Addressing Disruptive Behavior in the Workplace
PostGraduate Assembly in Anesthesiology
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### Executive Director

Stuart A. Hayman, M.S.

### Editorial Deadlines

- January 15 • April 15  
- July 15 • October 15

Non-member subscription: $40 yearly

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President’s Message

What’s in a Name?

ROSE BERKUN, M.D.

For many years the New York State Association of Nurse Anesthetists (NYSANA) has been aggressively pushing a bill that would grant a nurse anesthetist the title of “certified registered nurse anesthetist.” Under this bill, in order to qualify to receive such title, an applicant would fulfill the following requirements: submit an application to the Department of Education, provide proof of a registered nurse license, show satisfactory completion of a program for nurse anesthetists, and pay a $50 fee. That’s the essence of the bill named “CRNA Title.”

Upon closer inspection of the bill, however, one will notice the absence of a significant provision. Nowhere in this bill is a requirement to define the scope of practice for the new title, in stark contrast to all other title bills.

The New York State Society of Anesthesiologists (NYSSA) supports granting CRNA title to nurse anesthetists. In fact, the “Safe Anesthesia Patient Protection” bill that the NYSSA supports grants a title to nurse anesthetists while at the same time it defines CRNA scope of practice. So why are nurse anesthetists so strongly opposed to this bill, which grants them the title they claim to want, and why do they continue to lobby on behalf of a title bill that does not include scope of practice? There can only be one reason: NYSANA and the American Association of Nurse Anesthetists (AANA) are using this bill as a back door to obtaining the right to practice independently in New York state.

In October 2012, Gov. Cuomo vetoed the same “CRNA Title” legislation, stating that the bill “fails to clearly address critical issues such as scope of practice, supervision and oversight.” To “clarify” that the bill will not change CRNA scope of practice, NYSANA added new language to show how sincere they are in their efforts to only obtain a title. The bill now states, “Nothing in this section shall be construed to define a scope of practice or permit independent practice for
certified registered nurse anesthetists.” However, the next sentence contradicts and overrides this sentence by stating, “The commissioner is authorized to promulgate regulations to implement the certification process set forth in this section.” And that’s the heart of the matter.

The establishment of a new nursing title requires the Board of Nursing to address such title and to provide what medical services can be delivered under such title. Because this bill does not define the new CRNA title’s scope of practice, it will be up to the Board of Nursing to define what CRNA scope of practice will be. That decision will be submitted to the Board of Regents and, if affirmed, will then move to be accepted by the commissioner of education, who is directed by this bill to create a new scope of practice for nurse anesthetists.

It has been a longstanding official goal of AANA to establish CRNA independent practice nationwide. They fought hard for nurse anesthetists to practice independently within the Veterans Health Administration system. Despite their loss, AANA continues to pursue the agenda of CRNA independent practice in multiple states, supporting the “CRNA Title” bill in New York state.

The NYSSA opposes the “CRNA Title” bill because this legislation fails to define the nurse anesthetist scope of practice consistent with current New York state standards, a standard of care that has significantly improved anesthesia outcomes over the last 20 years and to which compromises have been repeatedly rejected by New York’s government leaders. We further contend that keeping anesthesia safe requires defining the roles of the anesthesiologist, operating physician and nurse anesthetist. Members of the NYSSA believe it is not possible to define the scope of practice of a nurse anesthetist without defining the roles of both the anesthesiologist and the operating physician. It is not possible to define the role of the nurse anesthetist without incorporating the requirement of physician supervision and defining such terms as “supervision” and “immediately available.” All schools of nurse anesthesia in New York teach the student nurse anesthetist to work under medical direction. Clinical training of student nurse anesthetists provides the direct
and personal supervision that the health code requires. It provides no training in independent practice.

With the help of all NYSSA members and our friends at the Medical Society of the State of New York (MSSNY), we were able to defeat the “CRNA Title” bill in the 2017 legislative session. We must continue to reach out to our legislators and educate them on the importance of protecting our patients by keeping physician supervision of nurse anesthetists in New York state.
NYSSA Delegates to 2017
ASA House of Delegates

All sessions related to the ASA House of Delegates will take place at the Boston Convention and Exhibition Center (Ballroom West) as follows:

**First Session** 8:00 a.m. — Sunday, October 22, 2017

**Second Session** 8:00 a.m. — Wednesday, October 25, 2017

**DELEGATES (VOTING)**

1. Dr. Melinda A. Aquino
2. Dr. Richard A. Beers
3. Dr. Audrée A. Bendo
4. Dr. Rose Berkun
5. Dr. David S. Bronheim
6. Dr. Jesus R. Calimlim
7. Dr. Christopher L. Campese
8. Dr. Gregory W. Fischer
9. Dr. Sudheer K. Jain
10. Dr. Vilma A. Joseph
11. Dr. Jung T. Kim
12. Dr. Tal S. M. Levy
13. Dr. Jason Lok
14. Dr. Elizabeth L. Mahoney
15. Dr. Scott N. Plotkin
16. Dr. Andrew D. Rosenberg
17. Dr. Lawrence J. Routenberg
18. Dr. Daniel H. Sajewski
19. Dr. Steven B. Schulman
20. Dr. Steven S. Schwalbe
21. Dr. Michael B. Simon
22. Dr. Tracey Straker
23. Dr. Lance W. Wagner
24. Dr. Matthew Wecksell
25. Dr. Richard N. Wissler
26. Dr. David J. Wlody
27. Dr. Salvatore G. Vitale

Scott B. Groudine, M.D. — ASA Director, New York State

**ALTERNATE DELEGATES (NON-VOTING)**

1. Dr. Michael Angelucci
2. Dr. Susan Bogdan
3. Dr. Jayapratap R. Chenna
4. Dr. Edmond Cohen
5. Dr. Alan E. Curle
6. Dr. Lawrence J. Epstein
7. Dr. Michael J. FitzPatrick
8. Dr. Jonathan S. Gal
9. Dr. Kevin M. Glassman
10. Dr. Melissa A. Kreso
11. Dr. Jennifer Macpherson
12. Dr. Nader Nader
13. Dr. Chantal M. Pyram
14. Dr. Meg A. Rosenblatt
15. Dr. Michelle Schlesinger
16. Dr. Joy Schwabel
17. Dr. David Seligsohn
18. Dr. Ketan Shevde
19. Dr. Peter A. Silverberg
20. Dr. Andrew M. Sopchak
21. Dr. Francis S. Stellaccio
22. Dr. Donna-Ann Thomas
23. Dr. Stacey A. Watt
24. Dr. Lee H. Winter
Editorial

Working to Empower All NYSSA Members

SAMIR KENDALE, M.D.

