Volume 66 Number 1 **Spring 2014**

SPHERE

Quarterly Publication

NYSSA • The New York State Society of Anesthesiologists, Inc.

Past presidents of the New York State Society of Anesthesiologists were recognized during PGA 67.

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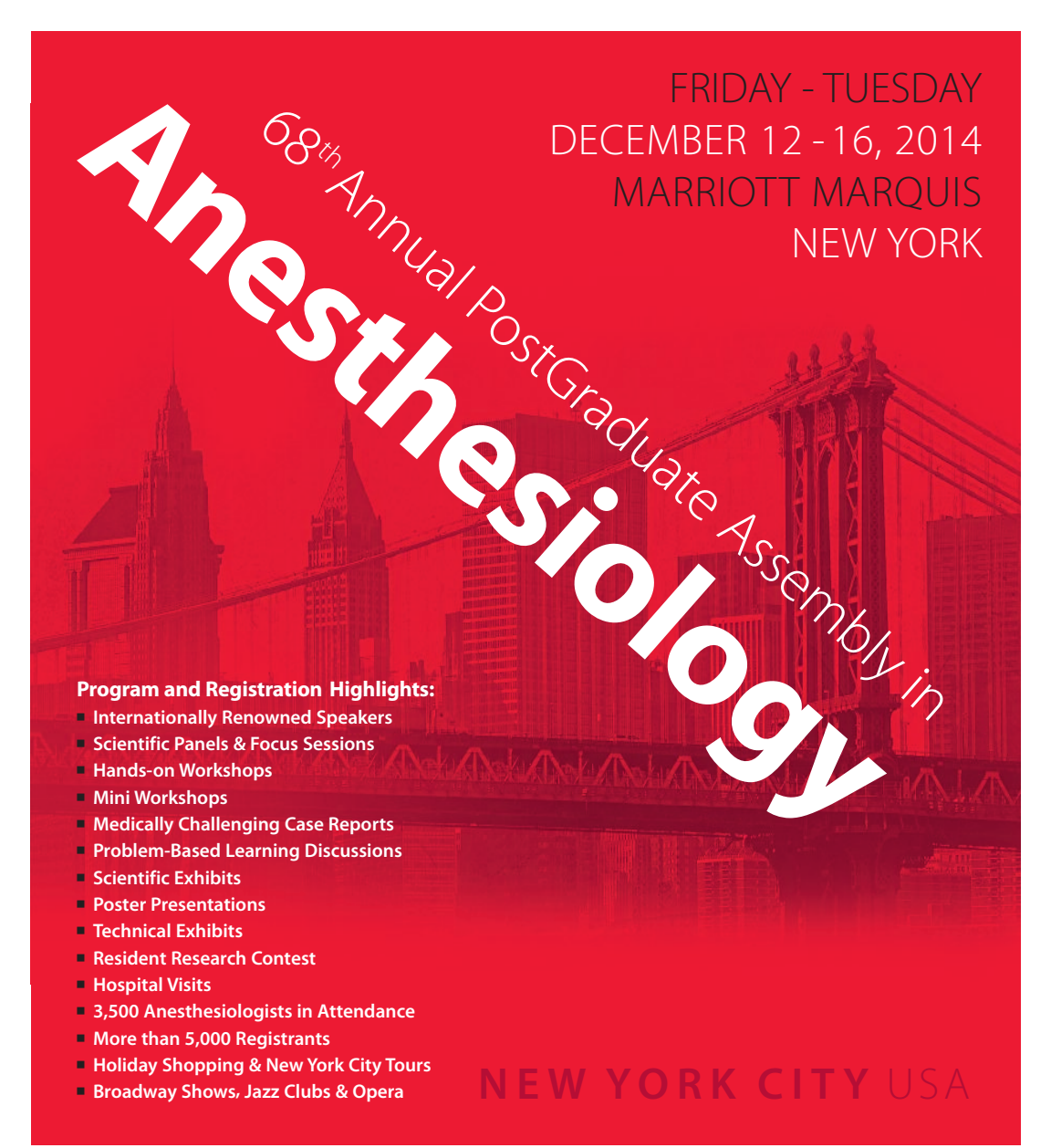
68th Annual PostGraduate Assembly in Anesthesiology



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Reflections on an Exciting Journey

OUTGOING PRESIDENT MICHAEL B. SIMON, M.D.

My fellow officers, delegates, distinguished guests, ladies and gentlemen: It gives me great pleasure to stand before you today. This weekend marks the end of a very exciting journey for me.

We are at one of the most monumental, life-changing, country-changing times in our history. We are in an age where healthcare is undergoing a monumental restructuring. We are in an age where we, as physicians, are challenged like never before. We are challenged to perform better, to qualify what we do, to work harder and leaner, and to do so in the face of questionable reimbursement. We are challenged to prove our worth as allied health providers argue to replace us both in and outside of the operating room.

Let me focus for a bit on our profession and, more specifically, on OUR NYSSA. For those of you who have been fortunate to be in the leadership of this fine organization for the past decade, you have seen us undergo an amazing transformation and I want to highlight some of these changes. At the same time, I want to frame the discourse.

At a time when organized medicine is in a precarious position, when most medical societies are suffering membership losses, our NYSSA finds itself in a very different place.

When arriving at a theme for this speech, I kept returning to a speech I heard several years ago by then-incoming AMA President Nancy Nielsen. Dr. Nielsen said, and I quote, "All of this may involve us in a new type of engagement with traditional adversaries. But, this is not conciliation. This is not capitulation. It is civil engineering." Ladies and gentlemen, civil engineering is exactly what we are doing. We are building bridges in an effort to make a better tomorrow for our Society, for our members, and, most importantly, for the patients we serve.

Let me speak more about these bridges and their significance insofar as our NYSSA is concerned. For years our organization was satisfied with the status quo, but I'm happy to tell you that we are now evolving. … We are building bridges that will take us well into the future, bridges that will enhance the status of our NYSSA both within the state and outside of it, bridges that will connect us to other organizations, and bridges that will allow us to provide better care to our patients tomorrow.

Bridges themselves are amazing feats. Every time I cross a bridge I am amazed, and very happy, that I am still way up there, suspended in the air. It is truly a wonder of engineering that these structures exist, and they exist where before there was only a gap, a space, a divide, an obstruction. They were built with a visionary at the helm, someone who saw where they wanted to go and simply had to devise the means to get there.

So how did our NYSSA get from the place it was several years ago to the very different place we are today? It was through careful bridge building in so many different ways. And as I sum up this year's activities and lay out a framework for where I believe we need to go, visualize the bridges we have built and be mindful of some of the engineers who have helped us get there.

Let me start with our NYSSA legislative agenda. For years, our Society has concentrated on one issue. I believe we can all recite by rote the tenets of our "safe anesthesia bill." We have gone before our legislators time and again; we have poured money into the PAC toward this goal; and we have all spent countless hours attempting to preserve the high-quality, safe care our patients deserve. But last year we began to feel a little disconnected from our representative allies. Along with the house of medicine, we faced the Medicaid Redesign Team and the beginning tide of healthcare reform, and we felt vulnerable and isolated. We needed to shore up that bridge, for of all the places we need to be strong and well connected, it is in Albany. So how did we do that and where are we today? I will tell you that in my 17 years with the NYSSA, I have never felt so well respected, liked, and welcome in Albany as I do today. And that didn't come easy. The bridge to Albany was built through hard work! Through the efforts of our lobbying team, led by Mr. Charles Assini and Mr. Bob Reid, and the foresight of our Government and Legal Affairs Committee leader, Dr. David Wlody, we repaved the bridge to Albany. We found ourselves welcomed warmly and it was truly bicameral and bipartisan. Now there will always be some naysaying politicians, but the majority of our representatives welcomed us. And not only did they welcome us, they knew our issues. This year we tried a new approach. At the request of Bob Reid, members of our Executive Committee made frequent, early trips to Albany. I personally drove that well-paved NYSSA bridge to Albany more than a dozen times, but it was well worth it. By the time we had our NYSSA Legislative Day, Albany was well-primed.

We all know how difficult success can be when you try to go it alone. So we built another type of bridge this year, one based on unity with kindred

spirits. We became the ninth specialty society to join the New York State Multi-Specialty Group. This group shares common goals, including preventing allied health providers from doing things they are **neither trained nor licensed to do**. With our brothers and sisters in arms, we had another lobby day where we learned about each other's issues and we lobbied together. And let me be clear, it was a much more powerful message, having an orthopedic surgeon sitting there explaining to a senator that he does not want a nurse anesthetist working unsupervised, caring for his patients. Ladies and gentlemen, this is what it's all about: creating relationships and networks for our specialty, for our NYSSA. We will continue to participate with the Multi-Specialty Group and we will look for even greater returns in the coming years.

Over the last year we have broached the subject of anesthesiologist assistants (AAs). We agreed to support the American Academy of Anesthesiologist Assistants (AAAA) in their quest for licensure and recognition in New York. The AAAA had a great year in New York state. This was achieved through the bridges we have built. The NYSSA, through the hard work of Mr. Stuart Hayman, was able to secure a generous grant from the ASA to aid with this issue. The AAAA retained a lobbying firm and saw bills presented in both houses of the New York Legislature. Several lobby days were dedicated to the AAAA bills and members of our Executive Committee joined Mr. Hayman and me in supporting the AAs in Albany. This was a great effort for several reasons. Primarily, AAs are recognized, respected, and safe providers of anesthesia care working in the care team mode. Their practice should not be restricted by the will of a few. They should enjoy the same practice rights as nurse anesthetists. Second, shortages in the anesthesia world are predicted. Shortages do not in any way mean we lessen the quality of care by turning allied health professionals into independent practitioners. Shortages mean we find more creative ways to extend ourselves. We introduce AAs into the mix, ensuring adequate care from providers who are trained and want to work in the care team mode.

