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SPHERE

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

From Albany to Capitol Hill: Advocating for Safe Patient Care

PGA70

PostGraduate Assembly in Anesthesiology

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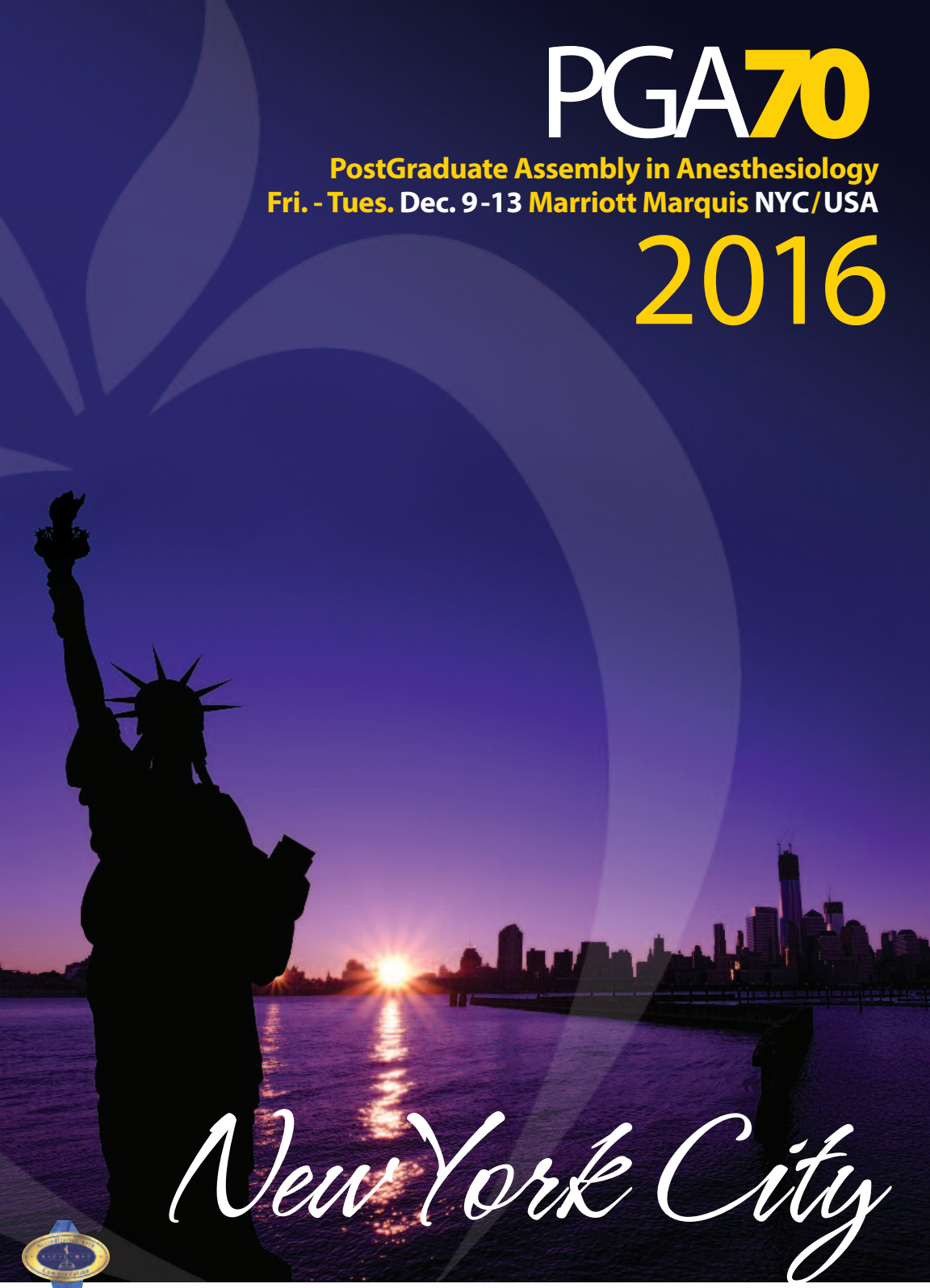
2016



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SPHERE

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NYSSA Business Address:
110 East 40th Street, Suite 300
New York, NY 10016
212-867-7140
Fax: 212-867-7153
www.nyssa-pga.org
e-mail: hq@nyssa-pga.org

Executive Director:
Stuart A. Hayman, M.S.

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Editorial Board

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President's Message

A Focus on Patient Safety

ANDREW D. ROSENBERG, M.D.

The world of medicine is rapidly evolving, and along with it the field of anesthesiology. It is our task to gaze into the future, to attempt to predict upcoming change, and to move our profession forward. While we learn to adapt to the increasing flow of patients from the inpatient to the ambulatory care environment, to mounting oversight based on performance metrics, and to changing reimbursement models, there are a few constants. For those of us in anesthesiology, the most important constant is patient safety.

We emphasize patient safety at multiple stages throughout our interactions with our patients. Prior to surgery, proper preoperative evaluation should be geared toward optimizing the patient as well as introducing healthy habit suggestions to those who are not following the healthiest lifestyles. In the operating room, safe care of the patient is overseen by the physician anesthesiologist, either independently or as part of the team-based approach. Proper postoperative management, including ICU care and effective pain management, is another important stage where we can ensure safe patient care. As a specialty, we have adjusted to changes in the outpatient arena, instituted perioperative care suggestions, and provided excellent care for inpatients and outpatients with increased acuity, including ICU care and pain management.

Patient safety should also be the focus of our advocacy efforts. As more independent nursing personnel are deemed acceptable for front-line medicine diagnosis and treatment, there is pressure throughout the country to enhance the scope of practice for all nursing personnel. While this may be appropriate in areas such as family practice and other medical fields, in an environment where immediate reaction and treatment may be necessary at any given moment, this movement should not translate into independent practice by nursing personnel in the operating room. We have an excellent track record, so why should the current care model change? Make no mistake, if we do not focus on this as an issue and we take our eye off the ball, the ball may be gone

and the game forever changed as those who push their political agendas get a foothold while we sleep.

How do we continue to advocate for our patients? The answer is: through the provision of safe care as well as the education of our political leaders. Having addressed patient care, what can we do about advocacy? Effective advocacy requires making certain our voices are heard. It also requires PAC dollars. We must keep our finger on the political pulse by understanding what is occurring in Albany and Washington and meeting with our politicians as issues arise. Just recently a number of us were elated when Sen. Catharine Young took her name off the title bill, which would have provided a title for nurse anesthetists without defining their scope of practice. Our elation was short lived, however, as the bill was picked up by another member of the state Legislature.

Recently I had the privilege of advocating on behalf of all NYSSA members. Along with David Wlody, M.D., and Stuart Hayman, I attended a Republican fundraiser, led by Sen. Young, in order to advocate for physician anesthesiologists. I then went to a fundraiser for New York Gov. Andrew Cuomo to do the same. I was pleased to be at both events; as I shook hands with many New York state leaders, I felt that my presence on behalf of physician anesthesiologists was noted.

What I have learned is that being excellent physicians is not enough. We must be seen and heard. I ask each of you to help out: by continuing to provide excellent patient care but also by seeking out and educating politicians in your district and donating to our PAC so we can attend fundraisers and advocate on behalf of our patients, ourselves and our profession. As the world of medicine changes, we cannot afford to be passive. We must protect our patients by advocating for the positive changes that will improve our specialty and against the changes that may ultimately cause harm. ■

Editorial

Transforming the Patient Experience

SAMIR KENDALE, M.D.

Within two hours of arriving at the hospital, my wife was already remarkably uncomfortable. She was post-dates with our first child and beginning an induction of labor. Neither of us knew how her body or the fetus would respond. Induction of labor is often painful, but, similar to other painful stimuli, the range of response is wide. Pain could start immediately or later, it could be gradual or sudden, and it could vary in quality. In my wife's case, the onset of pain was sudden and severe. As someone with a relatively high pain tolerance and a fair amount of trust in the medical system, she didn't hesitate to call the obstetrician for an assessment. Within 10 minutes, the anesthesiologist was in the room, the epidural was running, my wife was experiencing much-needed relief, and both of us were able to get some rest before the big event. (For those wondering, no, I did not perform my wife's labor epidural.)

Why am I relating this somewhat personal anecdote? After witnessing my wife's experience, I can't imagine her enduring this process without the aid of neuraxial analgesia. This was a reminder not just of the role of the anesthesiologist in direct patient care, but also of the necessity of anesthesiologist engagement in the evolution of healthcare systems.

