The Oxcart Ambulance: A Medical Mission in Rural Nigeria
PGA 71
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In Jahun, Nigeria, an ox cart is often used as an ambulance by those who cannot afford a car. One woman traveled via ox cart for three days, in obstructed labor, to get to the hospital.

Cover photo courtesy of Kiri Mackersey, M.D.
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President’s Message

Working Hard to Help the NYSSA Thrive

ROSE BERKUN, M.D.

“My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style.”

— Maya Angelou

It is a great honor to serve as president of the New York Society of Anesthesiologists. With that honor, however, comes great responsibility. Many of our members may wonder, “What does the NYSSA president actually do?” It’s a valid question, and one I will address in this issue.

The president is responsible for leading the organization, ensuring that we stay on course as defined by our mission statement, coordinating activities, and communicating with our members as well as with NYSSA leadership; our lobby team, Reid, McNally and Savage; our legislative counsel, Charles Assini, Esq.; and other medical societies, including MSSNY and the ASA. Planning the year with an understanding of the broader picture is another key aspect of the president’s role. This involves being aware of our key objectives, organizing activities accordingly, and working within the scope of NYSSA policies and procedures.

The mission of the New York State Society of Anesthesiologists is to advance the specialty of anesthesiology and to provide the safest and highest quality patient care to the people of New York state. To ensure that we achieve our mission, we must work with our members, legislators and patient advocates.

I am very passionate about the NYSSA, what it stands for and the progress that has been made over the years in advancing patient safety, developing scientific programs for the annual PGA meeting — the third largest anesthesia meeting in the world — and addressing the specific needs of our members. My goals for the year include increasing our membership; frequent communication with members,
both electronic and in person; providing leadership development for residents and young physicians; promoting women anesthesiologists to positions of leadership; leading our legislative advocacy efforts; raising a substantial amount for NYAPAC; developing a strong and lasting relationship with the Medical Society of the State of New York; and assuring that both legislators and New Yorkers have a clear understanding that anesthesiologists are physicians.

Increase NYSSA Membership
Membership is not only important for the strength of our society, but also for our standing within the ASA. The larger the membership of the NYSSA, the more delegates we send to the ASA and the stronger our voice is on the national level. In order to increase our membership I decided to concentrate on institutions instead of districts. I have met and will continue to meet with senior leaders of large institutions to explain the value of NYSSA membership, including education, advocacy and leadership development.

Establish Regular Communication With NYSSA Members
We are taught that when we fill out a medical record, we must document each one of our actions or it’s assumed that we did nothing. I feel the same way about communication between NYSSA leadership and our members. It is important for me to keep members well informed and involved in any capacity, whether legislative, educational, leadership or mentorship. To accomplish this, I am utilizing communication as well as in-person meetings. Each month we distribute a newsletter to the membership with the latest information on our activities, member news, and regulatory and legislative updates. I write each newsletter myself, which is then converted to the electronic format by Lisa O’Neill at the NYSSA office. I hope you find my newsletters informative and interesting. I appreciate your feedback. It was a pleasure attending meetings in districts 2, 7 and 8 and I look forward to meeting with members of other districts in the near future.

Provide Leadership Development for Residents and Young Physicians
Our society has great leaders who understand the importance of staying involved and actively participating in our day-to-day activities,
whether legislative, academic or organizational. However, the future success of the NYSSA will be determined by the up-and-coming younger members. It is crucial to get our residents involved, to identify future leaders of our society, and to develop their leadership skills. To initiate the process, I appointed a resident member to each district’s list of officers. I spoke to the resident leaders at the PGA, the ASA’s Legislative Conference, and the NYSSA’s Legislative Day in Albany and encouraged them to continue being involved. I have personally reached out to young members and identified several who exhibit strong leadership abilities, members such as Dr. Jonathan Gal, co-chair of the Legislative Affairs Committee; Dr. Janine Limoncelli, co-chair of the Ad Hoc Committee on Women Physician Section; and Dr. Meera Kirpekar, secretary of the NYSSA Resident and Fellow Section and a resident scholar in policy at the ASA’s Washington, D.C., office. I look forward to identifying and mentoring more young leaders.

**Create an Ad Hoc Committee on Women Physician Section**

Women in medicine have come a long way from the days of Elizabeth Blackwell, the first woman to receive a medical degree in the U.S. However, many obstacles still remain for women physicians once they graduate from medical school. Many residency programs are still male dominated, and few women physicians are able to move up the academic ladder or achieve a leadership position in private practice. Pay discrepancy still exists, and the invisible glass ceiling is still reflecting the light from above. The goal of creating a standing committee for women physicians is to identify the deficiencies and areas of need when it comes to women in anesthesia and to develop ways to fill in the gaps. The committee has been working hard and has already developed several CME programs for the PGA and a page for the NYSSA website, identified mentors whose information will be available to all women physician members, and is working on the best programs for residents and medical students. The committee will provide the tools to empower women anesthesiologists and develop successful leaders for our society.

**Promote Advocacy and the NYSSA’s Legislative Agenda**

Our legislative advocacy efforts are vital to the strength of our society. The main goal of the NYSSA’s advocacy efforts is to maintain the
highest standard of patient care, which means preserving physician supervision of nurse anesthetists. I continue to meet with numerous legislators in Albany and in my home district. It is important to remain bipartisan when it comes to promoting our agenda and to reach out to both Republican and Democratic members of the Legislature. This year I met with many members of the Senate and the Assembly. In particular, Sen. John DeFrancisco, Senate deputy majority leader and the 2016 recipient of the NYSSA’s Legislator of the Year award; Sen. John J. Flanagan, Senate majority leader; Sen. Catharine Young, chair of the Finance Committee; Sen. Mike Ranzenhofer, chair of the Corporations, Authorities and Commissions Committee; Sen. Patrick Gallivan, vice chair of the Committee on Education; Assemblyman Ray Walter, member of the Committee on Health; Assemblyman Robin Schimminger, chair of the Committee on Economic Development, Job Creation, Commerce and Industry; and many others. I continue to advocate on behalf of our patients and our members.

For our annual Legislative Day in Albany, I worked to develop a brand new marketing package that clearly identifies us as physician anesthesiologists and boldly states that when seconds count, physician anesthesiologists save lives. With the help of the ASA we initiated an aggressive media campaign that included video messages to the legislators, radio commercials and op-eds in Albany newspapers to clearly identify deficiencies in the nurse anesthetist title bill, a bill that may lead to CRNA independent practice.

**Support NYAPAC**

I cannot emphasize enough that we are only as strong as our PAC. It is vital to support legislators who understand and support our bills. In order to get a better handle on PAC contributions, I asked our staff to provide a breakdown by committees and districts. The goal of $240,000 is easily achieved if each member contributes just $100. I have personally reached out to committee chairs and district directors. As I mentioned in my first newsletter, the district with the highest PAC contribution will be officially recognized at the annual House of Delegates meeting and the members of the committee with the highest participation will be invited to the president’s reception.
at the PGA. I urge each and every one of you to make a contribution to NYAPAC. Our future depends on it.

