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The winter edition of *Sphere* marks my final written message as president of the NYSSA. I am both honored and proud to have served as your president. The NYSSA is a phenomenal organization. We are a group of more than 3,600 physicians who strive daily to deliver safe patient care. We are also part of a storied tradition of providing first-class medical education to those in our state, our country and around the world through the PostGraduate Assembly in Anesthesiology (PGA). How many state societies have the reputation we have for an educational meeting of this caliber? We are unique.

We must continue to focus on both patient safety and physician education as the environment changes around us. First, concerning patient safety, it is critical that we maintain the physician-led anesthesia care team that has resulted in safe anesthesia care in New York state. Make no mistake about it, this model of care is under fire. The nurse anesthetists have been extremely active in Albany in an attempt to gain “title” as a first step in their ultimate desire for independent practice. We must not allow them to win an issue that can compromise patient care — the granting of “title” without defining scope of practice. The Department of Health defines a nurse anesthetist’s scope of practice, as should any proposed legislation that may ultimately become law. Not defining scope of practice is potentially very dangerous, as it would create a question in the operating room as to who is allowed to do what and who is in control.

As an organization, we favor the concept of granting “title” if it is associated with a definition of scope of practice that includes that nurse anesthetists work under the supervision of physicians. My fellow NYSSA members and I have been very busy working on your behalf to protect our patients. We were successful this year, but the fight is far from over. Please consider becoming active to help your profession. You can do this through PAC contributions, meeting with your representatives in Albany, or sending appropriate emails and letters when called upon to do so. It
is important that you are engaged in protecting your future and the future of your profession.

Second, as far as the PGA is concerned, we need to maintain this event as one of the premier medical educational meetings in the United States. We have a well-deserved excellent national and international reputation with regard to our annual meeting. There are so many dedicated NYSSA members who organize and lecture at the PGA and I want to thank all of them for their hard work and commitment. In particular, I want to single out PGA General Chair Richard A. Beers, M.D., and Scientific Programs Chair Audrée A. Bendo, M.D., for their leadership of PGA 70. I hope all NYSSA members take full advantage of all the meeting has to offer.

I just returned from the ASA annual meeting and I am pleased to note the great involvement of New York physicians, both in academic and political areas. All members of the NYSSA should take pride in our level of participation.

Once again I would like to take the opportunity to thank all those who work tirelessly for our specialty and for the future of safe anesthesia care in New York state, care that is led by physician anesthesiologists. I thank our officers and staff members, especially Executive Director Stuart Hayman, as well as our legal advisors and lobbyists for their hard work and valuable advice throughout the year. I wish Rose Berkun, M.D., great success in her upcoming year as president. She is an extremely hard worker and a tireless advocate for physician anesthesiologists. Please give her your support. In closing, I thank you again for allowing me the opportunity to lead the NYSSA this past year. ■
Editorial

Taking Care of Ourselves Will Help Us Better Care for Our Patients

SAMIR KENDALE, M.D.

Anyone who has ever worked nights in a windowless operating room knows that the only way to tell when it’s morning is to look at the clock. After spending the night resuscitating a patient who is hemorrhaging during a C-section, maintaining hemodynamics in a mesenteric ischemia patient desperately trying to progress to septic shock, or administering anesthesia to a 95-year-old with a hip fracture, you may feel like a superhero. After all, we anesthesiologists know that our medical knowledge and clinical experience make us the most qualified to handle these types of situations.

I fondly remember a time when, after everything settled down, the call team sat in the room adjacent to the PACU recounting the events of the night, simultaneously wide awake yet drained, proud of what we had accomplished but thankful our shift was nearly over. For me, the impending sympathetic surge resulted in a period of high productivity (e.g., feverishly cleaning my apartment after I got home) before the crashing wave of exhaustion hit, resulting in my sleeping until dinnertime. After multiple nights like this, though, a general weariness can set in. It’s a feeling many of us have experienced before. Most times, the exhaustion is tempered by the satisfaction of the job or finding other means of coping, and we recover to serve once again. For some of us or our colleagues, the heavy weight is never lifted.

Perhaps even more potent than the long and busy hours, however, is the impact of a difficult case or an adverse event. Everyone has experienced the gut-wrenching feeling when, despite creating an optimal plan and remaining vigilant throughout the perioperative course, something bad happens. The impact may not even be directly proportional to the intensity of the incident. A postoperative sore throat or corneal abrasion can potentially be as distressing as objectively more serious events. What do we, as anesthesiologists, do next when facing these situations? Sometimes the answer isn’t clear, and the course of action can vary depending on the event, the personalities of those
involved, the environment, institutional policy and culture, or a variety of related factors.

We shouldn't be ashamed to acknowledge the emotional challenges of our profession, and we should be sympathetic to those who are struggling to overcome these challenges. I'm sure some of those reading may respond to this commitment to psychological well-being by lamenting the “weakening” of the medical field, convinced that we are breeding a “generation of whiners.” (These are real words I have heard.) To those skeptics, consider the more empirical facts that the burned-out physician is bound to be less productive and more prone to committing medical errors. The burned-out physician is less likely to become involved in the department. The burned-out physician is less likely to advocate for our specialty.

Dr. Melinda Aquino and Dr. Sergey Pisklakov use this issue to provide an introduction to the concept of wellness. Thanks to these authors, we can begin to have a better understanding of how we can best take care of ourselves, our friends, and our colleagues so that we can continue providing the best care for our patients.

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Dr. James Cottrell Receives Leadership Award From the Arthur Ashe Institute for Urban Health

James E. Cottrell, M.D., distinguished service professor and chair of anesthesiology and Garry S. and Sarah Sklar professor in anesthesiology at SUNY Downstate Medical Center, was recently honored with a 2016 Leadership Award by the Arthur Ashe Institute for Urban Health (AAIUH). Dr. Cottrell is also a member-at-large of the New York State Board of Regents.

Each year the AAIUH honors individuals and organizations that are making significant contributions to urban communities in the areas of health, education, medical research, community service, and philanthropy. In accepting the award, Dr. Cottrell noted that the AAIUH’s Health Science Academy, which the Institute runs in cooperation with SUNY Downstate, aims to increase minority member participation in medicine “by offering under-represented middle and high school students exposure to the health science field, and extra help to become a doctor, nurse, or medical technician.”