When we met with the deputy commissioner of state education, he told us that on average the time frame for the introduction of a new type of provider to New York is measured in decades. I would guess based on the momentum developed this year that he will be very mistaken.

Two years ago, we got a history lesson about the birth of the American Society of Anesthesiologists. I'm always so proud to share that history and remind folks how the origins of organized anesthesia were right here in

New York. For those who participated in the ASA House of Delegates this year, this fact was made quite evident. Yet our Society has built far-reaching bridges. We have been active in reaching well beyond our borders. We are the only state society to have a presence at multiple international meetings every year. This is no small feat, yet one we find quite valuable. This year I had the honor and privilege of representing our NYSSA and the PGA in Barcelona and Canada. We are a recognized name abroad, something we should all be very proud of. I want to point out that our participation at the European Society meetings actually predates the ASA's involvement there. I am so pleased to once again welcome our distinguished international guests. Remember, these bridges are two-way, and I look forward to strengthening the relationships we have developed and nurtured.

Our NYSSA is one of the largest component societies within the American Society of Anesthesiologists. Our sheer numbers make us one of the top two most influential state societies. Yet, in the past, we rarely took advantage of that. New York was like a sleeping giant within the house of the ASA. Well the giant has awoken. New York has been seen as a rising force. We have built bridges within the entire organization and will continue to do so. Most recently, we have had three ASA meeting chairs from New York, and I'd like to recognize the fine work done by Drs. Andy Rosenberg and Rebecca Twersky, and, most recently, Dr. Audrée Bendo. We have also had Dr. Scott Groudine made chair of the section on clinical care within the ASA. It doesn't stop there. We have new NYSSA members active on most every influential committee within the ASA. We have multiple NYSSA members already planning to run for higher office within the ASA in the very near future. We have also maintained a high profile at the Board of Directors level as well as within the House of Delegates. But here's the key: We aren't doing it alone. We are building relationships with other delegations, both large and small, and working together to accomplish common goals. We need to continue on this path, always being mindful of what is important for our NYSSA.

We have also distinguished ourselves in our political action committee fundraising. In one year, New York went from next-to-last to one of the top five ASAPAC performers! I have personally accepted the challenge to make the NYSSA number one next year. Having the largest concentration of anesthesiologists right here in the metro area, we should have no problem doing this, and I call upon you all to help us reach that goal.

Now what kind of small local bridges have we built? For more than two decades we have rallied hard behind the concept of physician-led anesthesia.

We have had, at least legislatively, a very adversarial relationship with the New York State Association of Nurse Anesthetists. While they have lobbied hard for independent practice, we have maintained that you get this right through education, not legislation. Our two societies have tried on several occasions to sit down and come to some agreement, yet every time we got nowhere. Typically, lobbyists and legislators are involved and, between the posturing and grandstanding, we accomplish nothing. Well, this year we attempted to build a bridge. Our leadership met with NYSANA's leadership. We locked the doors and limited participation, barring the lobbyists and execs. We found the meeting to be cordial and respectful. We left feeling very hopeful. NYSANA's main focus right now is passing a title bill here in the state. Currently, nurse anesthetists practice without licensure beyond that of an RN. We are the only state in the country where that situation exists. Our NYSSA has stood firm that the only way we would lend support to a "title bill" would be if it addressed "scope of practice" as we would define it. Now I will tell you we left that meeting with an agreement on just that point. Within a week's time, NYSANA let us know that they would like to return to the drawing board. They want to go back to just a title bill discussion. We made it clear that we would be happy to meet again, but any title discussions must be based around scope definitions. This is non-negotiable, yet there can be give and take on both sides. We will continue to build this bridge. The leadership of NYSANA is anxious to work with us and I am trying to maintain a significant degree of optimism. So while some may accuse me of building a "bridge to nowhere," I say, "Stay tuned" and we will keep you all well-informed of our progress.

This past year we also engaged more with our membership. We undertook a campaign to help our NYSSA members to identify themselves as "physician anesthesiologists" by providing them with a "PHYSICIAN" badge buddy. These have become so wildly popular that physicians in multiple specialties have begun asking us for them. As we continue down the path of allied health providers seeking to further misrepresent themselves as "Doctors," we must protect our patients and demand truth in advertising and truth in identification.

I now want to share with you all a look into my crystal ball. I spoke last year about the changing times and the need for us, as a specialty, to evolve. We have seen more sweeping change to every aspect of healthcare than ever before. The small anesthesia practice that is based solely on delivering quality care cannot exist in the future. Our future lies in expanding our role. Our future lies in taking control of and owning the

entire perioperative arena. Our future lies in being able to prove our worth, both in terms of quality and outcomes. Our NYSSA future lies in being able to provide that bridge for our members. Some of us belong to ultra-large anesthesia groups that have spent countless hours and dollars preparing for this future. But most of our members have not. Many of our members are reluctant to embrace change.

We all know the system had to change. We have been willing participants in the most broken system one could design. For the wealthiest country in the world, we have managed to have a healthcare system that failed to provide coverage for more than 46 million individuals, a country comprised of some the most unhealthy citizens ever. We fight childhood obesity, adult obesity, smokers, diabetics, and a whole slew of those who just refuse care. We have a system where the middleman sucks up the healthcare dollars. And we have a system where the majority of healthcare dollars are spent in the last years of one's life. So, yes, the system had to change. Now, what it morphed into, I shudder to say, may be far less ideal. I could speak about the Affordable Care Act for the next day, but that's not what I want you all to take home.

The world of anesthesia is changing. The way we deliver care is changing. Let us control every aspect of that change that we can. In the words of Warren Buffet, "In a chronically leaking boat, energy devoted to changing vessels is more productive than energy devoted to patching leaks."

I'm sure you're all thinking, "But so much of this change is outside our reach, outside our influence …" I submit to you that this is not the case. The framework for this overhaul is still being established. The buzz words are cost, quality, preventive care, access, efficiency, etc. The methods for reaching these goals are evolving. We need to be change agents. We can drive much of this change toward a positive outcome. Our value will be measured by how well we shepherd this process.

At the beginning of my presidency, I formed an ad hoc committee to look into the future. I wanted this committee to start laying the foundation for our bridge to the future. I tasked this learned group with examining future models of delivery and reimbursement. The goal was that, based on the committee's findings, our leadership could decide if the NYSSA would need to make some major adjustments. After all, as leaders in the specialty of anesthesia, our membership looks to us for guidance. If different things will be expected of us, what better organization to provide guidance, education, and leadership than ours?

This committee, which was named the "Ad Hoc Committee," was chaired by Dr. Frank Overdyck and I'd like to offer him a warm thank you. His leadership was inspiring and the dialogue throughout the committee meetings was thought-provoking. The committee, it turns out, was very similar to the ASA's "Committee on Future Models of Anesthesia Practice." In fact, the committee projected a model not dissimilar to the perioperative surgical home as proffered by the ASA. That being said, I don't want to take up this time giving a lecture about the surgical home; but I do want you all to realize that this is the future of anesthesia practice. It will have many different forms and flavors, but some semblance of the surgical home will be the model by which we will practice. The groups and providers who embrace this concept sooner rather than later will reap the benefits.

I'm happy to report that our next president, Dr. Lawrence Epstein, has agreed to keep this committee intact and it will actually have a more appropriate name, the "Committee on Future Models of Practice." The committee will also be putting several recommendations before this House later today. One will be very bold, suggesting that we change the name of our Society to better reflect what we currently do and what we will do in the future. Our NYSSA needs to be a model for the future practice of anesthesia and perioperative medicine. I ask you all, as these discussions unfold, to keep an open mind. We can no longer stick our heads in the sand and wish it all away. The time for change is now and change is happening with or without us.

I want us to build that bridge to the future, one we can be proud of. Together we will accomplish great things. There may be disagreement as to the future name of our Society, but that's not the heart of the discussion. What needs to be embraced by all is that the landscape has changed. We need to focus on the future and explore newer models for delivering efficient, high-quality, physician-led care. Only we can build this bridge!

Our NYSSA has been busy working for our members. We have secured our place in organized medicine in this state and beyond. I need to take this opportunity to thank several people. First off, my Executive Committee and Board of Directors: You folks have been models of dedication. You have helped keep this Society moving forward. Your tireless devotion to this organization has not gone unnoticed. We all owe you a debt of gratitude.

To my colleagues at North American Partners in Anesthesia, and, specifically, the Anesthesia Department at Vassar Brothers Medical Center: A sincere thank you. You have enabled me to have all the time and support necessary to carry out the duties of this office. On behalf of the NYSSA and myself, thank you!

No medical society runs itself. Our NYSSA is truly a model medical society. Six years ago we decided to make some changes, putting our Society on course for the future. That started with the recruitment of a new executive director. We could not have been more fortunate. The recruitment of Mr. Stuart Hayman was a game changer for the New York State Society of Anesthesiologists. My friendship with Stuart goes back about 16 years. He is an asset that we cannot take lightly. Mr. Hayman and his staff do an amazing job keeping this organization functioning, not like it did in the 1970s, but as a lean, modern, electronically connected, efficient machine. We also need to offer our sincere thanks to MaryAnn Peck, Will Burdett, Debbie DiRago, Lisa ONeill, Colleen Ryan, Kathy Felicies, and Sandy Rogers. You all do an amazing job!

Incoming President Dr. Lawrence Epstein presents a plaque and special award to outgoing President Dr. Michael Simon.

To the entire team that keeps our NYSSA in focus in Albany, a sincere thank you. Bob Reid, Chuck Assini, Shauneen McNally, Marcy Savage, Padraic Bambrick: Your influence in state government is unequaled and we are so fortunate to have you leading on that front. We cannot begin to thank you enough for what you do every day.