**Develop a Strong and Long-Lasting Relationship With the Medical Society of the State of New York (MSSNY)**

MSSNY’s support on critical NYSSA issues is important and makes our legislative efforts stronger and more effective. As a chair of the Legislative Committee for Erie County and a member of the Legislative Committee of MSSNY, I developed a close relationship with the leaders of MSSNY, including Dr. Malcolm Reid, immediate past president; Dr. Charles Rothberg, MSSNY president; Dr. Tom Madejski, president-elect; Dr. Joseph Sellers, PAC chair; and many others. I was appointed MSSNY PAC co-chair and last year was elected delegate to the AMA from MSSNY. I continue to advocate for the NYSSA at the MSSNY annual House of Delegates meeting. A strong relationship with MSSNY leadership provides greater insight into the state and national healthcare agenda as well as opportunities to influence policy decisions on state and national levels and to garner support for the NYSSA’s legislative efforts at critical times.

All this work requires a tremendous amount of time. In private practice, income depends on hours worked. This translates to a significant pay cut for anyone who serves as NYSSA president. However, the benefits to our society heavily outweigh a one-year decrease in income. What’s more, there is incredible satisfaction from communicating with members, obtaining legislative victories, seeing the NYSSA grow and succeed in important initiatives, inspiring young members and residents, and watching our newest volunteers become strong leaders. I would like to see our organization continue to grow and gain strength as one of the largest medical societies in organized medicine. ■
April 19, 2017

Dear Members of the NYSSA,

We would like to express our sincere apologies to the members of the New York State Society of Anesthesiologists, Inc., and Executive Director Stuart Hayman for the production mistake with the spring issue of Sphere.

One of our production employees mistakenly overlooked one spread in the binding process, which resulted in the omission of pages 1, 2, 67 and 68 in the last issue. These pages included the table of contents, the list of Sphere’s editors and editorial board, the final page of the new member listing, and the list of NYSSA officers. Unfortunately, this error was not discovered before the magazine was mailed.

As a result of this production error, the employee responsible has been counseled again on our standard operating procedure of comparing the approved proof to the product before binding.

We value our long standing relationship with the NYSSA and we hope to regain your trust and confidence.

Our sincerest apologies,

[Signature]

Scott Reighard
COO
The Standard Group
I want to thank Mr. James Robb and Ms. Donnaline Richman, Esq., for contributing an interesting case study to the spring issue (Sphere 2017; 69(1):43-47). I found the case presented informative; however, some of the points made were incorrect and, as Sphere is a publication of the NYSSA, these matters must be corrected.

Troubling to me are the statements in Mr. Robb’s conclusion (p. 44). He lists five reasons why the case presented could not be defended. The first two are: “This patient’s excessive weight, diabetes, and hypertension clearly required preoperative medical clearance … The patient was not intubated to provide a safe airway. This was of particular importance since he was placed in the prone position.” Ms. Richman states (p. 45) that, “Any patient who has been determined to be an ASA 3 risk clearly must have medical clearance.” Both authors are also critical that this patient did not have a preoperative ECG or blood work.

Unfortunately, it appears that many non-anesthesiologists need to be reminded that all anesthesiologists are physicians. Therefore, when we proceed with an anesthetic, that patient is medically cleared for anesthesia. Evaluating a patient’s response and appropriate fitness for the proposed anesthetic and surgery is what anesthesiologists do. To suggest that we need to have our medical judgment seconded by another physician who has no formal training in anesthesia is wrong. It is not required by law, regulation, guidelines or the standard of care. NYS ambulatory regulations section 755.4 states in part: “(f) a physician examines each patient immediately prior to surgery to evaluate the risk to anesthesia and the procedure to be performed.” CMS condition of participation: anesthesia services §482.52 (b) (1) states: “A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.” Who better to do this evaluation than a physician with anesthesia training, an anesthesiologist! In both of these case analyses it is stated that proceeding with an ASA 3 patient in the office setting without medical clearance is indefensible. However, since there
was a physician involved in the anesthetic care of this patient that burden was met. The patient was cleared by an anesthesiologist, the physician who best knows the physical demands of surgery and anesthesia and the risks involved. Asking for unnecessary consultations increases costs and delays in the provision of care.

Other statements about the care of this patient that are presented as dogma are less straightforward. Many anesthesiologists would do this surgery (anal fistulectomy) under Monitored Anesthesia Care (MAC). The fact that only propofol, midazolam, and local anesthesia were given seem to imply that MAC was the anesthetic used in this case. This type of surgery lends itself nicely to this form of anesthesia. Although the full medical record was not presented, implying that intubation is necessary for MAC anesthesia in the prone position is also not supported by law, regulation, guidelines or the standard of care.

In this day of providing the best care the most economically, physicians are being asked to do only necessary lab test, ECGs, and consultations. No evidence was presented that suggested any of these were necessary prior to proceeding. To suggest that they were required without a specific indication other than ASA 3 status is wrong. Although there is much to criticize about the care this patient received, not getting another physician to do the anesthesiologist’s job and “clear” the patient, not intubating a patient under MAC anesthesia, and not ordering unnecessary labs for a procedure done under MAC where little fluid shifts or blood loss are expected should not be included in this list. It is important that these “misconceptions” published in the last issue of Sphere stand corrected.

Scott Groudine, M.D.
NYSSA Board Member
A few months ago, there was a shortage of stopcocks in the operating rooms for anesthesiologists to use. The anesthesia techs were flooded with phone calls requesting stopcocks for the total intravenous anesthesia cases, for sedation cases to attach to the pumps, and for cardiac cases to use with central lines. They could only reply, “Sorry, we are out,” or, in response to those detailing the absolute necessity of the stopcocks, “I’ll have to go to another floor to find some, but you will have to wait.” The shortage didn’t last very long, perhaps only a day or two, before the new shipment arrived and the cart drawers were once again overflowing with the familiar little packages. In the interim, however, the responses to the shortage ranged from placid indifference, to quiet grumbling, to vocal outrage. I won’t pretend I was immune to the discontent; I landed firmly on the side of the quiet grouters while trying to rig up combinations of tubings to circumvent the need for stopcocks (with only marginal success).

Similar to equipment shortages, national drug shortages are not a new occurrence either. There is currently a rocuronium shortage, and recently there have been shortages of neostigmine, lidocaine, midazolam, and lactated Ringer’s solution. At one point during my residency training, there was even a shortage of both propofol and etomidate, forcing us to learn how to use alternate drugs for induction of general anesthesia and sedation. Interestingly enough, shortly after that experience, European manufacturers of propofol, upon hearing news that propofol was potentially going to be used for lethal injections in the state of Missouri, threatened to sanction the export of the drug to the entire country. While there are some stateside companies that manufacture propofol, the vast majority of the U.S. supply is imported from Germany. Such sanctions would have severely limited the quantities of propofol available in the country, and those few months of training with other drugs would have been especially useful.
When faced with these practice challenges, our skills as anesthesiologists are often tested. Can we alter the anesthetic to avoid stopcocks? Can we use different combinations of drugs to achieve the same effect when one drug is not available? Can we really provide an appropriate anesthetic in the dark corner of the interventional radiology suite with only two square feet of space and 20 feet to the head of the patient?

