee on Respiratory Care. He received the Eliasberg medal in 2003.
David L. Reich, M.D., arrived at Mount Sinai in 1984 and completed a residency in anesthesiology and a fellowship in cardiothoracic anesthesia. He served as the Horace W. Goldsmith Professor and chair of anesthesiology from 2004 to 2014 and was named president and COO of The Mount Sinai Hospital in 2013. Dr. Reich’s research interests include neurocognitive outcomes following thoracic aortic surgery, outcome effects of intraoperative hemodynamics, medical informatics, and hemodynamic monitoring. He has published more than 130 peer-reviewed articles, 30 invited articles or editorials, and 30 book chapters. He is an associate editor of the text *Cardiac Anesthesia* and editor of *Monitoring in Anesthesia and Perioperative Care*. He is co-editor of the first edition of *Perioperative Transesophageal Echocardiography*. He is a member of the International Organization for Terminology in Anesthesia (IOTA) of the Anesthesia Patient Safety Foundation, and works with IHTDSO and HL7 to create international standards for anesthesia terminology for electronic patient records. Dr. Reich serves on the editorial board of the *Journal of Cardiothoracic and Vascular Anesthesia*. At Mount Sinai, he has served for more than 10 years on the Appointments and Promotions Committee. Dr. Reich also served as the president of the medical board in 2011-2012. He is one of the course directors of the law and business of medicine elective for the medical school and continues to hold the Horace W. Goldsmith Professorship.

Andrew B. Leibowitz, M.D., graduated from the Mount Sinai School of Medicine in 1983 and completed a residency in internal medicine at Montefiore Medical Center, followed by an anesthesia residency and critical care fellowship at Mount Sinai. In 1989 he joined the faculty in the Department of Anesthesiology and the Department of Surgery, dividing his clinical practice between the operating room and surgical intensive care unit. He developed the surgical nutrition support service and the central access program for Mount Sinai and served as director of the Anesthesiology Critical Care Fellowship. He is board certified in internal medicine, anesthesiology and critical care and
has been a professor of anesthesiology and surgery at the Mount Sinai School of Medicine since 2009. He was appointed executive vice chair of the Department of Anesthesiology in 2004 and became the system chair of anesthesiology at the Icahn School of Medicine at Mount Sinai in March 2014. He also serves as the interim director of the Institute for Critical Care Medicine at Mount Sinai. He is recognized as an outstanding teacher and has received the best teacher award for several years running from the residents and critical care fellows. He serves on the editorial boards of the *Journal of Cardiothoracic and Vascular Anesthesia* and *ICU Director* and is a reviewer for *Critical Care Medicine* and *Chest*.

Meg Rosenblatt, M.D., began her residency training in anesthesiology at The Mount Sinai Hospital in 1986, and became the director of the Division of Orthopedic and Regional Anesthesia, where she developed a distinguished fellowship. In 2006, along with her Sinai colleagues, she published the first case report of the use of intravenous lipid emulsion to treat local anesthetic systemic toxicity (LAST) in a human, a therapy that has become the standard of care for the treatment not only of LAST, but other toxidromes as well. Dr. Rosenblatt has been an active member of several planning committees for the annual meeting of the ASA, serving for 15 years on the Problem-Based Learning Discussion Committee, six as chair, and for nine years on the Fundamentals of Anesthesia Learning Track, three as chair. Her service to the NYSSA, particularly the PGA meeting, includes participation on the Committee on Annual Sessions since 2000. She is currently the assistant to the general chair of this committee. In 2014, Dr. Rosenblatt accepted the position of chair of the Department of Anesthesiology at Mount Sinai St. Luke’s and Roosevelt hospitals.

Adam Levine, M.D., graduated from the Icahn School of Medicine at Mount Sinai in 1989. He is a professor of anesthesiology, otolaryngology and structural and chemical biology, a master educator of the Institute of Medical Education at the Icahn
School of Medicine and serves as vice chair of education for the Department of Anesthesiology. He has been the program director for the Department of Anesthesiology residency at Mount Sinai since 1996 and director of simulation since 1994.

Dr. Levine is an expert in anesthesia for otolaryngologic surgery and is senior editor of the reference textbook “Anesthesiology and Otolaryngology.” He has developed innovative programs of simulation-based education and assessment. He is an editor on the ASA Editorial Board on simulation education that oversees the ASA simulation endorsement program. Dr. Levine is also a site visitor for the Society for Simulation in Healthcare accreditation program. Since 2010, he has been the program director of the ASA-endorsed HELPS (Human Emulation, Education, and Evaluation Lab for Patient Safety and Professional Study) Center program and has been conducting courses to satisfy MOCA® Part IV requirements for ABA recertification. In 2013, Dr. Levine served as the senior editor of “The Comprehensive Textbook of Healthcare Simulation.”

As a testament to his teaching abilities, Dr. Levine was the 2009 recipient of the International Anesthesia Research Society Lifetime Achievement Award for Teaching.

Edmond Cohen, M.D., graduated from the University of Florence School of Medicine in Florence, Italy. Dr. Cohen completed his anesthesia residency and cardiothoracic anesthesia fellowship training at The Mount Sinai Hospital. He is a professor of anesthesiology and director of thoracic anesthesia at the Icahn School of Medicine at Mount Sinai in New York City. He is recognized as a world-renowned leader in thoracic anesthesia. For the last 20 years he delivered the thoracic refresher course lectures at the ASA meeting. He has chaired thoracic workshops at the ASA, PGA, IARS SCA, ESA and the World Congress.

Dr. Cohen is the editor of “The Principles of Thoracic Anesthesia” and the associate editor of the book “Principles and Practice of Anesthesia for Thoracic Surgery.” He is on the editorial boards of numerous journals and
is an expert reviewer for several journals, including *Anesthesiology* and *Anesthesia & Analgesia*. He is the inventor of the “Cohen Endobronchial Blocker,” used worldwide to provide one lung ventilation. In 2014, Dr. Cohen organized the first PGA Thoracic Symposium, which was very successful and is planned again for the 2015 PGA.