Developing the infrastructure for and maintaining labor analgesia programs requires continuous input from multiple healthcare professionals, from labor and delivery nurses to obstetricians to anesthesiologists. Likewise, developing protocols and infrastructures for new hospital programs necessitates a multidisciplinary approach. These transformations are perpetual, especially with the rapid changes in national and state healthcare policies, new areas of importance to patients and hospital administrators, and the soaring pace of technological advancements. As anesthesiologists, we are uniquely positioned to take the reins in these arenas, or at the very least to involve ourselves in these programs at our local institutions. Some of these areas include using electronic health data to analyze surgical quality and OR management,

sitting on committees that establish enhanced surgery after recovery protocols, or spearheading and demonstrating the value of anesthesiologist-led perioperative programs.

Additionally, coincident with the role of the anesthesiologist in perioperative programs is our importance in the area of pain management. With regard to labor analgesia, every patient has the right to decide her birth plan; however, it is our responsibility to provide the information and resources our patients need to make informed decisions about their options. This may seem obvious to those of us practicing here in New York, but it is something often taken for granted, as was pointed out to me during residency by my attendings who had grown up or trained in countries where labor analgesia was considered an utmost luxury, if it was even available.

There is an acceptance that labor can be a significantly more comfortable experience with the addition of neuraxial analgesia. Why, then, is this mentality not always translated to the surgical patient? Often, there is a resignation to the idea that pain is simply a necessary product of surgery. Of course this is true to some extent, but, with all the techniques in our arsenal, we should be instrumental in forming anesthetic plans and protocols aimed at minimizing postoperative pain while maximizing patient safety, a task that strongly demonstrates the value of our expertise. This includes early identification of patients at high risk for difficult postoperative pain management, development of systems for early referral to the pain management service, involvement in deciding adjunctive premedication in the aforementioned enhanced recovery after surgery protocols, and providing education about all of the analgesic options to surgeons and patients alike.

For example, I was involved in a case recently in which I mentioned paravertebral blocks for adjunctive pain control and was surprised that the surgeon was not even aware of the technique. I took this as a failure on my part for not sharing information about this procedure with the surgical team earlier. We are our patients' strongest advocates when it comes to pain management, and these approaches are only the tip of the iceberg in terms of our ability to transform their surgical experience. ■

From the Executive Director

Your Malpractice Carrier's Financial Stability Matters

STUART A. HAYMAN, M.S.

My father was a man of few words, although he liked to impart pearls of wisdom. When I was looking into purchasing an unusually low-priced used car, he reminded me of the principle of "caveat emptor." He also liked to say, "If it seems too good to be true, it probably is." This same logic should be applied to the purchase of your medical malpractice insurance.

New York state's medical malpractice market has experienced a major transition, and not necessarily for the better. Risk retention groups (RRGs), which sprung up as a result of the Federal Liability Risk Retention Act of 1981, have been expanding aggressively in New York state. Unsuspecting policyholders have been flocking to these groups without understanding the potential risk they are placing themselves in. Many of these RRGs have been undercutting state-approved malpractice rates for select customers. It is important to fully understand the nature of the coverage you are purchasing, as well as the fact that RRGs do not typically provide the security and stability you will find with a New York state malpractice carrier like MLMIC.

When it comes to rates and financial reserves, RRGs are not regulated by New York state but, rather, by the federal government. That means that if they experience a cycle of losses, it is likely they will pack up and move out of New York, leaving their physician policyholders with NO malpractice coverage. Another potential outcome if RRGs experience losses would be their need to drastically increase policyholder premiums to cover those losses. Again, since RRGs are not regulated by New York state, they are not required to file rate increases with the state. It is conceivable that policyholders could be stuck absorbing a 100 percent-plus rate increase in any given year.

As if the aforementioned isn't bad enough, the above scenarios could also leave physicians who are insured through RRGs scrambling to replace their malpractice policies. There is no guarantee that a state-approved

carrier will be in a position to help out those who are negatively affected by the actions of an RRG. Any carrier's underwriters would have to consider the loss of the physician's current policy as well as all other risk factors before a coverage decision is made. At the very least, this process takes time and may put those affected in a very undesirable position.

I am not alone in my concern over the malpractice marketplace. The influx of RRGs has also raised red flags with legislators, regulators, attorneys, and the administration of Gov. Andrew Cuomo. Beyond the potential problems I have highlighted, these groups have also discussed the very real possibility that physicians will find themselves personally exposed to malpractice claims. (Goldberg, D. [2016, April 9]. Growing concern over shifts in N.Y. medical malpractice market. *POLITICO New York*. Retrieved from www.capitalnewyork.com/article/albany/2016/04/8596203/growing-concern-over-shifts-ny-medical-malpractice-market.)

New York has five "state" admitted carriers: Medical Liability Mutual Insurance Company (MLMIC), Physicians' Reciprocal Insurers (PRI), the Academic Group, Hospital Insurance Company, and the Medical Malpractice Insurance Pool. Unfortunately, all these carriers are feeling the impact of RRGs in the New York market. In many cases, the RRGs have sold policies to physicians from lower-risk specialties, leaving state-approved carriers with higher-risk policyholders, as well as fewer policyholders overall. This has the potential to harm the financial stability of all state-approved carriers over time, and has probably already done so.

MLMIC: Owned and Managed by Physicians

The NYSSA's endorsed malpractice carrier, MLMIC, was established by New York physicians approximately 40 years ago. MLMIC is the largest medical liability insurer in New York, and one of the largest companies of its kind in the nation. MLMIC's mission is to offer insurance at cost and to provide the strongest possible defense for claims without merit, as well as prompt, equitable compensation to those with legitimate claims. Additionally, the company has been working vigorously to reform the inequitable medical liability compensation system in New York.

MLMIC is owned entirely by its policyholders. All profits earned are either rebated back to physicians via dividends or used to reduce future premiums. In fact, MLMIC is currently offering a 20 percent dividend to any policyholder insured by May 1, 2016, who maintains continuous

coverage through July 1, 2016. Through the years, MLMIC has issued more than $300 million in dividends to its policyholders.

MLMIC operates without a profit motive. Instead, the company works to provide much-needed relief to policyholders while maintaining financial stability. The NYSSA endorses MLMIC for all the reasons noted above, and because MLMIC has remained committed to the physician marketplace even during times of extreme adversity and volatility.

We are proud to continue our endorsement of MLMIC. For more information about your current MLMIC policy or to obtain a new policy, visit **www.mlmic.com** or call 888-996-1183. ■

70th PGA Scientific Exhibits Poster Presentations Medically Challenging Case Reports

If you are interested in submitting applications to exhibit your projects at the upcoming **70th PostGraduate Assembly in Anesthesiology** — **December 9-13, 2016**, 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, 2016.

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, 2016.

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

Professional Liability Insurance Coverage: What You Need to Know to Select the Correct Carrier and Coverage

AL ANTHONY MERCADO, ESQ.

In today's volatile medical malpractice environment it is more important than ever to carefully investigate and properly select a professional liability insurance carrier. In doing so, it is necessary to understand how the type of coverage, as well as the terms and conditions of that coverage, can potentially impact the practitioner, practice and/or institution falling under the coverage. Having a better understanding of certain key aspects of insurance coverage is an important first step in making the correct selection of a professional liability carrier.

Claims-Made vs. Occurrence Coverage

There are the two basic types of professional liability insurance coverage available to physicians, practices and/or institutions: "claims-made" and "occurrence." It should be noted that there are significant differences between the two types of policies and not all insurance companies offer both types.

A "claims-made" form of coverage protects a policyholder for alleged acts of medical negligence that both occur and are reported to the insurance carrier during the time the policy is in continuous force, or are reported within 60 days following the policy's cancellation or non-renewal.

An "occurrence" form of coverage protects the policyholder for alleged acts of medical negligence while the policy is in effect, no matter when a claim is reported to the insurance carrier.

Of significance, at the termination of claims-made coverage, an insured will be required to purchase "tail coverage" in order to avoid having a gap in coverage. "Termination" of coverage includes: cancellation/non-renewal, a decrease in limits, a reduction in coverage, and/or retirement/disability/death. The cost of tail coverage generally depends on the reason for the termination of coverage. If the termination is due to cancellation/non-renewal, the cost of the tail coverage will be a percentage of the occurrence coverage. While tail coverage can be expensive, the cost of this coverage is

provided by the insurance carrier in the event of death/permanent disability/full retirement.

The premium for a claims-made form of coverage is usually a calculated percentage of the occurrence coverage premium and increases on an annual basis until it reaches maturity during the eighth year. In essence, the claims-made coverage is less expensive than the occurrence coverage at the inception of the policy, but becomes more expensive each year until it reaches maturity. At maturity, the premium for claims-made coverage is roughly 105 percent of the occurrence coverage premium.

If coverage is purchased on behalf of a physician, he/she should be sure to understand what type/form of coverage is being purchased, if tail coverage will be necessary, and which party (the physician or the entity purchasing the policy) will bear the expense for that coverage.

What and Who Is Covered

What is covered by a professional liability insurance policy and the specific criteria for denial of coverage are set forth in the terms, conditions and limitations of the policy. Generally, such policies cover physicians for acts and/or omissions that occur when providing professional services to a patient — acts or omissions outside the delivery of professional services to a patient will generally not be covered. Further, and of critical import, carriers not licensed in New York may change policy terms, conditions and limitations without the approval of the New York State Insurance Department and without notice to policyholders.

