NYSSA Committees Serve the Members and the Mission
PostGraduate Assembly in Anesthesiology
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President’s Message

Promoting Our Important Work
VILMA A. JOSEPH, M.D., M.P.H., FASA

The legislative session is underway and I am delighted to share an exciting development with NYSSA members. New York Assemblywoman Rodneyse Bichotte and state Sen. James Gaughran have introduced legislation addressing nurse anesthetist scope of practice and restricting the use of the term “anesthesiologist.” These bills were introduced into the Higher Education committees in the Assembly and Senate. Essentially, A.7100/S.5885 would codify the existing health code. Nurse anesthetists would be required to be supervised by physician anesthesiologists, operative physicians, podiatrists or dentists under certain circumstances. The legislation does provide title to nurse anesthetists, who historically have been considered registered nurses by the Department of Education. Another issue that is addressed in this legislation is the use of the term “anesthesiologist.”

We are all aware that transparency is important to our patients. Allowing other specialties like nurse anesthetists and dentists to utilize the term “anesthesiologist” is deceptive. Other states have had mixed success with this matter. For instance, Texas has passed legislation that prohibits nurse anesthetists from using the term “nurse anesthesiologist,” with violators subject to criminal prosecution. In New Hampshire, however, the Board of Nursing has approved the use of the term “nurse anesthesiologist.” The legislation proposed in New York, A.7100/S.5885, would restrict the use of the term “anesthesiologist” to those “authorized to practice medicine.” The benefit of this legislation is that it would impact multiple specialties.

In contrast to the above Assembly and Senate bills, legislation has been introduced in the New York Senate that would change the health code: S.2563. New York Sen. Jamaal Bailey has once again introduced a bill that would allow nurse anesthetists to have a collaborative relationship with physicians and full prescriptive authority. While the physician’s opinion would supersede that of the nurse anesthetist if there were a dispute over an issue, the collaborating physician would have up to three months to review a chart. There would be no requirement for physicians to be immediately available. We will keep members informed about the status of both pieces of legislation.
Legislation that would impact anesthesiologists has also been introduced at the federal level. The U.S. Senate is considering the STOP Surprise Medical Bills Act, which mirrors some of the essential elements of New York state’s out-of-network billing legislation. It would remove patients from the dispute process, instead allowing insurance companies to utilize a percentage of in-network payment, and it includes an independent dispute resolution process. Luckily, Rep. Joe Morelle is working on bipartisan legislation that would emulate the work he did in creating the 2015 New York out-of-network law. Another interesting bill is H.R.1554, which would allow residents and fellows to defer their loans, interest-free, until after they finished their training. In addition, S.2666 would allow anesthesiologists who work in rural hospitals to be paid out of Medicare Part A, just like nurse anesthetists. A special thanks to all the attendings and residents who lobbied this spring!

NYSSA members are also continuing our efforts to promote the important work that anesthesiologists do in the perioperative setting. On the national level, we have asked the American Society of Anesthesiologists and the National Medical Association to co-sign a letter to the writers of a television show that features an anesthesiologist as a main character. This Golden Globe-winning show is called “Black-ish,” and it just wrapped up its fifth season. Our letter not only commends the writers for presenting anesthesiologists in a positive light, it also offers our services if the writers are in need of specialty-related content suggestions. We hope to have the show creator’s wife, Dr. Rainbow Edwards-Barris, speak at the Women in Anesthesiology Committee’s Clinical Forum at this year’s PGA.

Finally, I encourage you to volunteer at the NYSSA booth at the New York State Fair on August 21 through September 2, 2019. More than one million people attend this event, which provides a great opportunity to showcase our specialty. Contact the NYSSA headquarters if you are interested in volunteering your time at the booth.

**In Memoriam**

It is with great sadness that I announce that NYSSA member Dr. Joyce McChesney of Rochester, New York, passed away on May 24, 2019, at the age of 92. Dr. McChesney joined the NYSSA in 1964 and became president in 1979. Predeceased by her daughter, Ida Rozanov, Dr. McChesney is survived by two sons, Irvin and Paul (Peggy); her son-in-law, Nick Rozanov; and six grandchildren.
Editorial

Recognizing the Importance of Communication

SAMIR KENDALE, M.D.

A central tenet of medical simulation is what is often called the “Basic Assumption.” This is the assumption that everyone involved in the simulation is capable of participating and is aiming to do his or her best. Similarly, years of working in team environments, teaching residents, and cooperatively running a household have taught me that it is not fair to judge a lack of action without clearly communicating the desire for that action. I shouldn’t fault a surgeon for moving the patient during airway management if I have not explained why that can complicate the procedure. I shouldn’t chide a new resident for not knowing how to spike an IV bag if I haven’t taught him or her how. Most of us do not have the power of telepathy, so I cannot assume someone else knows exactly what I want or need at any given time if I do not communicate properly.