**Gregory W. Fischer, M.D.**, completed medical school at the University of Zurich in 1998. He then entered residency programs in anesthesiology and critical care in Switzerland. Interested in cardiac anesthesia, he came to the United States for fellowship training at Mount Sinai. After his fellowship in 2004, he was recruited to join the faculty at Mount Sinai as an instructor of anesthesiology. He is now a professor of anesthesiology and cardiothoracic surgery at the Icahn School of Medicine at Mount Sinai, the director of adult cardiothoracic anesthesia for the Mount Sinai Health System, and interim medical director of the adult cardiothoracic ICU.

Dr. Fischer holds Swiss, European and American board certification in the specialty of anesthesiology and is board certified in critical care in Europe. Additionally, he is board certified in perioperative transesophageal echocardiography by the National Board of Echocardiography (NBE). He is a member of the Exam-writing Committee for Basic Perioperative Transesophageal Echocardiography (Basic PTEeXAM) for the National Board of Echocardiography and is on the editorial board of the *Journal of Cardiothoracic and Vascular Anesthesia*.

Dr. Fischer is a nationally and internationally recognized expert in the field of cardiothoracic anesthesia. His areas of interest include neurocognitive outcomes after cardiac surgery, perioperative measurements and implications of cerebral oxygenation, and the clinical impact of real-time 3D TEE in the perioperative period.

He published more than 70 peer-reviewed articles and he has authored 13 book chapters in both cardiac and general anesthesia textbooks. Dr. Fischer is co-editor of the textbook “Perioperative Transesophageal Echocardiography.”
Dr. Fischer is regularly invited to lecture at major anesthesiology meetings, including the annual meetings of the American Society of Anesthesiologists (ASA) and the American Society of Echocardiography (ASE).

Yaakov (Jake) Beilin, M.D., came to the Mount Sinai School of Medicine as a medical student in 1983 and completed his residency in anesthesiology with a specialty year in obstetric anesthesia at Mount Sinai in 1991. Dr. Beilin is currently professor of anesthesiology and OB/GYN and the vice chair for quality at the Icahn School of Medicine at Mount Sinai. He is also the director of obstetric anesthesia and the director of the obstetric anesthesia fellowship at The Mount Sinai Hospital. His research interests include neuraxial anesthesia, coagulation, and patient safety. He has published more than 75 peer-reviewed articles and 30 book chapters. He is also an editor of the 5th edition of the premier obstetric anesthesia textbook Chestnut’s Obstetric Anesthesia: Principles and Practice. Dr. Beilin serves on the editorial board of the International Journal of Obstetric Anesthesia and the Obstetric Anesthesia Digest. He is also a member of the Research Committee for the Society for Obstetric Anesthesia and Perinatology (SOAP) and was a member of the planning committee for the 2015 SOAP annual meeting. Dr. Beilin serves on the Committee on Continuous Quality Improvement and Peer Review for the NYSSA, and he has been a member of the planning committee for the ASA educational track on obstetric anesthesia for the past six years.

Other well-known members of the department include:

Dr. Elizabeth Frost is the longtime editor of pre-anesthesia evaluation published in Anesthesiology News and an internationally known neuroanesthesiologist. She is a professor of anesthesiology at the Mount Sinai School of Medicine, and she served many years as the business manager of the PGA. Dr. Frost currently chairs the International Scholars Program.

Dr. George Silvay is a former member of the cardiothoracic anesthesia group and presently in charge of the cardiac pre-anesthesia clinic. He has been the
program director for the international symposium “Clinical Update in Anesthesiology, Surgery and Perioperative Medicine” for the last 34 years and, together with Dr. Karel Cvachovic, program director for the triennial “International Symposium: Perioperative Care for Seniors” in Prague, Czech Republic.

Dr. Jeffrey Silverstein was the vice chair for research in anesthesiology at the Icahn School of Medicine at Mount Sinai as well as the associate dean for research and director of the Program for the Protection of Human Subjects at Mount Sinai. His was the PI for several NIH-funded research projects directed toward outcomes research in geriatric anesthesia. Dr. Silverstein passed away on July 27, 2015. He will be sorely missed.

The department continues to grow and the junior faculty members are following the long and strong record of academic excellence and emphasis on superior clinical care established by the founders of the department more than a century ago.

Ingrid Hollinger, M.D., is a professor of anesthesiology and pediatrics at the Icahn School of Medicine at Mount Sinai in New York, New York.

Photographs courtesy of the Mount Sinai Archives.

BIBLIOGRAPHY


Euroanaesthesia
The European Anaesthesiology Congress

28-30 May 2016
London, UK

Abstract Submission
1 November - 15 December
registration@esahq.org
www.esahq.org

European Society of Anaesthesiology
Double Lumen Simulator: An iPad App Review

DIVYA CHERUKUPALLI, M.D.

Application Name:
Double Lumen

Cost: $4.99

Developer:
Crystal Clear Solutions

Review: Imagine that you are a new anesthesia resident and you have to check the position of a double lumen tube (DLT) after placing it in a patient undergoing a VATS procedure. How would you check the position of the tube and troubleshoot if necessary?

This app comes in handy in the above scenario. It includes a set of videos that show bronchoscopy views, left main stem intubation, etc., to orient the new user. The simulators section has 18 simulations that allow the user to push the DLT, pull it out, or change the viewable lumen. It’s an intelligent simulator that takes into account the multiple choices you have and lets you know how you are doing. The images are real bronchoscopy images, which are excellent. After using this app, I can say that it’s a fun way to learn about DLT troubleshooting.

The downside of this app is that it only has a basic set of maneuvers and cannot compare to the use of an actual bronchoscope in the operating room. In the future it would be nice to see a 3D simulator with more advanced bronchoscope maneuvers like flexion and rotation.

Bottom Line: Double Lumen is a good app to learn about DLT placement, especially for a novice resident who does not have much experience in an operating room.