The terms of the policy will also set forth "who" is covered under the insurance policy. Depending on the coverage and insurance company, there may be an opportunity to insure certain practitioners and employees for an additional cost.

There are acts that are generally excluded from coverage: intentional injury, assault, battery, criminal acts, violations of law, discrimination, contractual liability, defamation, etc. While these acts may not be covered by most professional liability policies, some carriers have additional limited coverages for these types of acts at additional cost. Similarly, some carriers offer additional coverage for administrative claims, employment claims, professional entity coverage and employee coverage at an additional cost.

Coverage Limits

The professional liability policy's "Declaration Page" will set forth: the annual premium, additional people insured under the policy and coverage limits. Depending on where care is being rendered, the policy should be carefully reviewed to determine whether the coverage limits meet state requirements as well as any additional requirements for facilities at which the physician maintains privileges. Similarly, certain coverage limits ($1.3 million/$3.9 million) are necessary to qualify for excess insurance in the state of New York.

Premium Cost

The premium cost generally reflects a company's underwriting analysis of risk and exposure in a certain location. Every purchaser of professional liability insurance should be wary of "deeply discounted" premiums that may not accurately assess risk and exposure.

Generally, premiums are paid on a yearly basis pursuant to the terms and conditions of a particular company. Some carriers offer discounts for premiums paid in full as well as payment plans.

It is important to understand that certain types of coverage (i.e., coverage offered by risk retention groups) may require policyholders to make capital contributions for several years in addition to their annual premiums. These capital contributions are risky and returns on these investments are not guaranteed.

Similarly, certain types of carriers that are not licensed in New York state may also change premium rates without the approval of the New York State Insurance Department and without notice to or approval by policyholders.

Reporting of Claims and Their Effect on Premiums/Non-Renewal

Generally, the terms and conditions of a professional liability insurance policy will require a policyholder to report any claims/potential claims/ lawsuits in a timely manner. The failure to do so can result in the insurance carrier denying coverage for failure to report.

In general, some insurance carriers increase premiums based upon increased severity and/or frequency of claims. Similarly, a non-renewal is

triggered through a carrier's review of the insured's claim history and/or method of practice. Some "mutual" insurance carriers base their decisions on a physician peer review process. Carriers licensed in New York are required to give 60 days' notice of non-renewal.

Of note, some carriers do offer discounts to their policyholders who have been in practice continuously for a certain period of time without claims.

Applications

Applications for professional liability insurance typically seek information about the applicant's professional background (e.g., education, state licensure, board certifications and facility privileges), claim/suit/underwriting history, and practice (e.g., specialty, hours, employees, and procedures performed), as well as professional issues (e.g., suspension/revocation/voluntary surrender/restriction of licenses pertinent to the practice of medicine and hospital privileges). The application may also seek information concerning the applicant's personal life (e.g., criminal convictions other than motor vehicle violations, and treatment for drug, chemical, alcohol or mental health problems).

Carrier's Approach to Litigation and Settlement

The decision to take a case to trial, or settle before trial, can have longstanding effects on a physician (i.e., reporting to the National Practitioner Data Bank, disclosure upon credentialing or re-credentialing, state profile websites, health insurance plans and/or insurance applications). Each purchaser of a professional liability insurance policy must ascertain wherein the power to control this decision lies. The inclusion of a "consent to settle" provision in an insurance policy usually provides the policyholder with input into the decision to settle. In general, understanding who owns and/or controls an insurance company can be critical in ascertaining the company's philosophy toward defending litigation or deciding to settle. For example, "mutual" carriers (owned and controlled by their physician policyholders) can take a very different approach to litigation and settlement than for-profit carriers owned and controlled by shareholders. Similarly, the financial condition of an insurance carrier can also affect its approach to litigation and/or settlement.

Attorney Defense Panel

Different insurance companies can work with drastically different attorney defense panels. Medical malpractice litigation is a unique area of law, with

many uncommon, and ever-changing, nuances. Medical malpractice litigation is best handled by attorneys with strong experience in this narrow field from inception through trial. In general, a carrier may, but is not required to, provide a policyholder with the ability to have input into the choice of defense counsel.

Clearly, there are many coverage factors that should be investigated and understood before selecting a professional liability insurance carrier. Understanding how these coverage factors can, and will, affect the physicians, practices and/or institutions falling under such coverage is the first, and perhaps most critical, step in ensuring the selection of the right professional liability insurance carrier and coverage. ■

Al Anthony Mercado, Esq., is with Fager Amsler Keller & Schoppmann, LLP. For further information, Mr. Mercado can be contacted via phone at 516-794-7340 or via email at amercado@fakslawfirm.com.

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, 2016.

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

App Review

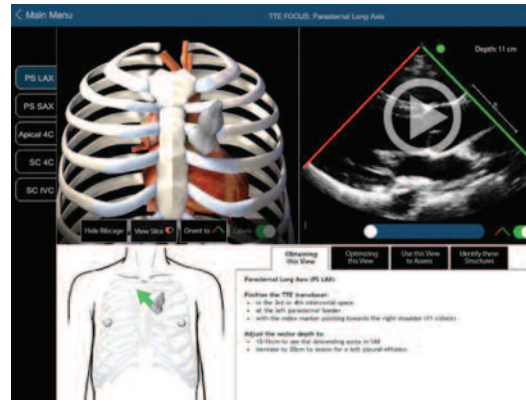
TTE FOCUS Views: An iPad App Review

DIVYA CHERUKUPALLI, M.D.

Application Name:
TTE FOCUS Views

Cost: $4.99

Developer:
University Health Network



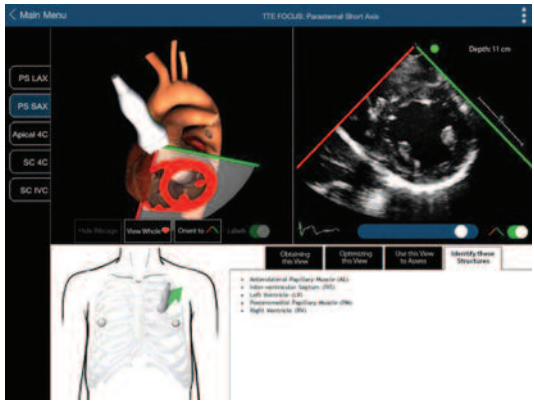
Images from the iTunes store, reprinted with permission of University Health Network.

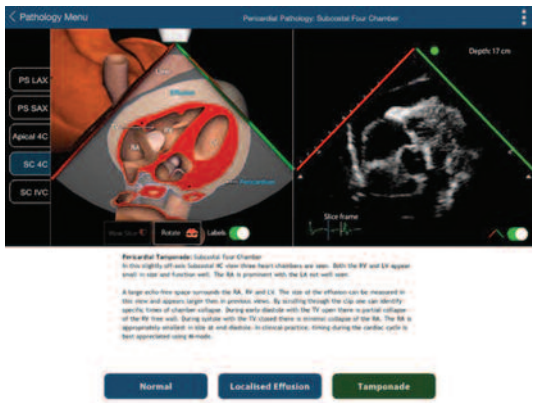
Review: Let us say a general anesthesiologist wants to quickly assess the cardiac function of a sick patient who is coming to the operating room for an emergent non-cardiac surgery. The general anesthesiologist often is not equipped with TEE skills. In addition, not all patients are intubated and under general anesthesia to facilitate TEE use. In such a situation, in addition to a good history and examination, a bedside focused TTE comes in handy. It is relatively simple to learn and use focused TTE perioperatively.

Focused TTE is also used by critical care and emergency medicine doctors to emergently and objectively assess cardiac function at the bedside. It can be used to assess volume status as well. To do this, the practitioner needs to understand the structures of the heart that are seen on the echocardiogram. This app is useful in learning and understanding these structures.

FOCUS (Focused Cardiac Ultrasound) uses five of the 20 standard views. The app has 3D models of these five views, which can be rotated in both the horizontal and vertical planes. The 3D model is useful to explore the relationship of the imaging plane to the heart. Sliced views with labeled structures and corresponding TTE views can also be seen. The app also reviews pathological conditions (effusion and tamponade) and their effect on cardiac function. The developer's website, **http://pie.med.utoronto.ca/tte/TTE_content/focus.html**, has the above features and a few more pathological conditions.

It is this author's hope that more anesthesiologists will use focused TTE when assessing their patients during emergencies and that it will be incorporated into residency training.





Images from the iTunes store, reprinted with permission of University Health Network.

The downside of the app is that it cannot replace a FOCUS/FATE (Focused Assessed Transthoracic Echocardiography) course or clinical experience. In the future, it would also be nice to see the app include the pathological conditions that are shown on the website.

