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SPHERE

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The SUNY Downstate Main Campus in Brooklyn, New York.

Photo courtesy of John Zubrovich.

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President's Message

Promoting Patient Safety

MICHAEL P. DUFFY, M.D.

I recently had the opportunity to visit Yosemite National Park, where the trails reminded me of our own Adirondack Preserve. This spring, a consumer magazine named Letchworth State Park the number one state park in the nation. We are truly fortunate to have such wonderful trails, lakes, shorelines, forests and preserves set aside by our predecessors, who worked with our government to secure these treasures for future generations.

In recognition of the present and future impact of government regulations and legislation, the NYSSA has been active on your behalf and on behalf of all citizens of New York though our legislative efforts. Our first success was the New York law banning "surprise bills" by out-of-network providers, which went into effect on April Fools' Day this year (coincidence?). The law helps our patients by making insurance plans responsible for communicating their benefits clearly, as well as reducing the stress of surprise bills for anesthesia services. The NYSSA disseminated several alerts on this issue and I hope all anesthesiologists were able to meet the new disclosure requirements for this law. No, it is not a perfect law, but they never are. The NYSSA worked hard to help craft the new protections for our anesthesiologists to help resolve billing disputes with health insurance plans while pegging claims to the FAIR Health database, which is far more favorable to physicians. The NYSSA will continue to monitor the dispute resolution process as regulations are refined.

Behind the scenes, the NYSSA worked very hard to promote our interests (i.e., safe anesthesia services and patient safety) with two separate government initiatives: One effort was led by the Department of Health's Office of Quality and Patient Safety and another was included in the governor's budget bill and was being debated by the New York state Legislature. On one front, the NYSSA's efforts included offering our insights into and experiences with office-based surgery. With short notice, Past President Dr. Larry Epstein, Dr. Rose Berkun, and Dr. Rebecca Twersky, along with too many NYSSA leaders to name, were able to craft

an impressive presentation and offer testimony to the subcommittee debating office-based surgery. On the second front, our members worked for several weeks to educate legislators about the unintended expansion of practice included in the budget's language as well as the need for genuine oversight and patient safety measures. We learned we were making good progress when Dr. Berkun and I were actively sought out by several members of the New York Senate leadership for our insights and opinions on office-based surgery during the MSSNY lobby day. While our legislative efforts were not completely successful, we were able to stop several measures relating to expansion of scope while promoting patient safety and physician oversight in the office surgery setting.

In addition, we continue to actively promote anesthesia assistant (AA) licensure in New York. AAs now can practice in 15 states as well as in VA hospitals in all states. California and Texas have pending legislation promoting AA licensure as well. The New York Academy of Anesthesiologist Assistants, Inc., an organization of AAs with ties to New York, has approached us about affiliating with the NYSSA. As non-voting, educational members, the AAs would require active NYSSA physician member sponsorship and all AAs would be required to be members in good standing of the ASA. This inclusion would allow us to share our NYSSA resources, including newsletters, practice alerts, and educational opportunities such as the PGA, as well as to collaborate on political issues. My hope is that this will provide a roadmap for inclusion of all anesthesia care providers under the physician-led care team model. I hope we can embrace this new AA organization within the NYSSA as a fraternal partnership.

One final legislative note: I want to thank all the NYSSA members who take the time out of their busy lives to come to Albany to advocate for our specialty. We are an organization of volunteers, so all our members who donate their precious free time should be applauded. We must also recognize the colleagues of those who attend who must cover the ORs in the attendee's absence. This enthusiasm makes our NYSSA lobby day in May so successful. It remains the primary vehicle we have to reach out to our legislators face to face. The number of legislators we talk with each year who do not have a clear idea of what anesthesia care is never ceases to amaze me. Most, however, are receptive to our concerns for our

patients' safety and we must continue to actively lobby to preserve physician-led anesthesia care.

Switching political gears, some good news is that we have a very strong upcoming field of potential NYSSA candidates for ASA leadership positions. We are working hard to garner resources for our upcoming political activities. Hopefully, we can promote our own New York candidates as the ASA campaign season begins. Just as important, it appears that the ASA election cycle now kicks off at the PGA, as all ASA candidates now feel the need to launch their candidacies there. We will again welcome the entire ASA leadership at this upcoming PGA. This highlights the growing prestige the PGA has in the national anesthesiology community. All NYSSA members should take pride in the tradition and success that is our PGA.

One final comment I will offer: Like many members, I become frustrated with the political process and what I perceive as the wheeling and dealing that takes place, all in the name of compromise. I fully understand that no matter how hard we try, we will never save a giant sequoia tree or have a park named after the NYSSA. However, I do believe that together we can advance patient safety and physician-led anesthesia care and that is enough of a legacy for me.

Happy trails. ■

69th PGA Scientific Exhibits Poster Presentations Medically Challenging Case Reports

If you are interested in submitting applications to exhibit your projects at the upcoming **69th PostGraduate Assembly in Anesthesiology — December 11-15, 2015**, 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, 2015.

WE DO NOT ACCEPT PAPER SUBMISSIONS.

Distinguished Service Award

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 Kathleen A. O'Leary, M.D., at NYSSA headquarters before July 15, 2015.

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

Kathleen A. O'Leary, M.D., Chair
NYSSA Judicial and Awards Committee

Editorial

What's in a Name?

JASON LOK, M.D.

"… that which we call a rose
By any other name would smell as sweet. …"
William Shakespeare, *Romeo and Juliet*, Act II, Scene II

As Juliet famously says to Romeo, the names of people or things do not define who or what they really are. Or do they?

Recently there has been renewed interest in changing the name of our specialty from "anesthesiology" to "anesthesiology and perioperative medicine." In particular, Dr. Zeev N. Kain has an editorial in *Anesthesiology* (Vol. 122, June 2015) regarding this proposed name change. The goal of this change would be to better identify our role in the perioperative surgical home model. This would impact the perception of our surgical colleagues and hospital administrators, since we do not just "put someone to sleep." Nonetheless, would the term "anesthesiology and perioperative medicine" alienate those who solely practice critical care or pain medicine? Would the new name be more cumbersome for and intimidating to the general public?

Rather than choosing between two names, I recommend keeping "anesthesiology" but adding a tagline underneath such as "Leader in Perioperative Medicine, Critical Care, and Pain Medicine." The decision regarding any possible name change should be data driven, like our recent acceptance of the term "physician anesthesiologist." This decision must be made thoughtfully while understanding its impact on such groups as policymakers, hospital administrators, and the general public.

Entrance to the Wood Library-Museum of Anesthesiology

Perhaps the name should only be changed at the departmental level.

This was one of several issues addressed during the ASA Committee on Communications meeting, held in April at the new ASA headquarters in Schaumburg, Illinois. The building is modern and spacious, incorporating the Wood Library-Museum of Anesthesiology. I took a photo of a bookshelf containing several years of our NYSSA House of Delegates manuals and PGA program books. I recommend visiting the ASA's new headquarters if you are ever in Chicago.

Visitors to the Wood Library-Museum of Anesthesiology will find shelves of NYSSA programs and manuals.

If you have not checked out our Facebook page yet, please browse the link: **www.facebook.com/nyssapga**. With 1,351 "likes," you can connect with members who have similar interests. Alternatively, our LinkedIn page can be "followed." Currently, we have 144 followers. Go to **www.linkedin.com/company/new-york-state-society-of-anesthesiologists**.

Don't forget to check out **www.nyssa-pga.org** to download this issue of *Sphere* along with other past issues since summer 2009. We welcome your feedback, whether favorable or not, along with any additional ideas or suggestions for *Sphere*. Correspondence should be directed to me at jlokmd@yahoo.com or Stuart Hayman at stuart@nyssa-pga.org. Thanks in advance for your interest and consideration. ■

From the Executive Director

Our Success Is Because of You

STUART A. HAYMAN, M.S.

During my nearly three decades in association management, I have heard multiple variations of the following quote: "Five percent of the members do 100 percent of the organization's work." While I have no doubt that this statement may accurately reflect the way many professional associations truly operate, I take pride in the fact that this is not the case with the New York State Society of Anesthesiologists.

In order to have a vibrant and influential professional association, you must have a collection of motivated volunteers. The NYSSA is one of the strongest medical associations in New York state, and one of the premier medical associations in the world. I don't make this statement simply to boast. Thanks to the PGA, the NYSSA has gained a global reputation for having one of the largest and most specialty-relevant annual medical education conferences in the world. This is indisputably attributable to the association's volunteers. The NYSSA also has a strong and respected voice when it comes to medical legislation and regulations in New York state. In addition, NYSSA leaders are frequently approached by other associations seeking advice on management, education and strategy. The NYSSA's history of successful activism can be attributed to the high level of involvement and support of dedicated members.

Professional associations are categorized as local, state, regional, national or international. Clearly, the influence and prestige of the association correlates with its size and the scope of its reach. An international organization would usually be considered at the top of the sphere of influence. The NYSSA is an extremely unique state association in that its educational sphere of influence is that of an international association (a state association that successfully operates on an international stage). The NYSSA's PGA is the third-largest annual anesthesia conference in the world. In fact, I am proud to say that the organization's educational efforts enhance patient safety and physician education worldwide. The NYSSA sponsors between 15 and 25 international scholars at the PGA

each year and between 25 percent and 30 percent of the paying professional attendees represent the international community.

The NYSSA's PGA is managed by nine committees that are comprised of 120 volunteers. Committee members work all year long to make this event successful. They actually start planning for the next PGA during the wrap-up meeting on the final day of the current PGA. These volunteers take pride in their work and donate countless hours to ensure that the PGA maintains the highest quality education.