A past president of the American Society of Anesthesiologists (2003), Dr. Cottrell was awarded that national organization’s highest honor, the Distinguished Service Award, in 2010.
From the Executive Director

The Year in Review

STUART A. HAYMAN, M.S.

As I have often done during my eight-year tenure at the NYSSA, I am utilizing this issue of Sphere to provide the membership with a synopsis of my annual report. My time at the NYSSA continues to be productive and fulfilling. The support of the NYSSA’s leaders and volunteers has enabled us to accomplish a great deal these past eight years.

Thanks to strong fiscal leadership, we celebrated the eighth straight year without a dues increase. The NYSSA’s current financial strength is a direct result of the tightening of the budget as well as the establishment of strong fiscal policies and safeguards. The NYSSA has NO debt and strong reserves. In fact, the organization is one of the stronger, more stable medical associations across the country and the healthiest component society of the ASA.

The NYSSA’s PAC continues to be quite active, as evidenced by a very successful fundraising year. I believe the NYAPAC is the second-largest physician PAC behind the Medical Society of the State of New York (MSSNY). That said, there is always room for improvement. The leadership and consultants successfully worked with MSSNY and other medical organizations to combat aggressive scope expansion bills and to shape other legislation (e.g., the out-of-network/surprise billing legislation). Several other state medical associations have reached out to the NYSSA leadership regarding strategy and language pertaining to the surprise billing legislation. This reflects the NYSSA’s reputation as a leader on issues impacting anesthesiologists around the country.

The staff and I remain eager to serve the NYSSA’s members. I consider myself extremely fortunate to work with such enthusiastic volunteers who trust and support me in carrying out the organization’s goals. I am also proud to be the leader of a small but proficient staff team. I want to thank all of you for your unwavering support.

It is my pleasure to provide a synopsis of the NYSSA’s activities this past year. For a complete copy of my annual report, please email me at stuart@nyssa-pga.org.
The NYSSA leadership continues to invest in the infrastructure and technology that will ensure the future of the organization and our ability to serve the evolving needs of our members.

To that end:

• The NYSSA purchased our Midtown office approximately six years ago. The value of this office space (which the NYSSA owns outright, with no mortgage) has more than doubled during this short period.
• In 2016, we reviewed alternative software and decided on Cvent for membership database, conference management and registration.
• We updated the legal and political resources on the “Members Only” section of the website.
• We repopulated the CapWiz system to assist members with state legislative letter campaigns.
• We conducted our fourth annual pre-Legislative Day video conference.
• We continued to utilize multiple technological resources to provide information to members, PGA attendees, and the public (e.g., Survey Monkey, Constant Contact, Facebook, Instagram, Twitter).
• We continued to digitize paper membership records.
• We assisted most NYSSA districts by providing administrative support.

Advocating for Members

During the 2014/2015 legislative session, both the New York state Senate and the Assembly felt the impact of significant leadership scandals that led to the election of two new legislative leaders: Democratic Speaker Carl Heastie from the Bronx and Republican Senate Majority Leader John Flanagan from Long Island.

In 2016, we participated in an extremely volatile legislative session. Thankfully, while a number of bills that were opposed by the NYSSA advanced out of committee, few were passed. Looking ahead to the next legislative session, the NYSSA must be prepared for a tough battle with nurse anesthetists, who no doubt will intensify their efforts to practice anesthesia without the supervision of a physician. In response, the NYSSA will continue to utilize additional resources to preserve patient safety and the quality of healthcare in New York.
I am extremely pleased with the improved communication, coordination and cooperation among the NYSSA’s legislative consultants, physician volunteers and staff. I believe we have optimized the organization’s ability to respond rapidly, appropriately and successfully to the issues that arise in Albany. The success the NYSSA continues to experience in New York would not be possible without the expertise and diligence of our outstanding consultants: Kern Augustine P.C., general counsel; Higgins, Roberts & Suprunowicz, P.C., legislative counsel; and Reid, McNally & Savage, LLC, our Albany-based lobbying firm.

In 2016, the NYSSA’s core group of volunteer leaders dedicated a tremendous amount of time and effort to the organization’s goals. I would like to thank the NYSSA’s current president, Andrew Rosenberg, M.D., who has been extremely active, including participating in multiple PAC fundraisers and attending countless legislative events around the state. I would also like to recognize: President-elect Rose Berkun, M.D.; Immediate Past President Mike Duffy, M.D.; Government Relations Committee Chairman David Wlody, M.D.; Economic Affairs Committee Chairman Steve Schwalbe, M.D.; and NYAPAC Chair Mike Simon, M.D. Additionally, I would like to recognize the members of the Executive Committee and the Board of Directors, all of whom give a significant amount of time to work on behalf of the members, the association, and the profession.

**Educating Members and the Public**

The PGA is one of the oldest, largest, and most successful anesthesiology meetings in the world. It accounts for 55 percent of the staff’s time annually. The PGA’s success is directly attributable to the leadership of General Chair Richard Beers, M.D.; Scientific Programs Chair Audrée Bendo, M.D.; and Scientific Programs Vice Chair Meg Rosenblatt, M.D. Additionally, David Wlody, M.D., has been a tremendous asset, providing sage advice to the leadership team.

The NYSSA’s accreditation, which is essential to the ongoing PGA program, would not be possible without the hard work of Francine Yudkowitz, M.D. In addition to the ongoing efforts to maintain the NYSSA’s accreditation, we are pleased to report that we will again be receiving MOCA credits for multiple PGA panels. Staff members have also been working with Edmond Cohen, M.D., to replicate the success of the thoracic symposiums that were held the previous two years.
Educating the public about the specialty of anesthesia and the issues that impact our members and their patients:

- We continued the joint New York State Fair effort with MSSNY.
- We continued to work with the New York City Department of Health and Mental Hygiene on data collection and education relating to safe injection practices.

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

- We collaborated with national and international organizations while marketing the PGA at the ASA, ESA and WFSA meetings. We also have collaboration agreements with the Canadian Anesthesiologists’ Society and several state component societies.
- I attended the Medical Society of the State of New York’s House of Delegates meeting, as well as some of their committee meetings.
- We continued to work with the New York Coalition of Specialty Care Physicians.