Most of the time, despite the occasional consternation (whether justified or unjustified), I’d like to think the answer is yes. We learn how to adapt as part of our training, which is why we can easily jump from taking care of the healthy 12-year-old who needs a laparoscopic appendectomy to the 68-year-old with severe aortic stenosis, COPD, and renal failure who just suffered a hip fracture. The problems change, the considerations change, and the solutions change. Adaptability means going beyond the standard cookie-cutter approach and rote responses.

Reading this issue’s feature article by Dr. Kiri Mackersey about her experience as part of a medical mission team in Nigeria in the context of the Great Stopcock Shortage of 2017 was enlightening. I have never practiced medicine in another country, let alone in an environment as starkly different from mine as an obstetric ICU in Nigeria. Dr. Mackersey’s story challenged me to rethink the limits of my own flexibility, and I hope that readers will do the same while enjoying her captivating and vivid storytelling.
How Do You Put Icing on a Crumbling Cake?

STUART A. HAYMAN, M.S.

During the past three decades, our elected officials have made a number of attempts to “fix” the American healthcare system. Regrettably, these efforts have dealt ineffectually with the biggest problems this country faces when it comes to healthcare: the number of uninsured and underinsured, and the rapidly rising cost of both insurance and medical care.

In 1992, politicians touted managed care as the answer to double-digit healthcare inflation. They claimed that managed care would ensure quality care while increasing access and affordability. But managed care lowered premiums only temporarily while doing nothing to address the uninsured, the underinsured, or spiraling healthcare costs.

In 2004, then-Democratic presidential candidate John Kerry touted a single-payer system, although we never learned the details of his plan to provide universal healthcare coverage. In 2008, then-Sen. Hillary Clinton outlined a plan that would include a combination of government assistance, incentives for preventive care, and a large investment in electronic medical records. She criticized the health insurance industry, condemning insurers for the huge amount of money spent on non-healthcare expenses.

During the debate prior to the passage of the Affordable Care Act (ACA), Americans were told that the ACA would result in improved access and affordability. While the ACA did increase access to health coverage for a significant number of Americans, it failed to contain costs. Insureds experienced significant increases in annual premiums as well as new and higher out-of-pocket expenses.

The ACA did have two noteworthy positive outcomes: The legislation brought attention to the absurdity of excluding people with pre-existing conditions from obtaining health coverage. It also brought to light the negative impact of forcing 21-year-olds off their parents’ plans before they...
could obtain their own health coverage. Regardless of the positive aspects of the ACA, this legislation fell far short of a comprehensive solution. The legislation continues to be viewed by many as just another example of politicians’ inability to solve a problem they don’t fully understand.

The recent election provided the Republican Party with the opportunity to offer an alternative to the ACA. Disappointingly, House Speaker Paul Ryan (R-Wis.) hastily and recklessly forced passage of a very harmful bill that he referred to in terms of its impact on taxes: “We are repealing Obamacare, and replacing it with good Republican tax policy.” No one should be comfortable with a healthcare initiative that prioritizes tax cuts and government savings over healthcare coverage, quality, and savings for patients.

The House bill moves U.S. healthcare 180 degrees in the wrong direction. In fact, the Congressional Budget Office (CBO) estimates that the legislation will increase the number of uninsured by 23 million, with 14 million losing their health insurance in the first year alone. What’s more, the CBO also estimates that the legislation will cause premiums to increase as much as 850 percent for older Americans and those with pre-existing conditions, making coverage unaffordable for the most vulnerable citizens.

The president of the American Medical Association issued the following statement immediately after passage of the American Health Care Act: “The bill passed by the House today will result in millions of Americans losing access to quality, affordable health insurance and those with pre-existing health conditions face the possibility of going back to the time when insurers could charge them premiums that made access to coverage out of the question.” It’s no wonder many Americans are questioning whether there is any elected official who has an adequate understanding of both the economics and the delivery of quality healthcare.

As members of the U.S. Senate begin the task of writing their own healthcare reform legislation, we can only hope that more reasonable voices prevail over those who seek to reward the healthiest and wealthiest Americans at the expense of those less fortunate. We have wasted too many years and resources on inadequate solutions. It is time to explore a universal healthcare solution that provides all Americans with enhanced access, improved outcomes, and economic safeguards.
Help the NYSSA Maintain Patient Safety: Support Physician Supervision of Anesthesia

Patient-Centered, Physician-Led Care
The New York State Society of Anesthesiologists, Inc.
Distinguished Service Award

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

As outlined in the NYSSA Bylaws:

1. The recipient must be an anesthesiologist who has been an active member in good standing of the NYSSA for a minimum of 10 years.
2. The recipient must have provided significant service to the NYSSA by playing an active role in anesthesia education and/or an active leadership role in the NYSSA.
3. The award cannot be given posthumously.
4. Serving members of the Judicial and Awards Committee and officers of the NYSSA are not eligible to receive the Distinguished Service Award.

Any member of the NYSSA may submit a nomination. There is no nomination form. We only request a letter indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. The candidate’s current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., at NYSSA headquarters (HQ@nyssa-pga.org) before July 28, 2017.

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

Michael P. Duffy, M.D., Chair
NYSSA Judicial and Awards Committee
‘Good Copy, Oscar Tango’: A Medical Mission in Nigeria

KIRI MACKERSEY, M.D.

“How about Nigeria?” The job was at a large, long-standing maternity hospital in northern Nigeria with Doctors Without Borders/Médecins Sans Frontières (MSF), an independent, medical humanitarian organization. It was my first assignment. My role would be head of the obstetric ICU and supervisor of the local nurse anesthetists in the operating rooms. MSF’s emergency obstetrics program at the Ministry of Health hospital in Jahun, Jigawa State, Nigeria, provides obstetric care and offers surgery for women with vesicovaginal fistulas. Although other areas in the north had been devastated by the ongoing conflict between Boko Haram and the Nigerian military, the security situation in Jahun was stable. The expat compound was colloquially known as Jahun Paradise and was rumored to have the best cook in MSF. I signed up.

The exterior of Jahun Hospital is seen after a day of heavy rain. After the water drains, groups of women and children cook and sell food in the street.
New York — Paris — Abuja — Jahun

I had been warned that Abuja Airport would be a goat-filled market of chaos and danger — don’t talk to anyone after the security gate and don’t walk out with anyone, even if they say that they are a policeman. In place of livestock, however, are businessmen, tourists, families coming home and a Nigerian movie star whose entourage rivals that of the Kardashians. I spend a couple of nights in Abuja receiving security and medical briefings before heading to Jahun.

The drive is about five to six hours to Jahun, depending on traffic. The drive takes seven hours on a good day … without military road blocks. You’ll be driving for eight hours, depending on weather. Are you ready for a nine- to 10-hour drive, more or less? At this point, I stop asking how long the drive to Jahun will take.