The NYSSA's leadership consists of the Executive Committee, the Board of Directors, district officers, delegates to the House of Delegates, and delegates to the ASA's House of Delegates. Those leadership positions are filled by 299 volunteers from the NYSSA membership. These individuals competently and proudly represent the NYSSA's members and their specialty, as well as the organization itself, in many ways. Unlike many other organizations, however, they are far from the only members contributing to the success and the reputation of the NYSSA.

The NYSSA also has 12 standing committees that are comprised of 316 additional active volunteers. These members consider matters pertaining to the organization's bylaws and procedures, and work to address challenges that impact all anesthesiologists, including patient safety, legal practice issues, political and economic issues, and so much more. They advise their colleagues and NYSSA staff on topics that are pertinent and timely.

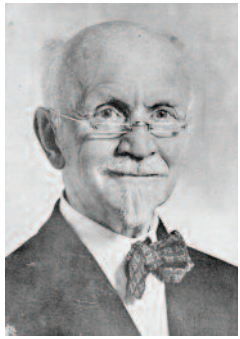
In any given year, there are approximately 735 volunteers working to accomplish the NYSSA's mission and goals. That is almost one-third of the association's active membership. I believe this is a tremendous testament to the dedication and commitment that all NYSSA members have to the specialty of anesthesia and to this organization.

It has been an honor to be at the administrative helm of such a prestigious organization for the last six-plus years. I will continue to work hard to guide and support the invaluable contributions of all the NYSSA's volunteers and to help ensure that the NYSSA maintains its status and reputation, both nationally and internationally, as one of the world's premier medical associations. ■

Downstate Medical Center: A Unique Training Experience

MARK JENSEN, M.D.

What comes to mind when you think about Brooklyn? Maybe it's a Jay-Z concert or a Nets game, or maybe it's riding the Cyclone on a summer night in Coney Island. It might be the Brooklyn Bridge, brownstone row houses, traffic lights, cars, horns, or hipster coffee shops. But whatever Brooklyn brings to mind, you are probably not thinking about anesthesiology. Maybe you should be.



Adolph Frederick Erdmann, M.D.

Believe it or not, Brooklyn was home to the first anesthesiology professional society in the United States. In 1905, Dr. Adolph Erdmann invited all physicians with an interest in anesthesia to a meeting at Long Island College Hospital (LICH) in Brooklyn's Cobble Hill neighborhood. The group met in the Polhemus Building at LICH and formed the Long Island Society of Anesthetists. The goal of the society was "To promote the art and science of anesthetics," and membership dues were set at $1 per year.[1]

As word of the new society spread, physician anesthetists from Manhattan and the other boroughs began attending the meetings in Brooklyn. These members soon represented a majority, so, in 1911, the group voted to broaden its name to the "New York Society of Anesthetists" (NYSA). As time went on, the organization began receiving membership requests from across the country and began to consider becoming a national society. In 1936 the name changed again — this time to the "American Society of Anesthetists." The term "anesthetists" was replaced by "anesthesiologists" in 1945 and the modern-day ASA was born. It all started in Brooklyn.

Brooklyn has also been the training ground for more anesthesiologists than many entire states. If Brooklyn were an independent city — as it was until 1898 — it would be the fourth largest in the U.S., behind only Chicago, Los Angeles, and New York.[2] The anesthesiology residency programs here are also among the biggest and oldest in the country.

A poster advertises the need for donations to build the main campus in Flatbush.

LICH opened in 1858 and admitted its first medical students two years later. Among the founding faculty was Dr. Austin Flint — best remembered for demonstrating the usefulness of the stethoscope in diagnosing heart and lung disease.[3,4] Dr. Flint delivered the first commencement address in the summer of 1860.[4] From the beginning, the curriculum combined classroom instruction with bedside teaching. While it may seem standard today, this curriculum was revolutionary for its time because bedside instruction had never been tried before in the United States.

LICH continued contributing to science and medicine well into the 20th century. Achievements from this era include the synthesis of the diphtheria anti-toxin, the first microdissection of an individual nephron, and Professor Alexander Skene's identification of two mucus-secreting glands at the base of the female urethra.[4,5,6] Dr. Skene recognized these glands as a source of infection in many of his patients. Today this structure is known as "Skene's gland," and there is a bust honoring Dr. Skene in Brooklyn's Grand Army Plaza.[4]

LICH served the people of Brooklyn during this period and became part of the landscape of the broader United States. Brooklyn experienced a population explosion after the Civil War — starting with approximately 400,000 residents in the 1860s and booming to more than one million in 1900.[7] Doctors at LICH found themselves treating freed slaves as well as immigrants from Ireland and other European countries. When the hospital on Ellis Island burned down in the 1890s, all immigrants arriving in the Port of New York went to LICH for screening and treatment. As polio became an epidemic in 1916, doctors at LICH created one of the nation's

President Eisenhower speaks at the opening of SUNY Downstate.

largest units for treating the disease, and LICH personnel served with distinction overseas during both world wars.

After World War II, times were changing in Brooklyn. The population was booming with soldiers coming home and new waves of immigrants, and it was obvious that Long Island College of Medicine had outgrown its campus in Cobble Hill. In 1950, the college merged with the State University of New York (SUNY) system to become SUNY College of Medicine at New York City, later to be known as SUNY Downstate Medical Center. The University bought some land in central Brooklyn's Flatbush neighborhood and in 1954 President Dwight Eisenhower laid the cornerstone for the Basic Sciences Building. Construction also began on a second teaching hospital in Flatbush and in 1966 University Hospital of Brooklyn opened its doors.[4]

The anesthesia landscape in Brooklyn was changing quickly too. In the years immediately after World War II, there were only three residency programs in the borough: Jewish Hospital of Brooklyn, Maimonides Hospital, and St. Catherine's Hospital. Anesthesia at LICH remained less advanced and did not include a formal anesthesia training program. Cautery and ether were used together, and OR staff wore rubber-soled buckskins to prevent fires. Difficult intubations were the responsibility of the surgical resident, and the anesthesiology instruction of medical students consisted of only two lectures on pulmonary complications of anesthesia and their management.[8]

James Cottrell, M.D.

Audrée Bendo, M.D.

David Wlody, M.D.

In 1952, Dr. Merel H. Harmel became the founding chairman of anesthesia at SUNY Downstate and began recruiting residents and faculty to the department. He instituted case conferences and mortality reviews and attracted visiting professors to create a vibrant academic environment. Dr. Harmel also started a continuing education program for all anesthesiologists in New York City.[8]

In 1968, Dr. Harmel moved to the Midwest to help start the Department of Anesthesia at the University of Chicago, and Dr. Benton King became SUNY Downstate's second chairman. Dr. King guided the department through the 1970s and was a pioneer in the development of the modern ventilator and disconnect alarm.[7] In 1979, Dr. James Cottrell, a noted neuroanesthesiologist at NYU, came to Brooklyn as Downstate's third chairman, a position he holds to this day. In 1988, Dr. Cottrell founded the *Journal of Neurosurgical Anesthesiology* and he was elected president of the ASA in 2003. He also received the ASA's Distinguished Service Award in 2007, and presented the Rovenstine Lecture at the ASA's annual meeting in the fall of that year.

Leadership of the residency program at Downstate has also been exceptionally stable. Dr. Audrée Bendo, who completed her residency and neuroanesthesia fellowship at Downstate, became program director in 1988; until she stepped down from her position in January 2014, her 25 years of service were the longest of any residency program director in the country. Dr. Bendo was chair of the ASA annual meeting in San Francisco in 2013 and is very active in the NYSSA. She currently serves as the department's executive vice chair.

The new program director at Downstate is Dr. David Wlody. Dr. Wlody is a Brooklyn native and has been director of OB anesthesia since 1988. He was president of the Society of Obstetric Anesthesia and Perinatology in

2006 and helped develop the current ASA practice guidelines for OB anesthesia. Dr. Wlody currently serves as general chair of the PGA.

Dr. Wlody works closely with Dr. Constance Hill, the director of medical student education at Downstate. A two-week anesthesiology clerkship is required for every student to graduate. Med students get hands-on experience with each phase of an operation and present a case at the end of the term for their final grades. The clerkship is popular, and many students request a fourth year elective to gain additional experience. In 2015, 11 percent of Downstate's graduating class chose a career in anesthesia.

Rebecca Twersky, M.D.

Along with education, Downstate is deeply committed to research, and there are many basic science and clinical research faculty in the department. Until this spring, the vice chair for research was Dr. Rebecca Twersky. While Dr. Twersky recently became the chief of anesthesia at Josie Robertson Surgery Center at Memorial Sloan Kettering Cancer Center, her contributions to Downstate deserve recognition. She has been involved in anesthesia professional societies for

Lenox Road entrance to University Hospital

more than 15 years and has served both as ASA meeting chair in 2006 and PGA general program chair in 2007-2009. She is also the past president of the Society for Ambulatory Anesthesia (SAMBA) and the recipient of its Distinguished Service Award. This award came, in part, from her development of a standardized ambulatory anesthesia curriculum that is now SAMBA's standard for all residencies in the United States. Dr. Twersky also served as director of SUNY Downstate's Institutional Review Board.