There has been a lot going on behind the scenes at the NYSSA in support of our state’s anesthesiologists. One particularly exciting development is the formation of the Ad Hoc Committee on Women Physicians. In this issue of Sphere, there is a brief description of the committee’s origins and the benefits that this group hopes to provide to the women physicians in the state. Women in our profession have unique needs; hopefully the NYSSA’s women members, especially those beginning their careers, will benefit from the mentorship opportunities and PGA sessions that will address these needs.

In a continuation of the wellness theme that we highlighted in the winter 2017 issue of Sphere, Drs. Melinda Aquino and Sergey Pisklakov address the topic of bullying. As anesthesiologists we have all been in tense situations: the unanticipated difficult airway, the sudden surgical bleeding, and the obstetric hemorrhage, to name just a few. Everyone handles these circumstances differently. And everyone likely has had a disagreement with a colleague, sometimes even in the midst of these tense situations. There is an appropriate time to be demanding for the sake of patient safety, but there really is no excuse for bullying or threatening behavior. While aggressive behavior in the healthcare field may seem like a remnant of days past, we newer physicians have heard our share of stories about hurled instruments, berated nurses, and medical students whose hands were slapped. It seems like a natural byproduct of high-risk situations and type A personalities, and of long hours coupled with short fuses; ultimately, however, the hostile environment that results from disruptive behavior is likely to make things worse for the patient.

There will always be challenging people with whom we are forced to interact. We all need to feel empowered enough to speak up when something around us is amiss, and to take the high road when placed in a compromising situation. Having open communication with our work colleagues goes a long way toward maintaining a positive work environment.
Finally, speaking of communication, we are very happy to announce the launch of the *Sphere* website. The website is viewable via both desktop and mobile devices. We will be publishing some of our more popular articles on the site, and encourage all of our readers to link to your favorite articles on social media by using the links at the bottom of each article. For example, if you want to share with family members and friends the amazing things that New York’s anesthesiologists are doing around the world, tweet the recent feature article about the medical mission in Nigeria. If you are concerned about the well-being of your colleagues in the medical field, share a link on Facebook to one of the wellness articles. *Sphere* authors devote a great amount of time and energy to writing these excellent articles; it would be terrific to increase the readership of their work! The *Sphere* website can be found at [http://nyssasphere.weebly.com](http://nyssasphere.weebly.com).

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**Participate in the Democratic Process**

You have an opportunity to voice your opinions on positions and policies of the New York State Society of Anesthesiologists at the annual Reference Committee Hearing, which is open to the membership at large.

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Saturday, December 9, 1:45 p.m., Marquis Ballroom (9th floor)

Reviewing: Officers and Directors reports; Bylaws & Rules; Communications; Government & Legal Affairs; Economic Affairs; Patient Safety and Quality Improvement; Pain Management; Critical Care Medicine; Judicial & Awards; Annual Sessions; Continuing Medical Education & Remediation; Academic Anesthesiology; and Retirement committee reports.

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All Officer, Director, Standing Committee, and Board of Directors’ reports are subject to review by a panel of your peers and are discussed at this open forum.

Please come to listen, learn, and, if you wish, to speak. Here’s your chance to have a direct impact on the decision-making processes that will steer the New York State Society of Anesthesiologists into the future.

For additional information, contact Stuart A. Hayman, executive director, at NYSSA headquarters.
Addressing Disruptive Behavior in the Workplace

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

The American Psychological Association defines bullying as “a form of aggressive behavior” intended to cause distress or harm. Bullying involves an imbalance of power between the aggressor and the victim. It can be identified when someone persistently perceives him or herself to be on the receiving end of negative actions from one or several persons over a period of time. The individual at the receiving end has difficulty defending against these actions. Bullying can be physical as well as relational. It is a way to gain power.¹

Physical bullying is obvious; in our society this form of bullying tends to be the province of children. Adults are more subtle and devious in their approach; their bullying can take a variety of forms, many of which may not be obvious to a third party. This allows bullies to continue their activities unchecked, enabling them to do what they want at the expense of others.

Aggressive and disruptive behavior in the workplace is fueling a nationwide grassroots legislative effort to force companies to draft and enforce policies aimed at stopping it. Bullying has been linked to higher costs in terms of turnover and insurance claims, and to decreased productivity.² In January 2009, a new standard issued by The Joint Commission (formerly JCAHO) went into effect. It requires hospitals to have “a code of conduct that defines acceptable, disruptive, and inappropriate staff behaviors” and for its “leaders [to] create and implement a process for managing disruptive and inappropriate staff behaviors.” The rationale for the standard states: “Leaders must address disruptive behavior of individuals working at all levels of the [organization], including management, clinical and administrative staff, licensed independent practitioners, and governing body members.” A Joint Commission sentinel alert includes “uncooperative attitudes” and “condescending language or voice intonation and impatience with questions” as disruptive behaviors.
The Joint Commission’s first-ever alert about the problem is the latest industry effort to address an issue that has challenged the medical community for years. Suggested actions include better systems to detect and deter unprofessional behavior; more civil responses to patients and families who witness bad acts; and overall training in “basic business etiquette,” including phone skills and people skills for all employees.\(^3\) The lack of action against disruptive and aggressive behavior can lead to serious liabilities since these incidents sometimes constitute not only bullying, but also sexual harassment and discrimination.\(^4\)