In conclusion, this summary is intended to provide a snapshot of the noteworthy initiatives we have undertaken on behalf of all NYSSA members and the specialty of anesthesiology. This has been another productive and successful year for the organization. I thank you for your continued support and for the opportunity to represent the NYSSA as your staff leader.

Have You Visited the NYSSA Website Lately?

Attention NYSSA Members: A FREE course on infection control is just a click away.

Find the information and resources you need at www.nyssa-pga.org.
Physician Wellness: Caring for the Caregiver

MELINDA AQUINO, M.D., AND SERGEY V. PISKLAKOV, M.D.

What is wellness? While many anesthesiology departments across the country have “wellness programs,” the term “wellness” has been applied in different ways. The National Wellness Institute shares the following interpretation of wellness:

- Wellness is a conscious, self-directed and evolving process of achieving full potential.
- Wellness is multidimensional and holistic, encompassing lifestyle, mental and spiritual well-being, and the environment.
- Wellness is positive and affirming.¹

The National Wellness Institute utilizes a model of wellness developed by its co-founder, Dr. Bill Hettler. The “Six Dimensions of Wellness” include: occupational, emotional, physical, social, intellectual and spiritual. According to the National Wellness Institute, “Wellness is an active process through which people become aware of, and make choices toward, a more successful existence.” By observing and applying the six components of the model, “a person becomes aware of the interconnectedness of each dimension and how they contribute to healthy living.”¹ This model explains the ability of each individual to contribute to his or her environment and community. It allows for the building of better social networks. Using this model we become able to learn the benefits of regular physical activity, healthy eating habits, strength and vitality, as well as personal responsibility, self-care and when to seek medical attention. The model encourages self-esteem, self-control, and determination as a sense of direction and helps to encourage creative and stimulating mental activities, and sharing your gifts and abilities with others.²

For years, employers have realized that on-the-job factors significantly affect workers’ ability to perform their duties appropriately and to be productive. Burnout is a known concern in terms of staff rotation and retention. Burnout is a state of emotional, mental, and physical exhaustion caused by excessive stress. It occurs when one feels unable to meet constant demands. The epidemic of burnout has spread around the world. This epidemic did not leave healthcare untouched. Significantly higher burnout rates have been found among anesthesia providers. The high
incidence of burnout was reported among anesthesiology residents and academic chairpersons. Individual factors, stress, family issues and lack of a supportive community can lead to exhaustion, inefficacy, and poor clinical performance.\textsuperscript{3}

Burnout can be easily mistaken for substance abuse, depression, or a personality disorder. However, in the case of burnout the symptoms are job-site related and more about dissatisfaction rather than hopelessness and withdrawal, as one finds in cases of substance abuse or depression. Those who experience burnout feel empty and devoid of motivation, and are beyond caring. Physicians experiencing burnout often don’t see any hope of positive change in their situations. If excessive stress is like drowning in responsibilities, burnout is like being all dried up. There is one additional difference between stress and burnout: while you are usually aware of being under a lot of stress, you don’t always notice burnout when it happens.\textsuperscript{4}

The term “second victim” refers to the healthcare professional who experiences emotional distress following an adverse event. This distress has been shown to be similar to that of the patient — the “first victim.” It leads to burnout as well. Common reactions can be emotional, cognitive, and behavioral. The coping strategies used by second victims have an impact on their patients, colleagues, and themselves. Because of this broad impact, it is important to offer support for second victims. It is critical that support networks are in place to protect both the patient and the involved healthcare providers. “Second victims” may experience lack of respect. This may be responsible for lack of workplace motivation and employee satisfaction, increased turnover, and a lack of trust and team building among anesthesia providers. It can cause serious damage to self-esteem and the ability to contribute.\textsuperscript{5}

It is the duty of the anesthesiology department’s leadership to listen, to mediate, and to be proactive in such cases. The second victims of errors often suffer in silence. Support must begin the moment an adverse event or outcome occurs. We need to facilitate the second victim’s receptiveness to receiving help and to understand the enormous emotional toll that second victims endure. Second victims have a right to participate in the process of learning from the error. The support of peers and organizational leaders is paramount. Certainly, patients and family members who are harmed come first; however, it is also important to take care of the
practitioners involved in the errors, especially when they meant to do good and now find themselves in a situation where a patient has been harmed by their unintended actions. Staff needs to be aware of available resources. Second victims deserve the presumption that their intentions were good. Nobody should be blamed or shamed for human fallibility. Second victims need compassionate help to grieve and heal, and department leaders must understand the psychological emergency that occurs when a patient is unintentionally harmed.

Some healthcare facilities have established special programs to prevent burnout and second victimization. These types of programs are still missing in the field of anesthesiology, however. Recently we established a Wellness Committee within the Montefiore Medical Center Department of Anesthesiology. We started by establishing a baseline for assessing staff burnout. We used the Maslach Burnout Inventory, a measurement tool that grades burnout, a three-dimensional syndrome made up of exhaustion and inefficacy. We also created the position of ombudsman, an individual who
will advocate on behalf of the rotating students, residents, fellows and attending faculty. To ensure confidentiality and independence, the position will be held by an attending physician who is not part of the department leadership.

Simple things like exercise, engaging in a hobby, and interacting with significant others are the best preventers of burnout. The role of an anesthesiology department is to enforce a respectful workplace environment. Burned out physicians can be taught the essentials of stress management and shown techniques that will enable them to deal with stress, making it manageable and thereby improving their performance and increasing their value to the department. The most obvious tangible benefit of supporting a colleague is an enhancement of that individual’s personal efficiency, since he or she can then focus attention on patient care and productivity.

Melinda Aquino, M.D., is an assistant professor of anesthesiology, pain medicine and regional anesthesiology in the Department of Anesthesiology at Montefiore Medical Center. She is co-chair of the Department of Anesthesiology’s Wellness Committee. Sergey V. Pisklakov, M.D., is an associate professor of anesthesiology in the Department of Anesthesiology at Montefiore Medical Center. He is also a member of the Department of Anesthesiology’s Wellness Committee.

