SPHERE

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On the cover:
An aerial view of NYU Langone Medical Center’s main campus, located at 550 First Avenue, between 31st and 33rd streets, in New York City.

Cover photo credit: Mary Kouw.
As this is my last presidential message for Sphere, I would like to thank everyone in our organization for the trust you placed in me to represent the New York State Society of Anesthesiologists (NYSSA). It has been my privilege and honor to speak on behalf of New York’s physician anesthesiologists and our patients. At the risk of having to apologize for sounding optimistic, I believe we have a bright future. Together with the American Society of Anesthesiologists (ASA), the NYSSA is working to ensure fair treatment by insurance payers; to reform the dysfunctional civil litigation system; to protect patient access to high-quality, physician-led care; and to prevent legislation that threatens public health. I am but one voice, however. There are so many individuals in our organization who give so freely of their time and talents and these active members help to amplify our message. On behalf of the NYSSA, I offer our gratitude.

One area where our membership lags is in professional citizenship. The NYSSA’s fundraising efforts continue under the leadership of Dr. Bruce Hammerschlag, and our NYAPAC is the second-largest physician PAC in New York, behind only the Medical Society of the State of New York (MSSNY). That said, less than 20 percent of our members contribute. This is disconcerting. I know that with legislative leaders resigning under threat of misconduct charges, our members may get discouraged. Yet we must continue the good fight within the halls of Albany by maintaining our focus on patient care and safety. 2016 will be a national election year and all the candidates will be looking for support for their campaigns. Becoming involved in these campaigns is the best way to build lasting relationships with our legislators. Please give generously of your time and money, as every bit counts. It’s your career and your patients’ lives we are advocating for.

I have been able to attend several fundraisers in my home district. New York state Sen. John DeFrancisco has been a strong supporter of ours on several important issues and I was once again in attendance at his fundraiser and golf tournament. As proof of our continued presence in his office, he expressed his support for the NYSSA and our issues without
prompting. I also met with my own representative, Assemblyman Bill Magee, in our community and he also supports the NYSSA in the Assembly. Finally, Dr. Rich Beers and I had a chance to talk with our congressman, U.S. Rep. John Katko, about our concerns regarding the “VHA Nursing Handbook” proposal to remove physician supervision of nurse anesthetists, which is a direct contradiction to the existing “Anesthesia Service Handbook.” I will continue to recommend that all our members take the time to visit with your legislative representatives in their local offices. Engage them when they are back home and become a medical resource for your community leaders. While very skilled in politics, our legislators need to be informed about medical issues. Adopt a legislator and appreciate the value and wisdom of donating to the ASAPAC and NYAPAC.

With so many New Yorkers being active within the ASA’s ranks, I sometimes think that we get complacent that we are well represented throughout the ASA. However, we still do not have a representative on the ASA Administrative Council, which wields the real power at the ASA. Hopefully that will all soon change. We have several talented candidates who have expressed interest in ASA Administrative Council positions in upcoming years. Dr. Larry Epstein is already actively campaigning for the assistant speaker position in 2016; others, including Drs. Mike Simon, Sal Vitale, and Andy Rosenberg, are all laying the groundwork for viable campaigns for future positions. These members are donating considerable personal time and effort while the NYSSA is investing resources to assist with these campaigns. One way in which every NYSSA member might help is by reaching out to friends and colleagues in other states. New York educates about one-fifth of the nation’s anesthesiologists. There is a good chance that many of you know an ASA delegate living in another part of the country. Please reach out to those individuals and encourage them to support our candidates, who are highly qualified and will serve our profession well.

The NYSSA continues to enjoy a close, productive relationship with the current ASA leadership. I wish to thank Drs. J.P. Abenstein and Daniel Cole, who, along with the rest of the Administrative Council, have been very supportive of the NYSSA. The certified anesthesiology assistants (CAAs) also benefit from their inclusion within the ASA; this is evidenced by support for their licensure in New York. I was unaware until this year that the CAAs practiced under a demonstration project in New York in the late ’80s and early ’90s. A. William Paulsen and Gregg Mastropolo from the Frank H.
Netter MD School of Medicine at the nearby Quinnipiac University use this issue of *Sphere* to educate our members about the long and successful history CAAs have here in New York, and to offer another alternative for the physician-led anesthesia care team model. Hopefully a new proposal might allow our New York medical centers to get behind “anesthesia assistant” as a new curriculum addition.

Lastly, the jewel of the NYSSA is the PostGraduate Assembly (PGA). This meeting is one of the oldest anesthesia meetings in the world and one of the most successful. The PGA meeting rivals the ASA and the European Society of Anaesthesiology meetings. Once again, the ASA Administrative Council (AC) will hold their meeting at the Marriott Marquis during the PGA this year. Future candidates for ASA office will launch their campaigns at the PGA. Anesthesiologists will come from all corners of the globe to attend our lectures. To acknowledge this remarkable meeting, the NYSSA will update our logo to include the PGA prominently. All NYSSA members contribute to the success of the PGA by attending, lecturing at and underwriting this event. Once again, thank you all.

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Editorial

Changing of the Guard

JASON LOK, M.D.

This is my final issue as editor of Sphere. It has been a great pleasure and privilege for me to oversee the various aspects of the NYSSA’s communications agenda, including Sphere, our social media initiatives, and various public relations endeavors aimed at our patients and policymakers. In addition, I have been blessed throughout the years with the incredible support and expertise of Sandy Rogers, Lisa O’Neill, and many fellow NYSSA members in the Communications Committee. I plan to continue to serve at the national level through my involvement with the ASA’s Communications Committee. I was fortunate to be involved in the ASA’s decision to adopt the term “physician anesthesiologist” as well as the development of the When Seconds Count™ campaign.

The NYSSA Communications Committee will be in very capable hands with the individual who is filling my shoes, Dr. Samir Kendale. I have worked with Dr. Kendale since he was the resident editor of Sphere, beginning in September 2011. He co-authored the article “The Three-Year M.D. Program at NYU: The Fast Track to Residency,” which was published in the summer 2015 issue, and contributed to the feature article that appears in this issue, “NYU Langone Medical Center: Made for New York.” Dr. Kendale is admired and well respected by my close NYSSA colleagues, and he will be working with the amazing and supportive committee members who made my tenure as chair of this committee so memorable. The transition will be a smooth one, as we discussed the objectives of the NYSSA Communications Committee at our recent meeting in San Diego.

If you were not able to attend the recent ASA meeting, you missed the discussion about an important issue: maintaining physician-led anesthesia care for our veterans. The concern involves the proposed modification of the “VHA Nursing Handbook,” which would threaten the current physician-led anesthesia care team. While it’s possible
that you are not personally involved with a VA hospital, the indirect impact of this change might influence you profoundly if it translates into further discontinuation of physician-led anesthesia care elsewhere. So, please share your stories about how our present involvement in the healthcare of our nation’s veterans has ensured their optimal health outcomes. Go to www.SafeVACare.org today.

Please mark your calendar for our second Physician Anesthesiologists Week, scheduled for January 31 to February 6, 2016. The plan is to inform policymakers, the media, and the public that “when seconds count, physician anesthesiologists save lives.” Please take this opportunity once again to advocate for our specialty and patient-centered, physician-led care.

You can find a comprehensive support toolkit created by the ASA to help you make the most of this advocacy and public outreach opportunity. ASA members can access the When Seconds Count™ Advocacy Toolkit at www.asahq.org/advocacy/when-seconds-count. The toolkit includes background information on the campaign; access to downloadable advocacy materials such as message maps, a policymaker brochure and frequently asked questions; and fact sheets. The toolkit has been expanded to include a PowerPoint presentation that can be used during this important week.