Disruptive behavior has been observed in almost all healthcare specialties. Physician behavior, however, may have the greatest impact because of the position of authority that doctors hold as members of the healthcare team.\(^5\) Out of fear of being intimidated or patronized, a team member may withhold valuable or even critical input, such as a medication error or a breakdown in adherence to safety protocols.\(^2\)

Ensuring good patient care and respect among all healthcare professionals is at the very foundation of the ethics advocated by the American Medical Association.\(^6\) Intimidating, condescending, off-putting, or discouraging behavior by the physician inhibits positive teamwork. If an OR staff works suboptimally because of disruptive behavior by the physician or another team member, overall care quality is compromised and patient safety is threatened. To mitigate these risks, healthcare organizations may need to re-examine their hospital harassment policies to ensure those policies include specific prohibitions. Hospitals need to create workplace conduct policies that forbid disruptive and aggressive behavior, bullying or harassment. Once policies are in place, comprehensive training courses should be given to all supervisors and physicians. If policies are violated, appropriate action should be taken against violators to ensure proper enforcement.\(^4\)

There is evidence that the prevalence of disruptive behavior in the medical world is high.\(^7\) The outburst by a physician in the OR is not uncommon. Bullying and mistreatment during training are also part of the experience for many early career doctors, medical students and residents.\(^5\) A 2004 study reported that 37 percent of doctors in
training had witnessed disruptive and aggressive behavior in the past year.\(^8\) One of the major reasons for disruptive behavior is the lack of training in management and communication skills. Why do victims often not speak out against perpetrators? Victims often believe that a complaint would blight their professional progress; with an intentional bully, this might be the case.\(^9\) The consequences of disruptive and aggressive behavior are far-reaching. There is evidence that this behavior is responsible for victims becoming stressed and depressed, leading to job turnover.

Although there would appear to be a difference between intentional and unintentional disruptive and aggressive behavior, the initially unintentional perpetrator may well come to gain satisfaction from this form of behavior, which will then, of course, be reinforced. Intentional bullying is a behavior that needs both decisive intervention and help.\(^9\)

Approaches to unintentional bullying should be both educational and organizational. Work with the individual accused of bullying may need to include psychotherapy to explore the reasons for bullying or aggressive behavior. It should also include improving interpersonal and self-awareness skills so that the bully can explore and adopt alternative ways of behaving.\(^10\) The organizational culture also needs to change. Hospitals, departments and individual personnel need to develop a higher level of awareness. Anti-bullying policies should be given a higher profile. This should encourage victims to come forward so that individual bullies can be identified.

Unintentional bullies will usually, although not always, respond to the strategies outlined above and modify their behavior. They may well respond to personal approaches on the part of the victim. Victims should also approach their professional associations for advice and support. Primary preventive methods may include providing educational materials and communication skills training for residents, staff, and educators. Education on abuse, discrimination, and harassment in the workplace, and how these can be addressed and averted, can also be presented in formal and informal curricula. Such initiatives should promote inclusive language and a culture of collegiality and respect for all faculty, staff, and trainees. Secondary preventive measures should rely
in part on clear reporting mechanisms so that any occasion of abusive or discriminatory language or behavior can be addressed as soon as it arises. In the meantime, and until further data confirm or deny the concerns identified here, we should be duly vigilant.

Melinda Aquino, M.D., is an assistant professor in the Albert Einstein College of Medicine and the Department of Anesthesiology at Montefiore Medical Center. Sergey Pisklakov, M.D., is an associate professor and director of the neuroanesthesia fellowship in the Albert Einstein College of Medicine and the Department of Anesthesiology at Montefiore Medical Center.

REFERENCES


The NYSSA Ad Hoc Committee on Women Physicians: A New Frontier

MELINDA AQUINO, M.D., AND JANINE LIMONCELLI, M.D.

INTRODUCTION BY NYSSA PRESIDENT ROSE BERKUN, M.D.:

In 2013, the American Medical Association established a Women Physicians Section in order to address gender differences as they apply to salaries, promotions, sponsorship, academic advancement and other issues unique to women physicians. I became a New York state liaison to this section. I was shocked to learn that there was pay discrepancy between male and female physicians. Advancement within academic and private practice was much harder for women. As of 2013, only 13 deans of medical schools were women. I read about young women physicians leaving academics because of lack of mentorship and support. I decided to form a network for women physicians in Buffalo, which evolved into an organization called UB DoctHERS with more than 300 members and growing.

Taking a closer look at anesthesia, I realized that the same issues faced female anesthesiologists. I wanted to establish a similar section within anesthesia as was created within the AMA. However, each organization has a unique structure and I saw that a women physicians committee was a more appropriate organization. By establishing the NYSSA Ad Hoc Committee on Women Physicians I was hoping to create a membership group that would address issues that are important and unique to women anesthesiologists.

The focus of the committee would be on leadership development, successful negotiating skills, and work-life balance, as well as on providing guidance, mentorship and sponsorship within academic anesthesia, the private sector and organized medicine. As of 2016, 26 percent of the NYSSA’s active members were women physicians. The member benefits offered by the new committee would also attract more female members, potentially increasing the delegate count to the ASA and helping develop future leaders of our society.

Not all NYSSA male members were receptive to creating a new standing committee. The Executive Committee agreed to look at the work of the ad hoc committee and committed to a three-year extension for the committee, at which time it will consider establishing a standing committee if progress is made.
Because of the tremendous job done by the ad hoc committee so far, significant progress has been made and I have no doubts that a standing women physicians committee will be established when Dr. Vilma Joseph is our president.

Dr. Berkun created the NYSSA Ad Hoc Committee on Women Physicians. She appointed Melinda Aquino, M.D., as the chair of the committee and Janine Limoncelli, M.D., as the vice chair. Twenty-three members from multiple hospitals representing all the NYSSA districts round out the committee’s membership. There are both female and male members.

The mission of the NYSSA Ad Hoc Committee on Women Physicians is to educate, empower, and engage women physicians in the field of anesthesiology in order to advance the careers of women physicians and the future of our specialty. We aim to do so by constructing a network of female leaders, providing resources to women in anesthesiology, and establishing a forum for collaboration. The committee’s goals are to enable members to advance, collaborate, lead and seek equal opportunities in the practice of anesthesiology. We will support, encourage, mentor and recruit future generations of women in anesthesiology.