Downstate's Department of Anesthesiology serves the people of Brooklyn in four unique clinical settings: University Hospital of Brooklyn, Kings County Hospital Center, Lutheran Hospital, and the Ambulatory Surgery Center at Downstate Bay Ridge. The University Hospital of Brooklyn (UHB) is located in the Flatbush neighborhood in the central part of the borough and it is the hub of the department's research, conferences, and guest lectures. Many patients are recent immigrants from economically underprivileged parts of the world, so they have had limited access to healthcare and present with significant comorbidities. The majority of patients at Downstate are ASA physical status III and IV.

Diabetes is endemic to this patient population, but it often has an atypical presentation. In the mid-1990s, doctors at Downstate noticed that middle-aged patients would come to the emergency room with

King's County Hospital seen from Clarkson Avenue

diabetic ketoacidosis (DKA), so they assumed it was a delayed onset of type I diabetes. But as more data came in, it became clear that this "Flatbush diabetes" did not fit neatly into either the "type 1" or "type 2" category. These patients were type 2 diabetics with DKA. Downstate treats hundreds of cases of this variant form of diabetes each year.[9]

UHB is the only academic hospital serving Brooklyn's 2.5 million residents, so the operating room is a busy place. There are between 40 and 50 cases scheduled each day, and cardiac, pediatric, and transplant surgeries are all routine. Downstate has one of the largest and most active renal transplant programs in New York, with three to four kidney transplants per month. Patients recuperate in a new unit on the building's 8th floor that is entirely dedicated to transplants.

Across the street from UHB is Kings County Hospital Center (KCHC), which is known for being Brooklyn's largest hospital as well as being the first Level 1 Trauma Center in the United States. The Trauma Service at KCHC remains robust, with more than 250 injured patients each month, and offers Brooklyn's only pediatric trauma team.[10] The president of the medical board at KCHC and medical director of perioperative services is Dr. Michael Mendeszoon, a proud alumnus of SUNY Downstate's anesthesiology residency program.

The Lutheran Hospital Emergency Department as seen from 2nd Avenue

When on call at KCHC, it is not uncommon to see victims of gunshot wounds, stabbings, blunt trauma, and burns. Many of these patients have blood or vomit in their airway and have to be rushed to the OR immediately after an endotracheal tube has been secured. Downstate residents work in this rough-and-tumble environment early in their PGY-1 year while rotating through the trauma bay and then again during their clinical anesthesia training. The clinical experience at KCHC was noticed by the U.S. military during the Iraq War, and today it is one of the training sites for battlefield medics before they are deployed.[11] This might be why police officer Herman Yan was quoted in *The New York Times* saying, "If I get shot, don't bring me anywhere else. Bring me to Kings County."[12]

Lutheran Hospital is across town in Brooklyn's Sunset Park neighborhood, and it is another clinical site for Downstate's residents and attendings. This spring, Lutheran entered a partnership with New York University Langone Medical Center and is now known as "NYU Lutheran." The area is changing too; the old industrial buildings on 2nd and 3rd avenues have been converted into art studios and family apartments, and Sunset Park is becoming an increasingly popular place to live.

Recent immigration has made Sunset Park extremely diverse with the development of New York City's largest Chinatown, Brooklyn's "Little Latin America," and a significant Russian population. Lutheran has adapted to its new multicultural setting by creating Brooklyn's only 100 percent Chinese-speaking unit and by hiring many bilingual staff. Anesthesiology residents and attendings who speak foreign languages are very helpful in this high-volume setting.

Like KCHC, Lutheran has received notice for its interesting cases. The ABC documentary "NY Med" began filming in Manhattan at Weill Cornell Medical Center but ultimately came to Lutheran for interesting content to fill the eight-part series.[13]

Lutheran is also where Downstate residents get much of their regional anesthesia training. Dr. David Seligsohn became director of regional anesthesia at Lutheran in 2013, and he advocates for regional techniques whenever clinically indicated. His efforts have paid off, as the number of regional blocks performed by residents has increased significantly. Today it is not uncommon for residents to perform blocks in the holding area and in the PACU throughout the day. The clinical director at Lutheran is Dr. Lance Wagner, known to the NYSSA as director of District 1.

Downstate also provides ambulatory anesthesia at an outpatient facility in Bay Ridge in south Brooklyn. The Ambulatory Surgery Center at Downstate Bay Ridge (ASC) has six ORs as well as on-site lab services, and can accommodate orthopedic, ophthalmic, gastroenterological, pediatric, ob/gyn, urologic, plastic, and general surgery cases.[14] As with any ambulatory center, the goal at the ASC is to maintain patient safety while offering a convenient alternative to a hospital setting. Downstate staff members evaluate patients on-site to see if they are good candidates for ambulatory surgery.

The ASC has grown into a busy place, with 20 to 30 cases scheduled each weekday; in addition to patient care, the staff focuses on fast room turnover times and short postoperative stays. Downstate residents enter this fast-paced environment with the need to learn techniques that will provide good anesthesia but not cause a delayed emergence or prevent discharge from the recovery room. Many graduates of Downstate's residency program have said that this experience sharpened their skills, helped them score highly on the boards, and made them ready for life in private practice.

Brooklyn is a dynamic, diverse, and exciting place, and the life of an anesthesiologist here is no exception. Between the trauma calls at Kings County, the multicultural population at Lutheran, and the extremely complex patients cared for at University Hospital, the anesthesia program at SUNY Downstate has tapped into Brooklyn's energy and diversity to create a truly unique training experience. It's not always easy to practice here, but many Downstate graduates say that after four years in Brooklyn, they feel prepared to practice anywhere in the world. If you can make it here, you can make it anywhere.

I think there's a song about that. ■

Mark Jensen, M.D., is a CA2 resident at SUNY Downstate.

The author wishes to thank John Zubrovich for his assistance with the photos for this article.

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The International Scholars Program

ELIZABETH A. M. FROST, M.D.

PGA 68 marked the 22nd anniversary of the International Scholars Program, a unique program that has earned the NYSSA tremendous admiration and much publicity, both at home and abroad. It has also helped the NYSSA cement lasting relationships.

For PGA 68, 22 international scholars representing 14 countries were selected from a list of 24 applicants. All those invited to the PGA were able to attend.

Scholars, all of whom are recommended by senior anesthesiologists in the United States or overseas, receive different financial awards, determined by their individual applications, ranging from free registration to shared hotel accommodations (this year at the Row NYC, the newly renovated Milford Plaza) and some meals, workshop and mini-workshop attendance. Airfare was not awarded again this year, although some departments contributed to airport transportation costs, especially if the scholars were presenting posters, which several of them did. The program is used as an award at the European Society of Anaesthesiology 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 on a walking

The 2014 international scholars pose for a picture with NYSSA volunteers.

tour of Rockefeller Center. The next day, scholars were invited to attend the House of Delegates meeting and many took advantage of the opportunity to learn 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 away 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 and Dr. Dawn Desiderio on a visit to Memorial Sloan Kettering Cancer Center. Several of the attendees have written to the NYSSA in the last few months 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 325 scholars from 59 countries attend the PGA. Many of these attendees, upon returning to their countries, have become program and residency directors, organizing specialty and board training certification. Some have even gone on to become departmental chairs and contributed to the world literature in major ways. Special thanks should be given to the NYSSA and 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 challenging situations.

Funding for the International Scholars Program, which is a tax-deductible contribution, is provided through the Anesthesiology Foundation of New York (AFNY) and by donations from the NYSSA and the Icahn School of Medicine at Mount Sinai. 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 Three-Year M.D. Program at NYU: The Fast Track to Residency

SAMIR KENDALE, M.D., JUSTIN FEIT, JOAN CANGIARELLA, M.D., ANDREW ROSENBERG, M.D., MICHAEL WAJDA M.D., AND JUNG T. KIM, M.D.

The New York University (NYU) School of Medicine has pioneered a new three-year M.D. program in which medical school training is accelerated and completed in three years as opposed to the traditional four.[1] Applicants are first accepted to the medical school and then enter a subsequent application process for the accelerated program. As part of the three-year program, students declare a specialty area of interest and are offered conditional acceptance to a residency program at the medical center through participation in the National Resident Matching Program (NRMP).[1] This innovative shift in the educational process promotes early collaboration with future colleagues, and, as Abramson et al. point out in a *New England Journal of Medicine* article devoted to this topic, saves time, lessens debt and creates a new bridge between undergraduate and graduate medical education.[1]

As the graduate medical education process, including residency and fellowship programs, has lengthened, and the average age of medical school students has increased, an accelerated program may be appealing as a means to progress more rapidly through the education process and into the workforce. The benefits of such a program include reduced overall cost by eliminating a year of tuition, as well as the more intangible advantages of becoming integrated within the medical system with access to research opportunities and mentorship within the department of choice. Such a pathway seems particularly suited for older applicants who may have some background in the medical field as EMTs, PAs, or RNs, and have already developed the maturity and experience to decide their future specialty. It is also appealing to applicants who may have had early exposure to a specific specialty and have already decided upon their career choice.

Due to the limited number of available residency spots within some specialty areas at NYU, the program's application process is competitive. Students do need to maintain strong academic performance throughout medical school to remain in the program, and meet regularly with various

advisors to address any academic issues and ensure that they are maintaining pace with coursework.

There is currently one student, Justin Feit, who is part of the accelerated three-year M.D. program and will be conditionally joining the NYU anesthesiology residency program upon completion of his medical school training. Justin discovered the program while interviewing for medical school at NYU, and appreciated not only the benefits of saving both time and money, but also avoiding the stress associated with the residency match and interview process by applying to the three-year track.