Bottom Line: Overall, this is an excellent app to get oriented to the ultrasound views of the heart and a good place to start learning focused TTE.

TTE FOCUS Views can be downloaded from the iTunes store. ■

Divya Cherukupalli, M.D., is a chief resident (CA3) at New York Methodist Hospital.

Legislative Update

CHARLES J. ASSINI, JR., ESQ.

Informing the NYSSA Membership — An Update

In my last column, I reviewed the strategic approach adopted by the NYSSA leadership team aimed at keeping NYSSA members informed about critical New York state legislative developments as well as budget developments (please see Reid, McNally & Savage's 2016 budget summary update below).

Upon reflection, there are at least two additional areas where the NYSSA leadership (President Andrew Rosenberg and the entire NYSSA Executive Committee) works closely with GLAC Chair Dr. David Wlody; GLAC Vice Chair Dr. Scott Plotkin; NYSSA Executive Director Stuart Hayman, M.S.; Reid, McNally & Savage, LLC (NYSSA's Albany lobbyists); and me to keep members informed. These two areas include significant New York state court opinions (that the American Medical Association has characterized as "abusive litigation against physicians") and the promulgation of New York state rules and regulations relating to the practice of anesthesia.

A recent New York state court opinion that the American Medical Association (AMA) characterized and listed on their abusive litigation against physicians website is the case of Davis v. South Nassau Communities Hospital (26 N.Y. 3d 563). In this case, New York state's highest court, the Court of Appeals, significantly altered the long-standing law that generally restricts a healthcare provider's duty of care to his or her patients. Stated alternatively, the issue before the court was whether a third party could assert a negligence claim against a medical provider for injuries the plaintiff sustained as a result of the medical provider's treatment of the patient. The court ruled in the affirmative and held that a physician is required to advise patients of the side effects of medication.

On the morning of March 4, 2009, Lorraine Walsh arrived at the emergency room of the South Nassau Communities Hospital complaining of pain. The personnel at the hospital administered to Walsh an opioid narcotic, then discharged her approximately 90 minutes later. The plaintiff was not warned about the side effects of the medication, which

would impair her ability to operate an automobile. The hospital personnel also did not ask the patient if she drove herself to the hospital.

About 19 minutes after her discharge from the hospital, Walsh drove her car over a double yellow line and crashed head-on with a school bus driven by plaintiff Edwin Davis. Davis suffered catastrophic injuries, including multiple skull fractures and resulting traumatic brain injury, as well as exacerbation of multiple sclerosis that had been asymptomatic prior to the accident.

The plaintiffs (Edwin and Dianna Davis) claimed that defendants should be liable for their injuries because they discharged Walsh in an impaired condition and failed to warn her of the dangers of driving in that condition. They further argued that this act or omission created a foreseeable risk to third parties traveling on the roads.

The Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA) submitted an *amicus curiae* ("friend of the court") brief by Kern, Augustine, Conroy & Schoppmann, P.C., that sets forth the following important public policy considerations for the court to consider in assessing the legal question before them because this holding significantly expands the legal duty of the healthcare provider and thus the liability of a healthcare provider to the general public. In many respects, the public policy argument mirrors the arguments being advanced by MSSNY to defeat regressive tort reform legislation supported by the Trial Lawyers Bar, including, for example, A.0285 (Weinstein)/ S.6596 (DeFrancisco) to amend the statute of limitations for medical, dental, or podiatric malpractice to include a discovery injury rule that allows the current 2 ½-year statute of limitations to run from the date an injured patient discovers, or should have discovered, that his/her injury was caused by malpractice. That is, if this bill is enacted, an enormous increase in the cost of liability insurance for physicians and hospitals could potentially occur. I believe that it would be worthwhile to review these important public policy arguments.

The following excerpt and notes are from the *amicus curiae* brief by Kern, Augustine, Conroy & Schoppmann, P.C.:

Public Policy Considerations

The Court stated in *Eiseman* that in determining whether to expand the duty of legal care one member of society owes to other members of society, the Court is bound to consider the larger issue of

social consequences of its decisions so that the legal consequences are limited to a "controllable degree." 70 N.Y.2d at 187. It is respectfully submitted that the ruling of the Appellate Division, Second Department should be affirmed because, if the Second Department ruling is reversed, and a physician is held to owe a duty of care to an indeterminate number of members of the community at large, the medical profession and the healthcare system would be exposed to profoundly adverse and unforeseeable hazards. The medical profession would be subject to a legal duty of care "beyond manageable bounds" and exposed to the foreseeable and unforeseeable consequences, "most especially for vast, uncircumscribed liability" *Ellis v. Peter 211 A.D.2d 353 at 357.*

According to the AMA report "Medical Liability Reform Now!"[2] physicians practice under the constant threat of medical malpractice suits. A 2007-2008 AMA survey found that 61 percent of physicians aged 55 and older have been sued at some point in their careers. Nearly 40 percent had been sued two or more times. Among surgeons age 55 and older, nine out of 10 had been sued. The data does not show that physicians are practicing bad medicine. Data from the Physicians Insurers Association of America (PIAA), an insurance industry trade association of liability insurers, shows that most liability claims are without merit. Sixty-five percent of claims that were closed in 2012 were dropped, withdrawn or dismissed. A little more than 8 percent of claims were decided by a trial verdict — 89 percent of which were won by the physician defendant in the case.[3]

From a number of perspectives the current liability system is extremely costly. PIAA data shows that the median indemnity payment on settlement claims that closed was $194,375. For tried claims decided in plaintiffs' favor, the median payment was $500,000. In addition to the costs generated by the amounts paid out to plaintiffs, the claims are also costly to defend. The average defense cost for claims settled in 2012 was $70,480. For tried claims it was $135,747 when there was a defendant victory and $253,920 for a plaintiff victory. For dropped claims, the average was $28,777.[4]

The lawsuit environment exacts a heavy toll for physicians and our healthcare system: rising professional liability insurance premiums for physicians; rising healthcare costs for patients; overly defensive (and thus more expensive) medical practices; early retirement for physicians; and physician relocations to states that

have adopted effective medical malpractice reforms. The problems have been even more pronounced in New York. New York is identified as among the states in crisis during the medical malpractice crisis of the mid-2000s, with increasing premiums, patients losing access to healthcare, and many physicians struggling to stay in practice.[5] The crisis in the mid-2000s was very detrimental to patients and their physicians. The stability of New York's healthcare system remains fragile, and it is the concern of AMA and MSSNY that if the Appellate Division, Second Department is reversed, and the Court expands physicians' duty of care to unidentified and indeterminate number of members of the general public, the healthcare system in the state can be in crisis again, if not subjected to even a greater crisis than the mid-2000s.

The fear of lawsuits affects the way in which physicians practice, and the medical liability system causes healthcare expenditures to be higher, as physicians are forced to practice "defensive medicine." According to a 2003 U.S. Department of Health and Human Services report issued during the last medical liability crisis, the cost of defensive medicine is estimated to range between $70 and $126 billion per year.[6] It is not possible to calculate the impact to overall defensive medicine costs if physicians' legal duty of care is expanded to indeterminate members of the general community.

Moreover, if a physician's duty of care is expanded beyond the patient to unidentified and indeterminate number of members of the general community, there may be circumstances where a physician may perceive that his or her legal duty to the patient may be in conflict with the "duty" to the general community. Within the physician-patient relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. Section 10.015 of the AMA Principles of Medical Ethics. If, however, a physician may be exposed to liability to members of the public for medical treatment that the physician provides to a patient, physicians may be reluctant to provide certain types of medical treatment to patients if it is believed that such treatment could expose the physician to lawsuits by members of the general community. For example, a physician may believe that certain medication therapy may be in the best interest of the patient, but may be concerned that even with full disclosure to the patient regarding the benefits and potential risks of the medication therapy, the physician may be exposed to lawsuits from members of the

community if it is alleged that the patient caused injuries to other persons because the medication, directly or indirectly, contributed to the patient's negligence. The chilling effect caused by such lawsuits may lead physicians to hesitate providing patients with treatments that have inherent risks and potential side effects. As the result of physician fear of being exposed to liability from individuals in the general public, patients may have reduced access to medically beneficial treatment.

If non-patients are allowed to sue a physician for the care the physician provided to a patient, and the non-patient alleges that the physician neglected to caution the patient about the side effects associated with the prescribed medications (e.g., drowsiness), the physician should have the opportunity to prove that the physician gave the patient the necessary warnings. To make this defense, the physician would need to disclose otherwise confidential physician-patient communications. Such disclosures would weaken the bond of trust between the patient and physician needed to foster effective medical care. Allowing lawsuits by non-patients would frequently involve such a consequence. MSSNY and AMA are deeply concerned that non-patient lawsuits against physicians would weaken the bond of trust between the patient and physician and would have a profound adverse effect impact [*sic*] on the ability of the physician to provide quality care to the patient.