Double Lumen can be downloaded from the iTunes store.

Divya Cherukupalli, M.D., is a CA3 resident at New York Methodist Hospital.
NYSSA Delegates to 2015
ASA House of Delegates

All sessions related to the ASA House of Delegates will take place at the Hilton San Diego Bayfront Hotel, CA, as follows:

**First Session** 8:00 a.m. — Sunday, October 25, 2015

**Second Session** 8:00 a.m. — Wednesday, October 28, 2015

**DELEGATES (VOTING)**
1. Dr. Melinda A. Aquino
2. Dr. David S. Bronheim
3. Dr. Christopher L. Campese
4. Dr. Vilma A. Joseph
5. Dr. Jason Lok
6. Dr. Andrew D. Rosenberg
7. Dr. Michael B. Simon
8. Dr. David J. Wlody
9. Dr. Michael P. Duffy
10. Dr. Ingrid B. Hollinger
11. Dr. Lawrence J. Routenberg
12. Dr. Steven B. Schulman
13. Dr. Tracey Straker
14. Dr. Richard N. Wissler
15. Dr. Richard A. Beers
16. Dr. Rose Berkun
17. Dr. Jesus R. Calimlim
18. Dr. Lawrence J. Epstein
19. Dr. Gregory W. Fischer
20. Dr. Charles C. Gibbs
21. Dr. Jung T. Kim
22. Dr. Scott N. Plotkin
23. Dr. Salvatore G. Vitale
24. Dr. Lance W. Wagner

Scott B. Groudine, M.D. — ASA Director, New York State

**ALTERNATE DELEGATES (NON-VOTING)**
1. Dr. Audrée A. Bendo
2. Dr. Peter A. Silverberg
3. Dr. Ketan Shevde
4. Dr. James S. Kikuola
5. Dr. Sudheer K. Jain
6. Dr. Jayapratak R. Chenna
7. Dr. Edmond Cohen
8. Dr. Jonathan S. Gal
9. Dr. Meg A. Rosenblatt
10. Dr. John A. Cooley
11. Dr. Prakash J. Rao
12. Dr. Matthew B. Wecksell
13. Dr. Michael J. FitzPatrick
14. Dr. Timothy J. Dowd
15. Dr. Archana Mane
16. Dr. Donna-Ann Thomas
17. Dr. Andrew M. Sopchak
18. Dr. Alan E. Curle
19. Dr. Jennifer A. Macpherson
20. Dr. Alison W. Vogt
21. Dr. Elizabeth L. Mahoney
22. Dr. Anthony DePlato
23. Dr. Nader Nader
24. Dr. Salvatore J. Parlato
25. Dr. Francis S. Stellaccio
26. Dr. Kevin M. Glassman
27. Dr. Daniel H. Sajewski
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Euroanaesthesia 2015
The European Anaesthesiology Congress

Dr. Michael Duffy addresses attendees of Euroanaesthesia 2015, held in Berlin, Germany.

NYSSA President Dr. Michael Duffy

Drs. David Wlody, Richard Beers, Michael Simon and Michael Duffy with NYSSA Executive Director Stuart Hayman at the PGA booth.
Canadian Anesthesiologists’ Society Annual Meeting

Presenters at Euroanaesthesia 2015 included Dr. David Wlody (top photo) and Dr. Richard Beers (right photo).

Dr. Michael Duffy represented the NYSSA at the Canadian Anesthesiologists’ Society Annual Meeting, held in Ottawa, Ontario.
Supporting New York Legislators

Sen. Mike Ranzenhofer, Dr. Rose Berkun and Assemblyman Ray Walter

Dr. Andrew Rosenberg with Assemblyman Dan Quart

Lt. Gov. Kathleen Hochul with Dr. Andrew Rosenberg

Drs. Michael Duffy, Cyriac Joseph and P. Sebastian Thomas
Dr. Vilma Joseph and Assemblyman Jeffrey Dinowitz (second from left) with members of the New York Coalition of Specialty Care Physicians.

Dr. Andrew Rosenberg, NYSSA lobbyist Bob Reid and Lt. Gov. Kathleen Hochul

Dr. Michael Duffy and Rep. John Katko

Dr. Scott Plotkin, Dr. Andrew Sacks, Sen. Mike Ranzenhofer and Dr. Jonathan Kaplan

Dr. Rose Berkun, Assemblyman Ray Walter and Dr. Scott Plotkin
2015 New York State Fair

The NYSSA and MSSNY shared an educational booth at the fair.

NYSSA resident and fellow members volunteered their time at the fair.
The regular 2015 legislative session came to an end in the early hours of Friday, June 26. It was a tumultuous session with the resignation of Assembly Speaker Sheldon Silver and Senate Majority Leader Dean Skelos, who were replaced by new Speaker Carl Heastie and Senate Majority Leader John Flanagan.

The session ran more than a week beyond the scheduled last day due to the inability of the governor and legislative leaders to reach an agreement on a number of outstanding issues. A deal referred to as the “Big Ugly” finally came together and was passed by both houses just prior to adjournment.

As we have updated you throughout the session, no scope of practice bills passed either house this year. Below we provide a complete update on all the legislation critical to the NYSSA. We also wanted to update you on our efforts on the “Badge Bill.” Late in the session, we worked with the sponsors to address the Healthcare Association of New York State’s (HANYS) concerns, but then HANYS sought additional amendments that would have weakened the proposed bill to the extent it would have eviscerated current New York state regulations. Current New York State Education Department regulations require all non-physician practitioners to wear a badge that must include their professional titles under Title VIII of the Education Law. HANYS sought amendments to restrict the areas where the badge must be worn. We worked closely with MSSNY on this bill.

All of us at Reid, McNally & Savage look forward to continuing to work with you to prepare for the 2016 session and the challenges that lie ahead.