Justin's father is an anesthesiologist and Justin was exposed to the field at an early age. As he began making decisions about his future career, including choosing to apply to medical school, he had the good fortune to be able to ask his father more expansive questions regarding the specialty of anesthesiology. He also had the opportunity to participate in research for two years within the Department of Anesthesiology at Columbia University, where he gained greater familiarity with both the clinical and research aspects of anesthesiology. Armed with these experiences, and with a desire to remain in New York City close to family and friends, Justin was confident in applying to the NYU three-year M.D. program.

The core curriculum between the three-year and the four-year M.D. programs at NYU is identical. For the three-year program, training begins six weeks earlier than for the four-year program. The fourth year of medical school training, typically devoted to elective specialty rotations and time to interview for residency positions, is simply eliminated. Even though he is still a year away from clinical rotations, Justin suspects that the transition to clerkships will not be dissimilar from that of his classmates. Because of this, he has felt no isolation from his classmates, either academically or socially.

All of the other practical and tangible advantages aside, what Justin values most is the early integration into the NYU Department of Anesthesiology. He regularly attends Grand Rounds, problem-based learning and improvement conferences, and spends clinical time with the department, allowing him to begin to understand the many varied aspects of being an anesthesiologist very early in his training. This also allows him to interact with resident and attending members of the

department on a consistent basis, becoming comfortable in the company of his future colleagues.

The three-year M.D. program at NYU offers students a chance to jump-start their careers, save both time and money, and, perhaps most importantly, join the physician community that they will be part of for the rest of their careers. Because the program is still in its infancy, it remains to be seen how students will fare as their education and careers progress, but it is a start to finding new ways to influence and develop the physician leaders of tomorrow. ■

Samir Kendale, M.D., Andrew Rosenberg, M.D., Michael Wajda, M.D., and Jung T. Kim, M.D., are anesthesiologists at NYU Langone Medical Center. Joan Cangiarella, M.D., is a pathologist at NYU Langone Medical Center. Justin Feit is a medical student at NYU School of Medicine.

REFERENCE

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Joseph P. Giffin Wall of Distinction Award

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 Kathleen A. O'Leary, M.D., at NYSSA headquarters before July 15, 2015.

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

Kathleen A. O'Leary, M.D., Chair
NYSSA Judicial and Awards Committee

Supreme Court Affirms Ruling on State Board Actions

DONALD R. MOY, ESQ.

In a 6-3 decision, in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*,[1] the United States Supreme Court affirmed a ruling by the Federal Trade Commission (FTC) that the North Carolina State Board of Dental Examiners ("State Board") engaged in anticompetitive and unfair competition in violation of the Federal Trade Commission Act when it engaged in acts to exclude non-dentist teeth whitening services in North Carolina. The Supreme Court held that because a controlling number of State Board members were practicing dentists, and, thus, "active market participants" in the occupation that the State Board regulates, the State Board could invoke state action immunity only if it was subject to active supervision of the state, which the Court held was not met in this case. The question that is raised by *North Carolina State Board of Dental Examiners* is whether physicians, dentists and other healthcare professionals should be concerned that service in a state professional board could potentially expose the individual to FTC action.

The North Carolina State Board of Dental Examiners is the agency that regulates the practice of dentistry. The State Board's principal duty is to create, administer and enforce a licensing system for dentists. The Board also has the authority to promulgate rules and regulations governing the practice of dentistry, provided such rules are not inconsistent with statutes and are approved by the North Carolina Rules Review Commission, whose members are appointed by the state legislature. With respect to non-dentists, the Board's authority is restricted to filing suit to enjoin unlicensed persons from unlawfully practicing dentistry. Under North Carolina law, six of the State Board's eight members are required to be licensed dentists engaged in the active practice of dentistry. The seventh member is required to be a licensed and practicing dental hygienist and the final member is required to be a "consumer." The dentist members of the State Board are elected by other licensed dentists in North Carolina.

Beginning about 2003, non-dentists started to engage in teeth whitening services. Many dentists in North Carolina complained to the State Board about possible harm caused by non-dentists providing teeth whitening services and about the lower prices charged by non-dentists for these services. Beginning about 2006, the Board issued at least 47 cease and desist letters on its official letterhead to non-dentist teeth whitening service providers, warning that the unlicensed practice of dentistry was a crime, and stating that teeth

whitening constituted the practice of dentistry. The North Carolina Dental Practice Act did not specify that teeth whitening constituted the practice of dentistry and the State Board did not issue a formal regulation on teeth whitening that would be subject to the review and approval of the Rules Review Commission. The State Board also sent letters to mall operators stating that kiosk teeth whiteners were violating the Dental Practice Act and advising the mall operators to consider expelling violators from their premises.

The FTC alleged that the actions of the State Board accomplished the intended result and non-dentists ceased offering teeth whitening services in North Carolina. The FTC alleged that the State Board's concerted action to exclude non-dentists from the market of teeth whitening services constituted an anticompetitive and unfair method of competition. The State Board moved to dismiss the FTC's complaint, alleging that as a state agency it was protected under state action immunity. An administrative law judge (ALJ) denied the State Board's motion and, after a hearing was conducted, the ALJ determined that the State Board had violated antitrust laws. The FTC ordered the State Board to stop sending cease and desist letters stating that non-dentists may not offer teeth whitening services and, further, required the State Board to issue notices to the earlier recipients of the cease and desist letters advising them of the State Board's proper sphere of authority and stating that the notice recipients had a right to seek declaratory rulings in state court as to whether teeth whitening constituted the practice of dentistry. The Court of Appeals for the Fourth Circuit affirmed the FTC.[2] The United States Supreme Court granted certiorari to review the case.

Ultimately, the Supreme Court held the actions of the Board were not protected. The Court held that in order for the Board's actions to be protected under the state action doctrine, the state regulatory process had to meet a two-part test: (1) the state must articulate a clear policy to allow the conduct and (2) the state must actively supervise the conduct. The Court held that the state, in the instant case, failed to supervise the conduct of the Board.

Application of the Supreme Court's Decision

Does the Supreme Court decision in *North Carolina State Board of Dental Examiners* have application to other states that have created state boards to regulate the health professions? Should a physician, dentist or other health professional contemplating service on a state board that regulates the profession be concerned that the Supreme Court decision could expose the licensed professional to antitrust actions? To address this question, it is necessary to ask what regulatory authority is conferred by the state to the state professional board, and, if regulatory authority is conferred to the state professional board, does the state exercise supervision over the state board's acts? For example, neither the New York State Board for Medicine nor any of the other state

boards that are appointed to advise and assist the New York State Board of Regents and the New York State Department of Education on matters of professional regulation would have the authority to unilaterally issue cease and desist letters to non-licensees, as the North Carolina State Board of Dental Examiners did. If the Board for Medicine or any other professional board in New York state believed that an individual was unlawfully engaged in the practice of a licensed profession, the board could not unilaterally issue a cease and desist order but could only alert the Department of Education and urge the department to take action.

While physicians and other licensed professionals may participate in state boards that have authority to discipline licensed health professionals, it is submitted that the state is actively involved in the discipline process to confer state action immunity. For example, in the case of professional misconduct involving physicians, a matter is not submitted to an investigation committee unless the director of the Office of Professional Medical Conduct (OPMC) determines that the matter warrants investigation.[3] If a majority of the investigation committee determines that a hearing is warranted, the director of the OPMC must concur with such determination before charges are brought against a physician.[4] Finally, the orders of the Administrative Review Board for Professional Medical Conduct or a determination of a committee for professional medical conduct are subject to judicial review under Article 78 of the Civil Practice Law and Rules.[5]

Thus, it is not believed that physicians, dentists and other healthcare professionals serving on any of the New York state boards for the professions need to be concerned with the Supreme Court's ruling in *North Carolina State Board of Dental Examiners*. To those healthcare professionals who ask why the state cannot delegate authority so that each profession can police itself without state interference or involvement, the Supreme Court's ruling explains why active state supervision is essential. ■

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 may be contacted at 800-445-0954 or via email at dmoy@drlaw.com.

NOTES

1. 135 S. Ct. 1101, February 25, 2015.
2. 717 F. 3d 359 (2013).
3. Public Health Law §230 (10)(C).
4. Public Health Law §230 (10)(D)(iv).
5. Public Health Law §230-c(5).

Senator Ranzenhofer Reception

Dr. Rose Berkun, Sen. Michael Ranzenhofer, and Dr. Scott Plotkin

MSSNY Legislative Day in Albany

Drs. Michael Duffy and Rose Berkun meet with members of Gov. Andrew Cuomo's staff.

Drs. Michael Duffy and Rose Berkun

AAAA Legislative Day in Albany

Dr. Michael Duffy (left) meets with Sen. John DeFrancisco (right) and his aide.

(Left to right) NYSSA lobbyist Bob Reid, William Paulson, Dr. Michael Duffy, and Dr. Michael Simon

(Left to right) William Paulson, Ermin Husic, Dr. Michael Duffy, Sen. John DeFrancisco, Gregg Mastropolo, and Dr. Michael Simon

(Left to right) Ermin Husic, Dr. Michael Duffy, Sen. John DeFrancisco's aide, and Sen. John DeFrancisco

MSSNY House of Delegates Saratoga, New York

(Left to right) Drs. Lawrence Routenberg, Charles Gibbs and Steven Schwalbe

Dr. Michael Duffy and Terrance Bedient

Dr. Rose Berkun

Drs. Charles Gibbs, Michael Duffy and Lawrence Routenberg

ASA Legislative Meeting Washington, D.C.