New ideas for Sphere will be discussed at the Communications Committee meeting during the 2015 PGA. In the past, the pros and cons of anesthesia-related issues were considered, along with current technology for practicing anesthesiologists and pearls of wisdom or practice tips. We continue to encourage submissions of case reports, clinical reviews, and book reviews. 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 Stuart Hayman at stuart@nyssa-pga.org. Thank you in advance for your interest and consideration.
“Made for New York,” NYU Langone Medical Center’s new motto, complements Bellevue Hospital’s timeless slogan, “No one is turned away.”

From Bellevue Hospital’s founding in 1736, to its merger with New York University Medical College (founded in 1841) in 1898, to its present day form, the NYU Langone Medical Center has strived to provide excellent patient care to the whole of the Big Apple and beyond — “the tired, poor, huddled masses, yearning to breathe free.” The anesthesia department has become instrumental in helping the NYU Langone Medical Center realize this ambition.

The NYU Medical Center is perfectly tailored for New York perhaps because it was founded in and grew up alongside the city. The Center traces its roots back to a six-bed infirmary on the second floor of the “Publick Workhouse
and House of Correction of the City of New York,” where City Hall stands now. After the yellow fever and smallpox epidemics in the early 1790s, city leaders took action and leased land in Kips Bay Farm known as Belle View. In 1794 they constructed a two-story pest house known as Belle Vue Hospital and treated the predicted influx of seasonal “fevers.”

The history to which the center has borne witness since those humble origins has been epic. In 1804, Dr. David Hosack, a Bellevue surgeon who performed the first successful ligature of an artery in the thigh, treated Alexander Hamilton after he was mortally wounded in his duel with Aaron Burr. In 1861, Dr. Valentine Mott of Bellevue Hospital, in order to provide medical care for Union troops, helped to organize the Ladies Central Relief Committee, the forerunner of the Red Cross. In 1865, Bellevue surgeon Dr. Charles Augustus Leale was the first doctor admitted to the presidential box at Ford’s Theatre after President Abraham Lincoln was shot. His tragic words, “His wound is mortal; it is impossible for him to recover” soon echoed around the world.

In its current form, the NYU Langone Medical Center is comprised of four hospitals: Tisch Hospital, the Rusk Institute of Rehabilitation Medicine, the Hospital for Joint Diseases, and, most recently, NYU Lutheran Medical Center. The NYU School of Medicine is affiliated with the Bellevue Hospital Center, the nation’s oldest public hospital, which serves as its primary teaching affiliate, as well as the Manhattan Veterans Affairs Medical Center, Woodhull Hospital in Brooklyn, Gouverneur Healthcare Services in Manhattan, and the VA New York Harbor Healthcare System — Manhattan campus. At present, the Center’s campus is undergoing a dramatic transformation, with construction currently underway at 34th Street and First Avenue in Manhattan of the state-of-the-art, 830,000-square-foot Helen L. and Martin S. Kimmel Pavilion, as well as the Hassenfeld Children’s Hospital. On 30th Street and FDR Service Road, NYU Langone’s new Science Building will encompass more than 365,000 square feet and 10 floors of laboratory space dedicated to research and education.

At the heart of this transformation is the strength and creativity of the NYU School of Medicine, the home to many key advancements in medical education, scientific research, and urgent public health issues. The faculty and alumni of NYU School of Medicine have contributed to the control of tuberculosis, diphtheria, yellow fever (Dr. Walter Reed discovered mosquito transmission in 1899), venereal disease, and, most recently,
Ebola; the development of vaccines for hepatitis B (developed by Dr. Saul Krugman in the early 1960s), polio (Dr. Jonas Salk, class of 1939, developed the first effective vaccine in 1953 and Dr. Albert Sabin, class of 1931, developed the live vaccine for oral administration in 1959) and cancer; advances in the treatment and prevention of stroke and heart disease (streptokinase was discovered by Dr. William S. Tillett in 1933); and the introduction of minimally invasive surgical techniques. In the early 1980s, clinicians and researchers at NYU School of Medicine — including dermatologists, infectious disease specialists, immunologists, oncologists, and epidemiologists — were among the first to identify an alarming increase in Kaposi’s sarcoma, opportunistic infections, and immune system failure among young gay men, and alerted health authorities to an imminent health catastrophe, soon to be known as HIV/AIDS.⁴

NYU School of Medicine is proud to have among its alumni and former faculty four recipients of the Nobel Prize in Physiology or Medicine: Baruj Benacerraf (1980) for “discoveries concerning genetically determined structures on the cell surface that regulate immunological reactions,” Otto Loewi (1936) for “discoveries relating to chemical transmission of nerve impulses,” Severo Ochoa (1959) for “discovery of the mechanisms in the biological synthesis of ribonucleic acid and deoxyribonucleic acid,” and Eric Kandel (2000) for “discoveries concerning signal transduction in the nervous system.”⁵

Although the NYU Medical Center helped to produce many illustrious medical and surgical figures — including Valentine Mott, the most famous
surgeon of his day; Dr. Mott’s protege, John Revere, the youngest son of Paul Revere; Frank Spencer, a pioneer in open-heart surgery; and Saul Farber, a trailblazer in renal physiology and internal medicine — anesthesia was a late arrival on the honor roll. This late appearance was part of the history of U.S. anesthesia as a separate physician-run specialty. Until the 1930s, the administration of anesthesia at NYU Medical Center and Bellevue would have been unrecognizable to a modern day practitioner: there was no formal instruction and most practitioners were self-taught; there were no preoperative workups, no notes in the charts, including intraoperative death documentation; and endotracheal intubation was prohibited by certain services for non-thoracic cases. Anesthesia was administered by the department of nursing with inhalational anesthesia as the only allowable method of delivery. Spinals were performed by unsupervised surgery residents, with a purported immediate fatality rate of one in 150. Overall, perioperative deaths were common and poorly investigated.6

The modern era of anesthesia at the NYU Medical Center began in 1935, when the head of surgery, Dr. Arthur Wright, wanted to improve delivery of anesthesia and surgical outcomes. Dr. Wright reached out to Dr. Ralph Waters, who founded the first post-graduate training program for anesthesia at the University of Wisconsin-Madison in 1927. Dr. Waters recommended that Dr. Wright hire a star alumnus of his program, Dr. Emery Rovenstine, who would go on to transform both the NYU Medical Center and the practice of anesthesia. To read more about Dr Rovenstine and Bellevue Hospital, see the article “Bellevue Hospital: A Place for Teaching” in the fall 2014 issue of Sphere.7

The educational pillar of the department is centered around the residency program. Approximately 75 house staff members, 140 attendings, and 50 certified registered nurse anesthetists (CRNAs) work together in a friendly atmosphere of teaching, supervision, and close interaction. Nearly 500 hours of conferences, seminars, case reviews, simulation exercises, and lectures are scheduled and conducted each year, with weekly anesthesia grand rounds, morbidity and mortality conferences, basic and clinical science seminars, daily early morning clinical case conferences, an active visiting professor program, and specialty conferences.

Simulation exercises are administered through NYSIM, a partnership of The City University of New York (CUNY) and NYU Langone Medical
Center. NYSIM is one of the nation’s newest, largest and most sophisticated urban health science simulation teaching facilities, located in a 25,000 square foot wing of Bellevue Hospital. Since its opening in September 2011, NYSIM has had more than 24,000 learner visits and delivered nearly 2,000 simulation courses for NYU and CUNY medical students, nursing and dental students, residents, staff physicians and nurses, physician assistants and respiratory therapists, as well as those in other healthcare fields. NYSIM offers training to first responders in the New York area, including firefighters and emergency medical services personnel.