*Registration of Professional Nurse Anesthetists*

**S0035 (DeFrancisco)/A3835 (Morelle) HELD IN COMMITTEE**

This bill amends the Education Law relating to registration of nurse anesthetists. The bill defines the requirements that must be met for a
registered nurse anesthetist to provide anesthesia services, including supervision by: an anesthesiologist, the operating physician, a dentist, an oral surgeon or a podiatrist, all of whom must be legally authorized to provide anesthesia services in their own right. The bill also defines the process that a nurse anesthetist must go through in order to become registered.

Health Insurance Reimbursement for Registered Nurse Anesthetists S2955 (Ritchie)/A7722 (Cahill) HELD IN COMMITTEE
This bill amends the Insurance Law related to reimbursing registered nurses anesthetists. The bill would make the anesthesia services performed by a registered nurse anesthetist eligible for reimbursement if the current policy provides coverage for anesthesia services. However, under this bill, the insurer is not responsible for reimbursing both a physician and a registered nurse anesthetist for providing the same anesthesia services.

Education Department Certification of Registered Nurse Anesthetists S3021 (Young)/A0140 (Paulin) HELD IN COMMITTEE
This bill amends the Education Law related to certification of registered nurse anesthetists. The bill lays out a step-by-step process for becoming certified as a registered nurse anesthetist:

- An application must be filed with the Education Department;
- The applicant must be licensed as a registered nurse;
- The applicant must have completed an educational program pertaining to anesthesia services; and
- The applicant must have paid the Education Department a $50 certification fee.

Mandatory CME for Pain Management and Addiction S4348 (Hannon)/A0355 (Rosenthal)
Legislation to require physicians and other prescribers to take a three-hour mandatory CME course every two years passed the Senate this year. The bill was brought to the Assembly floor but no vote was taken.
The bill would mandate curricula that would include: I-STOP and drug enforcement administration requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention screening and signs of addiction; responses to abuse and addiction; and end-of-life care.

The NYSSA issued Action Alerts to the members during the legislative session asking them to call their state representatives to voice opposition to the bill. A memo in opposition was sent to all members of the state Legislature and Reid, McNally & Savage walked the halls of the Capitol to communicate concerns to elected officials and key staff.

**Statute of Limitations S0911 (Libous)/A0285 (Weinstein)**

The NYSSA is strongly opposed to legislation that would change the current statute of limitations from 2-1/2 years to the date of discovery. According to a recent report by Milliman (Milliman Actuarial Study, 4-9-14), if this legislation is enacted, medical liability premiums will increase by nearly 15 percent, in excess of $150 million per year.

The NYSSA worked jointly with the Medical Society of the State of New York (MSSNY), other physician specialty organizations, and medical malpractice carriers to defeat this legislation. Members participated in several action alerts and other activities to bring attention to the problems with the medical liability environment in New York state.

This year, for the first time ever, the Assembly passed the bill. The bill was moved to the floor in the Senate but no vote was taken. The new Senate majority leader, John Flanagan, said that he wants to discuss passage of this bill next year as part of a “broader package of reforms.” Gov. Cuomo has stated publicly that he will sign legislation if passed by both houses. Clearly the 2016 legislative session will be challenging on this front.

**Electronic Prescribing Mandate Delayed for One Year**

The NYSSA successfully advocated for passage of legislation in both houses to delay for one year the March 27, 2015, implementation of the e-prescribing mandate that was enacted in 2012 as part of the Internet System for Tracking Over-Prescribing/Prescription Monitoring Program (I-STOP) law. The governor signed this bill into law.
Other Legislation of Interest: Passed Both Houses

Hospital Sepsis Data Collection S4874 (Hannon)/A7456 (Gottfried)
The purpose of the bill is to allow time for the development of appropriate analytics to ensure that the data that is collected is complete and accurate and the calculations used to develop risk adjusted mortality rates have been evaluated and tested. At the conclusion of the pilot period, all data will be posted on DOH’s website.

Penal Law Protections for Assaulting Emergency Medical Service Paramedics and Technicians S4839 (Golden)/A7345 (Lentol)
This bill would include emergency medical service paramedics and technicians among those professionals against whom an assault with the intent to cause physical injury resulting in on-duty physical injury is a Class D violent felony offense.

Non-Specific Orders, Tuberculosis Tests S0103 (Hoylman)/A7034 (Glick)
This bill will allow registered professional nurses to administer any test, not just a PPD, to detect or screen for tuberculosis under a non-patient specific patient order.

Meningococcal Immunizations S4324-A (Hannon)/A0791-C (Gunther)
This bill would require immunization against meningococcal disease for students entering, repeating or transferring into the seventh and 12th grades.

Epilepsy on Death Certificates S1789 (Griffo)/A2359 (Brindisi)
This bill would require that when an autopsy is conducted of a deceased human who has epilepsy or a history of seizures that an investigation and determination must be made as to whether the deceased suffered a sudden unexpected death due to epilepsy. Any such determination must be noted on the medical certificate portion of the death certificate.

Nurse Practitioner (NPs) Technical Amendments S2300 (Hannon)/A4140 (Gottfried)
The Nurse Practice Act was amended in 2014 to eliminate the requirement for a written practice agreement with a physician for NPs with more than 3,600 hours of practice experience and replace it with a collaborative agreement. This bill would make technical amendments to the Public Health Law, Education Law, General Business Law, and the Vehicle and Traffic Law to eliminate requirements for a written practice agreement and
replace them with a requirement for a collaborative agreement with a physician. The provisions of these laws were overlooked when the 2014 law was passed.

**NYSSA’s Annual Legislative Day in Albany**

**Pre-Legislative Day Webinar (May 18, 2015)**

Our pre-Legislative Day webinar had strong participation from our members. Dr. Duffy provided updates on key legislation and Bob Reid, Shauneen McNally, Marcy Savage, Stuart Hayman and I provided additional information of importance.

**Annual Legislative Day (May 19, 2015)**

The NYSSA annual Legislative Day in Albany was once again well attended by NYSSA leadership and members from every district (the list of attendees is printed below). We greatly appreciate the efforts by these dedicated members to attend our annual Legislative Day. Based on the strong participation of our members, we were able to schedule appointments with 91 legislators (50 Assembly members and 41 senators). During our Tuesday morning breakfast, we also had the privilege of having Sen. John Flanagan, the new Senate majority leader, Sen. Thomas Croci and Sen. Michael Venditto address our group.