REFERENCES

Where anaesthesiologists meet in Europe

Euroanaesthesia 2017
The European Anaesthesiology Congress
Geneva, Switzerland
03-05 June 2017

Focus Meeting 2017
on Perioperative Medicine
Regional Anaesthesiology in Perioperative Setting
09-10 November 2017
Tel Aviv, Israel

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Alexander W. Gotta, M.D.
1935-2016

Alexander W. Gotta, M.D., passed away on October 13, 2016, at the age of 81. Dr. Gotta was born in Brooklyn, New York. He attended St. John’s University and the New York University School of Medicine. He completed his anesthesiology residency at New York Hospital – Cornell Medical Center, where he met his wife, the late Dr. Colleen Sullivan Gotta.

Dr. Gotta served as a captain in the United States Army Medical Corps. He was an attending anesthesiologist at New York Hospital, St. Mary’s Hospital, Memorial Sloan-Kettering Cancer Center, and the University Hospital of Brooklyn, and was chief of anesthesia at Long Island College Hospital and Kings County Hospital.

Dr. Gotta was a prominent member of the NYSSA, serving as president in 1996. He served as the chair of the PGA from 1994 through 1996.

Dr. Gotta will be remembered as an outstanding clinician, a dedicated teacher, and a leader in the field of anesthesiology. He is survived by his daughter Nancy Hintersteiner and her husband Jason.

The staff at SUNY Downstate Medical Center

I became chair at Downstate in 1979 and was lucky enough to have Alex Gotta join me as my first vice chair shortly thereafter. Alex was a true academic and a man for all seasons. He could do any job that became available. He served as our program director and promptly got us off probation. This attracted Downstate medical students to our program and started us on the way to reclaiming an outstanding program with an enviable board pass rate. We were lucky to be invited to expand our program to Long Island College Hospital and who better to serve as its chief than Alex. The hospital profited for years under his leadership.

Continued on page 18
Alex was never happy with the status quo and soon he wanted another challenge. He found one as director of anesthesiology at KCHC where he finished his career and made many long-lasting friends.

James E. Cottrell, M.D.

I had the pleasure and honor of working with Alex Gotta to develop and co-chair the NYSSA Retirement Committee. We became close friends and spent many hours talking about life, family, and history. An avid reader, Alex was always ready to recommend the next book for me to read. I particularly enjoyed his wry sense of humor, the twinkle in his eye, and how he vigorously promoted ideas that he thought would better our society … and, of course, how proud he was of his Polish heritage.

A clear thinker and a tireless worker, Alex determined that the NYSSA needed to do something of lasting significance to benefit our retired members and those facing retirement. He developed and promoted a popular PGA focus session that still deals with topics of need and interest to those who have given many years of service to the specialty of anesthesiology. Alex was an originator of the NYSSA Distinguished Service Award; he deservedly received the award in 2010. It was a high point of his career. Alex was very proud of the NYSSA and the contributions he made to our association.

Alex Gotta was a true gentleman. I will miss our conversations, his comments about life, and his book recommendations.

Michael Jakubowski, M.D.

Dr. Alexander W. Gotta was a strong figure in SUNY Downstate’s history. He was a superb teacher and mentor with a fantastic fund of knowledge. Anesthesia history and management of facial trauma were two of his academic passions. Both he and his lovely wife were important clinical leaders in our group, he serving as chair at KCHC and at LICH. From my medical student rotations through graduation, Alex helped shape solid clinical and academic habits. We will never forget lessons learned from Alex Gotta.

Lance W. Wagner, M.D.
**In Memoriam**

**Herbert Ketcham Morrell, M.D.**

**1927-2016**

Herbert Ketcham Morrell, M.D., one of the pioneers in anesthesiology in upstate New York, passed away on April 15, 2016. Dr. Morell was a graduate of White Plains High School (New York) and St. Lawrence University. He received his M.D. from SUNY Upstate School of Medicine. He completed an internship at St. Joseph’s Hospital in Syracuse and a residency at Grasslands Hospital, Valhalla. He was chief of the Anesthesia Section, U.S. Naval Hospital, Charleston, South Carolina. He later became chairman of the Department of Anesthesiology at St. Joseph’s Hospital and joined the faculty at SUNY Syracuse, becoming clinical professor.

Dr. Morrell served the NYSSA in many capacities, including as a committee chair, vice speaker of the House of Delegates, and as NYSSA president in 1973. He was the 2008 recipient of the NYSSA’s Distinguished Service Award. He also served as chair of several ASA committees and as ASA president (1985).

“He was a great mentor,” said Dr. Peter Kane. “He encouraged a number of people to become involved in organized medicine by talking about the importance of being ‘politically active.’”

During Dr. Morrell’s tenure as NYSSA president, he played a major role in the creation of the “Ethical Guidelines for the Practice of Anesthesiology.” Also during his tenure, the American Medical Association, through its Council on Medical Education, approved in full the “NYSSA Programs of Continuing Education.” Dr. Morrell led the NYSSA to develop the “Standards of Care in Anesthesiology.” These standards were later adopted and promulgated by the ASA.
In Memoriam

Alan I. Posner, M.D.
1935-2016

Alan I. Posner, M.D., passed away on July 23, 2016, at the age of 80. Dr. Posner was born in Brooklyn and was a graduate of Alfred University. He earned his medical degree from Chicago Medical School. He was a longtime member of the NYSSA. Dr. Posner was preceded in death by his wife, Ann, and is survived by his three children and six grandchildren.

Alan Posner is one of the main reasons I chose anesthesiology as a specialty and also decided to join Schenectady Anesthesia Associates. As a medical student spending a summer in anesthesiology at Ellis Hospital, Alan was my mentor. He showed me how to pour ether as an anesthetic. What other clinician in my age group has had this opportunity? Alan loved to teach. Even though he left academia at Columbia University, he continued to teach. He was chief of anesthesia at Ellis Hospital for years and loved his interactions with the other leaders at the hospital. He showed them the importance of anesthesia and our department became well respected under his supervision. Alan always had a smile on his face and a song in his mind. He was constantly singing, particularly to his young patients on induction of anesthesia. One of the high points of his career was the years spent as speaker of the House of Delegates (1990-2001). He studied Robert’s Rules and later Sturgis Parliamentary Procedure. I believe many of the words that are read now at the House were written by Alan. Alan passed away after a hard-fought battle with Parkinson’s disease. He will be missed by all who knew him.