The Jahun Hospital maternity division operating theatre building (the sign above the door reads O.T.). On the left is the edge of the central courtyard where families sleep and cook while their loved ones are receiving care.
ICU: India Charlie

We arrive in Jahun in the late afternoon. Finally I see the promised goats surrounded by a distinct lack of chaos or danger. My Australian predecessor wastes no time showing me around the hospital. I put down my bags and 10 minutes later I’m on an ICU round. The ICU has eight beds run by a local staff of two nurses and a charge nurse, Helene. At the start and conclusion of the round I am greeted with “The new med anesthetist! You are welcome.” At the door to the ICU we wash our hands and change from outside shoes into rubber clogs and white coats. The room is simple and functional, each bed separated by a nylon curtain. The head of the bed can be raised mechanically and every component can be wiped clean. There are several fans and two air conditioning units that provide welcome relief from the heat outside. We start the round immediately at bed one.
Bed one: an 18-year-old G3P0 with eclampsia. She was seizing at home for about nine hours before she was brought in and delivered a deceased term baby last night. BP 185/101. No hyperreflexia, no headache. Magnesium treatment is halfway complete and she’s on labetalol. The labetalol is increased. Bed two: a 20-year-old G4P1, eclampsia. Seized again last night despite magnesium. There’s a low-grade fever and she’s drowsy and incoherent. We start a discussion: is it a postictal state, a stroke in progress, magnesium or the benzodiazepines used to break the seizure? Blood pressure is controlled, pupils equal and reactive, limbs are symmetrically hypotonic. Continue magnesium, check mag levels and electrolytes, rapid malaria screen. In my head I imagine the work-up she would receive in New York: a CT head, cultures from every orifice, anesthesia team on standby to intubate. Bed three: 25-year-old G6P3, eclampsia. She has finished magnesium treatment and is on oral anti-hypertensives.
Northern Nigeria has one of the highest rates of preeclampsia in the world. No one knows exactly why. It could be nutritional deficiency in magnesium or a genetic predisposition, but more universal reasons, such as second marriages with multiple gestations, cannot be ruled out. The American obstetrician on our team shakes his head. He’s never seen three recently eclamptic women in the same room before. “Sahnu?” The patient in bed three nods. “Sahnu” is Hausa, the predominant language in this area. It is one of those indispensable, Swiss Army pocketknife words: how are you?/I’m fine/hello/thank you/OK/I’m sorry. By the end of my mission it forms the backbone of my vocabulary.

We move on. Bed four: a 17-year-old G1P1, jaundice, abdominal distension, renal failure, lethargy, normotensive, no seizures. Her baby is in a crib beside the bed. We stand around scratching our medical heads. One of the local doctors suggests herbal toxicity. The woman has been taking a local herbal concoction of potash and plants to speed labor — her tongue is still dark from the ash. These mixtures are usually made by traditional healers and come with a high risk of liver failure. Will the lab
do liver enzymes? Our new French lab technician has recently catalogued the reagents — she is hopeful. The obstetric ultrasound confirms ascites. I move up onto her chest. The curvilinear ultrasound probe just about fits between her ribs and I see a hyperdynamic, empty heart. We start IV fluids and discuss transfer to a larger state hospital.

The women in beds five and six have recovered from postpartum bleeds and are ready to move to the step-down beds in the adjacent room. Helene calls their names out the window. The central courtyard is full of waiting aunts and grandmothers who feed, wash and transfer our patients. “Fatima … Family of Fatima! Come to the ICU.” A few minutes later, Family of Fatima is cloaking her in a long hijab and bright cloth “wrappa,” the traditional dress in this area. They scoop up her brightly bundled baby and walk across the doorway into the general ward. Here she will have her own bed for a couple of nights, then she will share her bed with another postpartum patient before returning to her own village. As they pass me, the women raise their hands and bow their heads: “Sahnu! Sahnu! Sahnu!”
Bed seven: a 16-year-old G1P1 with anemia. Her presenting hemoglobin was 2, presenting complaint: dizziness while walking. She had delivered at home two days previously and her baby is beside her. After 4 units, the hemoglobin on our bedside fingerstick is now 6. She feels good. We debate transfusing another unit. She is nutritionally deprived and is about to spend the next few months breastfeeding. I grab the obstetric ultrasound probe (my echo). Her left ventricle is hyperdynamic and relatively empty. We take a vote and the transfusers win. We also add some high-calorie nutritional supplements.

We turn to our last bed. She’s 35, G5P2 with weakness. She was brought in by her family an hour ago, unresponsive. The story is that she delivered at home overnight. She then became confused and lost consciousness in the early hours of the morning. It’s now evening. The outgoing medical anesthetist educates me: only the men drive and they may be reluctant to travel at night or in poor weather. Our admissions come in mainly between 9 a.m. and 11 a.m., regardless of the onset of symptoms. Some women travel for days, from neighboring countries, for the free, high-quality care that MSF delivers. The lucky ones come by car, the rest by oxcart. Our patient flails her left side but her right side is immobile. Blood pressure is uncontrolled, Babinski’s ... I have not checked for this sign since I was a medical student. I doubt myself and repeat the test. Up-going. Her prognosis is grim. Long-term treatment facilities and rehab units do not exist in Jahun and her ongoing care will place an enormous burden on her extended family. The team is silent for a moment, deeply aware of the repercussions if no recovery is made.

The static of a walkie-talkie breaks my reverie. India Charlie, this is Oscar Tango, do you copy? We copy. India Charlie, is the med anesthetist with you? Good copy, she’s coming.

**Operating Theatre: Oscar Tango**

The nurse anesthetist is struggling with an intubation. I take over and, after the tube is in, find out what is going on. Uterine rupture from a combination of eclampsia and protracted labor. Extra IV lines are secured and we cover her with a washable forced air warmer. Fresh blood is ordered from the blood bank. It arrives four minutes later, still warm from donation. In Jahun, the family of the patient “repays” by donating the number of units used by the patient. There is always a line of willing husbands and fathers on the bench outside the blood bank, waiting for a
spot in the “bleeding room.” The type and screen is done on a large porcelain tablet. Blood is screened for hepatitis, HIV, syphilis and malaria. Malaria positive blood is still used — in an endemic area, too many units would be wasted otherwise — but the recipient is simultaneously treated. Packed cells are available for the neonates, everyone else gets whole blood.

Hysterectomy underway, I explore the drug cabinet. It’s fully stocked with a familiar family of emergency medications. Stacks of single-use syringes and needles are neatly organized. A separate, locked shelf contains controlled substances and there is a log book in the office nearby for periodic inspections by the Ministry of Health (MOH). All controlled substance containers are discarded separately. The MOH inspector will compare the log book with the collection of vials. While I understand how narcotics and benzodiazepines made the controlled list, the reason for locking up ephedrine, caffeine and methylergometrine is more of a mystery.

One of several medical shops in the town of Jahun that sell basic medical supplies and hygiene products. Most patients get their prescription medications from the hospital prior to discharge.
I turn to the anesthesia machine. I had read the orientation pack but the chrome box is quite different in practice. The nurse smiles. “Not like the one you are used to?” It reminds me of a gramophone from 1950.