The first thing committee members did was to send a survey to all the female members of the NYSSA to assess the need for such a committee, and the needs we can fulfill. The preliminary results of the survey have been analyzed and categorized. As a committee, we will use this data to target and address the current challenges facing women. The survey revealed that lack of mentoring was the number one need that members want to be fulfilled. Other needs identified included professional advancement (including career advancement, negotiation skills, networking and visibility, public speaking and conflict resolution). Challenges in one’s career, including work-life balance, time management, and gender biases were also cited as important issues.

The committee has created a Web page that is available to the members of the NYSSA and serves as a resource for women physicians. Dr. Maya Jalbout Hastie has done an excellent job as our webmaster. The page can be accessed by logging onto the NYSSA website, or by our direct link: [http://tiny.cc/NYSSAWomen](http://tiny.cc/NYSSAWomen). There are drop-down
menus for event listings; current articles of interest; job postings; open
discussions of issues and questions put forth by members; advice;
mentorship; opportunities to network; a residents’ section; career and
professional development; and information about leadership, work-life
balance, advancement and other issues our members are facing. We
will be building a network of mentors and hope to foster the
connections between members and mentors. We also have a section
called “The Doctor Is In – Ask Us” where members can post questions
and concerns, and anyone can offer advice and comments. This section
acts as a live blog.

This year there will be a PGA focus session on December 9, 2017.
The content will include career advancement, preparing for leadership
positions, networking, self-promotion, negotiations, and work-life
balance. There will be three or four speakers discussing these issues.
The format will be an innovative and interactive session with female
leadership in anesthesiology.

One very important goal of the committee is to establish a
resident/medical student section, which will be headed by Morgan
Montgomery, M.D., currently a CA-2 resident at Mount Sinai Hospital.
The goal is to create a relationship with medical schools and residency
programs to educate medical students and residents on the challenges
they will face, and to assist them with any issues they need help with
as they advance in their careers.

The survey revealed that NYSSA members felt there is a great need
for mentoring. Our goals include setting up mentoring networks and
mentoring tools for mentees. Drs. Vilma Joseph and Tracey Straker
will be leading this section. Dr. Morgan Montgomery will be the
resident/medical student liaison for the residents’ mentorship. We
will establish networks for career mentoring, development and
advancement, to include key female leaders from the community, the
NYSSA and the ASA.

In the future we hope to establish a social media presence to include
both Facebook and Twitter pages. We also plan on creating mini
workshops for future PGA meetings. There are many other projects
that are being considered and developed, and we will keep you
informed as we progress.
This is only the beginning. The committee is comprised of highly bright, energetic individuals who meet via telephone on a monthly basis. We are dedicated to advancing the needs of women in anesthesiology and are open to any and all suggestions. Please feel free to contact us via the NYSSA website by clicking on our Web page, or email us at women@nyssa-pga.org. Please follow us on the website often, as new articles, questions, job postings, etc. are added daily. We look forward to serving the needs of the women in our society, and to becoming a standing committee in the near future.

Melinda Aquino, M.D., is chair of the NYSSA Ad Hoc Committee on Women Physicians and Janine Limoncelli, M.D., is vice chair.

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

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

Visit http://nyanesthesiologyfoundation.org and make your donation today.
An Introduction to the NYSSA’s New Law Firm

MATHEW J. LEVY, ESQ.

We are extremely honored to be chosen as the NYSSA’s new general counsel. I would like to introduce myself and my law firm, Weiss Zarett Brofman Sonnenklar & Levy, P.C. (Weiss Zarett). I am a partner at Weiss Zarett, and I co-chair the firm’s corporate transaction and healthcare regulatory practice. I will be the partner in charge of the NYSSA account. Our firm has a concentration in representing healthcare professionals in connection with their transactions and regulatory needs. Among the areas in which we focus are structuring and negotiating joint venture arrangements, the purchase and sale of medical practices, drafting and negotiating shareholder/operating/partnership agreements and employment agreements, compliance programs, HIPAA privacy regulations, and fraud and abuse (i.e., Stark and anti-kickback, third-party audits involving Medicare/Medicaid and private payors, and licensure issues before the Office of Professional Medical Conduct). The firm also advises healthcare clients on day-to-day business operations that have drawn the attention of the FBI, the Office of the Inspector General (OIG), the district attorney, the attorney general, and the Office of the United States Attorneys.

Weiss Zarett’s attorneys can assist members of the healthcare industry with a wide array of legal services, including civil and administrative litigation; healthcare regulatory issues, including HIPAA; fraud and abuse, including Stark and the anti-kickback statutes; Medicare/Medicaid and other third-party payor audits; bankruptcy/creditors’ rights; and commercial real estate transactions. My bio can be found at: http://weisszarett.com/lawyer/Mathew-J.-Levy_cp16495.htm.

We are here to help the members of the NYSSA and would be more than happy to assist you with any questions or concerns relating to your practice. As a member benefit, we are providing a free initial phone consultation for NYSSA members.

We will provide articles on healthcare-related topics for the NYSSA’s publications and make presentations at NYSSA meetings. We will also be in attendance at the PGA, and we are looking forward to meeting all of you. We have experience presenting on a wide range of health law
issues, including the formation of mega groups, fraud and abuse, medical records, confidentiality and protected health information, employment contract negotiations, and licensure issues. We will also be reaching out to the NYSSA’s district presidents to discuss programming and the needs of each individual district.

I have known NYSSA Executive Director Stuart Hayman for more than 15 years; I am excited to work with Stuart and the entire NYSSA team. Healthcare is an exciting field that is constantly changing; I am certain that we will be able to provide you with the legal guidance necessary to help you navigate the current healthcare climate. Please contact me at 516-926-3320 or mlevy@weisszarett.com should you have any questions or concerns, or if you are interested in discussing a future presentation.