In the words of Alex Haley, "In every conceivable manner, the family is link to our past, bridge to our future." I ended my address last year by telling you how I was humbled and made to see things a little differently when my daughter, Michaela, presented me with her version of a presidential gavel. I have kept this gavel near and cherished it this entire year. I have also learned a great deal this year from my son Christian, for he reminded me of the meaning of fatherhood and that the joy of being a father is greater than any other. My son Stefan reminds me all the time of the struggles of being a young man, trying to launch a career, always remembering your roots, and being mindful of those we must mentor. And lastly, my wife, Gail, has been an amazing source of inspiration, encouragement, and devotion. Gail, you have been the voice of reason and a source of strength and I thank you for your love and support.

Ladies and gentlemen, thank you! ■

Dr. Michael Simon shares a moment with son Christian, daughter Michaela, and wife Gail.

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President's Message

Inaugural Address to the NYSSA House of Delegates

LAWRENCE J. EPSTEIN, M.D. — DECEMBER 14, 2013

As my term as president of the NYSSA begins, I am trying to add clarity to my goals for the coming year. I am truly lucky to have served on the Executive Committee under, without exception, effective, energetic presidents with vision and perspective.

With any organization, goals cannot be set, no less achieved, without first reviewing the organization's mission. Our mission statement reads: "The New York State Society of Anesthesiologists, Inc. (NYSSA) is an organization of physicians and scientists dedicated to advancing the specialty of anesthesiology and providing the safest and highest quality patient care to the citizens of New York State."

How does the NYSSA "advance the specialty of anesthesiology"? We do this through education, providing for a strong social network, advocacy and public relations, research, and remaining relevant to future practice models.

For too long, the standing of the physician — in our case, the physician anesthesiologist — has gradually eroded in our society and, sadly, we have done little to oppose this. We are grouped with caregivers who have significantly less training under the title of "providers." To quote a speaker at this year's Medical Society of the State of New York (MSSNY) HOD, "I didn't go to 'provider school,' I went to medical school." Every training program for nurse anesthetists now issues a "doctor of nurse anesthesia" degree. A currently practicing nurse anesthetist can add that "degree" by completing a six-month course. This course can be completed entirely online. No clinical work. Some with those degrees now introduce themselves as "Doctor." This is misleading to patients and insulting to physicians, who have earned the privilege of using the title "Doctor" in a medical setting. This is not just an issue for physicians. Nurses' aides and medical assistants are confused with nurses, physical therapists with their assistants, and so on. In an effort to protect our patients, last year we championed a proposal at MSSNY's HOD to press for passage of a "truth in advertising/ID" bill that would require that the ID currently required to be worn by every licensed caregiver in New York state prominently feature the basis for their licensure. We have placed

one of those badges at every seat here today; as members, you have already received this badge in the mail. This was modeled after similar legislation passed three years ago in Pennsylvania. In other words, an M.D. or D.O. would have "PHYSICIAN," a nurse anesthetist would have "NURSE," etc. Our motion passed and the bill had backing in both New York state legislative houses, but, ultimately, it failed after being amended. We will continue our efforts to pass this legislation; until then, we have provided "PHYSICIAN" ID tags to all of our members. Similar tags are now being distributed by MSSNY.

There cannot be a president-elect address without addressing the Anesthesia Care Team, or, more accurately, the assault on the Anesthesia Care Team. This year, the Veterans Administration set new policies, eliminating physician supervision of nurse anesthetists throughout the entire VA medical system. Here in New York, our best protections from independent practice have been the high-quality service we provide to New Yorkers in every corner of our state and the protections written into the New York State Health Code (405). Other protections are inherent in New York's political machine, which feeds off conflict and abhors resolution. Unfortunately, while this system has protected us, it also perpetuates the conflict. Frankly, I think both the NYSSA and NYSANA have wasted far too much effort and money on this battle. In this changing world of medical economics, I believe the future of nurse anesthetists would be a lot brighter if they spent their efforts on strengthening their alliance with anesthesiologists and the care team model. NYSANA desperately wants a title bill to pass in New York. We have met with the NYSANA leadership and promised our support for a title bill, as long as it includes clearly defined scope of practice, based on the current Health Code. Interestingly, when we met with the NYSANA leadership, they supported that exact statement. Unfortunately, politics intervened. There is no question that the safest, most efficient and least expensive model for delivering anesthesia services is the Anesthesia Care Team: a physician working with nurse anesthetists or anesthesiology assistants. We will continue to try to find common ground with NYSANA and to support the efforts of the anesthesiology assistants in New York state. I do believe that, ultimately, NYSANA and AANA will realize that as medicine changes, they will be better off allied with us.

Medicine is changing. We need to position ourselves and our specialty to thrive in whatever future model evolves. There is no question that the government payers are moving toward "population management," global payments and capitation models such as ACOs. This focus presents a

unique opportunity for our specialty. We are at a crossroads where the payment models will increasingly be based on quality. The NYSSA and ASA are synonymous with patient safety and quality, as evidenced by the fact that our specialty is the only one in New York to have had a reduction in malpractice insurance rates during the last decade. Going forward, the ASA has taken the lead on "safety and quality" with the promotion of the "surgical home," which I believe should be just one of many components of our strategy. We must parlay our focus on and expertise in patient safety and quality into leadership positions in our hospitals and communities. Remember, more than any other factor, quality (i.e., patient safety) drives cost. We will have many opportunities to add value to the anesthesiology department. The "surgical home" addresses the entire perioperative period, where we have unmatched expertise. In fact, there are opportunities outside of this period as well. Twenty percent of Press Ganey survey questions relate to pain. By providing a comprehensive inpatient pain service (including, but not limited to, postoperative pain), we can help our institutions lower their pain scores, improve the Press Ganey scores, and thereby increase their Medicare reimbursement by millions of dollars per year. Our expertise in perioperative medicine and intensive care can help our institutions increase the quality and throughput of our surgical cases, reduce complications such as line sepsis and DVT, and reduce readmissions, all major components of cost.

However, we must recognize that many of us are uncomfortable with these goals. We feel unprepared. Most anesthesiologists trained and still practice in environments where the only time the cash comes in is when the meter is ticking, when you are actually in the room providing care. It is our job — the leaders in this room, the NYSSA and ASA — to educate our colleagues. With this goal in mind, this year's PGA has four focus sessions, 10 scientific panels, three mini-workshops, and six PBLDs relating to perioperative medicine. I intend to reappoint the Ad Hoc Committee on Perioperative Care, which I will rename the "Ad Hoc Committee on Future Practice Models." Part of this committee's mandate will be to act as a resource to the PGA leadership to help shape our educational offerings. This committee will also be charged with working together with our Communications Committee to keep the membership abreast of the expected changes in our practices and their implications.

The lifeblood of a society of our size is our communications infrastructure. Until now, district meetings, particularly in the upstate districts, have had limited attendance because of the geographic

limitations. In the year 2014, there is no excuse for limitations on a member's access to the activities of the Society. The NYSSA already owns software that would allow for attendance, via the Internet, by any member, to any district meeting. I have instructed the Communications Committee to facilitate the "broadcast" of all district meetings. I have also instructed the Bylaws Committee and our speaker and vice speaker to determine if any additions/changes need to be made to our bylaws and/or administrative procedures to allow for full participation, including voting, by members who are connected electronically.

Nowhere in our mission statement does it say, "Earn a profit," but we do have a fiduciary responsibility to our current and future members. In 2008, the year of our last dues increase, we had assets of $1.2 million (not including property of $1.4 million) and liabilities of $2 million. We had a contract (for the PGA) with the Hilton with a possible liability

Dr. Lawrence Epstein receives the president's gavel from Dr. Michael Simon.

in a bad (not catastrophic) year of $1.5 million to $3 million. In other words, a bad PGA could have bankrupted the NYSSA. Luckily, we had excellent leadership from our Executive Committee and BOD, particularly our treasurers (Dr. Salvatore Vitale and now Dr. David Bronheim). We hired a new executive director (Stuart Hayman) and, over the ensuing years, after the sale of our Fifth Avenue office and the purchase of our current space — along with aggressive management of our income, expenses and the PGA — we reached the end of 2012 with $3 million in cash/stock, as well as property conservatively valued at $2.6 million and absolutely no debt. We now have an organization that is lean and stable and we need to keep it that way.

The NYSSA is in a strong financial position. Thankfully, I see no need to increase dues, but we desperately need to increase spending in one area: advocacy, both in New York state and on a national (ASA) level. Unfortunately, the NYSSA cannot, as a not-for-profit organization, contribute money to PACs (without being taxed). This must come from the individual members. We have local and national issues that will directly affect our current and future members and it is simply a "pay-to-play" system. Every year (prior to this one) at the ASA HOD, New York has been embarrassed by the low participation in ASAPAC. This has

Dr. Lawrence Epstein and his wife, Erica Epstein, spend time with Dr. Michael Simon and his wife, Gail Simon.

directly affected the success of our national candidates. Our immediate past president, Michael Simon, has worked hard to increase our participation. In fact, as a direct result of his hard work during his presidency, New York made the top five for funds raised, although we remain among the states with the lowest participation rates. Many, if not most, of the issues I mentioned earlier are of national or even international concern. Each state component sends a director and alternate director to sit on the ASA Board. As one of the largest state components of the ASA, we seat 25 delegates (second only to California). We are proud of the fact that the last two ASA annual meetings were chaired by New Yorkers and that two of the last 10 ASA presidents were from the NYSSA. However, we are very concerned that currently there is no one from New York on the Administrative Council. Additionally, very few of our members chair or even sit on ASA committees. We have opportunities to execute our mission statement on the larger stage, but we must cultivate these opportunities. This means mentoring candidates for national office.

With this in mind, this year's dues statement includes an additional suggested contribution to NYAPAC as well as an insert with information on how to contribute to ASAPAC. This will also appear on the electronic registration. We want to win the Alabama Cup in 2014!