As NYU Medical Center embarks on its newest expansions, including both the internal transformation of its campus as well as its external merger with Lutheran Medical Center, there is a feeling of confidence that the Department of Anesthesiology, Perioperative Care and Pain Medicine, with its emphasis on education, research and clinical skills, will continue to provide excellent patient care to all for many years to come.

Since its establishment as one of the first academic departments of anesthesiology in the world, the NYU Department of Anesthesiology, Perioperative Care and Pain Medicine continues a legacy of leadership, innovation, and academic excellence. Some notable affiliates are detailed below.

**Virginia Apgar, M.D.** (Class of 1937)
A pioneer of teratology and the effects of obstetric anesthesia on the newborn child, Dr. Virginia Apgar received her anesthesia training under Dr. Roventine. She developed the universally accepted and aptly named Apgar score in 1952 in order to quickly assess the health of a newborn child after birth, ultimately decreasing infant mortality and laying the foundation for neonatology. She was published multiple times and received numerous awards, including the Distinguished Service Award from the American Society of Anesthesiologists (ASA) in 1966 and the Ralph M. Waters Award from the ASA in 1973; she also held multiple honorary doctorates. A powerful and successful physician, Dr. Apgar continues to be a role model for many, having been commemorated on a U.S. postage stamp in 1994 and inducted into the National Women’s Hall of Fame in 1995.
Stuart “Stu” Cullen, M.D. (Class of 1938)
Dr. Stuart Cullen also studied under Dr. Rovenstine and started the departments of anesthesiology at the University of Iowa and the University of California San Francisco, securing funding and developing groundbreaking research, which led to numerous publications. His distinction as vice president of the American Board of Anesthesiologists (ABA) in 1960 and president of the ABA in 1961 solidified his place as a leader in the field. Dr. Cullen also worked with the World Health Organization on projects in Denmark and the Middle East, and he was awarded the Distinguished Service Award by the ASA in 1964 for professional achievements throughout his prolific career.

John Adriani, M.D. (Class of 1938)
Credited with innovations in saddle block anesthesia, axillary brachial plexus blocks, glucose in spinal anesthesia, nerve stimulators in regional anesthesia, studying succinylcholine, and the importance of cuffed endotracheal tubes, Dr. John Adriani remains one of the most influential anesthesiologists of the 20th century. In addition to editing for Anesthesiology for nine years, he has received multiple awards. These included the ASA’s Distinguished Service Award in 1949, the Distinguished Service Award of the International Anesthesia Research Society, the Ralph M. Waters Medal, and the Award in Anesthesiology in 1968. Dr. Adriani became chair of the Department of Anesthesiology at Charity Hospital in New Orleans, the largest hospital of its kind in the world at the time, where he revolutionized how anesthesia providers are trained. As a director of the ABA from 1960-1972, during which time he served one term as ABA president, and chairman of the Examinations Committee in 1964-1965, Dr. Adriani helped shape what the board exams are today.

Emanuel “Manny” Papper, M.D., Ph.D.
(Class of 1942)
Another trainee of Dr. Rovenstine, Dr. Emanuel
Papper conducted research involving the hemodynamics of intravenous morphine, circulatory adjustments during spinal anesthesia, and pain management. After serving as a major in the Army Medical Corps during World War II, for which he earned the Army Commendation Medal, he would eventually become chief of anesthesiology and operating rooms at Walter Reed. As the first chair of the Department of Anesthesiology at Columbia University College of Physicians and Surgeons, he created subspecialities in pediatric, obstetric, and neurosurgical anesthesia. He later moved to Miami where he served as dean of the University of Miami School of Medicine and vice president of medical affairs until his retirement in 1981. During his long career, he held many academic board positions with the ASA, NYSSA, and ABA; these included director of the ABA in 1956, vice president of the ABA from 1963-1964, and president of the ABA from 1964-1965.

David Lubarsky, M.D., M.B.A. (Class of 1987)
A former resident and cardiac anesthesia fellow from NYU, Dr. David Lubarsky took charge of the vascular, transplant, and intensive care programs at Duke while working to improve and secure the financial integrity of the department. He has since moved on to the University of Miami, where his refined business acumen and love of informatics has helped improve patient care, increase efficiency, and reduce costs, bringing the practice of anesthesia into the 21st century. He continues to work with residents in the operating room and remains one of the nation’s experts in abdominal aortic aneurysms, having authored the related chapter in the textbook *Clinical Anesthesia*.

Andrew D. Rosenberg, M.D. (Class of 1983)
Dr. Andrew Rosenberg is the current chair of the Department of Anesthesiology, Perioperative Care and Pain Medicine. A former chief resident and cardiac anesthesia fellow at NYU, he remains an active leader in the field as chair of multiple ASA committees, president of the Academy of Anesthesiology (2011-2012), vice president of the NYSSA (2014), and president-elect of the NYSSA (2015).
Levon Capan, M.D.
Dr. Levon Capan is the current vice chair and associate chief of anesthesia at Bellevue Hospital and an expert in trauma and ICU, authoring the book *Trauma: Anesthesia and Intensive Care* with now retired Bellevue staff member Sanford Miller, M.D. Each morning, Dr. Capan leads a case discussion with the residents and students in a mock oral boards scenario, which trains the residents to think quickly and to articulate their thoughts in a concise and meaningful manner.

Michael Schlame, M.D., Ph.D. (Class of 2004)
As the current director of the cardiothoracic anesthesia program at NYU, Dr. Michael Schlame divides his time between working with residents in the operating room and performing research in the Department of Cellular Biology. He has a particular interest in Barth syndrome, a hereditary cardiomyopathy that also affects skeletal muscles, growth, and neutrophils, for which he has received grants from the National Institutes of Health and the American Heart Association. In addition to his basic science contributions, he sits on the Scientific and Medical Advisory Board of the Barth Syndrome Foundation and currently serves as its chairman.

Bernardo Rudy, M.D., Ph.D.
A new hire in the department, Dr. Bernardo Rudy serves as vice chair of research in the Department of Anesthesiology, Perioperative Care and Pain Medicine. He is a senior investigator at NYU, interested in the cellular mechanisms of electrical signaling in neurons and how they contribute to brain function. Collaboration with basic neuroscience is crucial to better understand the mechanisms of action of anesthetics, the short- and long-term effects of anesthetics, pain mechanisms, and the role of cortical GABAergic inhibitory neurons in anesthesia.
Thomas J. Blanck, M.D.
A former chair of the department, Dr. Thomas Blanck now devotes his time to basic science research involving the neurocognitive mechanisms of pain. His most recent work examines the role of oxidized calmodulin in the hippocampus in ischemic reperfusion.

Guang Yang, Ph.D.
An assistant professor in the Department of Anesthesiology, Dr. Guang Yang focuses on synaptic dysfunction in neurodevelopmental and neurodegenerative disease, including the widely publicized effects of childhood anesthesia and their relation to cognitive effects in adulthood. She also investigates how immune disorders contribute to neuropathology such as multiple sclerosis, Alzheimer’s, and chronic pain. A rising star in the world of neuroscience research, Dr. Yang and her lab remain a tremendous asset to the department.

James Mckeever, M.D., and Patrick Smollen, M.D., are CA2 anesthesiology residents and Samir Kendale, M.D., is an anesthesiologist at NYU Langone Medical Center in New York.

REFERENCES
5. Ibid.
7. Ibid.
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Telemedicine and Electronic Medical Records

MICHAEL J. SCHOPPMANN, ESQ.

Healthcare providers are increasingly adopting the use of technology to evaluate and treat patients in both traditional and non-traditional settings. The widespread adoption of electronic medical record (EMR) systems is improving healthcare efficiency and patient safety by making patients’ medical records more accessible among providers.