I follow a standard mental algorithm: first find the “on” switch. There are six dials and two pressure gauges on the Monnal D2. My predecessor points out the pressure dial, rate setting and pressure alarms. There’s an oxygen blender and an isoflurane vaporizer. Monnal has continued manufacture of these simple models as a service to medical NGOs — they are easy to maintain, easy to transport and difficult to break. In terms of the circuit, everything except the endotracheal tube is reusable. The sterilization room has a counter window into the operating theatre — central supply gives us immediate service!

The next five weeks of my assignment pass quickly. I’m on call around the clock and every few days there is a soft nighttime knock at my door. Sometimes I’m called to help with mystery diagnoses (a thyroid storm, an acute non-obstetric abdomen, liver failure, psychosis mimicking a stroke) or to the operating room when a spinal won’t go in easily for an overnight C-section. I use the OB ultrasound for echo often, and rapidly discover that these young women have far from young hearts. Admissions for heart failure come in two or three times a week and some have concomitant valvular disease. I dredge up knowledge from medical school, consult my pocket pharmacopeia, and ask the local doctors if this is what a malaria spleen feels like. Every day I feel humble and grateful.

How to treat burnout? Talk to colleagues, get a massage? Rest on holiday? Quit your job? Become an administrator? Perhaps. For anyone who still has the embers of medicine alight, my advice is to drop the pressures of the Joint Commission, escape the clipboards and walk away from the man who didn’t like the “feel of the pillow” in PACU. Go and treat people who ask for nothing and give only gratitude in return. I hope I helped them. There is no doubt that they helped me.

Kiri Mackersey, M.D., is an attending cardiothoracic anesthesiologist at Montefiore Medical Center.
The New York State Society of Anesthesiologists, Inc.

Joseph P. Giffin
Wall of Distinction Award

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

As outlined in the NYSSA Bylaws:

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

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

3. The Wall of Distinction award can only be conferred posthumously and is not required to be awarded annually.

Any member of the NYSSA may submit a nomination. There is no nominating form. We request only a letter from you indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. If available, the candidate’s current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., at NYSSA headquarters (HQ@nyssa-pga.org) before July 28, 2017.

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

Michael P. Duffy, M.D., Chair
NYSSA Judicial and Awards Committee
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Professor of Anesthesia, Harvard Medical School and Massachusetts General Hospital,
Co-Founder APSF
Anesthesiology's Leadership in Patient Safety: Lessons from the Past and Planning the Future

IFPSQ.ORG
ASA Legislative Conference, Washington, D.C.

Rep. Andrew Harris (left) and Dr. Christopher Campese enjoy the view from the top of the U.S. Capitol Building.

(Left to right) Drs. Alexander Mazerov, Ashley Whisnant, Morgan Montgomery and Jonathan Gal

(Left to right) Drs. Ted Kim, Andrew Rosenberg, David Bronheim and Jonathan Gal

Members of the NYSSA delegation take time for a photo.

Drs. Jason Lok and Scott Plotkin

Drs. Andrew Rosenberg, Ted Kim and Vilma Joseph
NYSSA Legislative Day in Albany
NYSSA Legislative Day in Albany

NYSSA members meet with Sen. Catharine Young’s staff.

Sen. Joe Morelle addresses the NYSSA delegation.

Dr. Rose Berkun and Sen. David Valesky

Dr. Rose Berkun and Sen. Mike Ranzenhofer

Drs. Andrew Rosenberg and David Wlody
(Left to right) Drs. Sudheer Jain, Vilma Joseph and Rose Berkun, Senate Majority Leader John Flanagan, and Dr. Andrew Rosenberg

Speaker Carl Heastie and Dr. Vilma Joseph

Bob Reid poses for a photo with Smokey the Bear.

(Left to right) Dr. Sudheer Jain, Dr. Andrew Rosenberg, Sen. John DeFrancisco, Dr. R. Jesus Calimlim, and Dr. Pratik Desai

Dr. David Wlody

NYSSA members meet with Sen. Jeff Klein’s staff.
Supporting New York Legislators

Gov. Andrew Cuomo and Dr. Andrew Rosenberg attend Derek Jeter Day at Yankee Stadium

(Left to right) MSSNY President Dr. Charles Rothberg, MSSNY Immediate Past President Dr. Malcolm Reid, New York State Senate Majority Leader John Flanagan, and Dr. Rose Berkun

Drs. Andrew Rosenberg, David Bronheim and Rose Berkun, New York State Senate Majority Leader John Flanagan, Sen. Catharine Young, and Dr. Jonathan Gal

Dr. Andrew Rosenberg and Sen. Catharine Young

Dr. David Bronheim, Sen. Kemp Hannon, and Dr. Rose Berkun
MSSNY House of Delegates

Dr. Rose Berkun at the MSSNY House of Delegates Reference Committee meeting

Dr. Steven Schwalbe

Dr. Richard Beers (middle)

Dr. David Wlody (second row, third from left)

New York Health Commissioner
Dr. Howard Zucker with Stuart Hayman

Dr. Lawrence Routenberg (second from left)
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Since 1998, breaches in infection control have resulted in 77 reported outbreaks of patient-to-patient transmission of hepatitis B or C virus in healthcare settings. Ten of these outbreaks involved anesthesia care, putting more than 70,000 patients at risk and infecting 153.

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- Prevention and post-exposure management of infectious diseases

To complete this online course, go to nyssa-pga.org and click on Online CME Course on Infection Control Training, located in the left sidebar.

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.

Credit Designation | Medcom, Inc. designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity. The course is approved by New York state to meet the NY infection control requirement.

Accreditation | Medcom, Inc. is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
NYSSA’s 32nd Annual Legislative Day in Albany

Pre-Legislative Day Webinar (May 1, 2017)

The NYSSA’s pre-Legislative Day webinar had participation from some of our members planning to attend our annual Legislative Day in Albany. Dr. Berkun (NYSSA president) and Dr. Epstein (an NYSSA past president) provided updates on the nurse anesthetist title bill (A0442 Paulin/S1385 Gallivan). Bob Reid provided additional information on the status of the bill and other updates of importance. Importantly, Dr. Berkun reviewed arguments in opposition to the nurse anesthetist title bill to advance to lawmakers during legislative visits. The memorandum is outlined below:

**Key Points in Opposition to Enactment of A0442 (Paulin)/S1385 (Gallivan) Title Bill**

Enactment of the Paulin/Gallivan bill (2017-18: A0442/S1385) will create a pathway for the commissioner of education to define and expand a nurse anesthetist’s scope of practice. It will remove the Legislature’s control as it pertains to NA scope of practice. Critical points in opposition:

- The Paulin/Gallivan bill does not restrict the commissioner of education from promulgating regulations, nor does the bill define parameters of a nurse anesthetist’s scope of practice. In fact, the commissioner of education will be mandated to define scope of practice, bypassing the legislators.
- In 2006, the New York state board for nursing attempted to circumvent the New York state Legislature entirely by working with the New York nurse anesthetists to create a “nurse practitioner in anesthesia” designation — an anesthesia delivery model that would render null and void the anesthesia care team model. This was stifled by the Legislature.
- In 2012, similar legislation was vetoed. At that time, it was stated that the certification, registration or licensure of professions involved in the administration of anesthesia must require a higher standard to
protect patients. The legislation must address “critical issues such as scope of practice, supervision and the regulator oversight role.”