Matthew J. Levy, Esq., is a partner at Weiss Zarett Brofman Sonnenklar & Levy, P.C. The firm can be found on the Web at weisszarett.com.

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Dr. Andrew Rosenberg speaks at the ESA meeting.

Dr. Rose Berkun

Dr. Audrée Bendo

Dr. Richard Beers

Stuart Hayman, Dr. Rose Berkun and Kelly Mancusi
Drs. Lawrence Routenberg (left) and Richard Wissler

Dr. Mike Duffy and Assemblywoman Pamela Hunter

Drs. Shannon Michel (seated, second from right) and Pratik Desai (seated, right) talk to fairgoers.

Kelly Mancusi, Dr. Rose Berkun and Will Burdett at the Canadian Anesthesiologists’ Society’s annual meeting in Niagara Falls

Drs. Rose Berkun (third from right) and past CAS presidents at the CAS annual meeting
Networking With Colleagues

Drs. Jonathan Gal, Rose Berkun and Sudheer Jain at a District 2 meeting

AMA President-elect Dr. Barbara McAneny and Dr. Mike Simon

Advocating for NYSSA Members

New York Gov. Mario Cuomo and former Vice President Joe Biden

Drs. Vilma Joseph and Iyabo Muse with New York Assembly Speaker Carl Heastie

Dr. Rose Berkun and New York Lt. Gov. Kathy Hochul

Drs. Ted Kim and Jonathan Gal with Stuart Hayman in Troy, New York

Drs. Mike Duffy and P. Sebastian Thomas with NYSSA lobbyist Bob Reid (center)

Drs. Eric Trachtenberg, P. Sebastian Thomas and Mike Duffy
Stony Brook Anesthesiology Alumni Cocktail Reception

Saturday, December 9, 2017
5:00-7:00pm

Yale Club of New York City
50 Vanderbilt Avenue
New York, NY 10017

All Stony Brook current and former residents and faculty are welcome.

RSVP: SBUH_anesthesia_alumni@stonybrookmedicine.edu by November 17, 2017

A Celebration of Research Excellence. Ranked #6 in NIH Funding among Anesthesia Departments
In her May 6, 2017, newsletter, Dr. Berkun provided NYSSA members with an update on the legislative session that ended in mid-June. In short, as Dr. Berkun noted, the nurse anesthetist title bill backed by the New York State Association of Nurse Anesthetists (NYSANA) did not advance to either the Assembly or Senate floor for a vote (S1385 Gallivan/A0442 Paulin). This represents a victory for patients in New York state because it preserves safe anesthesia practices by maintaining the existing physician-led anesthesia care team. If the nurse anesthetist title bill is enacted, safe anesthesia care would be undermined because the bill:

- Fails to mandate the existing patient safety requirement of physician supervision of every anesthetic.
- Creates a title for a nurse anesthetist but does not define the scope of practice of the profession — unlike all critical care health professions recognized by the New York state Legislature.
- Fails to define, even in basic terms, the scope of the nurse anesthetist’s role in the operating room during the administration of potentially lethal drugs, which is unprecedented and unsafe.
- Fails to clearly address critical issues such as scope of practice, supervision, and the oversight role and regulatory jurisdiction of the affected agencies (state Education Department and Department of Health); such omissions create a risk of inconsistent standards and confusion for consumers.

Dr. Berkun also emphasized the need to be vigilant in educating our lawmakers about the importance of preserving the physician-led anesthesia care team and to refute misstatements of fact made by NYSANA and other special interest groups that support the dismantling of the physician-led anesthesia care team. We can expect NYSANA to advocate for passage of their nurse anesthetist title bill in the next session. Please recall that there is absolutely no practice setting in New York state in which a nurse anesthetist is restricted from administering
anesthesia under the physician-led anesthesia care team, as mandated by long-standing New York state health code provisions and office-based accreditation standards.

I have reprinted below the memorandum that Dr. Berkun referenced in her president’s newsletter (in its entirety). This information will be useful for future meetings with your lawmakers and may be helpful when confronted by others who question the NYSSA’s goal in supporting the safe anesthesia bill, which preserves the physician-led anesthesia care team model (S4422 DeFrancisco/A1829 Morelle).

**Just the Facts: Answering NYSANA’s Memo in Opposition:**

**A1829 (Morelle)/S4422 (DeFrancisco) Safe Anesthesia Bill**

**What they said:** This bill purports to codify the practice of nurse anesthesia. It does not. It was written by doctors to protect the practice and employment of doctors at the expense of nurses. This bill was written and introduced by special interests — the New York State Society of Anesthesiologists and the Medical Society of the State of New York — and intends to allow physicians to exert control over nurses.

**Just the facts:** The NYSSA did not write the bill. MSSNY did not write the bill. New York’s legislators wrote the bill.

This bill grants title to nurse anesthetists and defines the scope of practice of a nurse anesthetist wholly consistent with existing standards set forth in the New York state health code Part 405.13 and Part 755.4. The health code mandates that a nurse anesthetist be supervised by a physician. The operating room is a unique environment; every surgery and procedure has risks. When seconds count, when a life hangs in the balance, when medical emergencies or other complications occur, it is imperative that the roles of the physician anesthesiologist and nurse anesthetist are clear. Enactment of the A1829 (Morelle)/S4422 (DeFrancisco) bill achieves this clarity.

**What they said:** Doctors cannot be allowed to control the profession of nursing. That’s why the New York State Association of Nurse Anesthetists (NYSANA), the professional association of nearly 1,400 certified registered nurse anesthetists (CRNAs) practicing in New York state, STRONGLY OPPOSES this bill.
**Just the facts:** A predominant method of delivery of anesthesia to patients in New York state is through the **physician-led anesthesia care team** wherein the physician anesthesiologist supervises nurse anesthetists (or resident physicians) in the provision of anesthesia care. The physician anesthesiologist may delegate monitoring and appropriate tasks to the nurse anesthetist while retaining **overall medical and legal responsibility** for the patient. As such, it is not possible to define the scope of practice of a nurse anesthetist without also defining the roles of both the physician anesthesiologist and operative physician.