I could not have reached this position without the sacrifices of many of those around me: my former business partner, Grigory Kizelshteyn; my current chairman, David Reich, and my colleagues at Mount Sinai; and, most importantly, the love of my life, my wife, Erica, and my kids, Marc and Mollie. Thank you. ■

68th PGA Resident Research Contest

If you are interested in submitting an abstract at the upcoming **68th PostGraduate Assembly in Anesthesiology — December 12-16, 2014**, please contact NYSSA headquarters for information:

NYSSA | 110 East 40th Street, Suite 300 | New York, New York 10016

Phone 212-867-7140 **Fax** 212-867-7153 **e-mail**: hq@nyssa-pga.org

Deadline for submissions is May 1, 2014.

Editorial

Preparing for the Upcoming Legislative Day

JASON LOK, M.D.

Last year, during the NYSSA Communications Committee meeting, then President-elect Dr. Lawrence Epstein suggested that our audience for awareness/support of physician-led care should be stratified into three main groups: the general public, other physicians, and legislators. Fortunately, as a member of the ASA's Committee on Communications, I helped play a part in the development of the ASA's educational initiative aimed at these distinct audiences: When Seconds Count … Physician Anesthesiologists Save Lives™.

If you visit www.asahq.org/whensecondscount.aspx you will find that the target audiences for this campaign mirror Dr. Epstein's vision: policymakers, physician members, the public, and the news media. While the ASA launched this educational endeavor in September 2013 to advocate for patient-centered, physician-led care and the best possible outcomes for all patients, there is still much to do to make all members aware of this incredible resource. For instance, the toolkit for policymakers and/or hospital administrators includes background information on the When Seconds Count™ initiative (video presentation and webinar) as well as downloadable advocacy materials (message maps, policymaker brochure, education and training fact sheets, and ASA education and training infographics). I highly recommend that all those who plan to attend the NYSSA's Legislative Day in May become familiar with these materials and utilize them when educating our state senators and Assembly members.

At the recent ASA Committee on Communications winter meeting in January, much of our strategic plan focused on member engagement, the When Seconds Count™ toolkit, state communications support, and federal legislative/regulatory support. Furthermore, there was an intensive discussion about partnership outreach, digital marketing, and national and social media. For example, rather than having just video testimonies from fellow physician anesthesiologists and patients, the suggestion was made to have a testimonial from a leader/president of a national surgical society. However, to accomplish this, we need to work on partnership outreach, such as hosting a summit on the future of surgical medicine.

Another suggestion was to make it possible to develop customizable presentations from charts, figures, images, and video on the When Seconds Count™ website that will be downloadable for use in educating policymakers/hospital administrators. Thus, this meeting was very productive, with many robust and creative discussions.

In the next issue of *Sphere*, we plan to resume our feature articles on medical missions by our fellow members. These articles serve as a counterbalance to our regular articles on scope of practice and reimbursement issues. We continue to call for submissions from those who can share their memorable experiences and the tough challenges they have faced, along with detailed photos of the location served. In addition, *Sphere* seeks personal interest stories from members with unique or interesting hobbies.

Attendees of the recent 67th annual PostGraduate Assembly in Anesthesiology had the opportunity to use the first app developed for the NYSSA. Much of the credit goes to Lisa ONeill, the NYSSA staff member who maintains our online community. The app, called "NYSSA PGA 2013," is free and can be downloaded to any iOS device through Apple's App Store. With this app you can gain access to the various sessions, speakers, attendees, and exhibitors at this conference. In addition, there is information on the very first PGA, launched on December 13, 1945, along with miscellaneous data such as maps, hotels, and travel arrangements.

Below you will find the 2013 update on our social media accounts:

YouTube: 3,932 views in the last 365 days
1,084 views between July 1, 2013, and September 30, 2013
5,542 lifetime views
1,680 lifetime views for our most popular video, "Chloroform Vaporizer"

Twitter: 412 total followers
200 new followers in 2013
90 new followers since July 1, 2013

Facebook: 900 total page likes
495 page likes since January 1, 2013
153 page likes since September 7, 2013

On the public relations front, Dr. Donna-Ann Thomas continues to work with Dr. Venkata Sampathi to promote the NYSSA's presence at the New York State Fair in Syracuse, to be held August 21 to September 1, 2014. If you are interested in volunteering your time at this year's fair, please note the dates now and contact the NYSSA headquarters for more information.

If you have any additional ideas or suggestions for *Sphere*, please feel free to e-mail me at jlokmd@yahoo.com or Stuart Hayman at stuart@nyssa-pga.org. Thanks in advance for your interest and consideration. ■

68th PGA Scientific Exhibits Poster Presentations Medically Challenging Case Reports

If you are interested in submitting applications to exhibit your projects at the upcoming **68th PostGraduate Assembly in Anesthesiology — December 12-16, 2014**, please visit the NYSSA website for instructions to submit online:

Go to **www.nyssa-pga.org** and click on **PGA Meeting** (available in May).

Deadline for filing is August 15, 2014.

WE DO NOT ACCEPT PAPER SUBMISSIONS.

A Look at the 67th PostGraduate Assembly in Anesthesiology Opening Session

PGA General Chair
Dr. David Wlody

(Left to right) Christian Simon sits with Drs. Michael Simon, Margaret Pratila and Richard Beers.

Incoming President
Dr. Lawrence Epstein

ASA President Dr. Jane Fitch

Outgoing President Dr. Michael Simon presents Dr. Margaret Pratila with the Distinguished Service Award.

A jazz ensemble performs at the opening session.

R.W. Robertazzi Memorial Panel

Scientific Programs Chair
Dr. Richard Beers

Dr. Robert Lagasse and Judith Jurin Semo, J.D.

Dr. Paul Barash

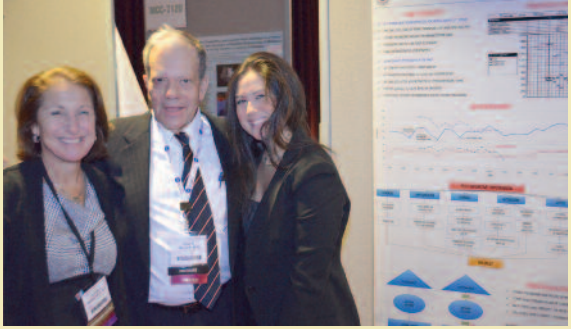
Dr. Alex Bekker

E.A. Rovenstine Memorial Lecture

Dr. David Wlody (left) presents Dr. David Chestnut with the Rovenstine award.

(Left to right) Incoming NYSSA President Dr. Lawrence Epstein, outgoing President Dr. Michael Simon, President-elect Dr. Michael Duffy, Treasurer Dr. David Bronheim, Vice President Dr. Andrew Rosenberg, Secretary Dr. Vilma Joseph, and Scientific Programs Chair Dr. Richard Beers

Poster Presentations



Dr. Audrée Bendo with Drs. Paul Barash and Sarah Herbst

Dr. Yarnell LaFortune

Drs. James Tse, Candy Anim, and Sagar Mungekar

Dr. Michael Entrup

Mr. Sergei Pisalakov and Dr. Deepa Asokan

Medical student Andrea Poon, B.S.

International Scholars Reception

International Scholars Chair Dr. Elizabeth Frost

(Left to right) Drs. Alessandra Binagui, Pinar Guner, and Nurla Monton Gimenez

A few of the 2013 international scholars

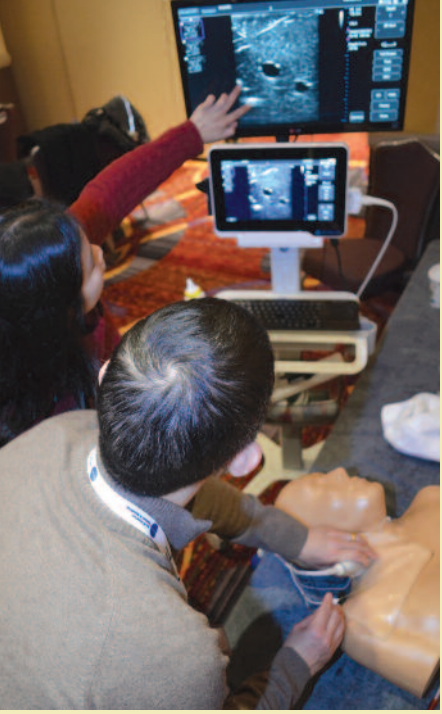
Dr. Michael Simon and Dr. Elizabeth Frost

(Left to right) Drs. Ingrid Hollinger, Nuria Monton Gimenez, and Alessandra Binagui

Dr. Lawrence Epstein

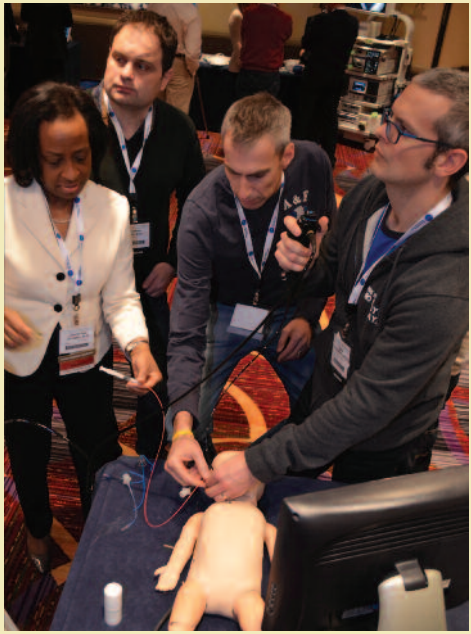
Dr. Michael Duffy

Dr. George Silvay with two of the 2013 international scholars



Workshops


Modern Anesthetic Techniques
Thoracic Operations
Tidal volume (10-12 ml/kg) should remain
same when changing from two-lung to one



Scientific Awards

(Left to right) Drs. Panchali Dhar, Harold Arkoff, Stephen Vitkun, and Rhoda Levine

(Left to right) Drs. Rhoda Levine, James Tse, Stephen Vitkun, Panchali Dhar, Trishna Upadhyay, Divina Santos, and Galina Leyvi