NOTES

2. Medical Liability Reform Now! The facts you need to know to address the broken medical liability system (2013 ed.), available at www.ama-assn.org/ama/pub/advocacy/topics/medical-liability-reform.page.

3. Id. at p. 6.

4. Id. at p. 6.

5. Id. at p. 10.

6. Id. at pp. 8-9.

According to the Medical Liability Mutual Insurance Company (MLMIC), although the court stated that there is no requirement to prevent a patient from leaving an office or facility after the administration of medication, prudence would dictate that the patient should have been sent home by taxi or with another responsible driver.

Dental Anesthesia Regulations

The New York State Department of Education recently proposed an amendment to Section 61.10 of the Regulations of the Commissioner of Education relating to the dental anesthesia certification requirements for licensed dentists. The rule makes definitional changes and adds new certifications for administering moderate sedation to pediatric patients and can be found at **www.regents.nysed.gov/common/regents/files/216ppcd2.pdf**.

Please note that Paul Goldiner, M.D., a past president of the NYSSA, and Executive Director Stuart Hayman attended a New York State Department of Education Board for Dentistry meeting approximately five years ago and provided testimony to the Board for Dentistry with respect to the promulgation of revisions to the dental anesthesia regulations. From that date, we have monitored developments. Based upon a review of the proposed regulations, the NYSSA leadership has submitted the following formal comment: "The NYSSA recommends that the administration of general anesthesia for children 2 years old and younger be permitted only in an accredited hospital or an accredited ambulatory care setting."

2016 Budget Update Summary from Reid, McNally & Savage, LLC

Below please find an update from Reid, McNally & Savage, LLC, NYSSA's Albany lobbyists.

March 30, 2016 – Final Health Language Bill 2016-17 SFY Budget

The Legislature printed the final Article 7 health budget legislation (language bill), which implements the health section of the final state budget. Please find the details of the final bill below:

Legislature Rejects Elimination of Prescriber Prevails

In the final budget bill, the Legislature rejected the governor's proposal to eliminate "prescriber prevails" under both FFS and Medicaid managed care.

Legislature Accepts Governor's Proposal on Prior Authorization of Opioids

The final budget bill accepts the governor's proposal to require managed care organizations in the state's Medicaid program to implement prior authorization of opioid analgesic refills exceeding four prescriptions in 30 days.

Electronic Prescribing Exemptions

The final state budget bill provides an exemption for practitioners from

electronic prescribing if they do not issue more than 25 prescriptions in a 12-month period (oral and written cumulatively). Under the law, a practitioner must seek a certification from the Department of Health for this exemption prior to the 12-month period. A certification submitted on or before July 1, 2016, is deemed in effect retroactively to the March 27, 2016, effective date of the law.

Legislature Rejects Governor's Changes to Excess Malpractice Program

The final Article 7 budget bill extends the Physicians Excess Medical Malpractice Program and extends the hospital excess liability pool by one year, through June 30, 2017. The final bill does not include the changes proposed in the executive budget. Final budget legislation that will appropriate monies for the program has not been printed.

Legislature Amends Physician Loan Repayment Program

The Legislature amended the physician loan repayment program as follows:

- Awards shall be made from the total funding available for new awards under the physician loan repayment program and the physician practice support program, with neither program limited to a specific funding amount within such total funding available;
- An applicant may apply for an award for either physician loan repayment or physician practice support, but not both;
- An applicant shall agree to practice for three years in an underserved area and each award shall provide up to $40,000 for each of the three years; and to the extent practicable, awards shall be timed to be of use for job offers made to applicants.

VHA Nursing Handbook Update from ASA

Amanda Ott from the Advocacy Division of the American Society of Anesthesiologists (ASA) has kindly offered the following update on the Department of Veterans Affairs' proposed VHA Nursing Handbook (update as of April 21, 2016).

ASA Members Continue to Advocate for Veterans' Safe Anesthesia Care

In response to the Department of Veterans Affairs (VA) advancing a proposed VHA Nursing Handbook, ASA members have been outspoken

advocates for safe VA care. Through the "Protect Safe VA Care" initiative, physician anesthesiologists, their families and friends have taken action to tell the VA that veterans deserve safe, high-quality, physician-led anesthesia care.

Since October 2015, ASA members have been using **www.SafeVACare.org** to submit their personalized comments on the importance of physician-led anesthesia care for veterans. ASA is opposed to the VA's proposal to remove physician anesthesiologists from veterans' care teams and has asked all its members to take action on this issue. Several veterans organizations, including AMVETS, the Association of the U.S. Navy and the National Guard Association of the United States, have joined in opposing this policy. Recently, more than 200 VA chiefs of anesthesiology and physician anesthesiologists sent a letter to the VA invoking a patient safety whistleblower program with their concerns about removing physician anesthesiologists from veterans' surgical care teams.

To take action, please submit a comment online at **www.SafeVACare.org** on the importance of providing veterans with the safe, high-quality, physician-led anesthesia care that they have earned and deserve.

For further updates on this issue and other ways to get involved, please:

- Join the ASA Grassroots Network at **grassroots.asahq.org**; and
- Check ASA's Washington Alerts at **www.asahq.org/advocacy/fda-and-washington-alerts**.

Supporting documents and additional information on the proposed VHA Nursing Handbook can be found online at **www.asahq.org/SafeVACare**. For more information, please contact Amanda Ott in ASA's Advocacy Division at 202-289-2222. ■

Charles J. Assini, Jr., Esq.
NYSSA Board Counsel and Legislative Representative
Higgins, Roberts & Suprunowicz, P.C.
1430 Balltown Road
Schenectady, NY 12309-4301
Our website: www.HRSLaw.us.com
Phone: 518-374-3399 Fax: 518-374-9416
E-mail:CJAssini@HRSLaw.us.com and cc: GKCarter@HRSLaw.us.com

Working Hard to Ensure Your Voice Is Heard

STUART A. HAYMAN, M.S.

One of the most important ways the NYSSA works on behalf of our membership is through legislative advocacy. From Albany, New York, to Washington, D.C., we continue to enhance our communication with and coordination among legislative consultants, physician volunteers and staff to foster an environment conducive to frank discourse and cooperation, as well as rapid response. We also explore and utilize additional resources as necessary to preserve patient safety and the quality of healthcare in New York and across the nation.

Thanks to the support and involvement of a cadre of dedicated members, the NYSSA continues to have one of the top physician PACs in Albany and we are one of the most noteworthy states in terms of our contributions to the ASA PAC. At the state level, our leadership, consultants and staff have successfully worked with the state medical society and other specialty societies to combat aggressive scope expansion bills, and we have worked to shape other important legislation. Additionally, we continue to advocate proactively for changes that would benefit your patients and your profession. On the national level, our volunteers are front and center with their colleagues from around the country to ensure that your voice is heard in the halls of the U.S. Capitol.

The NYSSA's volunteer leaders devote tremendous time and effort to further the organization's goals. In May 2016 alone, 39 NYSSA members participated in the NYSSA's Legislative Day in Albany and 27 members took part in the ASA's annual Legislative Conference in Washington, D.C. These individuals take time away from their practices and families to work on behalf of their colleagues, patients and profession. As staff members, we recognize that we could not do the work of the NYSSA without these dedicated physicians, and we are grateful for their participation.

We welcome the involvement of all NYSSA members in the organization's advocacy efforts. No amount of time is too little and no monetary donation too small. To learn more about how you can make a difference in the future of your specialty, check out our website at **www.nyssa-pga.org** or call us at 212-867-7140.

The following pages offer a brief look at the events we recently attended and the legislators we lobbied on behalf of all New York anesthesiologists.

ASA Legislative Conference, Washington, D.C.

Members of the NYSSA delegation greet Sen. Charles Schumer.

(Left to right) Drs. Salvatore Vitale, Michael Duffy, Alan Curle, Scott Groudine, Lawrence Epstein and Michael Simon

(Left to right) Drs. Jonathan Gal, Chris Campese, David Bronheim, Andrew Rosenberg, Matthew Lee, Michael Duffy, Lawrence Epstein, Shawn Sikka, Rose Berkun, Salvatore Vitale, David Currie, Aisha Hasan, Michael Simon, Steven Shulman, Scott Plotkin, David Wlody and Jason Lok meet with Sen. Charles Schumer (center).

(Left to right) Drs. Chris Curatolo, Lee Winter, David Bronheim, Chris Campese, Vilma Joseph, Shawn Sikka, Jason Lok, Lawrence Epstein, Salvatore Vitale, Michael Duffy, Andrew Rosenberg, Scott Groudine, David Wlody, Rose Berkun, Michael Simon, Steven Schulman, David Currie, Scott Plotkin, Alan Curle, Matthew Lee and Melinda Aquino with Stuart Hayman

(Left to right) Drs. Lee Winter, Chris Campese, Michael Simon, Duncan McLean, Jason Lok, Salvatore Vitale, Scott Plotkin, Lawrence Epstein, David Wlody, Michael Duffy, Rose Berkun, Andrew Rosenberg, Jonathan Gal and Aisha Hasan meet with Sarah Reingold (fourth from right) from Sen. Kirsten Gillibrand's office.