**DISTRICT 1**

Dr. Lance Wagner  
Dr. David Wlody

**DISTRICT 2**

Dr. Himani Bhatt  
Dr. David Bronheim  
Dr. Christopher Curatolo  
Dr. Jonathan Gal  
Dr. Ingrid Hollinger  
Dr. Meera Kirpekar  
Dr. Tal Levy  
Dr. Jonathan Plaut  
Dr. Shawn Sikka  
Dr. Aaron Trimble  
Dr. Taylor White  
Dr. Lee Winter

**DISTRICT 3**

Dr. Vilma Joseph  
Dr. Salvatore Vitale

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Dr. Robert Eberle  
Dr. Scott Groudine  
Dr. Michael Jakubowski  
Dr. Lawrence Routenberg  
Dr. Michael Simon

**DISTRICT 5**

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Dr. Minji Cho  
Dr. Michael DeCicca  
Dr. Michael Duffy  
Dr. Matthew Lilien  
Dr. Jason Lok

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Dr. Michael Nayshtut  
Dr. Richard Wissler

**DISTRICT 7**

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Dr. Jonathan Kaplan  
Dr. Scott Plotkin

**DISTRICT 8**

Dr. Dale Anderson  
Dr. Christopher Campese  
Dr. Kevin Glassman  
Dr. Steven Schulman  
Dr. Alan Strobel
Legislative Day Materials
We updated our Legislative Day 2015 materials, which can be found on the NYSSA website at http://members.nyssa-pga.org/Scripts/4Disapi.dll/4DCGI/members/legislative.html under “NYSSA’s Annual Legislative Day in Albany 2015.”

The New York Coalition of Specialty Care Physicians Legislative Day
The New York Coalition of Specialty Care Physicians legislative day was held on May 12, 2015. Dr. Duffy presented to the Coalition participants our views on preserving the present safe anesthesia standards in New York state and reasons for the NYSSA’s opposition to NYSANA’s slate of bills to inappropriately expand their scope of practice. Dr. Duffy supplied the Coalition with copies of the NYSSA’s Legislative Day brochure and the Coalition distributed them.

CapWiz
In an effort to supplement our advocacy efforts in Albany, the following CapWiz documents were created. The NYSSA leadership, Stuart Hayman, Bob Reid, Shauneen McNally and I want to extend our appreciation for the wonderful response that was exhibited by the members who contacted their legislators about the bills of interest. Your involvement is critical to the NYSSA’s Government and Legal Affairs Committee (GLAC) agenda, and we thank you for it.

Action Alert:
Oppose action to create “New York Health Act,” a new system under which the government would create a universal single payer health plan to pay for healthcare services.
The New York state Legislature is considering legislation (A.5062 Gottfried/S.3525 Perkins) that would create “New York Health,” a new system under which the government would create a universal single payer health plan to pay for healthcare services. What is known about this system signals that it will hew closely in structure and practice to the nationalized healthcare systems in places like Canada and the United Kingdom. What is not known
about this system is how New York Health would impact system-wide healthcare costs and what that impact will mean for the tax burden and access to high quality care for the citizens of New York.

Please note that on the NYSSA website there is a copy of the letter that the NYSSA has signed onto, prepared by the New York State Society of Plastic Surgeons, that outlines comprehensive arguments against this legislation. We urge you to review the same.


To view a sample letter that you can send to your legislators, go to www.capwiz.com/nyssa-pga/issues/alert/?alertid=66108771.

B. A.7722 Cahill/S.2955 Ritchie (Reimbursement for Nurse Anesthetists by Health Insurance Companies): June 2, 2015

Action Alert:

Oppose action to a bill to amend the Insurance Law to authorize health insurance reimbursement for nurse anesthetists providing services at the discretion of insurance companies.

The New York state Legislature is considering legislation (A.7722 Cahill/S.2955 Ritchie) that would amend the Insurance Law to authorize health insurance reimbursement for nurse anesthetists providing services at the discretion of insurance companies. The language of this bill is totally inadequate because it fails to define the nurse anesthetist’s scope of practice consistent with the current New York state standards that mandate physician supervision of nurse anesthetists in hospitals and ambulatory surgical centers. The sponsors of this legislation assert that the inability of nurse anesthetists to bill independently limits them; however, the arguments asserted to support this bill are either factually flawed or misleading. In point of fact, nurse anesthetists are not permitted, under existing New York state Medicaid rules, to bill independently because state law mandates a physician anesthesiologist medically direct a nurse anesthetist in the administration of anesthesia. This requires the physician anesthesiologist to be responsible for pre-operative, intra-operative, and post-operative care of the patient, a duty that requires the discipline of extensive medical training.

To view a sample letter that you can send to your legislators, go to www.capwiz.com/nyssa-pga/issues/alert/?alertid=66203626.
C. A.0285 Weinstein/S.0911 Libous (Date of Accrual for Malpractice Cases): June 3, 2015

Action Alert:
Oppose action to a bill to amend the civil practice law and rules in relation to accrual of certain causes of action (e.g., malpractice).
The New York state Legislature is considering legislation (A.0285 Weinstein/S.0911 Libous) that would amend the civil practice law and rules in relation to accrual of certain causes of action (e.g., malpractice).

To view a sample letter that you can send to your legislators, go to www.capwiz.com/nyssa-pga/issues/alert/?alertid=66217641.


Action Alert:
SUPPORT action to a bill to amend the Education Law to provide for greater transparency on the part of healthcare practitioners when identifying themselves to patients and the public.
The New York state Legislature is considering legislation (A.7129 Stirpe/S.4651 Griffio) that would amend the Education Law to add a new section entitled “Healthcare professional transparency,” part of which provides that a healthcare practitioner who delivers medical care to a patient must wear a photo ID name tag that includes the type of license issued by the state Education Department to the practitioner, to minimize patient confusion.