Telemedicine technologies offer great promise for the practice of medicine, as well as patient convenience. The Centers for Medicare & Medicaid Services (CMS) defines telemedicine to include two-way, real-time interactive communication between the patient and the distant site physician or practitioner but not communication via telephone, email or fax. Simply put, telemedicine is the practice of medicine through secure video conferencing between a physician at a distant site and a patient at the originating site.

Physicians treating patients via telemedicine are held to the same standard of care as those who administer healthcare services in a traditional in-person office setting. Just like an office-based physician, a physician practicing via telemedicine has a duty to be available for care when it is needed. Patients should be able to seek follow-up care from the physician who conducted the telemedicine encounter.

Concerning the prescribing of medications via telemedicine, again, the same standard applies to telemedicine physicians. Prescribing may be done at the professional discretion of the physician so long as it is in accordance with current standards of medical practice. The physician may exercise good medical judgment and prescribe medications as part of the telemedicine encounter. In most states, however, the law requires an in-person physical examination before a controlled substance is prescribed.

In certain situations, an emergency plan also may be required and should be provided to the patient when the care indicates that a hospital visit is necessary. It is important to note that for worsening medical conditions, treatment via telemedicine is not a substitute for the function of a physician in a traditional in-person setting.
Before engaging in the practice of telemedicine with a new patient, the physician must establish a formal physician-patient relationship with the prospective patient. Some states institute a higher standard for physicians who use telemedicine. For instance, some states require an in-person visit in addition to any clinical examination performed via telemedicine given that the knowledge of the patient’s prior history may provide for better patient evaluation and treatment.

The standard of care also requires that the physician maintain a record of each patient encounter that accurately reflects the patient’s presenting symptoms as well as the evaluation and prescribed treatment. Telemedicine encounters must be documented in the same way as other meetings or appointments between a physician and a patient.

While the use of technology offers opportunities to improve the delivery of healthcare, it may also present privacy and security risks. Before patients virtually connect with their doctors via telemedicine, physicians must guarantee the same level of privacy expected during a traditional office visit.

Patients must be aware of and consent to the potential benefits and risks associated with telemedicine and the use of EMRs, including delays, failure of equipment, and potential security breaches. Patients must review consent forms for the inclusion of patient informed authorization for telemedicine services.

Due to the increased use of EMR systems, patients must also review the notice of privacy practices (NPP). The NPP should describe a patient’s right to access his/her health records held in an EMR format, if the physician has an EMR system in the practice. It must explain the types of uses and disclosures of a patient’s health records that a physician is allowed to make. It must also explain that the physician will obtain the patient’s permission before using the patient’s health records for any reason. Most physicians distribute the NPP upon the patient’s first visit. It is important to note that the physician cannot use or disclose patient health information in a way that is not listed in the NPP.

Many hospitals and physician practices have successfully implemented the use of EMR systems and telemedicine technologies as part of their services. The access to information, accessible expert advice, equal standards of care, and complete patient records are among the benefits of such technological advancements in healthcare.
Nationwide, state legislatures are enacting telemedicine reimbursement laws stating that private insurers and Medicaid plans are required to provide coverage for telemedicine services to the same extent they cover in-person medical services. The law states that deductibles, co-insurance or other conditions for coverage of telemedicine must be consistent with those of in-person visits.

The advent of new technologies, including EMR systems and telemedicine technologies, is changing the dynamics of the physician-patient relationship and making it more convenient for patients to obtain care. The existing governing principles of professional conduct remain the same, however, and adherence to those principles must be foremost in the minds of every healthcare professional as technology pulls and pushes medicine forward.

For more information regarding the use of telemedicine technologies and electronic medical records, please contact Michael J. Schoppmann, Esq., at 800-445-0954 or info@drlaw.com.

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This activity has been planned and implemented by the Duke University Health System Department of Clinical Education and Professional Development and destinationCME, for the advancement of patient care. The Duke University Health System Department of Clinical Education and Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing education for the healthcare team.
New York State Operating Room Demographics, Structures and Metrics in 2015

KARL O. KRISTIANSEN, B.S., STEVEN D. BOGGS, M.D., M.B.A., AND
MITCHELL H. TSAI, M.D., MMM

The typical hospital OR has an average annual operating budget of $21 million, and accounts for up to 60% of a hospital’s revenue and 40% of its expenses. Given these statistics, it should come as quite a surprise that OR governance structures range from no formal arrangement to multi-disciplinary committee strategies. Furthermore, there is scant information on the capacity of the operating suites, the surgical caseloads by specialty, the types of management practices, and, most importantly, the level of involvement by anesthesiologists. Recently, we invited NYSSA members to participate in a survey to help us all better understand the demographics of anesthesiology groups at a district level. We used a previously developed survey tool, which consisted of 26 questions that covered the following topics:

1) OR demographics and staffing (NYSSA district, type of hospital, case volumes and specialty categories, the number of anesthetizing locations, composition of the anesthesia healthcare teams);

2) OR management (e.g., first case start and turnover times, utilization rates, staffing ratios, overtime, contribution margin, growth in caseload, and block allocations); and

3) OR governance structures.

At the close of the survey, we received 49 responses (1.5%) from eight (8) districts from the approximately 3,500 emails sent to the addresses in the NYSSA member database.

Our limited survey indicates that orthopedics and general surgery constitute approximately 40% of surgical workloads. Divided evenly at 20% for both specialties, these percentages are greater than the national averages (18.1% for orthopedics, and 5% for general surgery). Full results by district are reported in Figure 1. We also found that the majority of hospitals (53%) staffed between one and 14 operating rooms, with 31% of hospitals staffing between 15 and 29 ORs, and only 16% of hospitals staffing more than 30 ORs. When we queried about the number of cases, we discovered that
many respondents (37%) did not know how many cases were performed at their hospitals. The second most common response indicated that their institutions performed between 5,000 and 9,999 cases per year. Given that the population of New York state is 19.75 million, we estimate that between 25 and 50 cases per 100,000 people are performed per year. These results are well below the findings of a recent World Health Organization study that reported 11,110 cases per 100,000 persons per year in high healthcare expenditure countries and the national estimates by Weiss in 2014 (5,026 per 100,000). We believe that improved survey response rates might fine-tune our estimates. Among all respondents, anesthesiologists staffed most of the anesthetizing locations, with the vast majority of hospitals having anesthesia personnel in at least 75% of their locations. Conversely, approximately 15% of respondents report having locations with nurses only. Of note, nearly 30% of the participants did not know how locations were staffed. The fact that there were two questions where “Blank/Unknown” was the most frequent response suggests that there is a place for increased education, locally and regionally, among anesthesiologists.

![Percentage of Cases at Each District](image)

**Figure 1:** Values reported are median percentages of hospitals in each district.

Responses to the topics addressed by each hospital’s OR management committee demonstrated that the same tactical and operational issues are important to all survey respondents, regardless of data being analyzed as aggregate or by OR size. We showed that OR block allocations are viewed as the most important issue addressed by these OR committees. We show in
Figure 2 that the importance of this issue is true regardless of the capacity of the OR. We also discovered that the most common OR governance structure is one individual at the top, usually someone with a nursing background. The second most common OR governance structure consists of a team of two (nurse and surgeon, nurse and anesthesiologist, or surgeon and anesthesiologist).