ASA Legislative Conference, Washington, D.C.

Stuart Hayman
and Dr. David Wlody
with Rep. Yvette Clarke

Dr. Salvatore Vitale, Stuart Hayman,
and Dr. Michael Simon

Dr. Lee Winter (left), Christina Parisi, legislative director
for Rep. Carolyn Maloney, and Dr. Andrew Rosenberg

Drs. David Wlody and Lawrence Epstein

(Left to right) Drs. Lee Winter, Matthew Lee,
David Currie, Steven Schulman, Lawrence Epstein, David
Bronheim, Chris Curatolo and Shawn Sikka

NYSSA Legislative Day in Albany

Drs. Michael Duffy, Jason Lok, Marcus Tholin, Jesus Calimlim and Jonathan Weaver meet with Sen. David Valesky (third from left)

Assemblyman Victor Pichardo (left) with Dr. Andrew Rosenberg

Drs. Scott Groudine and Mazin Albert participate in a meeting with a representative from Sen. Jeffrey Klein's office.

(Left to right) Drs. Brandon Kandarian, Taylor White, Ashley Whisnant, Meera Kirpekar, Christopher Curatolo, Shawn Sikka and Jonathan Gal

Drs. Andy Rosenberg, Scott Groudine and Melissa Ehlers meet with Sen. Kenneth LaValle's staff.

Drs. Alan Curle and Duncan McLean

NYSSA Legislative Day in Albany

NYSSA Executive Director Stuart Hayman, Sen. Diane Savino, and Dr. Lance Wagner

NYSSA lobbyist Bob Reid (left) and Charles Assini, Esq., address Legislative Day participants.

NYSSA President Dr. Andrew Rosenberg addresses members on Legislative Day as Dr. Michael Duffy looks on.

NYSSA lobbyist Padraic Bambrick (left) and Dr. David Wlody discuss safe anesthesia with Sen. Jeffrey Klein's staff.

Drs. Lisa Lind Phillips, Alan Strobel and Lee Winter

Assemblyman Anthony Brindisi with Dr. Andrew Rosenberg

Dr. Scott Plotkin, Assemblywoman Crystal Peoples-Stokes and Dr. Rose Berkun

(Left to right) Drs. Andrew Rosenberg, Scott Plotkin, David Wlody, Rose Berkun, Aisha Hasan, Michael Duffy and Jason Lok

(Left to right) Drs. Jonathan Weaver, Jason Lok, Andrew Rosenberg, Salvatore Vitale and Michael Duffy, Sen. John DeFrancisco, and Drs. Jesus Calimlim, Marcus Tholin and Larry Routenberg.

Sen. Susan Serino and Dr. Andrew Rosenberg

Drs. Scott Plotkin and Rose Berkun meet with Sen. Robert Ortt's legislative assistant, Gloria Pham.

Sen. Catharine Young's staff assistant (left) meets with Drs. Michael Duffy, Scott Plotkin and Andrew Rosenberg.

MSSNY House of Delegates

New York state Commissioner of Health Dr. Howard Zucker, an anesthesiologist and member of the NYSSA, addresses the MSSNY House of Delegates.

NYSSA Delegates Drs. Steve Schwalbe (standing, second from left) and Rose Berkun prepare to speak at the MSSNY House of Delegates meeting.

In the News

Dr. Lawrence Epstein poses with Dr. Sanjay Gupta prior to participating in an Anderson Cooper town hall special on the opioid epidemic.

New York Anesthesiologists to Contribute Expertise at the World Congress of Anaesthesiologists (WCA) 2016

In September 2016 the 16th World Congress of Anaesthesiologists (WCA) will return to build on the huge success of the Buenos Aires Congress in 2012. Taking place in Hong Kong, the WCA has been described as "the Olympics of anaesthesiology" and is a unique occasion to bring the specialty together, with anesthesiologists given the opportunity to network with colleagues from every corner of the globe.

The New York State Society of Anesthesiologists has a rich history of involvement in previous World Congresses. NYSSA President Dr. Andrew D. Rosenberg was an ASA official delegate at the World Congress of Societies of Anaesthesiologists in Buenos Aires in 2012.

At the WCA 2016, New York state anesthesiologists will again be a notable part of the Congress as members of the Scientific Committee, specifically in the Ambulatory, Regional, and Respiratory and Airway subcommittees.

In total, there will be 20 different scientific tracks at the WCA 2016, organized by leaders in each field, together with symposia on anaesthesia and cancer as well as obesity and sleep medicine. NYSSA members of the WCA's Scientific Committee will chair sessions and lead workshops in a number of these scientific tracks.

A few highlights in the Ambulatory track include discussions on value-based anaesthesia care titled "PONV: Can more expensive drugs save money?" and "Ambulatory anaesthesia in the U.S. - future trends" by Dr. T. J. Gan, a member of the NYSSA Academic Anesthesiology Committee. Dr. Gan will also chair the session "Effective pain and post-operative nausea and vomiting (PONV) management."

Dr. Irene Osborn, a member of the NYSSA PGA Scientific Panels Committee, will chair the VL (videolaryngoscopy) and thoracic anaesthesia workshops, as well as co-chair the session on "Difficult airways in subspecialties."

Dr. Edmond Cohen, a member of the NYSSA PGA International Scholars Committee, will facilitate a problem-based learning discussion on "Endoscopic treatment of chronic obstructive pulmonary disease (COPD)" and chair the session titled "Lung injury in thoracic surgery," both on the Respiration and Airway track.

The WFSA and NYSSA's overlapping leadership, specifically Dr. Mark Lema (treasurer of the WFSA and member of the NYSSA Academic Anesthesiology Committee) and Dr. Vinod Malhotra (chair of the WFSA Constitution Committee and member of the NYSSA PGA Scientific Panels Committee) will also contribute to the WCA's Scientific Programme with sessions in the Professional Practice and Safety and Quality tracks, respectively.

Another highlight of the WCA will be the Harold Griffith Keynote Lecture, typically given by an important figure in the global anaesthesia community.

The WFSA is very proud to announce that Dr. Atul Gawande — surgeon, writer, and public health researcher — will be one of the speakers at the 2016 Harold Griffith event. Dr. Gawande has been a staff writer for *The New Yorker* since 1998 and is the author of four best-selling books — *Complications, Better, The Checklist Manifesto* and *Being Mortal: Medicine and What Matters in the End* — that focus on the challenges of modern surgery and medical care.

Dr. Gawande will be joined by Tore Laerdal, managing director of Laerdal Global Health, to give the Harold Griffith Lecture at the Hong Kong Convention Centre on Wednesday, August 31. As two innovators in the field of medical care and global health, Dr. Gawande and Mr. Laerdal will share their views on the future of global health. This promises to be a very exciting addition to the programme.

The 16th World Congress of Anaesthesiologists (WCA 2016) will be continuing on its successful international path by providing a scientific and networking platform in the exciting city of Hong Kong from August 28 to September 2, 2016. For more information or to register, go to ***http://wca2016.com/registration.htm***. ■

WCA 2016 HONG KONG
28 August – 2 September 2016
Hong Kong Convention and Exhibition Centre

Organizer:
World Federation of Societies of Anaesthesiologists

Host Organizer:
SAHK

16th World Congress of Anaesthesiologists

28 August – 2 September 2016
Hong Kong Convention and
Exhibition Centre

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OCTOBER 21-25 BOSTON, MA	2017	OCTOBER 3-7 WASHINGTON, D.C.	2020
OCTOBER 13-17 SAN FRANCISCO, CA	2018	OCTOBER 9-13 SAN DIEGO	2021
OCTOBER 19-23 ORLANDO, FL	2019	OCTOBER 29- NOVEMBER 2 NEW ORLEANS	2022

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American Society of Anesthesiologists®

The 34th Annual International Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine

MENACHEM WEINER, M.D., GEORGE SILVAY, M.D., PH.D., AND CHRISTOPHER CURATOLO, M.D., M.E.M.

The 34th Annual Update in Anesthesiology, Surgery and Perioperative Medicine, organized by the Department of Anesthesiology, Icahn School of Medicine at Mount Sinai in New York, was held in January in San Juan, Puerto Rico. The long-standing symposium continued its successful run, with more than 200 participants from 19 countries (Austria, Belgium, Brazil, Canada, China, Czech Republic, Denmark, Finland, Georgia, Germany, Greece, Israel, Italy, Netherlands, Slovakia, South Africa, Turkey, the U.K., and the U.S.).

The symposium highlighted six special lectures from renowned physicians in anesthesiology and surgery. During the first day, Dr. Silvester Krčméry (Bratislava, Slovakia) presented the GRESSNER Gold Medal from the Slovak Society of Gerontology and Geriatrics to Dr. George Silvay.