To view a sample letter that you can send to your legislators, go to www.capwiz.com/nyssa-pga/issues/alert/?alertid=66313716.

A Report and Request from the American Society of Anesthesiologists (ASA)

Be an Advocate for Patient Safety
As the Department of Veterans Affairs (VA) continues to advance a proposed VHA Nursing Handbook that would threaten patient safety by removing physician anesthesiologists from veterans’ care, ASA members are encouraged to be active advocates on behalf of their patients and the specialty.
ASA remains actively engaged in efforts to encourage VA officials to remove the anesthesia provisions from the VHA Nursing Handbook, and has been supported by the medical community, lawmakers, and veterans service organizations (VSOs). Recently, the Association of the U.S. Navy (AUSN) wrote another letter to VA Secretary Robert McDonald outlining their serious concerns about the negative impact this proposed policy could have on veterans’ safety. More than 85 congressional letters have also been sent to VA officials. Communication from constituents and stakeholders to lawmakers remains the best way to protect veterans’ high-quality anesthesia team-based care. To be involved, please join the ASA Grassroots Network and check ASA’s Washington Alerts for the latest news and developments.


Supporting documents and additional information on the proposed Nursing Handbook can be found online at http://www.asahq.org/advocacy/federal-activities/legislative-activity/vha-nursing-handbook.

For more information, please contact Pat Daly in ASA’s Advocacy Division at (202) 289-2222.

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Case Report

Spontaneous Cerebral Spinal Fluid Leak and Intracranial Hypotension During Pregnancy

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

Abstract

Spontaneous cerebral spinal fluid (CSF) leak causing spontaneous intracranial hypotension (SIH) is an uncommon condition characterized by postural headache secondary to low CSF pressure. Here we present a case of spontaneous CSF leak causing SIH in a 29-year-old woman. She was G10 P7 at 28 weeks’ gestation with a history of headache, nausea, vomiting, neck stiffness, and photophobia. Findings from an MRI brain scan led to a diagnosis of SIH. She was treated with an autologous epidural blood patch with delayed improvement. She subsequently remained symptom free and delivered a healthy boy at term.

Introduction

The production, absorption, and flow of cerebrospinal fluid (CSF) play key roles in the dynamics of intracranial pressure. Alterations in CSF pressure may lead to neurologic symptoms, the most common being headache. Most often, the headaches associated with low CSF pressure are orthostatic and occur after lumbar puncture, but similar headaches may result from spontaneous decrease in CSF pressure due to spinal CSF leaks, or from excessive drainage from a CSF shunt.1,2 Headache attributed to spontaneous intracranial hypotension has been recognized with increasing frequency. Orthostatic headache, low CSF pressure, and diffuse meningeal enhancement on brain magnetic resonance imaging (MRI) are the major features of the classic syndrome. However, some cases lack one or more of these.2 The diagnosis should be considered in patients who present with positional orthostatic headache, with or without associated symptoms, perhaps in the setting of minor trauma, and in the absence of a history of dural puncture or other cause of CSF fistula. Confirmation of the diagnosis requires evidence of low CSF pressure by lumbar puncture, and/or evidence of CSF leakage on imaging with MRI, computed tomographic myelography, or radioisotope cisternography.
Headache, nausea and vomiting are common first trimester symptoms in pregnancy and may relate variably to hyperemesis gravidarum or to migraine, which can present de novo. These symptoms may also, less commonly, relate to SIH, as in this case.

**Case Report**

A 29-year-old woman, gravida 10, para 7, had a sudden onset of severe postural headache at 28 weeks’ gestation. She reported developing spasm in the mid-upper part of her back approximately one week previously. After this subsided somewhat, she started to develop a tension-like bifrontal headache, which gradually worsened over the week. She had little to no pain when lying down, but would develop an intense headache upon sitting or standing. She denied any fevers or chills but did have some mild phono- and photophobia accompanied by nausea and vomiting. She also reported a “muffled-like” sensation in her ears when sitting and slight blurry vision. She initially presented to her obstetrician, who prescribed acetaminophen and sumatriptan, thinking her symptoms were caused by migraine. She did not improve and was subsequently admitted to Kings County where her workup included an MRI/MRV, which was consistent with low-pressure headache. She was subsequently transferred to Bellevue for further management.

Results of medical and neurologic examinations were normal, and no lumbar puncture was performed to measure CSF pressure. There was no history of dural puncture or other trauma prior to developing the headache. Brain MRI showed a diffuse subdural fluid collection and narrowing of the ambient cistern, confirming the diagnosis of spontaneous intracranial hypotension. Neurological and neurosurgical consults were obtained and they agreed about the possibility of SIH and CSF leak and advised to perform an EBP. The patient had been under conservative treatment for the past two days in the hospital without any improvement.

An epidural blood patch (EBP) was performed at the T12/L1 level. Twenty cc of autologous blood were drawn from the left antecubital vain and injected into the epidural space. The patient reported immediate but incomplete headache relief. She was maintained supine and re-evaluated several hours later; again there was residual headache. The neurosurgery and neurology consults recommended repeating the EBP for the residual headache after a repeat MRI showed bilateral subdural parietal enhancement likely secondary to brain sagging from a CSF leak, which appeared to be resolving. However, the patient refused. A few days thereafter, the patient was discharged from the hospital with almost complete headache resolution. Follow-up with the
neurology clinic revealed that she was headache free by one week post hospital discharge. She subsequently remained symptom free and delivered a healthy boy at term.

The images below are similar to our patient’s studies.