- The current legislation falls far short of the aforementioned requirements, and creates “a risk of inconsistent standards and confusion to consumers.”
- Additionally, if this were to pass, patients from underserved communities are more likely to receive a lesser standard of care.
- Nurse anesthetists currently are defined and recognized in accordance with Section 700.2 of the New York state health code, and are granted credentials to administer anesthesia in all venues where anesthesia is delivered. Nurse anesthetists, therefore, have specific recognition, distinguishable from other non-physician health professionals, to administer anesthesia.
- Remedies to correct this legislation have been introduced over the years: bill A1829, sponsored by Assemblyman Morelle (same as S4422 sponsored by Sen. DeFrancisco), protects all consumers and creates standards in law recognizing the professions administering anesthesia and providing title to a registered nurse and/or certification to a nurse anesthetist or CRNA recognizing their role but with critical consumer protections.

The NYSSA’s position supports nurse anesthetists getting a title as long as any bill includes NA scope of practice consistent with DOH and section 405.13. This is the currently defined and long-standing New York state physician-led anesthesia care team model.

Annual Legislative Day (May 2, 2017)
The NYSSA annual Legislative Day in Albany was once again well attended by NYSSA leadership and members from every district (the list of attendees is printed below). We greatly appreciate the efforts of these dedicated members to attend our annual Legislative Day. Based on the strong participation of our members, we were able to schedule appointments with 86 legislators (51 Assembly members and 35 senators). During our Tuesday morning breakfast, we also had the privilege of having Deputy Majority Leader Sen. John DeFrancisco and Assembly Majority Leader Joseph Morelle address our group. As prime sponsors of the NYSSA-backed safe anesthesia bill, it was reassuring to hear their strong commitment to preserving the existing standards of anesthesia care (the anesthesia care team) as embodied in the New York
state health code. We also had the privilege of hearing from Sen. Mike Ranzenhofer and Assemblyman Sean Ryan during our breakfast session.

**DISTRICT 1**
Dr. Lance Wagner  
Dr. Lee Winter  
Dr. David Wlody

**DISTRICT 2**
Dr. Gregory Fischer  
Dr. Jonathan Gal  
Dr. Ingrid Hollinger  
Dr. Sudheer Jain  
Dr. Meera Kirpekar  
Dr. Alexander Mazerov  
Dr. Morgan Montgomery  
Dr. Roland Rizzi  
Dr. Andrew Rosenberg  
Dr. Ashley Whisnant

**DISTRICT 3**
Dr. David Bronheim  
Dr. Lawrence J. Epstein  
Dr. Vilma Joseph  
Dr. Matthew Wecksell

**DISTRICT 4**
Dr. Mazin Albert  
Dr. Robert Eberle  
Dr. Melissa Ehlers

Dr. Scott Grouidine  
Dr. Nathan Maltezos  
Dr. Lawrence Routenberg  
Dr. Salvatore Vitale

**DISTRICT 5**
Dr. J. Robert Calimlim  
Dr. Pratik Desai  
Dr. Michael P. Duffy  
Dr. Jason Lok

**DISTRICT 6**
Dr. Alan Curle  
Dr. Melissa Kreso  
Dr. Richard Wissler

**DISTRICT 7**
Dr. Jane Arcadi  
Dr. Rose Berkun  
Dr. Elizabeth Mahoney  
Dr. Scott Plotkin  
Dr. Anthony Winkowski

**DISTRICT 8**
Dr. Christopher Campese  
Dr. Kevin Glassman  
Dr. Lisa Phillips-Lind

For those of you who were unable to attend, we were confronted with a significant challenge: namely, the nurse anesthetist title bill (A0442 Paulin/S1385 Gallivan) was voted on by the Assembly Higher Education Committee on May 2, 2017. As you may recall, this bill provides for licensure and certification of “certified nurse anesthetists” by the New York State Department of Education. Critical to the NYSSA is the language in the legislation does not provide for any direction to the department relative to physician supervision. In the past, the department has advocated for independent practice for nurse anesthetists through former leadership at the Office of the Professions. In the last legislative session (2015-2016), this bill moved through the Assembly Higher Education Committee and Assembly Ways and Means Committee.
Committee without a negative Democratic vote but was held up by Assembly Majority Leader Joseph Morelle. It appears the nurse anesthetist title bill is again gaining momentum.

Please be aware of the following message NYSANA is presenting to legislators:

- “CRNAs are the anesthesia providers of the future.”
- “Anesthesia is 50 times safer today than in the 1980s and equally safe provided by either a CRNA or anesthesiologist.”
- “CRNAs are qualified to administer every type of anesthesia in any healthcare setting.”
- “CRNAs are the most cost-effective anesthesia providers.”

(Nursing Economics 2010)

In view of the foregoing developments, your involvement in our governmental advocacy plan is essential. As such, please consider pursing the following action items at this time:

- If you are scheduling a district meeting in the near future, update your district on these initiatives and consider inviting Stuart Hayman, Bob Reid, and Chuck Assini to address your district.
- Review the NYSSA website for information, including supporting and opposing memorandums on legislation and a memorandum entitled “Importance of the Physician Anesthesiologist’s Role in the Delivery of Safe and Cost Effective Anesthesia Care: Refuting Myths and Setting the Record Straight,” which refutes NYSANA misstatements, including those recited above. This part of the NYSSA website can be found at http://www.nyssa-pga.org/legislativeregulatory-issues under “NYSSA’s Annual Legislative Day in Albany 2017.” (Note: You must sign in to access this page.)

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Mount Sinai Medical Center Hosts PGA 70 Participants

BRYAN HILL, M.D., AND GEORGE SILVAY, M.D., PH.D.

PGA 70 continued a tradition that began several years ago: the pre-PGA hospital visit. PGA attendees were once again given the opportunity to spend a day at a major medical center in New York City, where they observed operating room procedures, networked, and discussed cases with prominent specialists in anesthesiology. Attendees viewed operating, recovery and emergency rooms as well as intensive care units. Participating hospitals included the Hospital for Special Surgery, Memorial Sloan-Kettering Cancer Center, Icahn School of Medicine at Mount Sinai, Montefiore Medical Center, SUNY-Health Science Center at Brooklyn, and Lutheran Medical Center.