The symposium program consisted of 92 lectures, six complimentary workshops, and an open discussion titled

Special Lectures Presented During the 2016 Symposium

MONDAY, JANUARY 18, 2016

Perioperative Medicine: Managing for Outcome
Mark Newman, M.D.
President and Merel H. Harmel Professor
Private Diagnostic Clinic
Duke University Health System
Durham, NC, USA

Health Care Reform and How Anesthesiologists Should Adapt
David L. Reich, M.D.
President and COO
Icahn School of Medicine at Mount Sinai Hospital
New York, NY, USA

TUESDAY, JANUARY 19, 2016

Twenty Most Important Anesthesia Articles Ever Published
Paul Barash, M.D.
Professor, Department of Anesthesiology
Yale University School of Medicine
New Haven, CT, USA

Regional Anesthesia in Cardiac Surgery
Mark Chaney, M.D.
Professor, The University of Chicago
Chicago, IL, USA

WEDNESDAY, JANUARY 20, 2016

Errors in Medicine: What They Should Mean to Patients, Providers and Policy Makers
Robert S. Lagasse, M.D.
Professor and Vice Chairman, Department of Anesthesiology
Yale University School of Medicine
New Haven, CT, USA

THURSDAY, JANUARY 21, 2016

Advances in Neuroprotection in Aortic Arch and Thoraco-Abdominal Aortic Repair
Christian Etz, M.D.
Professor, Leipzig Heart Center, Leipzig University
Leipzig, Germany

Dr. George Silvay receives the GRESSNER Gold Medal from the Slovak Society of Gerontology and Geriatrics.

"Is something new in cardiac surgery and anesthesiology?" that provided cutting-edge information. In addition, a dedicated research session with prizes was devoted to residents, fellows and junior attendings. There were 16 presentations, with first prize awarded to Dr. Marcin Karcz from Rochester, New York, for his presentation titled "High throughput screening reveals the mitochondrial complex I inhibitor nor-nicotine is cardio-protective in ischemia-reperfusion injury when delivered at reperfusion."

The symposium was held at the picturesque Marriott Resort in San Juan. While the days were busy with lectures, workshops and discussions highlighting current information in anesthesiology, surgery and perioperative medicine, participants also had time to enjoy the ocean and beach. During an evening reception, participants had the opportunity to reconnect with colleagues and old friends from around the world and discuss topics presented at the meeting.

Mount Sinai will host the 35th Annual International Symposium: Clinical Update in Anesthesiology, Surgery and Perioperative Medicine from **January 15-20, 2017, at the Marriott Resort, Casa Magna, Cancun, Mexico**. All are cordially invited to attend. Please send inquiries to Dr. George Silvay at George.Silvay@mountsinai.org. ■

Complimentary Hands-On Workshops

TUESDAY, JANUARY 19, 2016
One Lung Ventilation
Edmond Cohen (NY), Dawn Desiderio (NY)

WEDNESDAY, JANUARY 20, 2016
Hands On Regional Blocks
Michael Anderson (NY), Lawrence Epstein (NY)

THURSDAY, JANUARY 21, 2016
Hands On Pacemakers and ICDs
Marc Stone (NY), Menachem Weiner (NY)
Difficult Airway
Andrew Goldberg (NY), Ian Sampson (NY)

FRIDAY, JANUARY 22, 2016
Transthoracic Echocardiography
Joerg Ender (Leipzig), Marc Stone (NY)

The conference had strong participation by resident physicians from around the country.

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Perioperative Mecine:

The Ageing Patient

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Euroanaesthesia

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European Society of Anaesthesiology ESA

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Course Directors: George Silvay, M.D., Ph.D., Marc Stone, M.D., Menachem Weiner, M.D., and Andrew Goldberg, M.D.

Marriott Resort, Casa Magna, Cancun, Mexico

January 15-21, 2017

For information: george.silvay@mountsinai.org

Until Next Time

VANESSA HOY, M.D.

It is hard to believe that this day has come. This is my final message to *Sphere's* readers. With every ending there is a new beginning. For me, that new beginning involves a move to Cleveland, Ohio, to begin a pediatric anesthesia fellowship.

I am experiencing a plethora of emotions as I prepare for the next stage beyond residency: stressed, scared, excited, curious, ambitious, hopeful, and happy. There is only one direction I am looking at and that direction is up. Yes, the specialty of anesthesiology is undergoing change; we cannot sit back and assume that everything will work out. I encourage all of you to lobby on the key issues that we are facing.

What makes *Sphere* unique are the stories, photos, articles about the NYSSA's advocacy efforts, essays, and case reports that appear in each issue, as well as the authors who contribute these pieces. Thank you for allowing me to serve as your resident editor for three years and to share my opinions on issues. Please welcome the new resident editor with an open mind. Allow him/her to use *Sphere* as a platform for advocating for our specialty, documenting, critiquing, conjuring up ideas, and, most importantly, voicing opinions to provoke discussion.

One of my favorite childhood books was "*Oh, The Places You'll Go!*" by Dr. Seuss. It says: "You're off to great places, today is your day! Your mountain is waiting, so … get on your way!" To every anesthesiology resident, fellow and attending, as you journey through our great specialty, never forget who you are and never stop fighting. As you provide anesthesia to your patients, do not think of it as a regimented, mundane routine, but as an opportunity to learn and to improve their surgical experience. As you assist your patients with their breathing and control their physiological parameters, this is the time when you are your patients' advocate.

Keep perfecting the art of anesthesia, advocating for our specialty and our patients, and pushing the boundaries of change.

Until next time, keep learning! ■

Vanessa Hoy, M.D., is a CA3 anesthesiology resident at SUNY Upstate Medical Center and Sphere's *outgoing resident editor.*

What Anesthesiologists Need to Know About the Data CMS Is Collecting on Them

CHRIS J. CURATOLO, M.D., M.E.M.

Did you know that the required quality data that all physician practices are mandated to submit to the Centers for Medicare & Medicaid Services (CMS) is sorted by each individual physician and will be available for public viewing? In 2017, this data will be posted on a CMS website called *Physician Compare*.[1] What's more, just as practices have begun to adjust to some of the recent changes in quality reporting, more changes have been announced. Let's approach these changes by first understanding where all of these programs came from.

In 2006, CMS launched the Medicare Physician Voluntary Reporting Program, followed by the Physician Quality Reporting System (PQRS) in 2010. This system, which mandates the reporting of quality data by anesthesiologists (e.g., PACU transfer of care documentation), was largely a "pay for reporting" program until bonuses changed to penalties in 2015. Penalties may be as high as 2 percent for all Medicare bills submitted for the entire fiscal year.

If PQRS incentivized practices to start reporting quality data to CMS, a newer program called the Value-Based Payment Modifier (Value Modifier) aimed to analyze the value of care being delivered. Value, which CMS views as quality divided by cost, is a primary concern of CMS. Starting in 2015, the Value Modifier analyzed the quality data submitted by practices and compared it to the cost of the care they provided. Practices with high quality and low cost would be rewarded, and those with low quality and high cost would pay penalties. The analysis is set up as a zero-sum system where the losers pay the winners (up to a 4 percent penalty). The more losers, the higher the bonuses paid to the winners. As an example, the 2014 data recently released by CMS on physician groups showed some groups, albeit a minority, will receive a 15 percent to 32 percent bonus on all of their 2016 Medicare payments for (a) satisfactorily submitting their quality data and (b) providing good value with either average quality/low cost or high quality/average cost.[2]

How does a practice go about reporting quality data to CMS? There are five approved methods, but most practices will use one of two methods. The first is a claims-based approach, where practices choose from the available PQRS measures and submit special CPT codes saying that something was either done or not done (e.g., a central line was inserted in a sterile fashion). The problem here is that most PQRS measures are primary care centric (e.g., 30-day readmission rates) and do not apply to anesthesiologists. Additionally, CMS is phasing out this method of submitting quality data and, as a result, new PQRS measures are not available for claims-based submission. The approach recommended by the ASA is the Qualified Clinical Data Registry (QCDR). Approved in 2014, our specialty's QCDR is the National Anesthesia Clinical Outcomes Registry (NACOR), which is maintained by the Anesthesia Quality Institute (AQI). Most importantly, you can submit anesthesia-specific quality measures (QCDR measures) in addition to PQRS measures. Submitting via the QCDR is free for ASA members.[3]

Recently, CMS has created additional programs. Seeing a fragmented set of multiple independent quality reporting programs (PQRS, Value Modifier, and electronic health record use), CMS set out to consolidate these programs into the Merit-Based Incentive Payment System (MIPS). How we get there is via the same legislation that ended the sustainable growth rate (SGR) formula. The SGR formula was the legislation you probably heard about every year because Congress had to act yearly, often at the 11th hour, to prevent the SGR formula from imposing a whopping 21 percent pay cut to Medicare payments to physicians. The legislation that ended the SGR formula, known as MACRA (Medicare Access and Children's Health Insurance Program [CHIP] Reauthorization Act of 2015), incorporates all of these quality programs under MIPS.[4] Much of the details are forthcoming, but know that MIPS will replace PQRS and the Value Modifier in 2017, less than a year away! As if that wasn't enough, MACRA also strongly incentivizes alternative payment models (APMs) such as patient-centered medical homes. An example of this is the perioperative surgical home.