Larry Routenberg, M.D. ■
Physicians’ Perspectives on Medical Marijuana in New York State

The medical marijuana landscape within the United States is changing rapidly. A Quinnipiac University poll conducted in May 2014 indicated that 83 percent of New York state registered voters supported allowing adults in the state to legally use marijuana for medical purposes if their doctor prescribes it.¹ In July 2014, New York became the 23rd state to legalize medical cannabis. The first dispensary opened in January 2016. As of November 7, 2016, 739 physicians (less than 1 percent of the estimated 90,000 physicians in the state) have registered with the state program and certified 9,852 patients.² The reasons for physicians’ willingness to register as licensed “recommenders” of marijuana, as well as their reasons for indifference or opposition to registering, remain elusive. Legal ambiguity exists, as marijuana remains classified as a Schedule 1 substance by the Drug Enforcement Agency.

The NYU Department of Anesthesiology, Perioperative Care, and Pain Medicine is conducting a survey entitled “New York Physicians’ Perspectives and Knowledge of the State Medical Marijuana Program.” The purpose of this survey is to collect data about (a) physicians’ comfort level and experience in recommending or supporting patient use of medical marijuana, and (b) physicians’ opinions toward the use of medical marijuana.

This survey is aimed at physicians who have completed their medical training and are in active practice. Completion of the survey is voluntary and responses will be anonymous. Your employment will not be affected by your decision to participate or not to participate in the survey, and participation cannot be linked to your employment record. Data collected from this survey will be used solely for academic purposes with the intention of publishing the aggregated data. The study has been approved by the Institutional Review Board of NYU School of Medicine. While you may not receive a personal benefit from completing this survey, it will provide valuable information about physician opinions regarding the role of medical marijuana in patient care as well as the willingness to recommend medical marijuana in the state of New York.

We are asking participants to disclose county of practice, which may influence the answers to some of the survey questions, justifying the
collection of this information. In addition to providing your county, we are asking participants to disclose practice setting, medical specialty and medical marijuana registration status. A combination of these answers can theoretically be used to identify some practitioners. You can choose to opt out of replying to these questions if you wish. You will also be given the option to withdraw from the study at the end of the survey. We will maintain strict control of our data and no individually identifiable information will be collected or reported in our findings.

The survey should take approximately 10 to 15 minutes to complete. You are providing your consent to participate when you follow the link to the Survey Monkey administered survey.

The survey can be found at www.surveymonkey.com/r/NYSSMJA5LD.

Thank you for your time and participation. If you have any questions, please feel free to contact the principal investigator, Lisa Doan (email: lisa.doan@nyumc.org).

REFERENCES
Anesthesiology 2016
Scenes From the ASA Annual Meeting

Drs. Linda Mason, Rose Berkun, Laura Dew and Mark Zakowski

Dr. Lawrence Epstein checks out the donation board for the ASA’s foundations.

Drs. Rose Berkun and Scott Groudine
NYSSA’s delegation to the ASA annual meeting

Drs. Lawrence Epstein, Andrew Herlich and Audrée Bendo

Drs. Salvatore Vitale and Vilma Joseph
Drs. Scott Plotkin, Rose Berkun, Yvonne Carney, Robert Lagasse and Elena Bukanova

ASA President Dr. Jeffrey Plagenhoef and NYSSA President-elect Dr. Rose Berkun

(Left to right) NYSSA Past Presidents Drs. Michael Duffy, Lawrence Epstein and Michael Simon with Executive Director Stuart Hayman
Drs. Ted Kim, Rose Berkun, Lance Wagner and Michael Duffy

(Left to right) Drs. David Wlody, Andrew Rosenberg and Lawrence Epstein

(Left to right) Drs. Ingrid Hollinger, Rose Berkun, Vilma Joseph, Tracey Straker and Melinda Aquino, and Florell Thomas
Dr. Francis Stellaccio waits for the start of the New York caucus.

ESA President Dr. Zeev Goldik (left) and NYSSA Delegate Dr. Tal Levy
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This continuing nursing education activity was approved by the Montana Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

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Government Advocacy: Setting the Record Straight

One essential component of an effective advocacy strategy is formulating and presenting concise and persuasive arguments within factually accurate position papers that are presented to lawmakers and regulators to advance the NYSSA’s position on critical issues. The NYSSA government advocacy team — consisting of the NYSSA’s president, Dr. Andrew Rosenberg, and the rest of the NYSSA Executive Committee (Dr. Rose Berkun, Dr. David Bronheim, Dr. Michael Duffy, Dr. Vilma Joseph, Dr. Jason Lok and Dr. Scott Groudine), Dr. David Wlody (Government & Legal Affairs Committee chair), Stuart Hayman (NYSSA executive director), Bob Reid (NYSSA Albany lobbyist), and myself — has worked diligently to accomplish this objective. I encourage you to visit the NYSSA website and review the various memorandums and position papers that we have prepared, particularly under NYSSA’s Annual Legislative Day in Albany 2016. Go to http://members.nyssa-pga.org/Scripts/4Disapi.dll/4DCGI/members/legislative.html.

Equally as important as presenting accurate information is responding to factually inaccurate statements and misleading arguments advanced by groups that are advocating opposing legislative agendas. To accomplish this objective, a document has been created entitled “Memorandum on the Importance of Anesthesiologists' Role in the Delivery of Safe and Cost-Effective Anesthesia Care — Refuting Myths and Setting the Record Straight,” which can be found on the above Web page. This document summarizes approximately 12 areas where the NYSSA has addressed factually inaccurate and misleading statements that have been advanced by NYSANA. Each year it becomes necessary to expand upon these areas.