For PGA 70, nine guests representing six countries accompanied Dr. George Silvey on a visit to the Mount Sinai Medical Center on Thursday December 8, 2016. The day began with a brief introduction and orientation by Dr. Silvay, who shared stories of the history of medicine in his home country of Czechoslovakia, his travels around the world, and his transition from cardiothoracic surgery to anesthesiology. Dr. Andrew Leibowitz, chair of the Department of Anesthesiology, spoke
about the origins of the Mount Sinai Medical Center and recent developments within the hospital. He was followed by Dr. Adam Levine, residency program director and director of the ASA-endorsed HELPS Simulation Program, who discussed Mount Sinai’s simulation center and its leadership role as one of the first ASA-endorsed maintenance of certification simulation sites. Group members then visited operating rooms to witness the latest in simulation, thoracic, liver, and cardiac surgery happening at Mount Sinai. The day concluded with Dr. Silvay and Dr. Bryan Hill discussing current events and issues found in liver transplantation and cardiothoracic medicine today.

Several of the attendees have expressed their gratitude for the knowledge they gained, describing how they will use that knowledge in their home countries. They also spoke about the friendships they formed. Since the inception of this program, the PGA has helped many visitors from around the world take a peek inside high-functioning hospital facilities in New York City. ■

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In keeping with its mission, AFNY provides PGA-related scholarships to the most enthusiastic and dedicated anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. During the past 24 years, more than 374 anesthesiologists representing 62 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

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

Visit nyanesthesiologyfoundation.org and make your donation today.
The 35th Annual International Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine

CHRISTOPHER J. CURATOTO, M.D., M.E.M., AND GEORGE SILVAY, M.D., PH.D.

The 35th Annual Update in Anesthesiology, Surgery and Perioperative Medicine, organized by the Department of Anesthesiology, Icahn School of Medicine at Mount Sinai in New York, was held in January 2017 in Cancun, Mexico. The long-standing symposium continued its successful run, with 153 participants from 19 countries (Austria, Australia, Belgium, Canada, China, Czech Republic, Denmark, Georgia, Germany, Hungary, Japan, India, Italy, Mexico, Netherlands, Poland, Slovak Republic, Turkey, and the U.S.).

The symposium highlighted five special lectures by renowned physicians and surgeons from around the world. The symposium consisted of 98 lectures and four complimentary workshops on a variety of topics. In addition, a dedicated research session with prizes was devoted to residents, fellows, and
There were 13 presentations, with first prize awarded to Zhi-Dong Ge from Milwaukee, Wisconsin, for his presentation titled “Cardiomyocyte-specific overexpression of human GTP cyclohydrolase 1 gene protects against cardiac remodeling and dysfunction after myocardial infarction in mice.”

The symposium was held at the picturesque Casa Magna Marriott Resort in Cancun, Mexico. While the days were busy with lectures, workshops, and discussions highlighting current information in anesthesiology, surgery, perioperative and pain medicine, participants also had time to enjoy the ocean and beach. During an evening reception, participants had the opportunity to reconnect with colleagues and old friends from around the world and to discuss topics presented at the meeting. One of the highlights of the meeting was a celebration of the 35th anniversary of the international symposium.

Participants enjoyed a wonderful celebration that featured pictures and memories from more than three decades of this special conference.

Mount Sinai will host the 36th Annual International Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine from January 14-19, 2018, at Atlantis, Paradise Island, Bahamas. All are cordially invited to attend. Please send inquiries to Dr. George Silvay at George.Silvay@mountsinai.org.
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ATLANTIS, Paradise Island, Bahamas

January 14-19, 2018

Final program and hotel information will be available in September 2017. Interesting cases and research abstracts will be accepted for oral presentation. For abstract form, contact: menachem.weiner@mountsinai.org. (Deadline: October 30, 2017)

For information: george.silvay@mountsinai.org
Ensuring Appropriate Representation of Anesthesiology in Healthcare Reform

DUNCAN MCLEAN, M.B.CH.B.

On March 6, 2017, the Republican leadership presented legislation to the House of Representatives with the intention of repealing and replacing the Affordable Care Act (ACA). On March 24, the American Health Care Act (AHCA) was removed from consideration on the House floor, only to be modified, reintroduced, and passed by the House on May 4, 2017. It is unclear how the House bill will be altered by the Senate; however, whatever form the final legislation takes, it is important that we ensure the best outcome for the American people.

The AHCA is controversial across both sides of the aisle for a variety of reasons. With regards to issues affecting anesthesiologists, a main concern is that the new legislation would increase the number of uninsured and underinsured Americans. There are also concerns that proposed funding cuts will adversely affect the response to the opioid crisis, among other key issues.

Moving forward, whichever shape any future healthcare reforms take, the American Society of Anesthesiologists (ASA) has outlined key areas of importance to our specialty:

• Maintaining/establishing access to affordable healthcare for all Americans
• Allowing access to physician-led care regardless of geographic location
• Remedying the shortage of critically important medications for safe anesthesia care and addressing access to affordable prescription drugs
• Adequately funding research
• Ensuring that quality measures are transparent and reported in a timely manner
• Promoting adequate ongoing funding for graduate anesthesia education programs

As always, it is important for us all to advocate for our patients and our specialty. The first step to successful advocacy is keeping informed. We will continue to update you through quarterly issues of Sphere, and you can stay informed through the ASA Grassroots Network, which can be found at www.asahq.org/grassroots.

Duncan McLean, M.B.Ch.B., is a CA2 resident at the University of Rochester and the RFS president.
An Inside Look at the Legislative Process

MEERA KIRPEKAR, M.D.

“Fast-paced.” “Unpredictable hours.” “Anticipating the unanticipated moments.” “A continuous wave of highs and lows in an effort to do good.” These phrases describe my life in the operating room as an anesthesiology resident as well as the month I spent learning about and participating in the legislative process as an ASA resident scholar in Washington, D.C.

The ASA’s Anesthesiology Policy Research Rotation in Political Affairs is “designed to allow resident physicians to experience the political, legislative and regulatory factors that affect the delivery of patient care.” The opportunity is extended to six anesthesiology residents in the country each year.

When I began my month working with the ASA’s Washington, D.C., office, just as when I began my residency in anesthesiology, my preconceived notions about the experience differed greatly from reality. Until my month in D.C., I did not fully appreciate the complexities of the continually changing landscape of U.S. healthcare. Being in D.C. during the month of March in particular opened my eyes to just how dynamic the issues are that affect anesthesiologists specifically and physicians as a whole.

One of the most interesting meetings I attended was the Affordable Care Act “repeal and replace” Ways and Means Committee budget hearing, during which lawmakers passionately argued every nuanced detail of the proposed legislation well into the night, each side endorsing opposing views in an effort to provide effective healthcare to as many Americans as possible. With the future of healthcare uncertain, it is more important than ever before to make our presence felt so that we have a voice in the future of our specialty and the safety of our patients.

To that end, I accompanied our lobbyists, who work continuously to give us a say in upcoming legislation, to a variety of meetings and events with lawmakers. These meetings provided insight into the differing opinions on Capitol Hill that ultimately affect our profession. Additionally, from my time spent at these events, I can say that lawmakers truly want to hear our real-life stories as physician anesthesiologists because only we can provide that in-depth look into what it is really like to work in a hospital taking care of patients in critical settings. By taking the time to meet with
lawmakers and help them understand what we do as anesthesiologists, we can better advocate for patient care. I also spent time interacting with the different departments within the ASA office — such as quality measures, state affairs, health policy research, payment and practice management, and congressional and political affairs — learning how the work of these departments serves our profession.