CSA Past President Dr. Peter Sybert (left) with Drs. Scott Groudine and Scott Plotkin

Dr. Michael Duffy with Drs. Paul Yost and Mark Zakowski

(Left to right) Drs. Michael Nayshtut and Scott Plotkin, an aide from Sen. John Katko's office, Dr. Michael Duffy, Stuart Hayman, and medical student Matthieu Newton.

NYSSA's delegation to the ASA legislative meeting

Dr. Michael Duffy, medical student Matthieu Newton, and Dr. Michael Nayshtut meet with an aide to Rep. Richard Hanna (second from left).

(Left to right) Drs. Michael Nayshtut, Tracey Gibson, Lee Winter, Scott Plotkin, Scott Groudine and Michael Duffy, Stuart Hayman, and Drs. Rose Berkun, Salvatore Vitale, Lawrence Epstein, Michael Simon, Jonathan Gal, Vilma Joseph, Andrew Rosenberg, Shawn Sikka and Chris Curatolo

ASA Legislative Meeting, Washington, D.C.

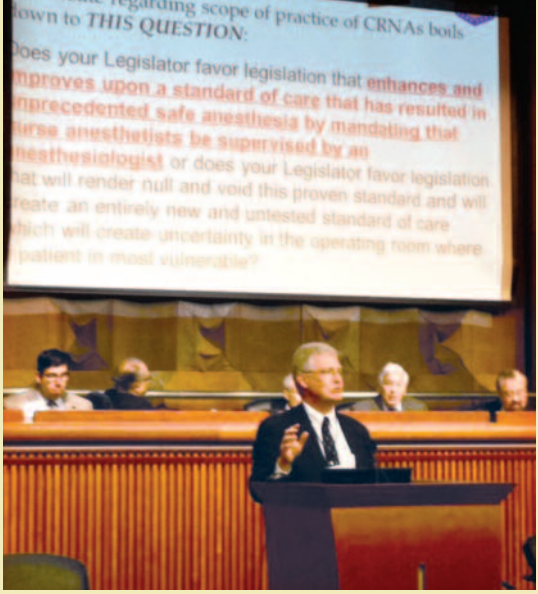
Drs. Andrew Rosenberg, Michael Nayshtut and Lawrence Epstein visit Rep. Carolyn Maloney's office

Drs. Michael Duffy, Shawn Sikka, Chris Curatolo and Jonathan Gal visit Rep. Carolyn Maloney's office

Drs. Tracey Gibson (left, front), Shawn Sikka, Vilma Joseph, Chris Curatolo and Lawrence Epstein meet with an aide from Rep. Eliot Engel's office.

Drs. Tracey Gibson, Vilma Joseph, Lawrence Epstein, Shawn Sikka, Jonathan Gal and Chris Curatolo meet with an aide from Rep. Eliot Engel's office.

New York Coalition of Specialty Care Physicians State Lobby Day in Albany



Dr. Michael Duffy

NYSSA President-elect Dr. Andrew Rosenberg (fourth from left) and members of the New York Coalition of Specialty Care Physicians meet with Assemblyman Richard N. Gottfried (sixth from left).

Dr. Michael Duffy surrounded by his Coalition colleagues

NYSSA Legislative Day in Albany

Sen. Kemp Hannon (left) with Drs. Michael Duffy and Rose Berkun

(Left to right) Drs. David Wlody, Ingrid Hollinger, Vilma Joseph and Michael Duffy in Sen. Jeff Klein's office

Sen. Joseph Griffo and Dr. Michael Duffy

Sen. Michael Venditto and Dr. Michael Duffy

Drs. Ingrid Hollinger, Vilma Joseph, Michael Duffy, and Scott Groudine meet with an aide to Sen. Jeff Klein (second from right).

Stuart Hayman, Sen. John DeFrancisco, Dr. Michael Duffy, and Dr. Michael Simon

Sen. John Flanagan and Dr. Michael Duffy

Dr. Michael Duffy

(Left to right) Dr. David Wlody, Chuck Assini, Esq., Sen. Kenneth LaValle, and Dr. Michael Duffy

From left, NYSSA lobbyist Bob Reid, Sen. Tom Croci, and Dr. Michael Duffy

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Legislative Update

CHARLES J. ASSINI, JR., ESQ.

New York State Budget Developments – Office-Based Surgery Update

Gov. Cuomo, as part of his 2015 executive budget proposal, sought to make amendments to several provisions of the public health law relative to office-based surgery and office-based anesthesia in order to strengthen provisions relating to patient safety. NYSSA leaders, working closely with Bob Reid and Shauneen McNally (the NYSSA's Albany lobbyists) and me, carefully reviewed the governor's proposal and identified provisions that we felt could actually imperil patient safety and lead to practices that far exceed the scope of the safe practice of procedures and operations for the office-based setting. NYSSA President Dr. Michael Duffy, Vice President Dr. Rose Berkun, and Executive Director Stuart Hayman joined Bob Reid, Shauneen McNally, and me in meetings with several key legislators and their staffs to convey our concerns and to request that the Senate and Assembly leadership amend the governor's proposal. Shauneen McNally prepared the following comparison of the office-based surgery center provisions in the final state budget to the governor's original proposal.

Comparison of Governor's Office-Based Surgery (OBS) Proposal to Final State Budget

The final state budget modifies the governor's original proposal as follows:

- Rejects the inclusion of podiatrists and chiropractors in the definition of office-based "licensees."
- Accepts the definition of "adverse event" to include an emergency department visit or assignment to observation services within 72 hours of the OBS. New qualifying language is added to require that the emergency room visit must be "for reasons related to the OBS encounter."
- **Rejects all references to "office-based anesthesia,"** including the proposed definitions of "office-based anesthesia," "major upper or lower extremity regional nerve blocks," and "neuraxial anesthesia."

- Rejects the requirement for practices and licensees to register with the New York State Department of Health (DOH) in order to perform OBS or office-based anesthesia.
- Accepts the requirement that licensees report adverse events and suspected transmission of a communicable disease to DOH within three (3) business days instead of one (1) business day of the event or suspected transmission.
- Accepts a requirement for licensees to report additional data such as procedural information needed for the interpretation of adverse events, **but rejects the requirement to report evaluation of patient care and quality improvement and assurance activities**.
- Rejects a limitation on OBS and office-based anesthesia to operations and procedures with an expected duration of no more than six (6) hours and expected appropriate and safe discharge within six (6) hours.
- Accepts a requirement for OBS practices to conduct quality improvement and assurance; utilize certification by an appropriate organization, hospital privileging, or equivalent methods to determine competency of practitioners to perform OBS; carry out surveys or complaint/incident investigations; and report to DOH any findings. **The bill rejects placing these requirements on office-based anesthesia**.
- Provides for confidentiality of information collected, maintained, and reported to DOH and the accrediting agencies and maintained by OBS practices under adverse event reporting, quality improvement, and quality assurance activities.

The final state budget does not include provisions contained in the Senate one-house proposal to establish an office-based surgery work group or a requirement for a facility fee to be paid to OBS centers.

Scope of Practice Update

New York State Bills 2015-2016 – Expansion of Nurse Anesthetists' Scope of Practice

The New York Association of Nurse Anesthetists (NYSANA) is once again this legislative session (2015-2016) promoting several bills aimed at securing independent practice for nurse anesthetists or significantly expanding the scope of practice of nurse anesthetists (see chart).

Bill No.	Sponsor	Purpose	Scope of Practice	Oppose/Support	Notes
A140 S3021	Paulin/ Young	Certification of CRNAs by SED. Education requirements by a national certifying body (e.g., AANA).	Fails to address scope of practice. Delegates authority to commissioner of SED to promulgate rules and regulations.	Oppose	See A3972/S2598 Gottfried/ Latimer
A3972 S2598	Gottfried/ Latimer	Certification of CRNAs issued by SED. Education requirements by a national certifying body (e.g., AANA). Program includes appropriate pharmacology component — may include ability to prescribe during perianesthetic.	Expressly provides for a CRNA to have prescriptive authority during the perianesthetic period but fails otherwise to address scope. Delegates authority to commissioner of SED to promulgate rules and regulations.	Oppose	See A140/S3021 Paulin/Young
A3941 S2048	Gottfried/ Hassell- Thompson	Certification procedures for CRNAs.	Authorizes a CRNA broad powers to administer anesthesia including the authority to prescribe; the bill will eliminate physician supervision requirements as set forth in the NYS Health Code and create instead a collaborative relationship between the CRNA and a licensed physician who may or may not be an anesthesiologist. Does not mandate that the collaborative physician be on-site but does require that a practice agreement be entered into for resolution of disputes.	Oppose	
A2363	Crouch	Mandatory health insurance coverage for independently employed CRNAs if anesthesia services are covered. Defines CRNA.	Does not establish physician supervision requirements of the CRNA in a manner consistent with workers' comp. and Medicaid reimbursement requirements. Independently employed CRNA. NYS DOH authorizing agency for CRNA.	Oppose	See S2955 Ritchie
S2955	Ritchie	Authorizes health insurance reimbursement for CRNAs.		Oppose	See A2363 Crouch

Importance of Anesthesiologists' Role in the Delivery of Safe and Cost-Effective Anesthesia Care: Refuting Myths and Setting the Record Straight

Background

The New York State Association of Nurse Anesthetists ("NYSANA") supports the enactment of legislation (S.2048/A.3941 Hassell-Thompson/Gottfried) that would eliminate the existing (and long-standing) NYS Health Department regulations that nurse anesthetists are to be supervised by an anesthesiologist or qualified surgeon.