Unfortunately, there are many other limitations to our results. As discussed, the response rate of 1.5% with only 49 responses limits the ability to detect any differences among groups. However, for the simple descriptive portions of this study, an “n” of 49 should be adequate to understand the current climate of operating room management and to qualitatively describe what things these managers measure and act upon. Despite these limitations, our survey helps to shed light on the surgical caseloads, the types of surgical procedures performed, and the staffing patterns of hospitals in the state of New York. The data show that there is diversity in the number of ORs per hospital, the number of cases performed, and the anesthesia staffing models in the different districts. Interestingly, trends of case type are similar among the different districts in New York and are congruent with national trends. With the push by the American Society of Anesthesiologists to develop the Perioperative
Surgical Home as the platform for the future of our specialty, we believe that anesthesiologists should understand the OR infrastructure and governance structures at their own institutions. In order to navigate the changing waters of healthcare reform, anesthesiologists will need not only clinical expertise, but also the operational knowledge of the anesthetizing locations, case types, and staffing models. In other words, anesthesiologists will need to extend their influence beyond the boundaries of the OR.

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The European Anaesthesiology Congress

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NYSSA Members Support New York Legislators

NYSSA Immediate Past President Dr. Lawrence Epstein (left), New York Assembly Speaker Carl Heastie and NYSSA President-elect Dr. Andrew Rosenberg

Dr. Lawrence Epstein, New York Assemblyman Joe Morelle and Dr. Andrew Rosenberg
Scenes From the ASA Annual Meeting
New York Caucus

NYSSA members participate in the New York caucus meeting.

Mid-Atlantic Caucus Meeting

Dr. Michael Duffy addresses the attendees at the Mid-Atlantic Caucus meeting.
NYSSA Board of Directors Meeting

NYSSA Board members discuss business during the ASA annual meeting in San Diego.

Board members celebrate Dr. Ingrid Hollinger’s birthday.
NYSSA and ESA Leadership

NYSSA Board members take time to network with ESA leaders.

NYSSA District 7 Fall Meeting

Drs. Rose Berkun, John Dombrowski, Scott Plotkin and Mark Lema
In the past decade in the U.S., there have been 33 reported outbreaks of patient-to-patient transmission of hepatitis B and C virus in healthcare settings due to breeches in infection control. Seven of these outbreaks involved anesthesia care, putting 55,000 patients at risk and infecting 144.

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

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

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A Look at New York’s History With Anesthesiologist Assistants

A. WILLIAM PAULSEN, MMSC, PH.D., CAA, AND GREGG MASTROPOLO, MMSC, CAA

Many NYSSA members may not be aware that anesthesiologist assistants (AAs) have a history of working around the country, including in New York. Initially, two AA programs were developed, one at Emory University in 1969 and one at Case Western Reserve University in 1971. Today there are 10 programs and one under development; still, the demand for AA graduates continues to exceed the supply. As the debate about the role of the anesthesiologist assistant continues, NYSSA members may find it helpful to know the evolution of the AA profession in the state.

Having worked for years with anesthesiologist assistants as director of cardiac anesthesia at Emory University, Dr. Joel Kaplan moved to New York in 1983 and assumed the position of chair of anesthesia at the Mount Sinai School of Medicine and The Mount Sinai Hospital. Soon after, Anita Guffin, an AA from Emory University in Atlanta, arrived and both she and Dr. Kaplan began to address the issue of permitting AAs to work in New York. They recognized that the best approach would be to propose a demonstration project under Public Health Law section 2807-h (Health Occupation Development and Workplace Demonstration Programs). Dr. Kaplan proposed the use of anesthesiologist assistants for the care of patients receiving anesthesia at The Mount Sinai Hospital. On April 10, 1984, Dr. Kaplan received permission from the New York State Department of Health to begin a two-year trial of anesthesiologist assistants at Mount Sinai. It was thought that the two-year trial would provide a sufficient period of observation to evaluate the performance and effectiveness of anesthesiologist assistants. In July 1984, Anita Guffin received privileges to practice as an anesthesiologist assistant at The Mount Sinai Hospital.

On August 5, 1985, Dr. Santo Berenato, representing the New York State Department of Health, Office of Health Systems Management, visited The Mount Sinai Hospital and provided his observations, which included this summary comment: “It is apparent from Ms. Guffin’s responsibilities at Mount Sinai that the anesthesia assistant can play a vital role in the provision of medical services.”
In a letter to Dr. James Glenn, president of The Mount Sinai Medical Center, Dr. David Axelrod, commissioner of health for the New York State Department of Health, wrote the following:

Dear Dr. Glenn:

Letters and comments from anesthesiologists and other medical specialties on staffs of medical centers and affiliated tertiary facilities have strongly endorsed authorization to utilize the anesthesiologist assistant (AA) as a member of the anesthesia care team.

In addition to representing a highly qualified health professional, the AA designation satisfies the criteria established for a category of specialist’s assistant (pursuant to the New York state physician’s assistant/specialist’s assistant law). At its meeting on August 22, 1985, the state Physician’s Assistant/Specialist’s Assistant Advisory Council adopted a resolution recommending designation of an anesthesiologist assistant as a category of registered specialist’s assistant.

We will consider the comments received from all interested parties [in] our final evaluation of this issue.

Sincerely,
David Axelrod, M.D.
Commissioner of Health, New York State Department of Health

According to Dr. Kaplan, Dr. Axelrod became ill and died during this time, so no action was taken by the commissioner’s office. Meanwhile, another AA came from Atlanta, but after a year he left to go to medical school. Dr. Kaplan was unable to recruit AAs and he proceeded with adding more residents and faculty until the department reached 100 residents and 50 faculty members. At this point there was no reason to continue recruitment of anesthesia providers and the project became dormant.

In 1995, an AA applied to join the Mount Sinai Department of Anesthesiology. Anita Guffin sent a letter to the Office of Health Systems Management of the New York State Department of Health informing them of the plan to hire another AA. Mr. James Tunny, assistant director of the Bureau of Standards Development, replied that Dr. Kaplan should request that this professional be employed and utilized within the demonstration mode. Around this time, Anita Guffin became ill and returned to Atlanta to be close to her family. In December 1997, Dr. Kaplan and Dr. Paul Goldiner sent the responses required by the workforce demonstration application to
Mr. Frederick Heigel, director of the Bureau of Hospital and Primary Care Services, in an attempt to reactivate the arrangement between Mount Sinai and the New York State Department of Health regarding the use of anesthesiologist assistants.

In 1998, Drs. Goldiner and Werner Pfisterer sent a letter to Dr. Michael Jakubowski, president of the NYSSA, urging support for AAs, especially in time for a meeting to be held by the New York State Department of Health on January 6, 1999, to discuss reactivation of the anesthesiologist assistant as an anesthesia provider. The results of the meeting would decide the fate of the Mount Sinai AA project.

Following the Department of Health meeting, Mr. Heigel sent a letter to Drs. Kaplan and Goldiner. The letter included three main points:

1. The AA program would be carried out pursuant to Public Health Law section 2807-h (Health Occupation Development and Workplace Demonstration Programs), which was due to expire December 31, 1999.

2. The New York State Education Department was undertaking an initiative to establish parameters for unlicensed assistive personnel that were consistent with protected scopes of practice for licensed professionals. This directly affected AA scope of practice.

3. There was a revision to the federal conditions for participation for hospitals that proposed a change to delete any specific definition of an anesthesia provider and, instead, limit the provision of anesthesia services to anesthesia administered “only by a licensed practitioner permitted by the state to administer anesthetics.” Dr. Heigel stated that since state requirements must, at a minimum, meet federal requirements, any such change would preclude the state’s opportunity to consider as a workforce demonstration project the use of unlicensed assistive personnel in this area. This marked the end of the demonstration project.