It was humbling to see the sheer volume of work and the amount of team effort that goes into advocating for our profession and the safety of our patients. More than anything, the political affairs rotation taught me that we cannot stop now. With the political climate changing not just year by year but minute by minute, we must put in the effort to protect the sanctity of our profession. We must thank the teams in the anesthesiology advocacy offices for their truly remarkable work, and we must take personal responsibility for ensuring our future and the future of our patients by staying informed about health news, donating to our political action committees, and calling our lawmakers.

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

71st PGA Scientific Exhibits, Poster Presentations, Medically Challenging Case Report Posters

If you are interested in submitting applications to exhibit your projects at the upcoming 71st PostGraduate Assembly in Anesthesiology — December 8-12, 2017, please visit www.pga.nyc for instructions to submit online (available in May).

Deadline for filing is August 15, 2017.
Submissions are only accepted electronically.
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Online contributions are also welcome. Go to:
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Have You Visited the NYSSA Website Lately?

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Go to www.pga.nyc and register today!
Membership Update

New or Reinstated Members
October 1 – December 31, 2016

Editor’s note: The following names were mistakenly omitted from the spring issue of Sphere due to an error during the publication binding process (see letter on page 8 of this issue).

Resident Members

**DISTRICT 6**
Adaora Chima, M.D.
Dale DiSalvo, M.D.
Laura Fornarola, M.D.
Peter Gajdek, M.D.
Michael Goetzelman, M.D.
Brett Harmon, M.D.
Nika Karimi, M.D.

**DISTRICT 8**
Dayo Lukula, M.D.
Nasim Nourmohammadi, D.O.
Meghan Park, M.D.
Marissa Rubin, M.D.
Michael Rubin, M.D.
Amit Singal, M.D.
Yang Zhang, M.D.

Medical Students

**DISTRICT 1**
Jonathan Korets

**DISTRICT 2**
Trung Pham

**DISTRICT 8**
Jonathan Guenoun

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**DISTRICT 3**
Charles Fierro, M.D.
Thiagarajan Meyappan, M.B.B.S.

**DISTRICT 5**
Hank Kang, M.D.

**DISTRICT 7**
Rengasamy Rajendran, M.D.
Robert Tick, M.D.

**DISTRICT 8**
David Elkin, M.D.
Steven Rothstein, M.D.
Membership Update

New or Reinstated Members
January 1 – March 31, 2017

Active Members

**DISTRICT 1**
Moinul Haque, M.D.
Gary Schwartz, M.D.

**DISTRICT 2**
James Alberti, M.D.
Aisha Baqai-Stern, M.D.
Emil Bogdanov, M.D.
Emily Chanan, M.D.
Grant Chen, M.D.
Linda Demma, M.D.
Cosmin Gauran, M.D.
Ryan Gualtier, M.D.
Leslie Hale, M.D.
Lee Hingula, M.D.
Gregory Johnson, M.D.
Ronald Kahn, M.D.
Jane Kim, M.D.
Gregory Kinsella, M.D.
Alison Krishna, M.D.
Nikhil Kumar, M.D.
Sarah Leavitt, M.D.
Alexandra Lewis, M.D.
Melanie Liu, M.D.
Geema Masson, M.D.
Mohan Obilisundar, M.D.
Parwane Pagano, M.D.
Vijay Patel, M.D.
Mohammad Piracha, M.D.
Benjamin Record, M.D.
Irwin Reich, M.D.
Jonathan Rosenstreich, M.D.
Alison Schmeck, M.D.
Sankalp Sehgal, M.D.
Sana Shaikh, M.D.
Sharad Sharma, M.D.
Liang Shen, M.D.
Monika St. Jean, M.D.
Howard Teng, M.D.
Somasundaram Thiagarajah, M.D.
Sherin Vargnese, M.D.
Stephanie Vecino, M.D.
Vijay Verma, M.D.
Brian Walker, M.D.
Kevin Walsh, M.D.
Melanie Witte, M.D.

**DISTRICT 3**
Hany Elazab, M.D.
Eric Fein, M.D.
Sarah Herbst, M.D.
Toni Manougian, M.D.
Irim Salik, M.D.
Kriti Sankholkar, M.D.
Allen Williams, M.D.

**DISTRICT 4**
David Leff, M.D.
Jacqueline Lozano, M.D.
Shamee Mane, M.D.

**DISTRICT 5**
Tamim Khaliqi, M.D.

**DISTRICT 6**
Wendy Bernstein, M.D.
Paul Guadagnino, M.D.

**DISTRICT 7**
Remek Kocz, M.D.
Membership Update

New or Reinstated Members
January 1 – March 31, 2017

Active Members continued

**DISTRICT 8**
Daniel Carter, M.D.
Emily Kahn, M.D.
Anna Kogan, D.O.

Ilya Krayevsky, M.D.
Anuj Patel, M.D.
Gerard Silva, M.D.

**DISTRICT 2**
Ben Zhou, M.D.

**Affiliate Member**

**DISTRICT 2**
Kudupudi Avinash, M.D.

**Resident Members**

**DISTRICT 2**
Kudupudi Avinash, M.D.

**DISTRICT 3**
Tania Cossio, M.D.
John-Paul Sara, M.D.

**Medical Student**

**DISTRICT 3**
Aryeh Ginsburg

**Retired Members**

**DISTRICT 1**
Akhtar Ali, M.D.

**DISTRICT 2**
Jacques Dole, M.D.
R. Harper, M.D.
K. Kathirithamby, M.D.

Anne Kolker, M.D.
Stuart Weg, M.D.

**DISTRICT 3**
Keith Brumberger, M.D.
Richard Gallagher, M.D.
Salem Jayagopal, M.D.
Membership Update

New or Reinstated Members
January 1 – March 31, 2017

Retired Members continued

DISTRICT 4
Charles Gibbs, M.D.
Richard Greenberg, M.D.

DISTRICT 5
Colleen O’Leary, M.D.

DISTRICT 6
Catherine Battaglia, M.D.

DISTRICT 8
Arun Agrawal, M.D., M.S., MBA
Steven Shoum, M.D.

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MLMIC ANNOUNCES A NEW 20% DIVIDEND

As New York’s #1 medical liability insurance provider, MLMIC is committed to putting policyholders first. That’s why we’re offering a 20% dividend on new policies and renewals.* With more than 40 years of experience; unparalleled claims, risk management, and legal services; and a recently announced decision to be acquired by Berkshire Hathaway Inc., no other insurer is better positioned to support you and your career. Today and tomorrow.

*The 20% dividend applies to policyholders insured by May 1, 2017 and who maintain continuous coverage through July 1, 2017 and is based upon the annual rate of premium in effect on May 1, 2017. The dividend will be paid as a credit on your July 1, 2017 renewal policy invoice.