**Brain MRI showing diffuse meningeal enhancement with low cerebrospinal fluid pressure headache**

![Brain MRI showing diffuse meningeal enhancement with low cerebrospinal fluid pressure headache](image)

**Brain MRI of a patient with low cerebrospinal fluid pressure headache. Contrast (gadolinium) enhanced T1-weighted images in axial (A) and coronal (B) planes show diffuse pachymeningeal enhancement (arrows).**

*Images provided courtesy of Dr. Simon Edelstein, Department of Radiology, Mount Sinai Medical Center, New York.*

**Brain sagging with low cerebrospinal fluid pressure headache**

![Brain sagging with low cerebrospinal fluid pressure headache](image)

Brain MRI of a patient with low cerebrospinal fluid (CSF) pressure headache (spontaneous intracranial hypotension). Noncontrast T1-weighted sagittal images were obtained before (A) and after (B) treatment. There is crowding and pointing of the cerebellar tonsils at the foramen magnum mimicking a Chiari 1 malformation on the first study (black arrow, image A). In addition, there is sagging of the brain resulting in inferior displacement of the floor of the third ventricle (white arrow, image A) as well as loss of CSF space in the suprasellar cistern. These findings have resolved on MRI six months later after treatment (B), which included draining of associated subdural collections.
Discussion

Pathophysiology — In the intact cranial vault, the brain is supported by the cerebrospinal fluid (CSF), such that a brain weight of 1500 g in air is only 48 g in CSF. As the CSF pressure decreases, there is a reduction in the buoyancy of the brain’s supportive cushion. As a result, the brain “sags” into the cranial cavity, causing traction on its anchoring and supporting structures.

Cause of headache — Traction on pain-sensitive intracranial and meningeal structures, particularly sensory nerves and bridging veins, is thought to cause cephalalgia and some of its associated symptoms. This traction is exaggerated in the upright position, hence the postural component of the headache. Secondary vasodilation of the cerebral vessels to compensate for the low CSF pressure may also contribute to the vascular component of the headache by increasing the brain volume. Because jugular venous compression increases headache severity, it seems likely that venodilation is a contributing factor to the headache.

CSF hypovolemia, rather than CSF hypotension per se, has been proposed as the underlying cause of the headache syndrome, as patients with normal CSF pressure have been described with clinical and radiographic features otherwise typical of orthostatic headache.

Cause of low CSF pressure — The clinical syndrome of headache attributed to spontaneous intracranial hypotension has been recognized for many years. The syndrome was first proposed in 1938 by Schaltenbrand, who termed it aliquorrhea, and described a headache virtually identical to that following LP. He proposed three possible mechanisms (decreased CSF production by the choroid plexus, increased CSF absorption, and CSF leakage through small tears) to explain the symptoms.

CSF leak — Today, the prevailing opinion about the etiology of headache attributed to spontaneous intracranial hypotension is CSF leakage at the spinal level, which may result from rupture of the arachnoid. A potential contributing factor to the development of spontaneous low CSF pressure is an inciting event, such as a fall, a sudden twist or stretch, sexual intercourse or orgasm, a sudden sneeze, sports activity, or “trivial trauma.” The location of CSF leaks associated with spontaneous intracranial hypotension is almost exclusively spinal; most occur at the thoracic level or
the cervicothoracic junction. Few, if any, result from leaks at the skull base. As an example, one series evaluated 273 patients with spontaneous intracranial hypotension, and none had evidence of a cranial CSF leak.\textsuperscript{14}

**Epidemiology** — The estimated annual incidence is five per 100,000. The peak incidence is around age 40, but children and the elderly are also affected. Women are affected more frequently than men, with a female-to-male ratio of 2-to-1.

**Clinical features** — Postural headache is usually but not always the major manifestation of headache attributed to spontaneous intracranial hypotension. Occasional patients report no headache, typically when other symptoms of low CSF pressure are predominant.\textsuperscript{14}

**Headache** — Headache attributed to spontaneous intracranial hypotension may be of sudden or gradual onset. It ordinarily develops within two hours, and in most cases within 15 minutes, of sitting or standing and is often described as throbbing or dull, and may be generalized or focal.\textsuperscript{15} Its severity is widely variable and ranges from mild to incapacitating. Frontal headache is reported by patients as often as occipital and diffuse pain.

Relief is typically obtained with recumbency, usually within minutes. In rare cases associated with an asymmetric cervical CSF leak, relief occurs only by lying on one side.\textsuperscript{16} The headache is seldom relieved with analgesics. Exacerbating factors include erect posture, head movement, coughing, straining, sneezing, jugular venous compression, and high altitude. Headache attributed to spontaneous intracranial hypotension may spontaneously resolve within two weeks. In some cases, it lasts months or, rarely, years.

**Associated symptoms and complications** — The most common, reported in about half of patients, are: neck pain or stiffness, nausea and vomiting.

**Examination** — The neurologic examination is typically normal in patients with headache from spontaneous intracranial hypotension. Unilateral or bilateral abducens nerve palsies have been reported, as have visual field defects.\textsuperscript{3} A slow or vagus pulse has also been described.\textsuperscript{5}

**Brain MRI** — The advent of MRI has greatly improved the diagnosis of headache attributed to spontaneous intracranial hypotension.

**Diagnosis** — The diagnosis of headache attributed to SIH should be considered in patients who present with positional orthostatic headache with
or without associated symptoms, perhaps following minor trauma, and in
the absence of a history of dural puncture or other cause of CSF fistula.
Headache caused by low CSF pressure following a lumbar puncture rarely
creates a clinical dilemma.

Confirmation of the diagnosis requires evidence of low CSF pressure by
MRI (e.g., pachymeningeal enhancement) or LP, and/or evidence of a CSF
leak on neuroimaging studies, mainly computed tomographic (CT)
myelography or, less often, radioisotope cisternography.

**Treatment** — Epidural blood patching (EBP) is the mainstay of treatment
for headache attributed to spontaneous intracranial hypotension.\(^4\)\(^,\)\(^17\)
Although data are lacking, clinical experience suggests that some patients
with this condition improve without specific treatment, given enough time.
However, in many instances intervention may be necessary, not only to
speed recovery, but also to reach full resolution.