(Left to right) Dr. Divina Santos, Dr. Rhoda Levine, Mr. Nathan Ayoubi, B.Sc., Dr. Igor Brokin, Dr. Stephen Vitkun, Dr. Panchali Dhar, and Dr. Galina Leyvi

House of Delegates Meeting

Dr. Michael Simon

Dr. Jane Fitch

The Iona College Pipers

ASAPAC Chair Dr. Michael Richardson

ASA President-elect Dr. John Abenstein

Reference Committee Chair Dr. Steven Schulman and HOD Speaker Dr. Charles Gibbs

Drs. Michael Simon and Lawrence Epstein

HOD Vice Speaker Dr. Tracey Straker

Christian Simon and Michaela Simon

Drs. Michael Duffy and Charles Gibbs

(Left to right) Drs. Michael Simon, Michael Duffy and Vilma Joseph with NYSSA Executive Director Stuart Hayman

District 5 Director Dr. Jesus Calimlim

Dr. Nader Nader

Dr. Scott Plotkin (standing)

District 6 Director Dr. Richard Wissler

(Left to right) Mr. Robert Reid, Dr. Andrew Rosenberg, and ASA First Vice President Dr. Daniel Cole

Dr. Michael Simon and Stuart Hayman

Drs. Melinda Aquino (second from left), Matthew Wecksell, Jason Lok, and Christopher Campese

Dr. David Wlody

Dr. Jennifer MacPherson

Dr. Bruce Hammerschlag

Past President Dr. Salvatore Vitale

District 1 Director Dr. Lance Wagner

NYAPAC Meeting

(Left to right) Drs. Bruce Hammerschlag, Richard Sommer, and Salvatore Vitale

(Left to right) Drs. Vilma Joseph, Melinda Aquino, and Ingrid Hollinger

Reference Committee Meeting

Drs. Jennifer MacPherson, Melinda Aquino, Ingrid Hollinger, and Matthew Wecksell

Dr. Lawrence Epstein

Dr. Michael Simon

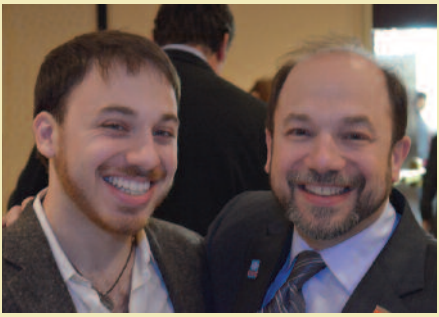
Scenes From the Speaker's Reception

From left, Drs. Lawrence Epstein, Jane Fitch and John Abenstein with congressional candidate Dr. Valerie Arkoosh and Dr. David Wlody

From left, Drs. Michael Simon, Scott Groudine, Margaret Pratila, and Vinod Malhotra

From left, Drs. Joan Asher, Melinda Aquino, Tracey Straker, and Vilma Joseph

Past President Dr. Peter Kane (left) and Dr. Lance Wagner

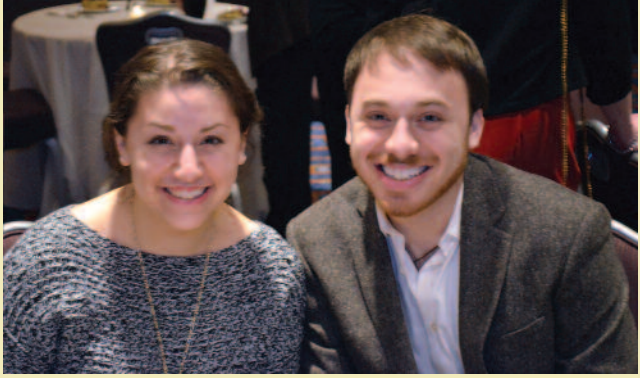


Marc Epstein and Dr. Lawrence Epstein

From left, Drs. Michael Duffy and Lawrence Epstein with ASA Director of State Affairs Jason Hansen, M.S., J.D., and ASA Vice President for Scientific Affairs Dr. Beverly Philip

Suzanne Lema and Dr. Mark Lema

Drs. Patricia Fogarty Mack and Peter Fleischut



Molly Epstein and Marc Epstein

Stuart Hayman, ASA CEO Paul Pomerantz, Nancy Beaumont, and Dr. Jane Fitch

ASA HOD Vice Speaker
Dr. Ron Harter and his family

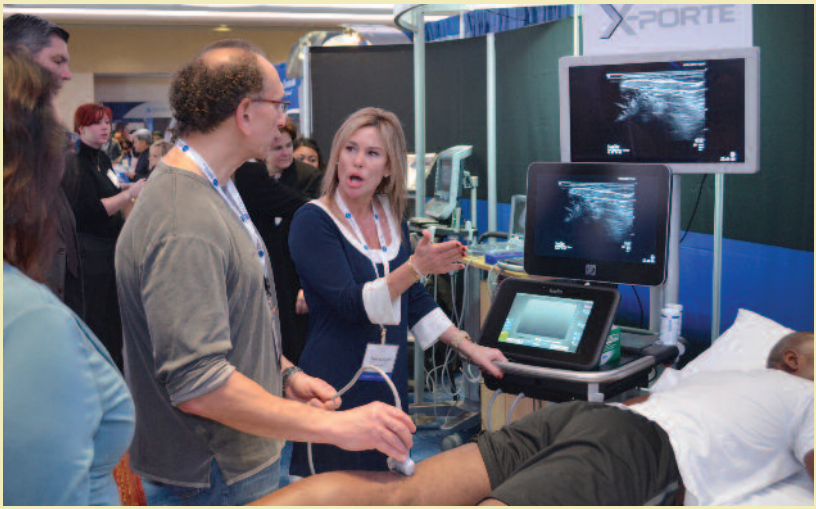
Dr. Salvatore Vitale, Dr. Beverly Philip, and Shiella Radel from Cadence Pharmaceuticals

Michael Schoppmann, Esq., and Doris Szalados

Dr. Michael Simon, Gail Simon, Erica Epstein, and Dr. Lawrence Epstein

Dr. Salvatore Vitale, Dr. Rose Berkun, Stuart Hayman, and Dr. Jana Janco

Technical Exhibits

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Technical Exhibit Reception

Scenes From the President's Reception

Dr. Michael Simon

The Simon Family

ASA Director for West Virginia
Dr. Robert Johnstone (left) and
Dr. Michael Richardson

Dr. Lawrence Epstein, Erica Epstein,
Gail Simon, and Dr. Michael Simon

MSSNY President-elect
Dr. Andrew Klineman (left) and
Michael Schoppmann, Esq.

Drs. Maris and Andrew Rosenberg, Dr. Santhanam Suresh, and ASA Chief Program Officer Chris Wehking, CMP

Andrew London, Dr. Kathleen O'Leary, Stuart Hayman, and Dr. Donna-Ann Thomas

Gail Simon, Dr. Michael Simon, Dr. Scott Groudine, and Susan Groudine

Noela Klineman, Dr. Andrew Klineman, Gail Simon, and Dr. Michael Simon

Gail Simon, Dr. Michael Simon, Sandra Abenstein, and Dr. John Abenstein

Gail Simon, Dr. Michael Simon, Dr. Michael Duffy, and Susan Duffy

Drs. Jane Fitch, Donna-Ann Thomas, and Audrée Bendo

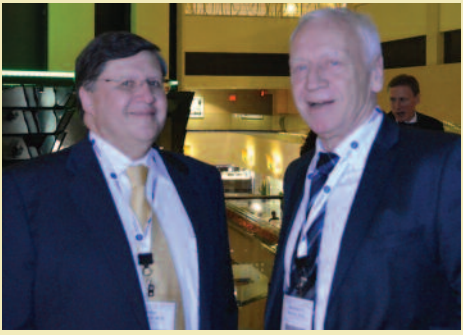
Dr. Cynthia Lien with her husband, Dan Brinzac

Dr. Peter Kane with Gail Simon and Dr. Michael Simon

Nancy Beaumont, Paul Pomerantz, and Georgia Society of Anesthesiologists Executive Director Jet Toney

From left, Drs. Michael Jakubowski, Mark Lema, and Kevin Roberts

Dr. Elizabeth Frost and her son, Neil



CSA President Dr. Peter Sybert (left) and ESA President Professor Dr. Eberhard Kochs

Dr. Michael Duffy, Dr. Nader Nader, and Faranack Nader

Suzanne Campese, Gail Simon, Dr. Michael Simon, and Dr. Christopher Campese

Dr. Audrée Bendo (second from left) and her husband, Steven Kramberg, with Dr. Michael Simon and Gail Simon

John Fitch, Gail Simon, Dr. Michael Simon, and Dr. Jane Fitch

Plans are already underway for the 68th annual PostGraduate Assembly in Anesthesiology.

Don't miss PGA 68: Dec. 12-16, 2014. Register at: www.nyssa-pga.org

HOSPITAL FOR
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BEST PRACTICES IN ANESTHESIA FOR ORTHOPAEDIC SURGERY

Sponsored by Hospital for Special Surgery Office of Continuing Medical Education

SATURDAY, MAY 3, 2014 • 8AM – 5PM

FACULTY
Hospital for Special Surgery Department of Anesthesiology

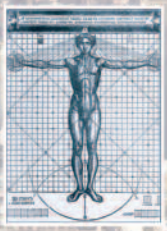
LOCATION
The Graduate Center, City University of New York
365 Fifth Avenue, New York City

PROGRAM HIGHLIGHTS
- Caring for Orthopaedic Patients in 2014 and Beyond
- Effective Strategies for Preoperative Evaluation of the Complex Orthopaedic Patient
- Managing an Acute Pain Service in the Orthopaedic Setting
- Innovations in Ultrasound for Orthopaedics
  - New Technologies
  - New Applications
  - Introduction to Hands-on Focused Assessed Transthoracic Echocardiography Exam (FATE)

REGISTRATION
Go to **www.hss.edu/cme** for more information and to register.

A discounted registration fee is offered to Members of the New York State Society of Anesthesiologists.