CMS is serious about paying for quality healthcare, as evidenced by the transition away from traditional fee-for-service payments and toward APMs. CMS has set a goal of APM use of 30 percent by 2016 and 50 percent by 2018. Physician anesthesiologists must continue to adapt to such regulatory changes if we wish to be successful in the future. With

the creation of our specialty's QCDR, as well as the evolution of the perioperative surgical home, we have made great progress in recent years. However, as Will Rogers remarked, "Even if you're on the right track, you'll get run over if you just sit there." As a specialty, we must keep moving forward on this track. It is now more important than ever to take the lead as perioperative physicians in our institutions. Ensure that your hospital and your lawmakers know the vital role you play in patient care, from the preoperative clinic through the intensive care unit and pain clinic. Educating policymakers on the lifesaving care we provide will help us better advocate for our specialty during future payment model deliberations. ■

Chris J. Curatolo, M.D., M.E.M., is a chief resident at The Mount Sinai Hospital, president of the NYSSA Resident and Fellow Section, and a member of the ASA Committee on Performance and Outcomes Measurement.

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Does the Medicare Opt-Out Rule Increase Access to Anesthesia Care?

SHAWN SIKKA, M.D.

Seventeen U.S. states currently operate under the Medicare opt-out rule, allowing anesthesia to be delivered by nurses without the supervision of a physician anesthesiologist. Proponents of the opt-out rule have long cited a lack of providers, particularly in rural areas, as a barrier to accessing care. A recent study published in *Anesthesia & Analgesia*, however, shows that the number of anesthesia cases performed in opt-out states is actually growing at a significantly smaller rate compared with states maintaining the requirement for physician oversight.[1]

Researchers gathered the number of Medicare claims and divided it by the population aged 65 and older to determine an anesthesia utilization rate. The opt-out states were organized into five cohorts based on the year they opted out. Four out of 17 opt-out states were not included in the analysis secondary to inconsistent data or varying usage of opt-out throughout the state. Utilization rates for three years before and after the opt-out rule was enacted were compared to non-opt-out states for the same time span.

The first state to opt-out was Iowa in 2001. Iowa experienced a growth rate of 16 percent compared to 32 percent for non-opt-out states. The second group consists of Idaho, Minnesota, Nebraska, New Hampshire and New Mexico, all of which opted out in 2002. This group showed an increase of 18 percent, while the non-opt-out states increased 26 percent. Group three comprises Alaska, Kansas, Oregon and Washington. These states had a 7 percent growth rate, compared to a 10 percent growth rate in non-opt-out states. Wisconsin and South Dakota opted out in 2005 and had a 9 percent decline, while non opt-out states only experienced a 5 percent decline. California opted out in 2009 and showed a 1 percent increase in growth rate over the non-opt-out states.

A lack of access to anesthesia services has long been cited as the main reason for the above states to abandon physician-led anesthesia in the operating room. Anesthesia growth rates in 12 of the 13 states studied are far behind the average growth and expansion of care that non-opt-out states have seen. Numerous studies have shown that patients have better outcomes, shorter hospital stays, and lower morbidity and mortality when a physician anesthesiologist is involved in their surgical care.[2]

Anesthesiologists remain leaders in quality, patient safety, and perioperative medicine and continue to provide outstanding care across the country. ■

Shawn Sikka, M.D., served as a policy research fellow in political affairs at the ASA headquarters in Washington, D.C. Dr. Sikka is a CA3 anesthesiology resident at The Mount Sinai Hospital in New York and serves as secretary and treasurer of the NYSSA Resident and Fellow Section.

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Physician Anesthesiologists Adapt, Improvise, and Overcome!

DUNCAN MCLEAN, M.B. CH.B.

For physician anesthesiologists, the impact of healthcare reform is a familiar conversation. Unfortunately, this topic is often viewed with trepidation. There remains much uncertainty, especially in regards to changes in reimbursement and anticipating the extent of the independence nurse anesthetists will have in the future. The role of the anesthesiologist, which was once limited to the operating room, is becoming ever broader: from the perioperative surgical home to pain management, critical care, the emergency room and throughout the hospital. While the job may look different from what many of us imagined, if we look back at the history of our great specialty it is difficult to imagine a more exciting time than the present.

Stephen Hawking is quoted as saying, "Intelligence is the ability to adapt to change." Generations of anesthesiologists before us have pioneered and adapted. As anesthesiology residents and fellows, we are the next generation; it is now up to us to pave the way for the future of our specialty. We will continue to face challenges, old and new. By

standing together with a united voice, we can and will continue to forge our place in the ever-changing and exciting healthcare landscape.

Your representatives from the NYSSA met in Albany in May and traveled to Washington, D.C., for the annual ASA Legislative Conference. We continue to educate our representatives to ensure that the voices of all anesthesiologists are heard. For those of us who are not physically present for the legislative process, there is still much that can be done. Be advocates for our specialty wherever you go. Show willingness to adapt and problem-solve in the workplace. Make yourselves the go-to people who can be relied upon when others cannot.

We understand that the burdens of residency and other commitments are already very high, making it impractical for many to commit extra time. However, please do not underestimate the impact of donating to the New York Anesthesiologists Political Action Committee (NYAPAC). In doing so, you will enable your representatives to best support you and to effect change, both at a state and national level. In addition, the ASA's Grassroots Network is an excellent source for the latest developments on political and legislative issues. Find out more, including how to get involved, at **http://grassroots.asahq.org/home**. ■

Duncan McLean, M.B. Ch.B., is a CA2 resident at the University of Rochester and president-elect of the NYSSA Resident and Fellow Section.

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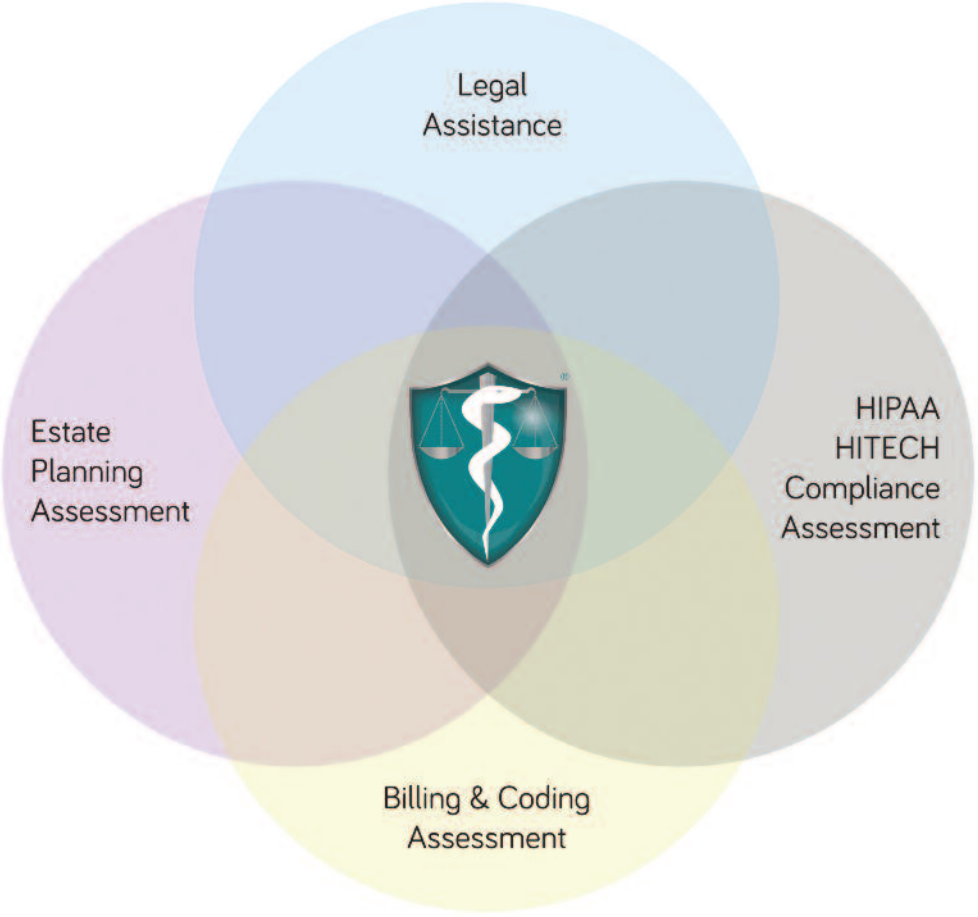

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