Initial therapy for most patients with a confirmed diagnosis of headache
attributed to spontaneous intracranial hypotension consists of conservative
measures and/or EBP. For patients who fail adequate conservative therapy
and repeated EBP, additional options include continuous epidural saline
infusion, epidural fibrin glue, or surgical repair of the defect.

**Prognosis** — Headache attributed to spontaneous intracranial hypotension
may resolve spontaneously within two weeks. In some cases, it may last
months or, rarely, years. However, intermittent headaches have been
reported at intervals of weeks, months, or years, probably caused by
intermittent CSF leaks. Furthermore, some patients have persistent
symptoms despite documented resolution of CSF leakage with therapy.\(^18\)

**Summary and Recommendations**

- For patients with uncomplicated headache attributed to
  spontaneous intracranial hypotension of mild to moderate severity,
  conservative measures (bed rest and generous caffeine intake) are
  the initial therapy.
- For patients who fail conservative treatment, EBP should be
  performed.
- For patients who have severe headache or disabling symptoms
  attributed to spontaneous intracranial hypotension, EBP is the
  initial therapy.
• For patients with headache attributed to spontaneous intracranial hypotension in whom the site of the CSF leak cannot be identified, continuous epidural infusion of saline or dextran may be useful.

• For patients with headache attributed to spontaneous intracranial hypotension who have failed an adequate trial of repeated EBP and have a clearly identified site of CSF leakage, surgical repair may be necessary.

• The estimated recurrence rate of spontaneous spinal CSF leakage is approximately 10 percent regardless of treatment.

REFERENCES


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Be Successful in a Pay-for-Performance Era

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

Physicians are now required by federal mandate to submit data on the quality of their care. There are two main approaches that an anesthesiology practice can utilize. The first is a claims-based approach, where CPT codes are submitted along with the anesthesia bill. These codes communicate things such as antibiotic administration prior to the start of surgery or sterile technique during the insertion of a central venous catheter. If a practice utilizes this method, at least 50 percent of claims sent to CMS must have quality codes attached. The downside to this approach is that your practice can only report on federal quality measures (i.e., PQRS – the Physician Quality Reporting System), many of which do not apply to anesthesiologists and other specialists (e.g., 30-day readmission rates). What’s more, practices don’t know whether they are satisfactorily reporting as the year goes by. The department or practice continues to send in its codes, but it is a mystery as to whether the practice will get a huge penalty for not meeting the reporting requirements. It is estimated that upwards of 20 percent of practices were not compliant with federal reporting requirements while using this method.

The second approach to reporting on quality, and the approach recommended by the ASA, is through the Qualified Clinical Data Registry, or QCDR. Approved in 2014, these are medical specialty registries such as the National Anesthesia Clinical Outcomes Registry (NACOR), which is maintained by the Anesthesia Quality Institute (AQI). By submitting your practice’s clinical information to the AQI via NACOR, anesthesiologists can fulfill federal requirements for quality reporting. There are many benefits to this. First, practices can choose anesthesiainspecific measures (e.g., PACU transfer of care notes, surgical safety checklist use, and postoperative normothermia) in addition to the less-specific, primary care-centric federal (PQRS) measures. Perhaps more importantly, practices also get to review their data in real time to see if they are compliant with reporting requirements so that there are no surprise penalties from CMS.

The QCDR is an incredible opportunity for anesthesiologists to shape how we measure quality, improve our outcomes, and reduce costs as a
specialty. While this method satisfies federal requirements regarding quality reporting, it is also a phenomenal tool for practices to improve the quality of the care delivered. Practices can gain insight into compliance and outcome rates to determine where improvements are needed. Nationally, such a large registry provides an incredible opportunity for research. This vast collection of anesthesia data will help anesthesiologists make that next quantum leap forward in safety, just as the specialty did a couple of decades ago. We must embrace these changes and use methods of reporting that improve the care we deliver to our patients.

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA3 anesthesiology residents at The Mount Sinai Hospital. Dr. Curatolo is the president of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary and treasurer.

Ensuring Access to Vital Anesthesia Services

CHRI$ J. CURATOLO, M.D., AND SHAWN SIKKA, M.D.

The ASA legislative conference was held in May in Washington, D.C., and drew a record-breaking 600 attendees from across the country. In addition to supporting our nation’s veterans by advocating against the VA’s proposed nursing handbook, we also promoted legislation to ensure access to colonoscopy screenings and rural healthcare.

The Centers for Medicare & Medicaid Services (CMS) expanded the definition of preventive services to include anesthesia for screening colonoscopies, thereby eliminating all cost-sharing requirements for Medicare patients. The moment a polyp or tissue is removed, however, the colonoscopy changes from preventive to diagnostic or therapeutic. The anesthesia fee for a therapeutic colonoscopy is not covered by Medicare, and unsuspecting patients suddenly find themselves left with a large bill. This is a strong deterrent to patients who wish to undergo a potentially lifesaving procedure.

Legislative efforts in the House of Representatives and the Senate are underway and have already received bipartisan support. The Removing Barriers to Colorectal Cancer Screenings Act would eliminate all cost
sharing for colonoscopies, even if a polyp is removed. This bill would help ensure access to colonoscopies and the necessary accompanying anesthesia services.

The rural “pass-through” program was created as an incentive for providers to practice in rural areas and allows hospitals to use Medicare Part A funds for anesthesiologist assistants and nurse anesthetists. Low Medicare Part B anesthesia payments and low patient volume in rural areas have made it difficult to keep physician anesthesiologists in these areas. The pass-through funds may not be used for contracting physician anesthesiologists without a change in the statute. Currently, approximately 600 hospitals across the country use pass-through funds.

The Medicare Access to Rural Anesthesiology Act would reform the program and allow such pass-through funds to be used for physicians. The bill has received support in both the Senate and the House of Representatives. The Hospital Improvements for Payment Act includes similar legislation to allow for rural pass-through provisions for anesthesia services. Both bills could allow hospitals to recruit and keep physician anesthesiologists and improve access in these underserved areas.

Continue to advocate for your patients’ rights, best interests, and access to quality anesthesia care.

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