One purpose of this article is to discuss an obvious fact that may be overlooked by a number of lawmakers and regulators: namely, the fact that the American Association of Nurse Anesthetists (AANA) and the New York State Association of Nurse Anesthetists (NYSANA) oppose and are actively attempting to dismantle the anesthesia care team model of
care. Their desire is to gain independent practice authority for nurse anesthetists to administer anesthesia. AANA is pursuing a strategy to gain independent practice by advocating for the Veterans Health Administration (VHA) Nursing Handbook and the proposed rule for advanced practice registered nurses (APRNs) practicing in VA facilities. The proposed rule would grant “full practice authority,” or the ability to practice “without the clinical oversight of a physician,” to all APRNs, including nurse anesthetists, in all VA facilities in all states regardless of state law and other current VA policies. Manuel Bonilla, M.S., ASA chief advocacy officer, outlined the ASA’s multi-pronged strategy to oppose the rule in an article published in the August 2016 edition of the ASA Monitor. Mr. Bonilla also summarized AANA’s strategy to encourage approval of the proposed rule:

In response to the ASA initiative, opponents of the team-based models of care, including the American Association of Nurse Anesthetists (AANA) and other nursing groups, executed an aggressive anti-physician campaign to build support among the nursing community, public and veterans in support of “full practice authority” for all APRNs in the VA. Among other initiatives, the nursing community launched a website, www.veteransaccesstocare.com, and released a new self-funded advocacy study that purported to show that nurse anesthetists provide care comparable to physician anesthesiologists. The AANA also launched a robust grassroots campaign targeting members of Congress, urging them to contact the VA in support of “full practice authority.”

(Bonilla M. 2016 Advocacy Update. ASA Monitor August 2016; 80(8):10.)

NYSANA similarly has demonstrated a strategy to dismantle the anesthesia care team and to promote initiatives to achieve independent practice, as illustrated by the following developments:

• Since 1997, NYSANA has supported the enactment of various bills to achieve independent practice (e.g., 2015-16 bill S.2048/A.3941).

• In 2004, NYSANA brought legal action against the New York State Health Department to block implementation of the Clinical Guidelines for Office-Based Surgery because the guidelines established, as a standard of care, the anesthesia care team consistent
with the New York State Health Code, which NYSANA opposed then and continues to oppose.

• In 2006, NYSANA attempted to circumvent the New York state Legislature entirely by working with the New York State Education Department, Office of Professions, to create a “nurse practitioner in anesthesia” designation — an anesthesia delivery model that would render null and void the anesthesia care team model.

• In 2011, NYSANA attempted to gain independent practice authority as part of the Medicaid Redesign Team (MRT) initiative.

• In 2014, NYSANA commissioned the Center for Health Workforce Studies (CHWS) to conduct a survey of hospitals in upstate New York in an attempt to show that there are barriers to using nurse anesthetists as anesthesia providers in hospitals. NYSANA’s goal was to garner the support of lawmakers to advance independent practice legislation.

• On two separate occasions, NYSSA and NYSANA leadership participated in roundtable discussions aimed at reaching a resolution on a legal definition for nurse anesthetist scope of practice. In both sessions, NYSANA leadership agreed to preserve the anesthesia care team model only to renege on this commitment within 24 hours of the roundtable discussion.

• With increasing frequency, nurse anesthetists who have obtained a Ph.D. in nursing are using the title “doctor” to introduce themselves to patients undergoing anesthesia.

As we gear up for the 2017-2018 New York state legislative session, and prepare for the outcome of the decision with respect to the VHA Nursing Handbook and the proposed rule for APRNs, we can be certain that AANA and NYSANA will once again be advocating to dismantle the anesthesia care team model of care. Our starting point in New York state will almost certainly be where we left off in the last legislative session: namely, NYSANA actively and aggressively pursuing enactment of the “phantom” nurse anesthetist title bill (2015-16 bill S.7166A/A.0140A). The intent of this bill, according to the bill’s sponsors, is merely to create a title “nurse anesthetist.” However, when reviewing the language of the bill — as well as the developments noted above that unequivocally prove
that dismantling the anesthesia care team model of care is NYSANA’s primary legislative objective — we know that the intent of the bill is not merely to grant a title. Please consider staying or becoming actively involved in working with the NYSSA leadership in order to ensure that your voice is heard in Albany and Washington in the upcoming year. ■

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Case Report

Anesthetic Management of 30-Week Parturient With Gestational Hypertension and Type I Arnold-Chiari Malformation

ANDREW P. AGOLIATI, M.D., MICHALE SOFER, M.D., AND CAITLIN GUO, M.D.
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Introduction

Type I Arnold-Chiari malformation is an acquired or congenital structural neurological disorder in which the cerebellar tonsils are displaced downward through the foramen magnum. The result is compression of the brain because of disruption of the normal flow of cerebrospinal fluid. Patients are frequently asymptomatic and the malformation is often discovered incidentally. However, there may be signs and symptoms such as, but not limited to, headaches, change in vision, muscle weakness, gait instability, coordination deficits and difficulty swallowing. The incidence of Arnold-Chiari malformation is thought to be one in 1,000 births. Prevalence is higher in females, with a female-to-male ratio of 3:1.

The presence of Arnold-Chiari type I malformation in laboring parturients presents challenges for the anesthesiologist. Uterine contractions, Valsalva maneuver, delivery and coughing, all of which accompany labor, can result in elevation of intracranial pressure, with further herniation of the cerebellar tonsils into the foramen magnum, thus augmenting symptoms. Ultimately this can prove detrimental to both mother and fetus. A multidisciplinary plan was developed for the care of a 16-year-old parturient with both newly diagnosed gestational hypertension and Arnold-Chiari malformation type I with interventricular clots.

Case Report

A 16-year-old women at 27 weeks gestation, gravida 2, para 0, presented to her ophthalmologist for new onset of blurry vision. The ophthalmologist diagnosed bilateral papilledema in the presence of both visual changes and hypertension (137/76), concerning for eclampsia. The patient was sent to Bellevue Hospital and admitted to the obstetrics service. She did not have any past medical history. Her past surgical history was significant for an uncomplicated dilation and curettage. Vital
signs were significant for a blood pressure of 141/78. Her laboratory values were within normal limits. A neurology consult was obtained and recommended magnetic resonance imaging, venography and angiography of the head.

The magnetic resonance findings were significant for indentation of both globes at their junction with the optic nerves, as is seen with papilledema. There was a 1.4 cm inferior displacement of the cerebellar tonsils below the foramen magnum. Intracranial MR angiography demonstrated no evidence of stenosis, occlusion, aneurysm or malformation.