Dr. Goldiner made one last-ditch effort to enable AA practice in New York. In October 1998, he sent a letter to Ms. Deborah Konopko, first assistant counsel to the governor, making the case that there were severe consequences to acute and long-term manpower issues at Mount Sinai that might be calmed if AAs were permitted to work in New York. He addressed cost containment issues and suggested that anesthesiologists, like other
physicians, should have a choice to choose a physician assistant or a nurse, in this case an AA or a CRNA. He went on to describe the differences between AAs and CRNAs. He stated that there are clear differences between AAs and CRNAs: “The AA curriculum emphasizes applied statistics, anesthesia technology and medical instrumentation for patient monitoring systems. This would make the AA especially qualified for assisting in the most complex surgeries within sub-specialties (cardiac and neuro anesthesia cases). This obviously would create the greatest benefit to improving the critical shortage of personnel at tertiary centers. AA and CRNA pathways are definitely different, creating advantages for tertiary centers. Each occupation should be allowed to practice freely according to their accepted credentials on federal and state levels. Choice, however, is paramount in determining their appropriate deployment.”

This request fell upon deaf ears in the New York government. Here we are more than 15 years later, still attempting to resurrect the practice of AAs in New York.

A. William Paulsen, MMSc, Ph.D., CAA, and Gregg Mastropolo, MMSc, CAA, are with the Frank H. Netter MD School of Medicine, Quinnipiac University.

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.
NYSSA Members Educate New Yorkers at the New York State Fair

SRINIVASA S. THOTA, M.D., M.B.B.S.

The spirit of volunteerism was alive and well this year at the NYSSA booth at the Great New York State Fair in Syracuse, New York. Continuing the tradition established in previous years, the anesthesiology residents and pain management fellows of SUNY Upstate Medical University manned the booth and provided curious onlookers with insight into the world of anesthesiology. Dr. Michael Duffy, Dr. Richard Beers and I volunteered, too.

Not only were members of the general public invited to practice intubations on a medical mannequin (and partake in our most commonly associated activity), they were also educated on the number of subspecialties that anesthesiology encapsulates, such as pain management and anesthesia for obstetrics. At every opportunity NYSSA volunteers discussed the role of physician anesthesiologists and their significance to the healthcare team. Fairgoers were also informed about the training that an anesthesiologist undergoes.

It is the nature of our profession to listen to health concerns from people when they learn that we are physicians (regardless of the specialty), and the State Fair was no exception. An elderly gentleman approached the anesthesiology booth and began chatting with one of our chief
residents, Dr. Indy Grewal. This gentleman reported general malaise as well as shortness of breath and mild chest discomfort. It took a lot of coercion from Dr. Grewal, but the gentleman reluctantly agreed to be taken to the Upstate Medical University Emergency Room. There, the ER physicians made a confirming diagnosis of acute myocardial infarction.

While the Great New York State Fair is usually seen as a platform for carnival rides and greasy (but delicious!) food, participating and volunteering within our community has brought education to the public and satisfaction to the many physicians at Upstate Medical University.

We hope to see more NYSSA members participate at next year’s New York State Fair.

Srinivasa S. Thota, M.D., M.B.B.S., organized the NYSSA’s participation in this year’s New York State Fair.

Have You Visited the NYSSA Website Lately?

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

Check it out at www.nyssa-pga.org.
Residents’ Night at the New York Academy of Medicine

ELIZABETH A. M. FROST, M.D.

September 30 marked the annual Residents’ Night at the New York Academy of Medicine. The competition, which is open to all anesthesiology residents in New York, allows these young physicians the opportunity to showcase their work and present it to their colleagues. This year, from 29 abstracts, seven were chosen for oral presentation. The rest were displayed in poster form. A panel of judges from academic departments, coordinated by Dr. David Wlody, reviewed the submissions and awarded three prizes in each category.

Winners this year for oral presentation included two first place recipients: Dr. Keshar Kubal representing New York Medical College for “A Risk INDEX for Outcomes in Cardiac Surgery Using Artificial Neural Network Analysis” and Dr. Erik Romanelli from the Albert Einstein College of Medicine for “Pilot Study: Systemic Inflammatory Responses during Robotic CABG Compared to Conventional Surgery.” Third prize went to Dr. Suzette Singh, also from the Albert Einstein College of Medicine, for “Postoperative Pain Comparison of Conventional Sternotomy versus Robotic Coronary Artery Bypass Grafting.” In the poster category, there was again a tie for first place, which was awarded to Dr. David Berman from the Icahn School of Medicine at Mount Sinai for “Creation of a Digital iBook Curriculum for Anesthesiology Residents” and Dr. Beamy Sharma from New York University Langone Medical Center for “Characteristics of Perioperative Reintubations.”

Dr. Rochelle McLaren from the Albert Einstein College of Medicine captured third prize with “Are Current Transfusion Practices Consistent with Recommended Guidelines?”

Residents’ Night was sponsored by North American Partners in Anesthesia.
Along with monetary awards, all participants were presented with certificates of recommendation and a one-year free associate membership in the Academy.

Prior to the oral presentations, a buffet dinner and wine bar gave the 80 physicians who attended an opportunity to network and view the posters. Other short presentations were given by Dr. Matthew Klein on “How Quality and Service are Inseparable in Anesthesia”; Dr. Shaesta Humayun, who explained how membership in the Royal Society of Medicine in London was achieved through the New York Academy; and Ms. Donna Fingerhut, who gave a brief overview of the workings of the New York Academy. Representatives from the New York State Society of Anesthesiologists reminded everyone of the upcoming PostGraduate Assembly.

The event was generously sponsored by North American Partners in Anesthesia.

The next meeting of the Academy Section on Anesthesiology will be held in the spring, with the ever-popular Anesthesia Jeopardy night. Departments are invited to send a two-person team to the competition.

Elizabeth A. M. Frost, M.D., is chair of the Section on Anesthesiology at the New York Academy of Medicine.
I have recently received inquiries from NYSSA members regarding the supervisory requirements associated with directing a student registered nurse anesthetist (SRNA) under New York state law and, in particular, under the New York state health code. The question presented is whether it is consistent with the state health code for an SRNA to administer anesthesia when an anesthesiologist or certified registered nurse anesthetist (CRNA) is NOT physically present in the same room. The short answer is “NO.” The practice would not be consistent with Part 405.13 of the health code. Title 10, New York Codes, Rules and Regulations (10 NYCRR) 405.13(a)(1)(v) states:

“(v) a student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs may administer anesthesia as related to such course of study under the direct personal supervision of a certified registered nurse anesthetist or an anesthesiologist.”

As such, unlike the health code provision (also found in 405.13(a)(1) — see below) governing the supervision of a CRNA, the standards set forth for directing an SRNA are more restrictive and more stringent.

“(iv) certified registered nurse anesthetists (CRNAs) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA,”

In addition to adherence to the New York state health code, the following issues should also be considered before allowing an SRNA to administer anesthesia without the physical presence of an anesthesiologist or CRNA in the same room:

A. **ASA Statement on the Anesthesia Care Team.** The practice allowing SRNAs to administer anesthesia without the physical presence of
an anesthesiologist must be consistent with the ASA statement on the anesthesia care team. Following is an excerpt from the statement.

**American Society of Anesthesiologists**

**STATEMENT ON THE ANESTHESIA CARE TEAM**

(Last amended on October 16, 2013)

**Medical Supervision of Non-Physician Anesthesia Students**

Anesthesiologists who teach non-physician anesthesia students are dedicated to their education and to providing optimal safety and quality of care to every patient. The ASA Standards for Basic Anesthetic Monitoring define the minimum conditions necessary for the safe conduct of anesthesia. The first standard states, “Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.” This statement does not completely address the issue of safe patient care during the training of non-physician student anesthetists. Further clarification of the issues involved is in the best interests of patients, students, and anesthesia practitioners.