In 2014, NYSANA commissioned the Center for Health Workforce Studies (CHWS) to perform a survey of hospitals in upstate New York. The facts and myths about the 2014 survey brief titled "Anesthesia Services Provided in Hospitals in Upstate NY" are summarized below.

FACT: The 2014 survey brief's "set of problems" is really a set of protections.[1]

— The "set of problems" presented by the CHWS survey as "barriers" to using nurse anesthetists as anesthesia providers in hospitals is really a set of protections.
  - Protection for patient safety.
  - Protection from liability.
  - Protection for the surgical team in the OR.
  - Protection for nurse anesthetists from the undesired consequence of an emergency that would stretch their bounds of education and training.

— Most, if not all, of the "barriers" suggested in the survey are ones New York anesthesiologists would agree are true, but for difference reasons:
  - *TRUE*, nurse anesthetists lack the ability to prescribe medications and to write patient treatment orders – **BECAUSE** they lack the proper medical training to safely perform this important duty.
  - *TRUE*, nurse anesthetists lack the ability to conduct patients' physical assessments – **BECAUSE** they lack the medical training to properly evaluate a patient's suitability to withstand surgery.
  - *TRUE*, nurse anesthetists are not permitted under existing New York state Medicaid rules to bill independently – **BECAUSE**

state law mandates a physician-anesthesiologist medically direct a nurse anesthetist in the administration of anesthesia. This requires the physician to be responsible for the preoperative, intraoperative, and postoperative care of the patient, a duty that requires the discipline of extensive medical training.

MYTH: *The 2014 survey brief suggested the set of problems associated with the provision of anesthesia services were barriers because nurse anesthetists are not being recognized as licensed independent anesthesia providers with a scope of practice.*

NYSANA has advanced what they have defined as the benefits of their proposal that fall within three categories: (1) cost, (2) access, and (3) improvement of quality of care. We refute their arguments as summarized below.

FACT: Anesthesia delivered by an independent nurse anesthetist does NOT cut costs.

— No third-party research has been conducted to determine whether independent practice of nurse anesthetists reduces costs.

— All of the research on this issue has been funded by nurses who have a direct economic interest in the result.

— If assessments are going to be made on the basis of cutting costs, the research should be conducted by a neutral and credible third party and not funded by an interest group.

— Medical care becomes exponentially more expensive if a patient has complications during surgery. If the nurse anesthetist cannot manage the complication, more resources will have to be pulled in to care for the patient, which costs the hospital, patient, and payer more money.

— From "Anesthesiology – First of Two Parts" by Richard A. Wiklund, M.D., and Stanley H. Rosenbaum, M.D., *The New England Journal of Medicine*, October 16, 1997, p. 1132:

> "Increasingly, anesthesiologists direct the preoperative assessment and preparation of patients for surgery with the aim of ensuring safe and efficient care while controlling costs by reducing unnecessary testing and preventable cancellations on the day of surgery. Fischer has shown that

requests for preoperative medical consultations are reduced by three quarters when the need for a consultation is determined by an anesthesiologist in a preoperative screening clinic rather than by a surgeon. Cancellations of operations due to unresolved medical or laboratory abnormalities are reduced by 88 percent, and the costs of laboratory tests are reduced by 59 percent, or $112 per patient. Unnecessary preoperative laboratory testing results in excessive healthcare and leads to excess morbidity."

MYTH: *Anesthesia delivered by an independent nurse anesthetist cuts costs.*

FACT: Anesthesia costs the same, no matter who administers it.

— Under Medicare and Medicaid, reimbursement for anesthesia services is the same whether it is administered by an anesthesiologist or a nurse anesthetist who is medically directed by an anesthesiologist or supervised by a surgeon.

— A nurse anesthetist who is supervised by a surgeon receives 100 percent of the Medicare payment. This means that a nurse anesthetist who administers anesthesia receives the same reimbursement under Medicare as an anesthesiologist who provides the anesthesia.

MYTH: *Anesthesia is cheaper when administered by a nurse.*

FACT: Nurse anesthetists are among the highest paid nurses in the industry.

— Some have argued that nurse anesthetists make less money than physicians and therefore cost the healthcare system less.

- In fact, an analysis of actual cost is complex, depending on a number of factors such as staffing ratios, number of anesthetizing locations, and amount of after-hours care.
- Depending on local circumstances, introducing nurse anesthetists may actually cost more than the physician-only delivery model.

MYTH: *Employing nurse anesthetists is cheaper than employing physician anesthesiologists, creating less of a burden on the healthcare system.*

FACT: Patients in rural areas currently have access to healthcare.

— A recent study by the NYSSA found that only one hospital in

New York state does not have an anesthesiologist on staff.

— In the absence of an anesthesiologist, the operating practitioner is present to supervise the nurse anesthetist.

— Independent practice of nurse anesthetists will not improve access to anesthesia care; for New York state rural hospitals, patients have access to appropriate anesthesia care.

MYTH: *The independent practice of nurse anesthetists will expand access to healthcare.*

FACT: Anesthesiology remains a life-or-death matter.

— Anesthesiologists have improved anesthesia safety and delivery for the benefit of their patients but risks still remain.

— There has been a decrease in anesthesia-related deaths over the past three decades:[2]

- From the 1950s through the 1970s, there were approximately **two deaths per 10,000 anesthetics**.
- Today, there is approximately **one death per 200,000 to 300,000 anesthetics**.

— Anesthesiologists have designed safer anesthesiology medicines, devices, and methodologies and preventable mishaps have declined.

— A physician applies advanced medical knowledge to diagnosing and preventing factors that contribute to complications for patients receiving anesthesia.

— According to the Agency for Healthcare Research and Quality (AHRQ), anesthesiologists prevent more than six excess deaths per 1,000 cases in which an anesthesia or surgical complication occurs.

— American Society of Anesthesiologist's ("ASA") comprehensive patient safety efforts over the past three decades were designated a "gold standard" for medical specialties in the Institute of Medicine report on patient safety, *To Err Is Human*.

— Anesthesiologists are needed to continue developing advancements in the specialty.

MYTH: *Anesthesiology is now so safe, anyone can do it!*

FACT: Nurse anesthetists receive nursing training, DOCTORS GO TO MEDICAL SCHOOL.

— Nurse anesthetists are competent to perform the technical

aspects of the administration of anesthesia, but do not have the education, skills, or training to fully manage patients, respond to medical complications, or advance the science of anesthesiology.

— Anesthesiologists have at least **eight years** of post-graduate education and training while nurse anesthetists only have **two to three years**.

- Anesthesiologists receive a college degree in pre-med, continue on to medical school, and then complete an internship and a residency. Many earn a fellowship in a subspecialty of anesthesiology.
- Nurse anesthetists obtain a college degree and then participate in a three-year anesthesia training program.
- As the aging population experiences more complex medical conditions, the demand for the anesthesiologist's skill and education will increase.

MYTH: *Nurse anesthetists and physician anesthesiologists receive the same amount of anesthesia training.*

FACT: Existing research offers limited data.

— The conclusions of the American Association of Nurse Anesthetists-funded studies — based on patient outcomes and cost analysis — are fundamentally flawed.

- These studies do not distinguish between complications resulting from surgery or anesthesia, nor do they discriminate between conditions existing prior to surgery and those resulting from surgical or anesthetic care.
- The *Health Affairs* paper reflects the weaknesses of billing data when used to make an assessment of safety and quality. These billing data were not created for this purpose and do not distinguish between complications resulting from surgery or anesthesia, nor do they discriminate between conditions existing prior to surgery and those resulting from surgical or anesthetic care. Further, one uses an insufficient number of cases to support any conclusions about mortality.

MYTH: *The research on safety is definitive.*

FACT: A vast majority of New Yorkers support physician-directed anesthesia.

— Ninety-two percent of New York state residents say they want

a physician to administer anesthesia and respond to anesthesia emergencies during surgery, according to a poll conducted by Tel Opinion Research of Alexandria, Virginia. A majority of New Yorkers also say they would not re-elect their state legislator if he or she voted to eliminate physician-directed anesthesia.
MYTH: *New Yorkers see no difference between a physician or a nurse anesthetist providing anesthesia.*

FACT: Student nurse anesthetists work under the direct personal supervision of an anesthesiologist or a nurse anesthetist.

— The New York State Health Code (Part 405.13) sets forth the standard of supervision of student nurse anesthetists. It is clear that the continuous presence of an anesthesiologist or nurse anesthetist is required.
MYTH: *Student nurse anesthetists may administer anesthesia without the direct, continuous, and personal supervision of an anesthesiologist or nurse anesthetist.*

FACT: It is not permissible for a hospital identification badge to indicate "doctor of nursing" for a nurse anesthetist.