The importance of clear and accurate communication in the medical field cannot be overstated and has led to the development of checklists in a variety of healthcare settings. Protocols like “time out” in the operating room, which can seem cumbersome to us all at times, prompt us to communicate with each other before proceeding, ensuring that we can then focus on providing the highest-quality care to our patients.

Why should communication outside of the operating room be any different? We should aim to be equally precise in our day-to-day communication. I shouldn’t blame my wife for not taking out the trash when we haven’t discussed who was responsible for doing that. Along those lines, as someone involved in the NYSSA, one of the most common questions I get is: Why should I join the NYSSA and how does it benefit me? I typically offer a range of responses: to meet other members of the anesthesiology community, to attend the PGA, to support the advocacy mission of the NYSSA. While those elevator pitches are accurate, it is often challenging to elucidate precisely what it is that the NYSSA does for its members on a weekly, monthly, or
yearly basis. With that in mind, we have decided to let all the NYSSA members take a look behind the curtain. With this and future issues, we plan to detail what many of the NYSSA committees do to support the organization’s mission. It is our hope that this more open level of communication will encourage you to take pride in and support the important work your colleagues do on behalf of all NYSSA members.
From the Executive Director

New York Sets the Standard for Surprise Billing Legislation

STUART A. HAYMAN, M.S.

In September 2008, as the NYSSA’s new executive director, I attended a joint hearing of the New York Insurance Department and the Department of Health on out-of-network insurance coverage and surprise billing. NYSSA officer Dr. Scott Groudine accompanied me that day, and he did an impressive job testifying on behalf of the NYSSA and the specialty of anesthesiology.

In a packed hearing room, patients shared egregious examples of excessive medical bills. At the conclusion of the testimony (from physicians, insurers and patients), Mr. Troy Oechsner (then the Insurance Department’s deputy superintendent for health) addressed the room. He said: “We must take the patients out of the middle of this issue and make this between the provider and the insurer. We need adequate disclosure and transparency from the healthcare facilities, physicians and insurers. We need adequate reimbursement from the insurers, and we need adequate physician networks that ensure up-to-date information and protections.”

New York’s out-of-network/surprise billing legislation was needed because many insurance companies were drastically reducing what they covered for out-of-network care, often covering only a meager percentage of the actual cost of care. Health insurers based coverage decisions on the severely inadequate Medicare fee schedule. They also gave patients and employers the false impression that their policies covered the policyholder’s physician of choice when, in fact, these policies often barely covered any out-of-network costs, leaving patients with unexpected, potentially enormous bills.

At the time, health insurers also seemed to be doing an end run around the important settlements that New York Gov. Andrew Cuomo fostered when he was attorney general. These settlements were supposed to end deception in out-of-network health insurance coverage. Insurers were forced to stop using the manipulated Ingenix database as the benchmark for out-of-network charge data, and they were required to contribute
tens of millions of dollars to create a new, self-sustaining, independent benchmarking database called Fair Health.

The regulations that took effect in New York as a result of this new legislation established a system with baseball-style arbitration, utilizing data/analytics that represented the claims of the privately insured only. For the patients who purchased out-of-network benefits, this meant that insurers would have to pay out-of-network claims based on non-governmental and reasonable reimbursement (no Medicare or Medicaid data artificially lowering reimbursement rates).

The insurers complained and threatened that insurance premiums would experience double-digit inflation; this never materialized. In fact, to this day I am not aware of a single complaint by New York insurers, going back to the implementation of this system in 2014.

Additionally, many in the medical community expressed apprehension that the cost and time associated with the appeals process would be a deterrent to physicians seeking fair payment for their services. However, New York state created a loser pays system, with simplistic forms, defined review criteria, and a 30-day window for arbitration. The results: We have not heard any complaints from physicians about the arbitration process.

Finally, the patients were taken out of the middle. This has made out-of-network/surprise billing a nonissue in New York state. The number of patient complaints since this legislation took effect has diminished to a negligible number. The media no longer publishes stories about patients being saddled with excessive medical charges. New York’s legislation was a win for the governor, legislators, insurers, physicians and patients. How many times can you say that about a piece of legislation?