During 1:1 supervision of non-physician anesthesia students, it may become necessary for the supervising anesthesiologist or nurse anesthetist to leave briefly to attend to other urgent needs or duties. This should only occur in circumstances judged to cause no significant increased risk to the patient.

This practice is to be distinguished from that of scheduling a non-physician student as the primary anesthetist, meaning that no fully-trained anesthesia practitioner is also continuously present to monitor the anesthetized patient. Though the brief interruption of 1:1 student supervision may be unavoidable for the efficient and safe functioning of a department of anesthesiology, the use of non-physician students as primary anesthetists in place of fully trained and credentialed anesthesia personnel is not endorsed as a best practice by the ASA. While the education of non-physician anesthesia students is an important goal, patient safety remains paramount. Therefore, the supervision of students at a ratio other than 1:1 must meet criteria designed to protect the safety and rights of patients and students, as well as the best interests of all other parties directly or indirectly involved: anesthesia practitioners, families, and healthcare institutions.

1. **Delegation:** All delegating anesthesiologists and the department chairperson must deem non-physician student anesthetists fully capable of
performing all duties delegated to them, and all students must express agreement with accepting responsibility delegated to them.

2. **Privileging**: An official privileging process must individually deem each student as qualified to be supervised 1:2 by an anesthesiologist who remains immediately available (see Addendum C). Students must not be so privileged until they have completed a significant portion of their didactic and clinical training and have achieved expected levels of safety and quality (if at all, no earlier than the last three to four months of training). Privileging must be done under the authority of the chair of anesthesiology and in compliance with all federal, state, and professional organization and institutional requirements.

3. **Case Assignment and Supervision**: Students must be supervised at a 1:1 or 1:2 anesthesiologist-to-student ratio. Assignment of cases to students must be done in a manner that assures the best possible outcome for patients and the best education of students, and must be commensurate with the skills, training, experience, knowledge and willingness of each individual non-physician student. Care should be taken to avoid placing students in situations beyond their level of skill. It is expected that most students will gain experience caring for high-risk patients under the continuous supervision of qualified anesthesia practitioners. This is in the best interest of education and patient safety. The degree of continuous supervision must be at a higher level than that required for fully credentialed anesthesiologist assistants and nurse anesthetists. If an anesthesiologist is engaged in the supervision of non-physician students, he/she must remain immediately available. This means not leaving the procedure suite to provide other concurrent services or clinical duties that would be considered appropriate if directing fully credentialed anesthesiologist assistants or nurse anesthetists.

4. **Back-up Support**: If an anesthesiologist is concurrently supervising two non-physician students assigned as primary anesthetists (meaning the only anesthesia personnel continuously present with a patient), the anesthesiologist could be needed simultaneously in both rooms. To mitigate this potential risk, one other qualified anesthesia practitioner must also be designated to provide back-up support and must remain immediately available.

5. **Informed Consent**: The chair of anesthesiology is responsible for assuring that every patient (or the patient’s guardian) understands,
through a standardized departm ental informed consent process, that the patient may be in the procedure room with only a non-physician student physically present, although still directed by the responsible anesthesiologist. In the best interest of all involved parties, documentation of this aspect of informed consent must be included in the informed consent statement.

6. **Disclosure to Professional Liability Carrier:** To be assured of reliable professional liability insurance coverage for all involved (qualified anesthesia practitioners, their employers and the institution), the chair of anesthesiology must notify the responsible professional liability carrier(s) of the practice of allowing non-physician anesthesia students to provide care without continuous direct supervision by a fully trained, credentialed and qualified anesthesia practitioner.

B. **Hospital Contract.** Are you contractually bound by a hospital contract to comply with all applicable laws, rules, and regulations (including the health code provisions referred to above) and the ASA guidelines? If yes, violating this contractual provision may be viewed by the hospital as a material breach of the contract, allowing for immediate termination.

C. **Billing Compliance.** The practice of allowing SRNAs to administer anesthesia without the physical presence of an anesthesiologist or CRNA may violate the group’s billing compliance program. Neither CMS nor Medicaid recognize SRNAs.

D. **FLSA Potential Issue.** There is a related potential legal issue that private groups should assess while engaging the services of SRNAs and this involves compliance with the Fair Labor Standards Act (FLSA). There is a case currently in the court system, Schumann *et al v. Collier Anesthesia, P.A.*, that may provide some guidance on this important legal issue when a final judgment is made. In short, plaintiffs/complainants (SRNAs) allege that they were employed by the defendant (Collier Anesthesia) within the meaning of 29 U.S.C. §203(g) as interns who were provided no monetary compensation; that they were registered nurses who did not have a valid license or certificate to practice medicine and did not have the requisite degree to work as nurse anesthetists; that they were scheduled to work based on the staffing needs of Collier and performed the routine work of Collier on a regular and recurring basis; that Collier is dependent on the work of interns for its normal daily

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operations and that Collier derived immediate advantage from their work; that defendant employed interns as substitutes for regular workers, and/or to augment its existing workforce during specific time periods; that if Collier did not use interns it would need to hire additional employees; that they received the same level of supervision as Collier’s regular workforce; that they did not satisfy any of the exemptions set forth in the FLSA; and that they worked more than 40 hours in a given week but were not paid time and one-half for the hours in excess of 40. Clearly, if the court rules in favor of the plaintiffs (that SRNAs are employees and protected under the FLSA), financial implications associated with their use may need to be assessed.

**Update from Reid, McNally & Savage, LLC, NYSSA’s Albany Lobbyists**

A. **Out-of-Network Law Effective March 31, 2015**

State regulations and a guidance document implementing the Out-of-Network (OON) law went into effect on **March 31, 2015**. The regulations were developed by the Department of Financial Services. They are the result of the passage of a law last year (Chapter 60 of the Laws of 2014). The law regulates OON healthcare services including billing, reimbursement and consumer disclosure for services provided to patients by healthcare providers who do not participate in a patient’s health insurance plan.

The law provides for an Independent Dispute Resolution (IDR) process for non-emergency surprise bills and emergency bills when there is a dispute between a physician or uninsured patient and a health plan.

A “surprise” bill is a bill for non-emergency services received by an insured patient from a non-participating physician at a participating hospital or ambulatory surgical center where a participating physician is unavailable, a non-participating doctor provided the services without the patient’s knowledge or consent, or unforeseen medical circumstances arose at the time of service.

There are currently three vendors that are utilized for the IDR process: IPRO, MCMC, and Amedics. The cost of the IDR process ranges from $225 to $325 per appeal. According to the Department of Financial Services, 77 IDRs have been initiated since the implementation of the law (59 emergency and 18 surprise). Thirty-five were rejected as ineligible, 12 were resolved through settlement, eight were resolved in
favor of the health plan (eight emergency), four were resolved in favor of the provider (four emergency), and four were a split decision (three emergency and one surprise).

For more detailed information, please go to the following documents on the New York State Department of Financial Services’ website:
ON Law Guidance: http://www.dfs.ny.gov/insurance/ihealth.htm

B. Practitioner Education for the Medical Marijuana Program
The following information is from the New York State Medical Marijuana Program website (www.health.ny.gov/regulations/medical_marijuana/practitioner)/:

As set forth in 10 NYCRR §1004.1(a), practitioners seeking to issue certifications for their patients to receive medical marijuana products must meet the following criteria:

• Be qualified to treat patients with one or more of the serious conditions set forth in subdivision seven of section thirty-three hundred sixty of the Public Health Law or as added by the commissioner. The law currently identifies the following severe, debilitating or life-threatening conditions: cancer, HIV infection or AIDS, amyotrophic lateral sclerosis (ALS), Parkinson’s disease, multiple sclerosis, spinal cord injury with spasticity, epilepsy, inflammatory bowel disease, neuropathy, and Huntington’s disease. Patients must also have one of the following associated or complicating conditions: cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms;

• Be licensed, in good standing as a physician and practicing medicine, as defined in article one hundred thirty one of the Education Law, in New York state;

• Have completed a four-hour course approved by the commissioner; and

• Have registered with the New York State Department of Health (NYSDOH).