In preparation for managing the patient’s pregnancy and delivery, a multidisciplinary meeting involved the obstetrics, obstetric anesthesiology, neurology, ophthalmology and neurosurgery departments. All parties were in agreement that the patient’s clinical picture contraindicated a Valsalva maneuver, thus the decision was made to perform an elective cesarean section. The patient agreed. The obstetric anesthesiologist, neurologist and neurosurgeon agreed that a Chiari I malformation in the setting of intracranial hypertension was a relative contraindication to neuraxial anesthesia because of the increased risk of further herniation, nerve damage and wet tap. The anesthetic plan for labor and delivery was to proceed with a cesarean section under general endotracheal anesthesia and to take precautions to avoid dramatic changes in intracranial pressure. The patient started taking acetazolamide, 250 mg, twice daily per the neurologist’s recommendation. Following the cesarean section, when the baby was no longer at risk from intravenous contrast, the mother would receive an MRI of the brain with and without contrast and an MRV with contrast for further evaluation of her intracranial anatomy.

At 37 weeks gestation the patient presented for a scheduled primary cesarean section in the setting of newly diagnosed Chiari I malformation with evidence of herniation and gestational hypertension. The 10 weeks following her diagnosis were uncomplicated and the patient tolerated acetazolamide without complications. On the day of surgery both the patient’s and the fetus’s vital signs were within normal limits. Bicitra (sodium citrate/citric acid) was administered to increase gastric pH for aspiration prophylaxis. The patient underwent general endotracheal anesthesia. Standard ASA monitors were placed. An 18 gauge
angiocatheter was inserted. Rapid sequence induction and intubation with cricoid pressure were performed, with a synchronized start of the procedure. Anesthesia was induced with propofol, fentanyl, lidocaine and rocuronium. Propofol and fentanyl were titrated to avoid rapid changes in hemodynamics during laryngoscopy. The airway was easily secured with a Glidescope under a grade II view. The patient tolerated intubation without hemodynamic instability or drastic alteration in the blood pressure. The operation was successful and a healthy male weighing 2,980 g with Apgar scores of nine at one and five minutes was delivered. Following delivery, the patient received Pitocin, 40 units, in 2 L of lactated Ringer’s; morphine, 6 mg, administered in divided doses; a remifentanil infusion for smooth narcotic wake up was started at .04 µg/kg/min and decreased to .02 µg/kg/min after the surgical wound was closed and the dressings applied. The patient was extubated on remifentanil, .02 µg/kg/min, without complication. Her neurological exam was unchanged, demonstrating bilateral papilledema and no neurological deficits.

The patient’s hospital stay was unremarkable and she was discharged on the fourth postoperative day. By the 14th day the patient was doing well and had returned to her normal functional status. She complained of persistent blurring of vision precipitated consistently only by watching television. She continued to take acetazolamide, 500 mg, twice daily.

**Discussion**

This case emphasizes the advantage of a multidisciplinary discussion to plan the management of pregnancy and labor in a symptomatic parturient with Arnold-Chiari I malformation. The anesthetic plan was developed after all expert opinions from the obstetrician, obstetric anesthesiologist, neurologist, and neurosurgeon were discussed. A standard anesthetic plan for parturients with Arnold-Chiari I malformation does not exist and all cases must be tailored to the individual patient.

The main anesthetic concerns in a parturient with symptomatic Arnold-Chiari I malformation are management of hemodynamics and intracranial pressure, preventing herniation and avoiding increases in signs and symptoms. Increased intracranial pressure associated with labor and labor pain can create a pressure gradient between the higher intracranial pressure and the lower pressure below the foramen magnum, causing
further cerebellar herniation, brainstem compression and worsening of signs and symptoms.\textsuperscript{4,5,6,7}

The choice between vaginal delivery and cesarean section in a parturient with Arnold-Chiari malformation is a debatable topic. Pain and uterine contractions during labor can increase cerebral spinal fluid pressure,\textsuperscript{6} possibly leading to herniation. Although vaginal delivery has been safely performed on patients with Arnold-Chiari malformation, it is not without risk. In a symptomatic parturient with Arnold-Chiari malformation, cesarean section is a viable option that obviates the labor-induced effects on intracranial pressure.

Neuraxial techniques have been safely performed in asymptomatic parturients with Arnold-Chiari I malformation for both labor and cesarean section, but they may also be hazardous. Intrathecal puncture, whether with a spinal needle, or accidentally during an epidural, can lead to herniation and detrimental alteration in cerebral perfusion. In the setting of symptomatic Arnold-Chiari I malformation, as demonstrated by this case, neuraxial anesthesia is contraindicated because of the increased risk of further herniation, nerve damage or wet tap.\textsuperscript{3}

General endotracheal anesthesia for cesarean delivery in a parturient with symptomatic Arnold-Chiari I malformation also presents risks to the parturient and fetus. Both direct laryngoscopy during intubation and coughing on the endotracheal tube during emergence may result in increased intracranial pressure. Parturients in general are at increased risk of aspiration and difficult intubation during direct laryngoscopy. Rapid sequence induction and intubation should be performed to prevent aspiration. Opiates should be used sparingly on induction, both to prevent the sympathetic response to direct laryngoscopy and to avoid neonatal respiratory depression. As demonstrated in our case, low-dose remifentanil during emergence reduces the incidence and severity of coughing and bucking from the endotracheal tube and potentially can reduce increases in intracranial pressure during emergence,\textsuperscript{8} but deep anesthesia should be avoided due to increased risk of aspiration in these patients.

In summary, this case demonstrates that general endotracheal anesthesia can be safely performed for the cesarean section of a parturient with symptomatic Arnold-Chiari malformation. ■
REFERENCES


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Enacting Change Through Relationships

DUNCAN MCLEAN, M.B.CH.B.

During the 2016 ASA annual meeting, Dr. Meera Kirpekar, Dr. Dave Currie and I (your NYSSA Resident and Fellow Section officers) met with many of our senior colleagues from across the nation. We attended the New York state caucuses and the ASA House of Delegates meeting, as well as many other fascinating talks and sessions. It is always inspiring to participate in the ASA’s political and scientific discussions. We left with a sense of energy and motivation to take back to our NYSSA programs.

When I talk with my peers, it appears that everyone is interested in some aspect of politics, even those who profess not to be. Many are reluctant to get involved, however. When I dig deeper, I discover that many people find the political world intimidating and potentially inaccessible. For us anesthesiology residents and fellows, the distance between our everyday lives and those who enact political change can seem vast. The truth, however, is that getting involved is not only possible but also easy.