Dr. Scott Groudine’s testimony in 2008, along with the efforts of many other physicians, medical society staff members, and government staff, led to the passage of what is now touted as the BEST out-of-network/surprise billing legislation in the U.S. Many additional years of hard work led to the implementation of the final regulations in 2014. A special thank you is owed to Dr. Groudine and many other physicians and medical society staff, including NYSSA members Drs. Michael Simon, David Wlody and Larry Epstein, as well as former MSSNY officer Dr. Andrew Kleinman and lobbyist Moe Auster.
As states across the country have struggled to pass legislation and regulations to tackle the problems associated with out-of-network/surprise billing, many have looked to New York to see what regulations we have implemented and if they are working. Unfortunately, few states have found a way to follow our lead. Of the states that did pass some type of out-of-network/surprise billing legislation, none have anything comparable to New York. Nearly five years after New York’s legislation was implemented, U.S. Sen. Bill Cassidy (R-La.) began working with a bipartisan group of senators to write legislation that would tackle this issue on the federal level. I commend the Senate’s effort. As we have seen in New York, resolving this problem requires removing the patient from the middle and creating a level playing field for physicians and insurance companies to resolve their disagreements. ■
Each year the House of Delegates of the New York State Society of Anesthesiologists bestows the Distinguished Service Award on an outstanding member of our Society. The award recognizes significant contributions to anesthesiology and the NYSSA and is the highest honor that our Society can give to any member.

As outlined in the NYSSA Bylaws:

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

Any member of the NYSSA may submit a nomination. There is no nomination form. We only request a letter indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. The candidate’s current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., FASA, at NYSSA headquarters (HQ@nyssa-pga.org) before July 31, 2019.

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

Michael P. Duffy, M.D., FASA, Chair
NYSSA Judicial and Awards Committee
NYSSA Committees Serve the Members and the Mission

SAMIR KENDALE, M.D.

Each and every day, in ways large and small, dedicated members volunteer their time to help fulfill the NYSSA’s mission to advance the specialty of anesthesiology and ensure that the safest, highest-quality patient care is available to all New York’s citizens. With 12 standing NYSSA committees, 11 standing PGA committees, numerous ad hoc committees, eight districts, and a Resident and Fellow Section, there is no shortage of opportunities to get involved and make a difference. In this and future issues of Sphere, the editorial board is pleased to highlight the work of a few of the NYSSA’s committees.

Communications Committee

The mission of the NYSSA Communications Committee is to develop and disseminate information for the benefit of NYSSA members as well as the general public. The committee’s goals support the NYSSA’s strategic plan extensively. Activities are focused into three major categories: Sphere (i.e., print communication), public relations (i.e., in-person communication), and the online community (i.e., digital communication).

Sphere is the NYSSA’s quarterly publication. In each issue, Sphere’s editors aim to engage members by showcasing the activities of NYSSA members (publicized through photo spreads of various legislative events, the PGA, and other national and international conferences) as well as articles of general interest, such as feature pieces on the different hospitals in the state, a wellness series, and essays on members’ medical mission trips. Regular content includes the president’s message, a legal article, a legislative report, updates from the NYSSA’s executive director,
a Resident and Fellow Section update, and membership updates. In addition, *Sphere* frequently includes case reports, medical app reviews, and reports of other scholarly endeavors by the membership.

*Sphere* is currently available as a print edition, as a PDF file on the NYSSA website, and as a blog version that includes selected articles likely to be enjoyed by a broader audience.

On the public relations front, the NYSSA typically shares a booth with the Medical Society of the State of New York at the New York State Fair, which is held each summer in Syracuse, New York. Dr. Parikshith Sumathi coordinates the exhibit and the volunteers for this event. Our goal is to educate the general public about physician anesthesiologists, including our many years of education and rigorous anesthesiology training. Booth volunteers spend most of their time explaining to the general public what physician anesthesiologists do every day in operating rooms, surgery centers, and pain clinics. Fair attendees can also have their blood pressure checked, and they can learn about and experiment with airway equipment. The fair allows anesthesiologists and anesthesia residents to interact directly with the public in a nonmedical setting.

Information about anesthesiology is provided to fairgoers who visit the NYSSA’s booth at the New York State Fair.
As more people turn to the Internet for their news and information, the Communications Committee is evolving in terms of the way we utilize electronic media. The Sphere website includes shareable articles that can be disseminated selectively by NYSSA members via Twitter, Facebook, email and other platforms. Our online presence has increased over the past few years, and we will continue to promote retweeting and sharing of ASA material not only to other NYSSA members, but also to other members of the medical and nonmedical communities in order to promote the NYSSA's message. We aim to drive traffic to the NYSSA website with the use of social media, and we have recently formed a subcommittee to focus on this goal.

As the NYSSA strives to support New York’s anesthesiologists, it is crucial that we continue to engage you, the members. The Communications Committee’s activities are designed to fulfill one part of the NYSSA’s overall mission.
Bylaws and Rules Committee

MATTHEW WECKSELL, M.D.