The four-hour NYSDOH approved course is now available online. The online course is provided by TheAnswerPage, an established online
medical education site, and includes the following topics: the pharmacology of marijuana; contraindications; side effects; adverse reactions; overdose prevention; drug interactions; dosing; routes of administration; risks and benefits; warnings and precautions; and abuse and dependence. The course will cost $249. Successful completion of the course will provide 4.5 hours of CME credits. The course may be accessed at www.theanswerpage.com/new-york-state-practitioner-education-medical-use-marijuana.

Following successful completion of the course, and upon full compliance with the other requirements set forth in 10 NYCRR §1004.1(a), practitioners may register with the NYSDOH Medical Marijuana Program. To begin the registration process, practitioners must e-mail the course completion certificate (in PDF format) to NYSDOH at mmp@health.ny.gov along with the practitioner’s state license number and Health Commerce System (HCS) User ID. Upon validation of the information provided, NYSDOH will send an e-mail confirmation to the practitioner containing a link that will authorize the practitioner to register.

Updates regarding the process for patient certification will soon be available on the NYSDOH Medical Marijuana Program webpage. Answers to frequently asked questions can be found at www.health.ny.gov/regulations/medical_marijuana/practitioner/faq.htm.

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MOCA 2.0: No More Test Every 10 Years?

CHRIS J. CURATOLEO, M.D., M.E.M., AND SHAWN SIKKA, M.D.

Beginning in January 2016, the American Board of Anesthesiology (ABA) will drastically change the Maintenance of Certification in Anesthesiology (MOCA). The update, known as MOCA 2.0, was announced to board-certified anesthesiologists (known as diplomates) in April 2015, and later discussed in a public press release.

The American Board of Medical Specialties established a “maintenance of certification” program in 1999. The ABA and other specialty boards then developed their own programs, with the launch of MOCA in 2004. Recertification centered on passing an examination every 10 years, logging continuous medical education (CME) activities, and participating in anesthesia-specific simulation scenarios. Certification was then extended for a 10-year period. In response to diplomate feedback and recertification trends in other medical specialties, the ABA began to search for a “more relevant and personalized approach to helping diplomates assess their knowledge and address knowledge gaps.”

MOCA 2.0 is still divided into four parts, but updates and modernizes several of them:

Part 1 — Professionalism and Professional Standing
Diplomates must hold an active, unrestricted medical license. No changes have been made.

Part 2 — Lifelong Learning
Diplomates will receive credit for activities such as participating in grand rounds conferences, taking ACLS courses, engaging in performance improvement activities, or receiving board certification. A self-assessment requirement for this part of MOCA was previously required but has now been removed.

Part 3 — Assessment of Knowledge, Judgment, and Skills
The recertification exam every 10 years will be replaced by a Web-based learning platform in January 2016 known as MOCA Minute. The goal is to continuously assess knowledge, fill knowledge gaps, and demonstrate
proficiency throughout the 10-year MOCA cycle. Diplomates will receive 30 questions per calendar quarter (i.e., 120 per year) via an ABA weekly email, Web portal, or mobile app. MOCA Minute will even present similar questions over time to help assess long-range retention of information. The user is given one minute per question and presented with the correct answer, rationale, and additional resources.

**Part 4 — Improvement in Medical Practice**

While previously centered around high-fidelity simulation once every five years, simulation is now just one of many activities that contribute to credit for MOCA part 4. These new activities include quality improvement projects, case discussion presentations, and the development of new clinical pathways.²

Overall, feedback to the ABA regarding this attempt to create a more flexible, fluid, and continuous learning system has been positive. Subspecialty questions are in the works, as are other systems of feedback and performance assessment for each individual diplomate participating in MOCA 2.0. Perhaps this will be called MOCA 2.1? Either way is fine as long as they don’t start calling it iRecertify.

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

**REFERENCES**


Advocacy and Policy Research for Safe Anesthesia

SHAWN SIKKA, M.D.

A close mentor of mine once said, “The more anesthesiologists that take part in government, the less the government takes part in anesthesia.” This inspired me to actively participate in the legislative process, and I was elected to serve as an officer in the New York State Society of Anesthesiologists Resident and Fellow Section. On several trips to Albany and Washington, D.C., I met with lawmakers to advocate on behalf of our specialty.

I was later delighted to be accepted as a resident scholar for the Policy Research Rotation in Political Affairs at the ASA office in Washington, D.C. Over the course of four very rewarding weeks, I gained a better understanding of the political and regulatory climate affecting the way we practice.

One of my main tasks was to advocate for safe anesthesia for our nation’s veterans. The proposed VA nursing handbook would require all advanced practice registered nurses, including nurse anesthetists, to practice independently at VA medical centers. I met with 12 senators and representatives to discuss my experiences working at the Bronx VA. Sharing my personal insights and real patient stories helped educate our lawmakers about the importance of preserving physician-led anesthesia for our nation’s veterans. I attended several congressional meetings of VA subcommittees and researched government accountability reports for useful information to support our cause.

Veterans, on average, have a higher ASA classification than their age-matched cohorts, present with advanced diseases due to a lack of primary care resources, come from a lower socioeconomic status, and are rarely optimized for surgery. On a personal note, I find it unjust that the patients I care for at The Mount Sinai Hospital in Manhattan will continue to have a physician anesthesiologist present in accordance with state law while veterans who risked their lives for our country, and with whom I serve just five miles down the road in the Bronx, will only have access to nurse-led anesthesia.

I also worked on a variety of projects for several departments at our national office. I attended conferences held by the Medicare Payment

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Advisory Commission (MedPAC) and summarized key changes affecting reimbursement for the ASA Department of Payment and Practice Management. I participated in CDC meetings on new opioid prescribing guidelines on behalf of the ASA Department of Pain Medicine and Federal Affairs. I helped to update our grassroots network of more than 10,000 ASA members and called upon them to take action in response to an article published in *Modern Healthcare* regarding scope of practice at VA medical centers. Alongside the Department of Quality and Regulatory Affairs, I helped develop new performance improvement measures for practicing pain clinicians. I researched state regulations and responded to member inquiries from across the country for the Department of State Affairs. On my last day, I gave a presentation to ASA staff members on a day in the life of an anesthesiologist. The presentation was geared toward the preoperative evaluation, concerns at different stages of an anesthetic, and the risks and benefits of anesthesia.

The ASA works tirelessly for its members. I can say from firsthand experience that your $20 resident donation will be put toward many great causes. With the new fiscal year upon us, I strongly encourage all of you to make a repeat or first time donation by going to [http://asahq.org/advocacy/asapac](http://asahq.org/advocacy/asapac). It is a small step to take for a big commitment to your patients and the future of your specialty.

If you would like more information on the ASA Policy Research Rotation in Political Affairs, please contact Government and Political Outreach Manager Amanda Ott at A.Ott@asahq.org, or go to [www.asahq.org/advocacy/federal-activities/items-of-interest/policy-research-rotation](http://www.asahq.org/advocacy/federal-activities/items-of-interest/policy-research-rotation).

*Shawn Sikka, M.D., is a CA3 anesthesiology resident at The Mount Sinai Hospital in New York. Dr. Sikka serves as NYSSA Resident and Fellow Section secretary and treasurer.*
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July 1 – September 30, 2015

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