One of the most important things we can all do is to form relationships with our local lawmakers. These relationships are extremely valuable. Even more valuable is getting to know your elected officials before you have the need to contact them about a particular piece of legislation. Reaching out through the ASA grassroots network is quick and easy. Go to grassroots.asahq.org, click on “Meet With Your Lawmaker,” and the rest is self-explanatory. Your legislators ran for office so they could represent the interests of their constituents; by meeting with them, you help them understand how they can best serve you.

As you are likely aware, one of the biggest legislative issues we are facing as a specialty is the potential for unsupervised CRNA practice being allowed in the new iteration of the “VHA Nursing Handbook.” The NYSSA and the ASA have represented us on this matter admirably, and we have been heard loud and clear. More than 90,000 people across the country made their voices heard by publishing their opinion that our veterans deserve the safest anesthesia care possible, which is physician-led anesthesia care. Thank you to all of you who commented and asked friends and family members to comment.

The issue of CRNA independent practice is not over yet, nor is it the only legislative challenge that we face as a specialty. In order for our voice to
continue to be heard in Albany and Washington, we rely heavily on contributions to the NYAPAC. Any donation helps, and every dollar adds weight to our stance when asking our legislators to stand up on our behalf. Please donate today at www.nyssa-pga.org/about/donate-to-nyapac. We cannot do this without you. Thank you.

Duncan McLean, M.B.Ch.B., is a CA2 resident at the University of Rochester and the RFS president.

The Memorable Anesthesiologist

DAVID G. CURRIE, M.D.

One morning a few weekends ago, I took my daughter to a nearby playground on the Upper West Side. I struck up a conversation with another father who mentioned that his child was born at my hospital, so I revealed that I was an anesthesiologist there. He excitedly told me about the anesthesiologist who took care of his wife: how he was informative, humorous, and reassuring, even when his wife needed an emergency cesarean section. This type of positive patient experience likely occurs frequently, but the patient and his/her family members have difficulty remembering the name of the anesthesiologist. I have noticed that when someone does specifically remember the anesthesiologist, that physician is often a leader in the department.

This is not a coincidence. It is an example of how the soft skills of patient care can be applied to leadership.

For anesthesia care to be team-based, anesthesiologists must excel in the soft skills of leadership. This requires active and formal recognition of the importance of these skills in training. Young anesthesiologists must have ample experience supervising and teaching other anesthesia providers prior to graduation, and residents should participate in hospital committees and professional societies so that they can experience firsthand the complex processes of a healthcare system and learn how to contribute to them.

As a CA1, I was scheduled to work with the chair of my department. We started a case, and, in an attempt to appear efficient, I charted while the surgical team gowned. As I finished, I turned and saw the chair of my department fastening the gown of a medical student. The attending surgeon exclaimed to the medical student, “That’s the chair of anesthesiology tying your gown.” This simple act changed the tone of the operating room and brought
our anesthesia team out from behind the drape. I realized that in my focus on efficiency, I had missed a unique opportunity to be a presence in the operating room, to be more than a faceless anesthesia resident in a cap and mask.

Anesthesiologists are uniquely positioned to provide leadership in the changing healthcare landscape. As the population ages, older and sicker people will be having surgery. Perioperative care will become more complex. Anesthesiologists will simultaneously need a broader knowledge base as well as improved communication skills, more creative problem-solving skills, and better leadership and supervisory skills.

There are simple ways to encourage the development of leadership skills in residency. Taking time to serve on hospital committees or participate in the ASA and the NYSSA will encourage anesthesiologists to push our profession to the forefront of patient care and safety. Team leader rotations that give senior residents the opportunity to supervise junior residents while also actively modeling their approach toward supervision will improve resident education and allow members of anesthesia care teams to work within their proper scope of practice. A faceless anesthesia provider can become a commodity, but when anesthesiologists apply these soft skills they become leaders and valued members of their healthcare communities.

David G. Currie, M.D., is a CA2 resident at Icahn School of Medicine at Mount Sinai St. Luke’s-Roosevelt and the RFS president-elect.

Let’s Ensure We Have a Seat at the Table

MEERA KIRPEKAR, M.D.

With healthcare delivery systems continually evolving, healthcare policy remains an ever-changing landscape. Over the next several years, important policy changes will likely be seen. We, as physician anesthesiologists, must hold a seat at the table in order to guide those changes that significantly affect our future. To that end, we must train future generations of anesthesiology residents not only in medical, clinical, and practical skills, but also in health policy and the legislative process.

Currently, very few, if any, anesthesiology programs in the United States contain either required or elective rotations in health policy for their residents. One of the only formal rotations in policy offered to residents is the ASA Policy Research Rotation in Political Affairs, which involves one month spent
in Washington, D.C., learning the legislative process both through formal education in the subject as well as meetings and events with lawmakers. While this is a truly fantastic opportunity for interested residents, only six spots exist per year — for the approximately 1,600 anesthesiology residents in 133 programs.

In contrast, according to a 2009 “Education News” article in the American Association of Nurse Anesthetists publication AANA Journal, 25 of the 105 CRNA programs at that time actually required their students to enroll in a semester-long health policy course, often with a component that encouraged their students to write letters to their lawmakers. The remainder of the programs offered “varying health policy content within their professional aspects courses”\(^1\) or health policy electives. Of the four New York-based CRNA programs, currently all four offer some form of health policy education. These requirements have only strengthened each year.

According to a 2014 “Educations News” article in the AANA Journal, “effective January 1, 2022, all newly enrolled students in nurse anesthesia programs must graduate with a doctoral degree,”\(^2\) thereby converting all CRNA programs to doctorate programs by 2022. According to the Institute of Medicine and Practice Doctorate Standards, this training recognized that “nurses should be prepared to participate in the public policy process required to transform the system of healthcare …”\(^2\)

These are precarious times for our profession. Our best recourse may lie in our future graduates, and we should equip them with the very best training for their careers. As Woody Allen once said, “80 percent of success is showing up.” If trainees don’t know what the issues are or how to become involved, they cannot show up to the legislative table. To affect future changes in healthcare policy, let us start by changing resident education. ■

Meera Kirpekar, M.D., is a CA3 resident at Icahn School of Medicine at Mount Sinai and the RFS secretary and treasurer.

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