**What they said:** CRNAs have been providing anesthesia care in New York for more than 150 years. Today, New York CRNAs work in hospitals, military facilities, ambulatory surgery centers, physicians’ offices, pain clinics, universities, dental offices, ophthalmologists’ offices, oral surgeons’ offices, plastic surgery centers, pain management clinics, prisons, and for the Department of Veterans Affairs.

**Just the facts:** The physician-led anesthesia care team is the standard of care in each of the venues listed where the administration of anesthesia occurs. In fact, the Department of Veterans Affairs in January 2017, after extensive analysis and review of comments, announced that they rejected a collaborative relationship for nurse anesthetists (even after approving collaborative relationships for three other advanced practice nurse specialties) because of significant questions raised about the safety of a “solo” CRNA model of anesthesia. The outcome of this final rule was to maintain physician-led anesthesia care in all VA hospitals.

**What they said:** CRNAs are master’s- and doctoral-prepared nurses with national certification who practice across healthcare settings, administering approximately 65 percent of all anesthetics provided in the U.S. CRNAs provide anesthesia care to all categories of patients, for all types of procedures, in every setting where anesthesia is administered. They are also the primary anesthesia providers in the majority of rural hospitals throughout New York state.

**Just the facts:** Anesthesiology is the practice of medicine. No matter how many doctoral degrees nurses have, those degrees are in
NURSING, not in medicine. In New York state, 100 percent of anesthetics are supervised by physicians because the New York state health code mandates supervision. In New York state, there are approximately 3,417 physicians who specialize in the field of anesthesiology and pain medicine; there are approximately 1,244 nurse anesthetists. Physician anesthesiologists are involved in every type of anesthetic procedure from the most basic to the most complicated. Physician anesthesiologists, with increasing frequency, complete enhanced subspecialty training in: pain medicine, hospice and palliative care medicine, sleep medicine, pediatric anesthesiology, cardiac anesthesiology, neurological anesthesiology, and other subspecialties. This enhanced training clearly distinguishes physician anesthesiologists from nurse anesthetists.

What they said: New York is home to some of the strongest CRNA graduate programs in the country. The existing requirements CRNAs must meet to receive their advanced degree have resulted in the high quality, professional standard of care exhibited by CRNAs today. CRNA education programs range from 24 to 36 months, result in master’s or doctoral degrees, and have been certified by the New York State Education Department (NYSED) as nurse practitioner programs. CRNAs acquire over 1,800 total patient care hours including research and clinical residency, and most have several years of advanced critical care nursing experience as well. Finally, CRNAs must pass a national certification examination and obtain 40 hours of approved continuing education every two years for re-certification.

Just the facts: There are significant differences in the education, training, and responsibilities of physician anesthesiologists and nurse anesthetists. Physician anesthesiologists are highly trained medical specialists: physicians who complete 12,000 to 16,000 hours of clinical training in anesthesia and in pain and critical care medicine. Nurse anesthetists complete only 1,651 hours of clinical training. A doctorate in nursing is not equivalent to a doctorate in medicine. New York state is also home to the strongest physician anesthesia programs in the U.S.

What they said: This bill would restrict the practice of CRNAs by only allowing them to practice in the presence of an anesthesiologist. This
does not reflect national standards of anesthesia practice or current practice in New York state.

**Just the facts:** This bill would simply maintain the current anesthesia delivery rules that already exist in New York state and does not require nurse anesthetists to administer anesthesia **only** under the supervision of an anesthesiologist. At the same time, it would grant the long-sought-after title the nurse anesthetists claim to be seeking. The verbatim language in this bill is:

> Section 1, Paragraph 4(b)(i): ... only under the supervision of an anesthesiologist who is immediately available; or **under the supervision of the operating physician who is physically present; or under the supervision of a dentist, oral surgeon or podiatrist who is physically present** ...

**What they said:** The language in this bill reflects conditions of participation in the Medicare reimbursement system under the federal Tax Equity and Financial Reimbursement Act (TEFRA). It has been clearly stated by the federal Health Care Financing Administration (currently the Centers for Medicare & Medicaid Services) that these TEFRA conditions do not constitute a standard of care in the delivery or administration of anesthesia. Rather, they constitute a method of reimbursement.

In other words, the conditions set forth in this bill specify what an anesthesiologist must do in order to be paid when a CRNA administers the anesthetic. These provisions do not pertain to the scope of practice of CRNAs and do not belong in an act codifying their practice.

**Just the facts:** The standard of care contained in the bill is wholly consistent with New York state health code Part 405.13 and incorporates language to define terms contained in the health code, including “supervision” and “physically present” to clarify the existing standard and not create a new standard. In other words, the A1829 (Morelle)/S4422 (DeFrancisco) bill does not restrict the practice of nurse anesthetists.

**What they said:** Rising healthcare costs coupled with fewer providers in underserved areas have had a severe impact on our healthcare system. Nationally, CRNAs make up almost half the total anesthesia-
provider workforce, but they represent only one quarter of New York state’s total anesthesia workforce, leading to limited access and increased costs.

**Just the facts:** In 2014, NYSANA commissioned a survey of 46 upstate New York hospitals on what NYSANA suggested were a set of problems sometimes associated with the provision of anesthesia services (prepared by the Center for Health Workforce Studies [CHWS], at SUNY Albany). The survey revealed that:

- Only 28 hospital administrators of the 203 hospitals in New York state (about 14 percent) responded to the CHWS survey and revealed that less than 13 percent of the respondent hospital administrators had any serious problems providing anesthesia services (equating to less than four out of 203 hospitals across New York state); and
- For those hospitals having trouble attracting physician anesthesiologists, they also had difficulty attracting nurse anesthetists in essentially the same proportion. The first highlight of the CHWS 2014 study claims that 40 percent to 50 percent of anesthesia services were provided by nurse anesthetists in upstate/rural hospitals, ignoring the fact, which they later acknowledge in the survey, that a physician anesthesiologist was also involved in 85 percent of those cases (an operative surgeon was supervising in the rest).