FOR ADDITIONAL PROGRAM INFORMATION, PLEASE CONTACT
Mary J. Hargett
Administrative Director, Education
Department of Anesthesiology
Phone: 212.606.1793
Email: hargettm@hss.edu



Hospital for Special Surgery is an affiliate of NewYork-Presbyterian Healthcare System and Weill Cornell Medical College.

The International Scholars Program

ELIZABETH A. M. FROST, M.D.

PGA 67 marked the 21st anniversary of the PGA International Scholars Program, a unique program that has afforded the NYSSA tremendous admiration as a society and provided the organization much publicity overseas. It has also helped the NYSSA cement lasting relationships.

For PGA 67, international scholars were selected from a list of 28 applicants. Of the 26 invited scholars, 24 attended, representing 18 countries. Reasons for nonattendance included lack of finances during war (Damascus), and the inability to get time off work. Five participants came from locations that were not previously represented, including Bangladesh, the Netherlands, Nicaragua, Nigeria, and Tenerife.

Scholars, all of whom are recommended by senior anesthesiologists in the United States or overseas, receive different financial awards, determined by their individual applications (a rigorous process), ranging from free registration to shared hotel accommodations and some meals, workshop and mini-workshop attendance, all of which are reimbursed after arrival. Airfare was not awarded again this year, although some of the mentors did provide airport transportation costs. Scholars are invited to present posters, and several did. The program is used as an award at the European anesthesia meeting (free registration).

After an International Welcome Reception on Friday evening, attended by several officers of the PGA and the NYSSA, Dr. Archana Mane from Albany Medical College accompanied some of the attendees to a symposium-sponsored dinner at the Marriott Marquis. She then took them on a walking tour of the Rockefeller Center Christmas tree and other New York City festivities. Dr. Ram Roth invited others to join his family for a Shabbat dinner at his home, introducing them to the intricacies of the New York subway system. The next day, scholars were invited to attend the House of Delegates meeting and many took advantage of learning a little more about the functions of the NYSSA.

On the final day of the meeting, there was a farewell breakfast. This event was again spectacular in that many pharmaceutical companies donated large amounts of equipment (mostly airway devices) and publishers gave dozens of textbooks, contributions that were enormously appreciated. Following the breakfast, many scholars took the opportunity to accompany Dr. George Silvay on a visit to Mount Sinai Medical Center.

Several of the attendees have written to the NYSSA in the last two weeks emphasizing the overall knowledge they gained and how they will use that knowledge in their home countries. They also spoke about the friendships they formed. These letters are on file at NYSSA headquarters.

Since the inception of this program, we have helped 304 scholars from 58 countries attend the PGA. Special thanks go to the NYSSA and to those members who have made financial contributions to this undertaking. Debbie DiRago should also be commended for her excellent coordination and solutions to what are often quite difficult situations.

Funding for the program, which is a tax-deductible contribution, is made through the Anesthesia Foundation of New York (AFNY). The Foundation awards scholarships and grants to enhance the training and education of the most enthusiastic, dedicated and committed anesthesiologists working in the developing world. Please help us continue this important endeavor by sending contributions to:

AFNY
c/o NYSSA
110 East 40th Street, Suite 300
New York, NY 10016

The Committee for International Scholars
Chairs: Elizabeth A. M. Frost, M.D., and Paul L. Goldiner, M.D.
Cheryl Gooden, M.D.
Vinod Malhotra, M.D.
Archana Mane, M.D.
Irene Osborn, M.D.
George Silvay, M.D. ■

The 2013 international scholars pose for a picture with NYSSA volunteers.

John Doe v. Guthrie Clinic: A Warning That Employees Need to Be Trained Regarding Confidentiality of Patient Information

DONALD R. MOY, ESQ., AND MICHAEL J. SCHOPPMANN, ESQ.

The United States Court of Appeals for the Second Circuit certified the following question for the consideration of the New York State Court of Appeals: "Whether, under New York law, the common law right of action for breach of the fiduciary duty of confidentiality for the unauthorized disclosure of medical information may run directly against medical corporations, even when the employee responsible for the breach is not a physician and acts outside of the scope of her employment."

In a decision issued by the New York State Court of Appeals on January 9, 2014, the Court, by a 6-1 vote, answered the question in the negative.

Background

Doe's claims arise from an incident at the Clinic in July 2010. Doe was at the Clinic to be treated for a sexually transmitted disease (STD). A nurse employed at the Clinic, having nothing to do with Doe's care, recognized Doe as the boyfriend of her sister-in-law. The nurse accessed Doe's medical records and learned that he was being treated for the STD. While Doe was still awaiting treatment, the nurse sent text messages to her sister-in-law discussing Doe's STD and medical condition. After Doe learned about the text messages and complained to the Clinic, the Clinic fired the nurse, and sent Doe a letter confirming that his confidential information had been improperly accessed and disclosed, and that appropriate disciplinary action had been taken.

Doe brought a diversity action in the United States District Court, Western District of New York. In the complaint, Doe asserted causes of action for common law breach of fiduciary duty to maintain confidentiality and numerous other causes of action alleging negligent hiring and training of the nurse. The U.S. District Court granted the Clinic's motion to dismiss all of Doe's claims. The Second Circuit affirmed the dismissal of Doe's claims except for the claim based upon breach of fiduciary duty, reserving this claim to be addressed by the New York State Court of Appeals. In its decision, the Second Circuit found that the nurse's actions were not foreseeable to the Clinic, and that her actions were not within the scope of her employment.[1]

Ruling of the New York State Court of Appeals

Citing an earlier ruling,[2] the Court held that, generally, a hospital or medical corporation may be held vicariously liable for the wrongful acts of its employees. However, under the doctrine of respondent superior, an employer

may be vicariously liable for the tortious acts of its employees only if those acts were committed in furtherance of the employer's business and within the scope of employment.[3] Thus, stated the Court, a medical corporation is generally not liable for the tort of an employee when such action is not within the scope of employment.

The Court concluded that a medical corporation's duty of safekeeping a patient's confidential medical information is limited to those risks that are reasonably foreseeable and to actions within the scope of employment.

Employer May Be Liable for Negligent Hiring or Supervision

The Court warned that even in cases where an injured plaintiff's claim for breach of fiduciary duty fails because the employee is acting outside the scope of employment, the plaintiff can sue the medical corporation for its own conduct for claims based upon negligent hiring or supervision, or similar claims. The court held that a medical corporation may be liable in tort for failing to establish adequate policies and procedures to safeguard the confidentiality of patient information or to train employees to properly discharge their duties under such policies and procedures. These potential claims should provide the incentive to medical practices to put in place appropriate safeguards to ensure protection of confidential patient information, stated the Court. However, since these claims had previously been addressed by the federal courts, the Court of Appeals did not address them.

Conclusion

While the New York State Court of Appeals answered the certified question in the negative, the Court's ruling should serve as a strong reminder that medical practices must develop and enforce policies and procedures to safeguard confidentiality of patient information. Employees must be appropriately trained regarding such policies and procedures and must understand that violation of policies and procedures is cause for disciplinary employment action. ■

Kern Augustine Conroy & Schoppmann, P.C., is General Counsel to the NYSSA and is solely devoted to the representation of healthcare professionals. The firm has offices in New York, New Jersey, Florida, Pennsylvania and Illinois and can be found on the Web at www.drlaw.com. Mr. Moy and/or Mr. Schoppmann may be contacted at 800-445-0954 or via e-mail at dmoy@drlaw.com and/or mschoppmann@drlaw.com.

CITATIONS

1. John Doe v. Guthrie Clinic, 710 F.3d 492 (U.S. Court of Appeals, 2d Cir. 2013).
2. Hill v. St. Clare's Hospital, 67 N.Y. 2d 72 (1986).
3. N.X. v. Cabrini Medical Center, 97 N.Y. 2d 247 (2002).

App Review

Virtual Practice With the TEE: An iPad App Review

MARK JENSEN, M.D.

Application Name: TEE Standard Views

Cost: $4.99

Developer: Toronto General Hospital, Department of Anesthesia and Pain Management

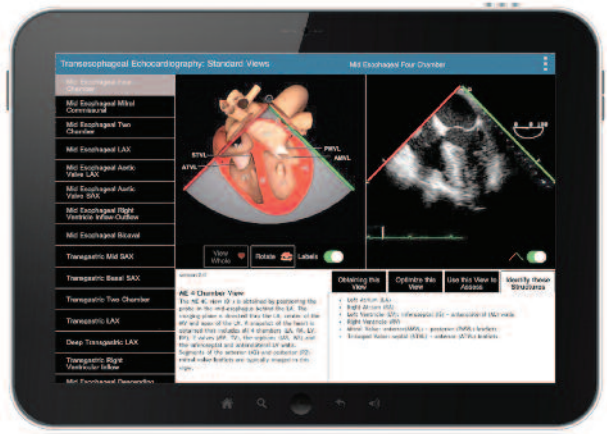


Image from *TEE Standard Views*, courtesy of Toronto General Hospital Department of Anesthesia and Pain Management, January 2014.

Review: What makes this app useful is its elegant layout: It displays a rotatable 3D model of the heart alongside a corresponding TEE clip. There is also a button that adds labels to structures within the heart and positions the heart in the same field as the TEE. This intuitive design makes it easy to see the approach of a particular view as well as how the valves, vessels, and wall motion interplay. In short, it makes learning a breeze.

All 20 standard TEE views are included in the program, and it is easy to navigate from one to the next. Once a particular view is selected, there are tabs that show the user how to achieve that view during a case, what the view can assess, and which structures the user should identify before moving on.

Bottom Line: This app is a smart way to become familiar with normal TEE views. It is a great value and an excellent teaching tool. It would be better if it had examples of pathology seen on TEE or allowed the user to move the probe in real time with a corresponding view. Nevertheless, this app is fun to use and provides an easy way to learn.