— 8 NYCRR (Education Department) Chapter 1 Part 29 Section 29.2(a)(4) and (9) provide:

> (a) Unprofessional conduct shall also include:
>
> (4) using the word "Doctor" in offering to perform professional services without also indicating the profession in which the licensee holds a doctorate; ...
>
> (9) failing to wear an identifying badge, which shall be conspicuously displayed and legible, indicating the practitioner's name and professional title authorized pursuant to the Education Law, when practicing as an employee or operator of a hospital, clinic, group practice or multiprofessional facility, registered pharmacy, or at a commercial establishment offering health services to the public;

— It is not permissible for an identification badge to indicate a "doctor of nursing" because the Education Department does not recognize that professional title.
MYTH: *If a nurse has a Ph.D. in nursing, he/she can use the title "Dr." before his/her name on an identification badge.*

E-Prescribing Law: Effective Date Delayed for One Year

The e-prescribing law's effective date has been delayed for one year (until March 27, 2016). On March 13, 2015, Gov. Cuomo signed into law Chapter 13 of the laws of 2015, legislation that delays for one year a provision adopted in 2012 that required e-prescribing of medications beginning March 27, 2015. Sen. Kemp Hannon, the prime Senate sponsor of the bill, set forth the following justification:

> New York adopted Chapter 447 of the laws of 2012, which requires the prescribers use electronic prescribing effective two years from when the department regulations were adopted. Those regulations went into effect March 27, 2013, and thus the electronic prescription requirement in New York is set to go into effect on March 27, 2015. This bill delays the effective day to provide an additional year to March 27, 2016. Unfortunately, the federal Drug Enforcement Agency moved slowly in certifying vendors who are authorized to transmit electronic prescriptions for controlled substances. As a result, many doctors and other prescribers around the state, many of whom have electronic records and e-prescribing capability, have contracts with vendors who have not yet received the necessary federal certification. This legislation will provide additional time to facilitate a smooth and appropriate implementation of electronic prescribing in New York.

For more information, please go to the the NYSSA website at **www.nyssa-pga.org**, click on the tab *Professional & Practice Issues* and then on *Legislative/Regulatory Issues*. At the top of the page, under *New York State's Electronic Prescribing Mandate*, you will find a link to the *Department of Heath Notice: ePrescribing Mandate Effective March 27, 2016.* **http://members.nyssa-pga.org/images/nyssa/pdfs/ePrescribing_Mandate_Effective_3_27_16.pdf**. This document has helpful information and links to documents on the Department of Health's website.

Congratulations, Dr. Epstein!

Congratulations to NYSSA Immediate Past President Larry Epstein, M.D., on his appointment to the New York State Education Department, Office of the Professions, Board for Medicine! ■

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NOTES

1. From "An Informed Response" 2014, prepared by Cameron S. Brown, Consulting Services, cameronsbrown.com.
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CME corner

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Case Report

Airway Management of a Pediatric Patient With Simpson-Golabi-Behmel Syndrome

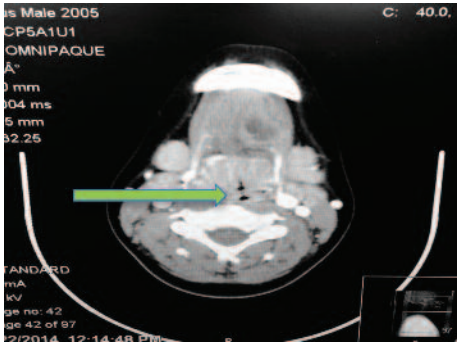
ROMAN MARGULIS, M.D., RONI MENDONCA, M.D., AND MICHAEL GIRSHIN, M.D.
DEPARTMENT OF ANESTHESIOLOGY, METROPOLITAN HOSPITAL CENTER AND WESTCHESTER MEDICAL CENTER, NEW YORK

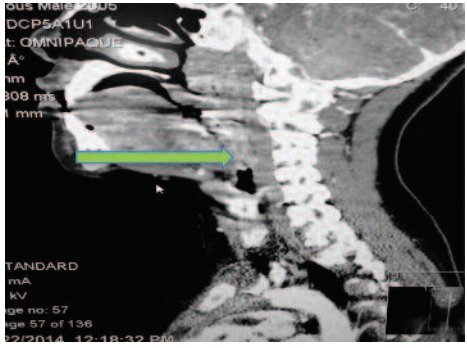
Summary

We present a case of a 9-year-old male with Simpson-Golabi-Behmel syndrome[1,2] scheduled to undergo a base of the tongue reduction. Our discussion highlights the anesthetic considerations and airway management of this rare disorder.

Case Report

A 9-year-old male with a history of Simpson-Golabi-Behmel syndrome and progressive shortness of breath was scheduled to undergo elective reduction of a mass at the base of the tongue. The patient was born at full term with normal birth weight and no detectable cardiac, pulmonary, or craniofacial anomalies. With the exception of mild developmental delay, he had an otherwise normal physical exam. Several weeks prior to the scheduled procedure he presented to an ENT physician with progressive difficulty breathing. There was no limitation to his physical activity prior to the current episode. On examination, a large tissue overgrowth was detected at the base of the tongue that was the likely etiology of his symptoms. He underwent radiological studies with the CT results presented below.





Figures 1 and 2: Arrows demonstrate significant narrowing of the supraglottic airway.

Our anesthetic management primarily focused on the safe establishment of an airway in a case where direct laryngoscopy would potentially be very difficult.[3,4] After consultation with the surgical team, it was decided that an awake fiberoptic technique was the safest course of action. A pediatric fiberoptic bronchoscope, size 5.5 oral ET tube, pediatric glidescope, and conventional airway equipment, as well as a tracheostomy, were available in the OR prior to induction.

In the holding area, 22G peripheral intravenous access was secured after application of EMLA cream for 25 minutes. While still in the holding area, we provided the patient and his family with a detailed explanation of all the necessary steps that would be taken to secure the airway while the patient was still awake. We gave the patient a tablet device that he could play with throughout the course of our management in order to distract him from the OR environment and the awake airway manipulations.

We also explained to the patient's mother her role in the OR and instructed her to remain calm and composed throughout the induction. Of note, during the time in the holding area and induction we maintained the patient in semi-sitting position with no evidence of respiratory distress, in spite of the severity of airway narrowing on the CT.

In the operating room, after routine ASA monitors were attached, the patient received glycopyrrolate, 0.2 mg IV. A 10 ml syringe with a flexible angiocath was used to intermittently administer a total of 15 cc of 2% lidocaine to the patient's tongue. Simultaneously, fentanyl (10 mcg/ml) was titrated to achieve sufficient sedation to allow the patient to tolerate awake intubation. The patient was able to maintain a conversation throughout the above events, and even to continue using the tablet device. Our sedation was guided by pulse oximetry, with a gradual reduction to a target saturation of 95% on room air from a baseline of 100%. Throughout this time, the patient received a total of 200 mcg of fentanyl in gradual, incremental doses. The fiberoptic bronchoscope was inserted through an oral airway and carefully guided through the oropharynx. Despite significant tissue overgrowth and friability, we were able to avoid any trauma to the surrounding structures and to obtain a direct view of the patient's vocal cords. An additional 3 ml of 2% lidocaine were administered through the bronchoscope, which was then guided through the vocal cords and into the trachea. The patient remained calm and focused, responding only with a mild cough. A size 5.5 ET tube was guided over the bronchoscope and into the trachea. After confirmation of position with capnography and auscultation, a conventional IV induction was carried

out. No muscle relaxant was administered. The surgery was successful, followed by uneventful extubation over a tube exchanger in the OR. Postoperatively, the patient was able to maintain his airway without difficulty and displayed immediate improvement of his respiratory symptoms.

Discussion

Simpson-Golabi-Behmel syndrome (SGBS) is characterized by pre- and postnatal somatic overgrowth, facial dysmorphism, developmental delay, and a variety of visceral and skeletal malformations.[5,6] The true prevalence is unknown and is estimated to be less than one in 200,000. The disease follows an X-linked recessive transmission pattern, with various severities depending on the individual genetic mutations involved (most commonly in the GPC3 gene). Most notably, SGBS carries an increased risk of neoplasm, usually malignant and occurring in the abdominal region — most commonly Wilms tumor and hepatoblastoma.[1] In our particular case, there was obvious concern about the etiology of the tongue mass and whether it might also represent a neoplastic manifestation.

Although there are many sedation techniques for awake fiberoptic intubation, it is well known that a combination of drugs can result in synergistic or antagonistic effects.[7] To eliminate these effects, we decided to use fentanyl as a single agent to provide sedation. The rationale for this technique is the ease of reversibility of a narcotic-only approach with naloxone. The avoidance of benzodiazepines reduces pharmacodynamic interactions between different classes of drugs, thus minimizing adverse effects such as respiratory depression.[8] In regard to airway topicalization, we found the slow administration of 2% lidocaine over the tongue, with gargling and gradual swallowing of the solution, the most easily applicable, painless, and comfortable approach for our patient.

We would like to emphasize the value of preoperative discussion with the patient and the family in order to establish realistic expectations of the future steps of anesthesia induction, including awake intubation. Lastly, the value of distraction for pediatric patients during induction has been reviewed extensively; in our experience, a tablet device provided an opportunity for age-appropriate distraction that worked especially well.

The primary purpose of our case report is to bring particular attention to the management of difficult pediatric and adolescent airways, as well as to bring light to an extremely rare genetic disorder. As evidenced by the NAP4 study, there is a clear association between underutilization of fiberoptic bronchoscopy for the difficult airway and adverse outcomes.[9] While it still

remains the gold standard, the role of fiberoptic bronchoscopy has been somewhat modified due to the advent of modern airway devices such as the GlideScope.

We found the technique utilizing awake fiberoptic endotracheal intubation in combination with proper patient and family preparation, utilization of a tablet device for distraction, topical anesthesia and intravenous fentanyl sedation to work exceptionally well in sedating and safely securing an anticipated difficult airway in a 9-year-old boy with a history of Simpson-Golabi-Behmel syndrome. ■

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Future Anesthesiologists Need Mentors

VANESSA HOY, M.D.