The current protocol in New York state is cost effective. Physician anesthesiologists avoid added consultations, screenings, and tests that drive up costs. According to a *New England Journal of Medicine* review,¹ “pre-surgical assessment and preparation of patients for surgery by physician anesthesiologists significantly reduces unnecessary testing and preventable cancellations of surgery. Physician anesthesiologists reduced medical consultation requests by 75 percent, the cancellation of operations for medical reasons by 88 percent and the cost of laboratory tests by 59 percent.” Under federal CMS guidelines, there is no reimbursement differential that favors nurse anesthetists over physician anesthesiologists and most commercial payers pay the same reimbursement. Finally, when nurse anesthetists’ compensation is adjusted to the same number and types of hours worked by physician anesthesiologists, nurse anesthetists are 70 percent the cost of private

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¹ The New York State Society of Anesthesiologists, Inc.
practice anesthesiologists and 93 percent that of academic anesthesiologists.

**What they said:** Presently, many New York state nurse anesthesia graduates are relocating to other states where they can practice to the full extent of their education and training. New York cannot afford to lose any more of its nursing workforce.

**Just the facts:** The number of nurse anesthetists practicing in New York state has steadily increased over the past several years. Now at 1,244 in the state, in 2001 they numbered approximately 800.

**What they said:** NYSANA supports the removal of barriers that prevent nurses from practicing to the full extent of their education and training. We believe that allowing nurses to practice to their fullest extent improves the quality of and access to healthcare for all New Yorkers. This bill does just the opposite.

**Just the facts:** The current scope of practice for nurse anesthetists is under physician supervision; nurse anesthetists’ training and education is based on the physician-led anesthesia care team model. The 2014 NYSANA commissioned survey mentioned above outlined a “set of problems” or barriers to a nurse anesthetist’s practice. The set of problems presented 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 physician anesthesiologists would agree are true, but for different 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.

**What they said:** On behalf of rural hospitals and the underserved, the practice of CRNAs needs to be preserved. This bill creates a disincentive for CRNAs to practice to the full scope of their education and ability, which could severely limit anesthesia services in rural and underserved areas of New York state.

**Just the facts:** The enactment of this bill A1829 (Morelle)/S4422 (DeFrancisco) will preserve the existing and long-standing New York State Department of Health regulations mandating the physician-led anesthesia care team. Nurse anesthetists have been administering anesthesia in all venues where anesthesia may be administered in accordance with this standard of care.

**Advertising the NYSSA’s Message on Safe Anesthesia Care for Patients**

This past session, the NYSSA government advocacy team (NYSSA Executive Director Stuart Hayman; Bob Reid of Reid, McNally & Savage, NYSSA’s Albany lobbyists; Dr. Rose Berkun and the NYSSA Executive Committee; and me) placed an advertisement in *Politico*, which is reproduced below. It is imperative, as part of the NYSSA’s multifaceted governmental strategy, to continue to seek new forums to advance our message to the Legislature and the public. We felt it was important that this advertisement be published during the final week of the session:

**A message from NYS Society of Anesthesiologists:**

Physician-led anesthesia medical care has led to unprecedented increases in patient safety in New York. Legislation under consideration by New York’s Legislature would create confusion regarding the roles of the physician anesthesiologist and other allied healthcare providers in the administration of anesthesia,
compromising safety for unconscious patients in the operating room. Learn more at http://www.nyssa-pga.org/politico/**

[The links to the NYSSA Memorandum in Opposition and bills are found on this Web page.] ■

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In Anesthesia, Patient Safety Should Be Fundamental

KIMBERLEY SCHULLER, D.O.

Most of us in a medical profession strongly believe in the saying, “Primum non nocere” (first, do no harm). Patient safety in the operating room relies heavily on the training and experience of the person providing the care. Nowhere is this more evident than in anesthesiology. The practice of anesthesiology has transformed significantly since its early days, requiring a tremendous body of knowledge, skill and expertise to safely anesthetize our patients. Unfortunately, many in government lack the understanding of what goes on in an operating room, yet they are charged with the responsibility of writing the legislation and regulations we all must conform to when caring for our patients.

In New York, as in many other states, the Legislature is considering changes to anesthesia care. Many understand that anesthesiology is the practice of medicine and, as such, anesthesia should always be provided by a physician or under the supervision of a physician. However, a growing minority are being pressured by lobbying groups (the New York State Nurses Association and the New York State Association of Nurse Anesthetists) to eliminate the need for physician supervision when nurse anesthetists work in the state. I hope to shed light on this issue, and to encourage the younger generation of physician anesthesiologists to get involved politically so that we can have a monumental impact on the future of anesthesia from a federal and state policy perspective.

When considering more independence for nurse anesthetists, we must first and foremost examine the educational differences between nurses and physicians. We would all agree that education plays a fundamental role in developing the skill set necessary to practice a healthcare profession safely. Physician anesthesiologists obtain a medical degree (M.D. or D.O.) after a bachelor’s degree, totaling eight years of post-secondary education. After medical school, residency training consists of a one-year internship followed by three years of training in anesthesiology. Some continue on for an additional one to two years and subspecialize, for a total of 12 to 14 years of higher education and 12,000 to 16,000 hours of clinical training. This training equips physicians with the knowledge we need to provide
comprehensive medical care to a population with a growing complexity of medical conditions, including an increasing number of both premature infants and elderly patients.

Most nurse anesthetists obtain a bachelor’s degree followed by two years of work experience in an intensive care unit. Then, if accepted, they pursue a master’s degree from a nurse anesthetist school, which entails approximately 1,700 clinical hours. In the past, some nurse anesthetists received their RN license after obtaining an associate degree and then went to nurse anesthesia school. Thus, some nurse anesthetists are practicing in New York state without having obtained even a four-year bachelor’s degree! Currently, there is a push for all advanced practice nurses to obtain a doctorate, which consists of an additional year of training and is geared toward measuring patient outcomes as well as understanding the healthcare system and quality and safety measures, not toward understanding the intricacies of complicated medical conditions.