Download TEE Standard Views from the Apple App Store or at http://pie.med.utoronto.ca/tee/. ■

Mark Jensen, M.D., is a CA-1 resident at SUNY Downstate.

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The 2014 Legislative Session

CHARLES J. ASSINI, JR., ESQ.

The 2014 legislative session is now underway. In accordance with our governance structure, an overview of the 2014 agendas for the Government and Legal Affairs Committee (GLAC) and Economic Affairs Committee (EAC) of the New York State Society of Anesthesiologists, Inc. (NYSSA) took place at the PostGraduate Assembly (PGA) in December 2013. The 2014 legislative session will be another challenging one since our agendas are ambitious, the issues are complex, and some issues are rapidly changing both on a state and national level. For example, the opt-out development occurring in Colorado — in particular, the court challenge interposed by the Colorado Society of Anesthesiologists (CSA) over the governor's opt-out decision — provides an interesting insight into the arguments advanced by the American Association of Nurse Anesthetists (AANA) to secure independent practice rights for nurse anesthetists (please see the end of this article for an update).

The purpose of this article is to provide a brief overview of the components of the NYSSA's advocacy program, the key legislative initiatives for 2014, and the CSA court challenge with respect to the opt-out issue.

There are four essential components to the NYSSA's governmental advocacy program:

1. Collaborating with NYSSA leadership.
2. Seeking input and assistance from GLAC and EAC members.
3. Maintaining our relationship with the American Society of Anesthesiologists' Advocacy Office in Washington (ASA-AO), the Medical Society of the State of New York (MSSNY), and medical specialty societies.
4. Promoting NYSSA members' continued involvement in governmental affairs.

1. Collaborating with NYSSA leadership. The legislative initiatives undertaken on behalf of the NYSSA membership are done collaboratively

with the oversight, input, and involvement of the NYSSA leadership, including, in particular, Dr. Larry Epstein, president; Dr. Mike Duffy, president-elect; Dr. Michael Simon, immediate past president; Dr. David Wlody, GLAC chair; Dr. Scott Plotkin, GLAC vice chair; Dr. Alan Strobel, EAC chair; Dr. Steven Schwalbe, EAC vice chair; Stuart Hayman, M.S., executive director; Bob Reid, Shauneen McNally, and Marcy Savage (of Reid, McNally & Savage, LLC), NYSSA's Albany lobbyists; and me, as legislative counsel.

2. Seeking input and assistance from GLAC and EAC members. The members appointed by Dr. Epstein to serve on the GLAC and EAC provide strong input, suggestions, and assistance in promoting their agendas. Dr. Epstein and his predecessors have done an excellent job of recruiting members who serve on the GLAC and EAC with great distinction and bring a wide range of skills, experience, and talent to these committees. This approach allows your "advocacy team" to be more effective in enhancing and promoting NYSSA's governmental affairs goals and objectives because of the input and expertise the GLAC and EAC members provide throughout the year.

3. Maintaining our relationship with ASA-AO, MSSNY, and medical specialty societies. Another critical component of our success in advancing the NYSSA's governmental affairs agenda is continuing our strong relationship with the ASA's Advocacy Office in Washington, MSSNY, and the medical specialty societies. These relationships are maintained and improved by the tireless efforts of our NYSSA leadership. NYSSA's relationship with these organizations will be particularly important in advocating for two legislative initiatives that have been established as priorities: "Out-of-Network" (OON) legislation and the Healthcare Professional Transparency Act (badge bill).

Out-of-Network S2551 (Hannon)/A7253 (Montesano)

Legislation was introduced for the second year in a row (S2551 Hannon/A7253 Montesano) to regulate billing, reimbursement and consumer disclosure for healthcare services provided to patients by "out-of-network" (OON) healthcare providers who do not participate in a patient's health insurance plan.

The bill defines usual, customary and reasonable (UCR) fees as those fees in the 80th percentile of all charges for health services performed by a provider in the same or similar specialty and provided in the same geographic area as reported by FAIR Health. Insurers that provide coverage for out-of-network services

are required to provide significant coverage of the UCR for out-of-network services. Insurers that provide coverage for out-of-network services are required to offer at least one policy or contract option in each geographical region covered that provides coverage for at least 80 percent of the UCR cost of out-of-network services after imposition of a deductible.

In addition, the bill establishes an independent dispute resolution process for a healthcare plan or patient who alleges that a physician charged an "excessive fee" for emergency services. "Excessive fee" is defined as greater than the UCR.

A health plan may not submit a dispute for review unless it has fully paid the physician's fee, except for the patient's co-payment, coinsurance or deductible for the services rendered. If the independent dispute resolution entity determines that the fee charged is excessive, the entity shall determine a reasonable fee for the services that shall not be less than the UCR. The determination made is binding on the healthcare plan, physician and patient and is admissible in any court proceedings between the parties or any administrative proceedings between the state and the physician.

In 2013, the OON bill passed the Senate and died in the Insurance Committee in the Assembly.

Healthcare Professional Transparency Act (Badge Bill)

Sen. Joseph Griffo and Assemblyman Al Stirpe introduced legislation this year to ensure that healthcare professionals have appropriate identification in one-on-one interactions with patients and in their advertisements to the public. The legislation was first proposed by then NYSSA President-elect Lawrence Epstein, M.D., at the MSSNY House of Delegates. The bill would specifically:

— require a healthcare practitioner providing healthcare services in this state to conspicuously post and affirmatively communicate the practitioner's specific licensure as defined under this section, which specifies that this shall consist of the following: (1) the healthcare practitioner shall wear a photo identification name tag during all patient encounters that shall include (i) the employee's name; (ii) large bold lettering that specifies the type of license held by the practitioner; and (iii) the expiration date of the license. The name tag shall be of sufficient size and be worn in a conspicuous manner so as to be visible and

apparent; and (2) the healthcare practitioner shall display in his or her office a writing that clearly identifies the type of license held by the healthcare practitioner. The writing shall be of sufficient size so as to be visible and apparent to all current and prospective patients; and

— prohibit a physician from holding oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the advertisement states the full name of the certifying board and the board either: is a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or requires successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for that training field and further successful completion of examination in the specialty or subspecialty certified.

The bill was opposed by the American Board of Physician Specialties (ABPS), which caused confusion and concern from members of the Assembly and subsequently the Senate prior to the end of the session.

In the Senate, the bill was discharged from the Higher Education Committee to the Rules Committee and was subsequently voted out of the Rules Committee to the Senate floor. There was no vote taken on the Senate floor. In the Assembly, the bill remains in the Higher Education Committee. We need to continue to educate legislators on this initiative.

In addition, our NYSSA delegate to MSSNY (Dr. Steven Schwalbe) will be presenting a resolution at the annual MSSNY meeting in February to seek their support of legislation to be introduced this legislative session that would "decouple" the no-fault fee schedule from the workers' compensation fee schedule in order to allow New York state physicians to bill no-fault recipients the physicians' usual and customary rates. MSSNY's support is critical to advance this legislative initiative. The reason this legislation is necessary is to address the inadequacy of the no-fault fee schedule, which has been tied to the workers' compensation fee schedule since 1977. The workers' compensation anesthesia conversion factor is one of the lowest in the nation, and there is a large disparity in the no-

fault fees between New York state and other states that have adopted no-fault because of the linkage with the workers' compensation fee schedule.

4. Promoting NYSSA members' continued involvement in governmental affairs. As you have heard time and time again, all politics are local. We have developed different approaches to keep you informed and to facilitate your participation in the governmental process. In short, one of the most important components of our advocacy approach is promoting the individual member's continued involvement in the governmental process, and one of the best opportunities the NYSSA presents for your participation in this process is the annual Legislative Day in Albany, to be held this year on Tuesday, May 20, 2014. We provide an overview of the key legislative proposals we will be presenting to lawmakers, guidance on how to interact with your lawmakers (and staff), handouts (e.g., memorandum in support, memorandum in opposition), and legislative appointments made on your behalf. Contact your district director if you are interested in attending this year's event.

There is one NYSSA member who illustrates how taking the initiative to meet with local lawmakers can make a difference in promoting the NYSSA's agenda: Dr. Rose Berkun. Dr. Berkun, District 7 director, is tireless in her efforts to attend her local legislators' events, makes visits to legislators' local offices, attends our annual Legislative Day in Albany, and participates in meetings with government officials. As a result of her efforts, the lawmakers in her district express a willingness to sponsor or co-sponsor bills that the NYSSA supports and to reach out to the legislative leadership on the NYSSA's behalf should the need arise. Additionally, Dr. Berkun has hosted fundraisers for the New York Anesthesiologists Political Action Committee (NYAPAC) at her home and dedicates at least one district meeting to discuss legislative issues. Dr. Berkun reviews our legislative materials thoroughly so that she fully understands the issues. This makes her a great communicator when meeting with her legislators. I would like to personally thank Dr. Berkun for her advocacy efforts.

There are many members like Dr. Berkun who put their time, energy, and effort into advancing our initiatives. I can guarantee you that these efforts make a difference. Please consider attending our annual Legislative Day in Albany on Tuesday, May 20, 2014.

Another avenue to consider if you wish to stay informed about legislative developments is to attend your NYSSA district meeting when your district director invites Bob Reid, Shauneen McNally, Marcy Savage, Stuart Hayman,

and me to participate. We have found these sessions to be constructive and helpful. Please also note that when we need your immediate assistance with respect to the sudden movement of a bill through the Legislature (typically at the end of the session), Stuart Hayman has implemented a Capwiz notification program. This allows our members to be alerted about an emerging legislative initiate and offers a brief letter that you can forward to your lawmaker. If you have any questions, comments, or suggestions on ways we can keep you better informed or involved, please let me know.

Update on Colorado Opt-Out

The Colorado Society of Anesthesiologists (CSA) has now filed its opening brief with the Colorado Supreme Court on its appeal of the Colorado opt-out. In essence, the appeal centers on the issue of whether the Court of Appeals erred in its finding (i.e., upholding the opt-out) that certified registered nurse anesthetists (CRNAs) who administer anesthesia are conducting independent nursing functions within the scope, role, and population focus (i.e., rural hospitals) that the nursing board approved for them; that they are not conducting delegated medical functions and, therefore, do not require physician supervision.