Every morning while in medical school, I awoke to the sound of the ocean and the sight of sunlight beaming through my dormitory blinds. This was a daily occurrence as I got ready for my lectures, as my medical school was located in the Caribbean.

Each year since graduation, I have taken a trip with my best friends from medical school. Since most of them are completing their residencies in their specific specialties, this year we decided to have a "blast from the past" moment and meet up at our school. As we traveled there, we reminisced about our past experiences and reflected on where we are today. There were definitely days and nights cramming for exams and stressful moments during clinical rotations, but these times were overshadowed by successful and joyful moments, experiences gained, and the friendships that were built. Who can forget the countless hours of retracting in surgery to the point you thought the numbness in your hand was normal, or the "marathon" rounds in the intensive care unit or ward, and the excitement of finally realizing where you matched for residency? During this year's annual trip, we decided to meet up with current medical students to give them our perspective on residency and the application process, and to offer our mentorship.

After talking with the medical students, I realized there were only a few students who expressed an interest in anesthesiology. Part of the misconception about our specialty is the idea that we just administer drugs, monitor vitals, help the patient breathe, and then wait until the surgical procedure is over. During my clinical rotations, anesthesia was integrated into my surgical rotation for two weeks. Though the particular hospital I rotated at did not have an anesthesia residency program, I was fortunate to have a great mentor who was also the chair of the department. Two weeks grew into a month-long rotation, during which time I quickly learned to appreciate the specialty. One of the best pieces of advice my mentor gave me was that "no case is just an ordinary case." From a simple laparoscopic cholecystectomy to an upper extremity cyst removal, the best "monitor" in the operating room is the anesthesiologist. How does one teach a medical student this and involve him or her in our specialty? I often notice medical students on their first day of anesthesia

elective just standing around rather than being incorporated into the care team. There are so many opportunities for students to be involved, from evaluating patients in the preoperative stage, to learning which medications to use and the different methods for airway management, to observing intraoperative monitoring and the post-anesthesia care unit.

Being mentored in a particular specialty is essential to the growth of medical students and residents. Effective mentors provide guidance, counseling, and, most of all, support and encouragement. The mentee should be willing to ask questions and should be open to guidance as well as positive and negative critiques. A constructive mentor/mentee relationship provides a foundation for the mentee to become a future mentor. I encourage every resident to be an advocate for our specialty and to mentor future anesthesiologists as we all navigate the many changes that are influencing the way we practice. ■

Vanessa Hoy, M.D., is a CA2 anesthesiology resident at SUNY Upstate University Hospital.

How to Read and Negotiate a Contract

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

Charles (Chuck) Assini, Esq., the NYSSA's legislative counsel and representative, spoke at PGA 2014 on contract negotiations and practice management issues, which we will summarize and discuss. This key information is vital for CA3s and fellows soon to enter the workforce, and very important background for the rest of us still in training.

Large private group practices: Such practices are increasingly dominating the marketplace. These practices have large legal teams that maximize protection for the group and often impose one-sided contractual provisions. No equity ownership positions are typically offered, meaning you may not share in the group's profits or have access to the group's books or records. Such organizations often have "at-will employment" clauses that allow termination of your contract without cause or reason. Be sure to check the period of advance notice required by your employer for at-will termination.

Covenant not to compete: When reading your contract, pay close attention to non-competition provisions that restrict you from practicing in a given area for a certain period of time — as high as five years and a 30 mile radius! This may restrict you from holding staff privileges, capital stock, or any direct or indirect interests at a hospital or practice where anesthesiology services are offered. Breaches for non-competition clauses include injunctive relief, compensatory fines, and payment of your group's legal fees.

Malpractice insurance: Know your tail coverage expenses and limits of liability, usually $1.3 million per occurrence and a $3.9 million aggregate. Does the policy contain a right to settlement clause? Penalties may be imposed for refusing to settle a claim deemed indefensible by defense experts. Settling a claim may also be reportable and searchable within the National Practitioner Data Bank.

Billing compliance: Governmental compliance audits are feared by private groups and academic institutions alike. Broad responsibilities are often imposed on physician employees to accurately record, document, and code for procedures. Recognize the language in your contract that may indemnify your employer for fines, damages, and legal fees and leave you solely responsible for a billing compliance audit.

Due Diligence: Research your group's surgical sites, hospital relations, and number of nurse anesthetists you are expected to supervise. Be familiar with your group's policies, rules, and compliance plan. These documents may reach as many as 100 pages. The concept of incorporation by reference obligates you to comply with the above or face early termination.

In summary, be knowledgeable and do not sign a contract without a thorough review. This may include the assistance of an attorney who specializes in medical contract law. Charles (Chuck) Assini, Esq., can be reached at CJAssini@HRSLaw.us.com should you have questions or need assistance. ■

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesiology residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.

What Does "Pay for Performance" Mean for an Anesthesiologist?

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

The way you will be paid as an anesthesiologist will change drastically during your early career. This newsletter aims to educate you on some of these changes so that they happen ***with*** you and not ***to*** you.

We continue to hear from our specialty's leaders that the successful anesthesiologist of the future **must** add more to a practice or department than administering medications as a technician in the OR. Practices need anesthesiologists who understand quality and models of payment in addition to perioperative care.

As healthcare has become incredibly expensive, the federal government and other payers want to improve the value of the care provided. The approach thus far has been to ask physicians to report the quality of the care they delivered. The result was the Physician Quality Reporting System (PQRS), which was started by the federal government in 2006 via the Centers for Medicare & Medicaid Services (CMS). Commonly referred to as "pay for performance," it was initially a "pay for reporting" program where practices were given Medicare bonuses for reporting various quality measures. Such measures included appropriate antibiotic administration and the maintenance of normothermia in the postoperative period. Starting in 2015, however, the program shifted to one with payment "adjustments" (i.e., penalties) of up to 2 percent for not satisfactorily reporting certain quality measures.

New in 2015, the Affordable Care Act called for the value-based payment modifier (VBPM). The VBPM, which was quickly implemented by CMS, determines value by comparing quality measures reported to the cost of care provided. Practices and departments with low value (i.e., high cost, low quality care) have their Medicare payments penalized in the following year. Practices with high value (low cost, high quality care) are rewarded with bonuses. When the quality reporting adjustment (PQRS, 0 percent to 2 percent) is added to the value-based adjustment (VBPM, - 4 percent to ≥+ 4 percent) practices, including ours, may be penalized **up to 6 percent of all payments**, receive no adjustment, or receive a bonus. You want to help your practice or department receive the latter.

The future of anesthesiology (and medicine in general) lies in a value-based system where quality will be scrutinized. Changes to how you are paid as an anesthesiologist are happening every day, and will affect your career. It is imperative that you, as a future anesthesiologist, position yourself to be a leader in your department or practice by understanding these changes. A bonus to your department of ≥ 4 percent of all Medicare payments will make you very popular. What's more, participating in quality reporting across a national level has created immense opportunities to improve the quality of our care while simultaneously increasing its value. Our patients and we (as taxpayers) deserve such improvements. ■

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesiology residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.

The Repeal of the Medicare Sustainable Growth Rate

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

A highly anticipated change in healthcare has occurred. The Senate passed and President Obama signed into law an incredibly important repeal of a Medicare payment system known as the Sustainable Growth Rate (SGR) formula. The SGR served to update Medicare's payments to physicians annually so that these payments did not exceed the GDP. The SGR regularly threatened huge payment cuts that were seemingly avoided at the last minute by patch measures passed on a yearly schedule. Just last year, a 24.1 percent cut in payments was narrowly avoided. With the passage of this important legislation, an annual formidable threat has been eliminated.

So what new legislation replaced the SGR? Under the new law, the conversion factor used to determine payments will increase by 0.5 percent annually for services provided on or after July 1, 2015. There will then be a 0.5 percent increase each year from 2016 to 2019. This rate will remain unchanged from 2019 to 2026, while providers become

involved in new programs aimed at improving outcomes and reducing healthcare spending. This is very similar to how other federal programs affecting healthcare have rolled out. They are first introduced with bonus periods over a usually large period of time so that providers, hospitals, and payers adjust to new rules and systems.

In addition to the PQRS (Physician Quality Reporting System) and VBPM (value-based payment modifier) programs, we now have another acronym and system to keep track of: the MIPS (Merit-Based Incentive Payment System). MIPS will debut in 2019 and combine the PQRS, VBPM, and electronic health record meaningful use programs. MIPS will score physicians on quality, resource use, and clinical practice activities. If the score is greater than a set threshold, physicians will be eligible for positive payment adjustments. A negative payment adjustment of up to 4 percent is also possible if the provider scores below a certain threshold. Such penalties are intended both to improve quality of care as well as to create one unified program.

The new law will also allow participation in alternative payment models (APMs). If a provider receives a minimum specified amount from an APM, he or she is eligible for a 5 percent bonus from 2019 to 2024, followed by a 1 percent bonus thereafter. The APM model may eventually lead to the introduction of anesthesiology-related payment models such as the perioperative surgical home.

The repeal of the SGR finally does away with a flawed and outdated system and eliminates the threat of large cuts to physician payments. The new payment plans are quality driven and offer potential solutions to the changing landscape of medicine. Being informed and staying active will make you a valuable member of your practice. Stay tuned! ■

Chris J. Curatolo, M.D., and Shawn Sikka, M.D., are CA2 anesthesiology residents at Mount Sinai Hospital. Dr. Curatolo is the president-elect of the NYSSA Resident and Fellow Section (RFS) and Dr. Sikka serves as RFS secretary/treasurer.

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