Understanding the educational paths each profession takes is a critical distinction that needs to be addressed. Nurse anesthetist education originally focused on providing a background in administering and assisting with the technical aspect of anesthetic services (a nursing service). It was always understood that providing anesthesia services without someone with medical training overseeing the procedure would put patients at risk. Nurse anesthesia schools are not medical schools, but they didn’t have to be because someone with medical training was always responsible for the patient’s care!

This leads us to the legislative fights now taking place in Albany. The New York State Association of Nurse Anesthetists has promoted the “registered nurse anesthetist title bill” (A0442/S1385), which provides for a title of “certified registered nurse anesthetist.” Currently in New York, nurse anesthetists are licensed as registered nurses. There is no separate license for nurse anesthetist. This lack of title has not deterred nurse anesthetists from practicing, as New York State Department of Health regulations permit this type of specialized nursing care. This is similar to the situation with physicians. We have a medical degree but are not licensed specifically as anesthesiologists. This lack of title protection for anesthesiologists has never been an issue. It is understandable that nurse anesthetists want to be recognized for their additional training; however, it is not needed for nurse
anesthetists to practice independently in this state. Most anesthesiologists have no problem establishing a new category of nursing licensure as long as the definition of that title is transparent. The definition of a “nurse anesthetist” must contain a scope of practice that has been earned by education and experience and not by political lobbying.

The current bills A0442 and S1385 would establish a title without defining scope of practice, which would be relegated to the New York State Education Department. This can eliminate the current, long-standing physician supervision requirement, whether by an anesthesiologist or surgeon, and the Legislature’s control in establishing a defined scope of practice. Putting the scope of practice definition in the hands of the Education Department can compromise patient health and safety due to the ambiguity that would result when deciding what it is, exactly, that a nurse anesthetist can do. This legislation recently made it out of committee in the Assembly and remained in committee in the Senate. Luckily the legislative calendar ended and now anesthesiologists have a few more months to educate our legislators on the important job we do.

Expansion of scope of practice by mid-level providers was a common theme in last year’s legislative agenda and probably will be in the next legislative session. There are a few bills that would expand scope of practice for nurse anesthetists. These include the “CRNA prescription writing authority” legislation (S1957), which would give nurse anesthetists the ability to prescribe medication during the peri-anesthetic period. To obtain this privilege the anesthetists will complete a short program; they would then obtain a certificate that would be approved by the Department of Education. Understanding the interaction between drugs and anesthetic agents is more complex than that. Even though anesthesiologists are required to attend four years of medical school and four years of residency training, we often are challenged by the pharmacology of our practice. Allowing practitioners with less training to prescribe drugs will put patients at risk.

Another bill, “CRNA collaborative practice” (S3501), would allow nurse anesthetists to obtain title certification and to administer anesthesia and pain therapies without the supervision of a qualified physician anesthesiologist. Additionally, it would abolish existing statewide regulations stating that if an anesthesiologist is not available, the
responsibility of supervision falls on the surgeon. Recently at the federal level, the safe VA care initiative rejected the idea of nurse anesthetists providing anesthetic services without the presence of a supervising physician because the federal government acknowledged that an operating room was a special environment where decisions need to be made quickly and those decisions can have a significant effect on patient care. In order to facilitate veterans care at VA hospitals, most advanced practice nurses had the requirement for medical collaboration or supervision removed. This did not extend to nurse anesthetists because of the large outcry from veterans and others concerned about patient safety.

Additionally, at the federal level there is the APRN Compact, which was approved by the National Council of State Boards of Nursing. It allows advanced practice nurses to get certified in their home states and then to practice in another participating state according to the scope defined in their home states. This compact includes nurse anesthetists. Therefore, if New York state were to join the compact, a nurse anesthetist from another state with less patient protections could practice independently in New York. This is a tremendous threat to our profession and our patients. So far, legislatures in only three states (Idaho, Wyoming and North Dakota) have supported this. It will take 10 states opting to participate before the compact will become National Council of State Boards of Nursing policy. Several key provisions of the compact are (www.ncsbn.org/Key_Provisions_of_New_APRN_Compact.pdf):

- An APRN multistate license is recognized as authorizing the APRN to practice in each party state, under a multistate licensure privilege, in the same role and population focus as in the home state.

- An APRN multistate license shall include prescriptive authority for non-controlled prescription drugs. An APRN shall satisfy all requirements imposed by the state for each state in which an APRN seeks authority to prescribe controlled substances.

- An APRN multistate license holder is authorized to practice independent of a supervisory or collaborative relationship with a physician.
While these issues deserve the attention of all anesthesiologists, they are of special concern to those just starting their careers in anesthesia. Unfortunately, the current world of anesthesia extends outside of the ORs, the intensive care units, and the office setting and into the political processes of our state and federal governments. In the modern world, medicine is not only practiced by physicians but by anyone who can influence the legislature. By and large many legislators want to do what’s right for their constituents, but if the only ones talking to them and supporting them politically and financially have ulterior motives, their view of what is best for our patients can be led astray.

Doctors tend to be busy caring for patients. Other healthcare providers have the time to try to obtain by legislation that which they did not get through education. As guardians of our patients’ health, it is important that legislators hear our voice. We must work to prevent a dual standard of care from developing in anesthesia care: patients who have a physician provide or direct their care and those who don’t. I will always insist that a physician be involved in the delivery of my anesthetic. But what about patients with limited resources and limited choices? They may be forced to receive care from someone who hasn’t obtained a medical degree. Currently, everyone in New York receives the same high standard of anesthesia care. We need to preserve that care by making time to speak to legislators and giving money to NYAPAC (www.nyssa-pga.org/about/donate-to-nyapac) and ASAPAC (www.asahq.org/advocacy/asapac). We need to get involved. People in Albany, New York, and Washington, D.C., are making decisions that will influence the practice of anesthesiology dramatically; they need to hear from you. The key to safe anesthesia care starts with physicians maintaining a prominent voice and role in the legislation of healthcare. Get involved!

Kimberley Schuller, D.O., is a resident physician at Albany Medical Center.
The Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai, New York, NY, USA presents the

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