Although the arguments advanced by the American Association of Nurse Anesthetists (AANA) to support the governor of Colorado's opt-out decision were put forth by the AANA's skilled team of appellate attorneys in an adversarial court proceeding, it would be shortsighted not to anticipate that these arguments will be presented to our lawmakers and state government regulators as well. Clearly, then, we need to be prepared to address some of the AANA's arguments. Please note that the following represents excerpts from the Brief of *Amici Curiae* American Association of Nurse Anesthetists and American Nurses Association (ANA) dated January 6, 2014, Case No. 12 SC 671.

I believe that you will understand the arguments without the necessity of reading the entire AANA/ANA Brief, the ASA/AMA Brief, and/or the other court documents. However, if you would like to obtain copies of the court documents (well over 500 pages), please feel free to contact me.

Page 12:

> [T]he FTC's [Federal Trade Commission's] comment letters affirm the national trend towards recognizing the propriety and importance of permitting non-physician healthcare practitioners to provide services to the full extent of their education and training. For CRNAs, this means providing anesthesia services within the full scope of practice and removing unnecessary restrictions on that

practice — including physician supervision requirements — which are not necessary for patient safety. Instead, as acknowledged by the FTC, restrictions on CRNAs' abilities to practice to the full extent of their education and training have an adverse effect on access to quality health care services and, inevitably, decreased competition leads to higher costs.

Page 14:

Contrary to the AMA and ASA's assertion, then, there is no "national standard favoring physician supervision of nurse anesthetists." (AMA/ASA Br. 8.) In fact, the federal regulatory agencies that have spoken publicly on non-physician scope of practice issues have affirmed that the national trend is ***contrary*** to the position presented by the AMA and ASA. The national trend is evidenced by CMS' [Centers for Medicare & Medicaid Services] relaxing of its regulations, the continuing trend towards states opting out, and the positions of the FTC and the IOM [Institute of Medicine]. Allowing CRNAs to perform anesthesia services to the full extent of their education and training is the logical result of recognizing that CRNAs are trained as independent anesthesia providers. The national trend reflects that it is in patients' best interests for [s]tates to support regulations which allow APNs and CRNAs to practice to the full extent of their education and training, thereby promoting increased access to quality care.

Page 18:

First, studies confirm that CRNAs provide safe, effective anesthesia services and that patients are not at risk when CRNAs are permitted to provide anesthesia services to the full extent of their scope of practice, regardless of physician supervision. There is no evidentiary support for any of the AMA and ASA's positions to the contrary. Second, CRNAs receive significant education and training in the administration of anesthesia and they are trained to be independent practitioners. Indeed, nowhere do the AMA and ASA claim that CRNAs do not receive the necessary training to administer anesthesia. Third, nurse anesthesia practice is cost-effective.

Page 27:

The additional education highlighted by the AMA and ASA is not required anywhere as a precondition for CRNAs to administer anesthesia because it is not necessary to the safe administration of anesthesia. Indeed, and importantly, the AMA and ASA have not

actually asserted that CRNAs do not receive sufficient training to safely administer anesthesia. The hundreds of thousands of anesthetics safely administered by CRNAs every year would immediately refute any such claim. By focusing on immaterial educational differences, the AMA and ASA hope to draw attention away from the more relevant issue: the fact that there are no discernible differences in patient outcomes when anesthesia is administered by anesthesiologists compared to CRNAs.

Please note that the NYSSA advocacy team will continue to monitor the Colorado court case and we will strive to be prepared to address arguments that may be advanced as a result of the AANA's advocacy efforts. ■

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Case Report

Venous Air Embolism During Non-Posterior Fossa Neurosurgery

NICHOLAS JOHN BREMER, M.D., AND JOHN ARD, M.D.
DEPARTMENT OF ANESTHESIOLOGY, DIVISION OF NEUROANESTHESIOLOGY,
NYU LANGONE MEDICAL CENTER, NEW YORK, NEW YORK

Case Summary

A 57-year-old female with treatment-refractory epilepsy was scheduled for bilateral stereotactic craniotomy, burr holes, and subdural electrode grid placement for invasive monitoring, lateralization, and localization of potential epileptogenic foci. General anesthesia was induced and the patient was positioned in a modified flattened beach chair position, per the surgeon's request. Elevation of the head above the heart was approximately 10 cm. A precordial Doppler probe was placed at the parasternal border at the level of the fourth rib for early detection of venous air embolism, with heart tones obtained and positive testing for air with agitated saline. General anesthesia was maintained with infusions of remifentanil, dexmedetomedine, 0.5 MAC sevoflurane and paralysis, and 1,500 cc of normal saline were given during the early stages of the procedure in order to avoid hypotension. Mild hyperventilation ($EtCO_2$ = 30) was maintained to facilitate exposure. After approximately four hours of surgery, a sudden 10 cmH_20 (33-23) drop in $EtCO_2$ was noted along with a drop in mean arterial pressure from 84 to 59. However, no abnormal sounds were noted from the precordial Doppler. At this time, the neurosurgeon was notified; he compressed the jugular veins and flooded the surgical field with saline, the bed was placed in Trendelenburg position, a 500 cc bolus of normal saline was given for hemodynamic support, and an ABG was obtained. The $EtCO_2$ began to rise to baseline levels within two minutes, and the ABG demonstrated a pCO_2 of 48, an increase from the baseline level of 36, consistent with our clinical suspicion of venous air embolism. The patient was hemodynamically stable throughout. The remainder of the surgery was conducted uneventfully with the patient in Trendelenburg position. In the PACU, a portable chest x-ray was normal, the pCO_2 had returned to baseline, and the patient had no cardiac or pulmonary complaints. The postoperative neurologic examination was unchanged, indicating that no paradoxical embolization had occurred. The patient has shown no sequelae from the event.

Discussion

Our practice incorporates prevention and early detection of venous air embolism, and rapid treatment should this complication occur. The current standard of care for detection of venous air embolism includes use of precordial Doppler and end-tidal carbon dioxide analysis.[1] Notwithstanding the high sensitivity of the Doppler monitor for detection of VAE (potentially it can detect 0.25 mL of air),[2] there was no change in heart sounds; the lack of detection could be the result of preoperative misplacement of the precordial probe, displacement of the probe intraoperatively, or that the embolism was small and incapable of producing a significant signal. Perhaps the use of a more sensitive TEE could have detected this event.[3]

Treatment classically includes flooding the surgical field with saline, compression of the jugular veins, Trendelenburg position, and aspiration of the central line, if present. If nitrous oxide is being used, it should be discontinued.[4] In our case, with respect to aspiration of the central line, there was a preoperative discussion of the risk of venous air embolism and a joint decision was made between the anesthesiologists and the neurosurgeons that central venous catheterization was unnecessary, given the low risk of life-threatening venous air embolism; the patient was not actually in a sitting position but in a flattened beach chair position in which the surgical field was only 10 cm above the heart, this was not a posterior fossa surgery, and predicted EBL was under 100 cc since only burr holes were made. From experience, even in massive venous air embolism situations, the utility of aspiration from the central line, the placement of which poses risks itself, is unclear, as it often does not return any air at all.

In summary, at-risk patients for venous air embolism can be managed safely using a variety of techniques, so long as the practice incorporates prevention and early detection. ■

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Anesthesia Residency, Part I

DIVINA J. SANTOS, M.D., UNIVERSITY OF MINNESOTA CLASS OF 1978

"Watch the front teeth!"
Learned laryngoscopy with blade from Wisconsin
The hardest laryngoscope to learn with
Cumbersome, unwieldy like the barrel of a gun
Poor muscle relaxation from gallamine

"If you can intubate with this, you can intubate anyone!"
We mastered art of blind nasal intubation in lieu of fiberscope
Securing airway without paralysis, sharing airway with surgeon.
Reusable rubber mask and endotracheal tube
A dream decades away: LMA, fastrac, glidescope.

Blood pressure taken for rise and fall of antecubital pulse
A trained finger on temporal artery or monitoring pupillary size
Electrocardiography a 3-lead affair viewed through six-inch oscilloscope
One ear for heart and breath sounds, swallows and sighs
Another for everyone else.

"You are not sticking any needle in my back, no you're not!"
In mid-1970s most patients feared regional anesthesia
Alternative was mask anesthesia for hours without headstrap.
Eager medical student taught laryngoscopy under deeper anesthesia
After all, seeing vocal cords is next best thing to being there.

"Doctor, when you tell him about anesthesia,
Can you avoid saying you will put him to sleep?
We recently put our dog to sleep."
Mother of a 6-year-old warned me at the door
I shall tell him about general anesthesia; will this do?

Ten-year-old for jejunoileal bypass
To reduce lipids before advent of statins
Father died of massive heart attack at 35
To allay her fears, a "dry run":
She chose strawberry flavored face mask.

continued on page 70

Elderly Englishman came for hip operation
Too miserable to wait
Two years under socialized medicine.
Asking if I would use chloroform, I teased
We have not used chloroform since Queen Victoria!

Trials, tribulations, tensions, hard feelings
Inherent to residency from diverse backgrounds
Not always seeing eye to eye
I arranged journal clubs, travelogues
Picnics at attending's home.

Specialties labeled with ingredients, flag of country
Fruits, vegetables, nuts and cheese for the timid.
Attending provided beverages, plates, cutlery
Parlor games, pool, piano, phonograph, playground.
Playing, singing, dancing

We realized the softer, more human side
Serious at work yet capable of relaxation and fun
A lesson in geography and acculturation
More similar than different
Fewer sorrows and tears.

Divina J. Santos, M.D., is an obstetrical anesthesiologist at Montefiore Medical Center, Wakefield Division.

Anesthesia Care: Are Your Practices Safe?

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