The Bylaws and Rules Committee ensures that the NYSSA’s bylaws serve the needs of the association and the members. This often means updating the NYSSA’s bylaws to conform with the ASA’s bylaws, which spell out requirements for component societies. When the ASA makes changes to its rules, we must amend our bylaws accordingly, while also ensuring that our bylaws best serve our specific needs as a New York society. We also act on suggested bylaws changes brought to us by both the NYSSA’s leadership and our general membership.

In recent years, members of the Bylaws and Rules Committee have discussed such issues as whether resident physicians should be allowed to be seated as delegates in the NYSSA House of Delegates and how to handle physicians who neither work nor live in New York but wish to be members of the NYSSA. The Bylaws and Rules Committee stands ready to address all issues referred to it by members of the NYSSA.

Matthew Wecksell, M.D., FASA, is the chief of general anesthesiology at Westchester Medical Center and the chairman of the NYSSA Bylaws and Rules Committee.
NYSSA Members Reach Out to the Community

Whether talking with visitors to the New York State Fair or giving a presentation about the specialty of anesthesiology to a group of high school students, NYSSA members are always looking for creative ways to give back to the community. This year, NYSSA President Dr. Vilma Joseph decided to provide a more organized way for members to get involved in community outreach.

The Ad Hoc Committee on Mentoring was formed to promote career advancement among anesthesiologists, to encourage medical students to consider a career in anesthesiology, and to promote the specialty to high school and college students. NYSSA members are encouraged to participate in career-oriented events and to become mentors in the classroom. Drs. Leroy Phillips, Wendy Bernstein, and Stacey Watt will spearhead the ad hoc committee’s efforts.

Even before the creation of this committee, NYSSA members were demonstrating their commitment to their communities. In the summer of 2018, Dr. Leroy Phillips, an assistant professor in the Department of

Dr. Leroy Phillips donated his time to talk about his career as an anesthesiologist with students participating in the Brooklyn-Queens-Long Island Area Health Education Center (BQLI-AHEC) Summer Health Internship Program.
Anesthesiology, Perioperative Care, and Pain Medicine at NYU Langone Hospitals, accepted an invitation from the organizers of the Brooklyn-Queens-Long Island Area Health Education Center. Dr. Phillips donated his time to talk about his career as an anesthesiologist with students participating in the Summer Health Internship Program. His presentation was followed by a question and answer session.

In January 2019, Dr. Stacey Watt, chief of anesthesiology for Kaleida Health and program director for the pediatric anesthesiology fellowship at the University at Buffalo, served as the event organizer when the Zonta...
Club of Grand Island sponsored its first-ever Amelia Earhart Inspiring Careers in STEM panel discussion on women in the sciences. Dr. Watt moderated the discussion, which featured women scientists on the University at Buffalo faculty. The panel included NYSSA Past President Dr. Rose Berkun.

In recognition of Dr. Watt’s work on this event and other community outreach activities, Grand Island recognized her as the Citizen of the Year in Science & Medicine at a reception held in Niagara Falls, New York, in early May.

We know that other NYSSA members have contributed to their communities by participating in educational and mentoring activities, and we hope to publicize these efforts in future issues of Sphere. We invite all NYSSA members to share with your colleagues how you are helping to inspire a new generation of anesthesiologists. Send your stories to Lisa ONeill at lisa@nyssa-pga.org.
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:

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2. The recipient must have provided significant service to the NYSSA by playing an active role in anesthesia education and/or an active leadership role in the NYSSA.
3. The Wall of Distinction award can only be conferred posthumously and is not required to be awarded annually.

Any member of the NYSSA may submit a nomination. There is no nominating form. We request only a letter from you indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. If available, the candidate’s current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., FASA, at NYSSA headquarters (HQ@nyssa-pga.org) before July 31, 2019.

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

Michael P. Duffy, M.D., FASA, Chair
NYSSA Judicial and Awards Committee
Understanding How to Respond to a Visit From an Investigator

MATTHEW J. LEVY, ESQ., AND STACEY LIPITZ MARDER, ESQ.

Introduction
As the government and private payors continue to invest resources in combating fraud and abuse in the healthcare system, many practices are being faced with unexpected visits from state and federal government and private investigators, including, but not limited to, investigators from the Office of the Inspector General (OIG), Medicare and the Office of the Medicaid Inspector General (OMIG), the Internal Revenue Service (IRS), the Office of Civil Rights (OCR), and the Occupational Safety and Health Administration (OSHA). In the event one of these investigators decides to make a visit to your office, it is imperative to understand how you and your staff should respond in order to ensure that your interests are protected and that your exposure is limited.

Ask for Proper ID
If an investigator knocks on your office door, the first thing you, or your staff member, should do is check the investigator’s identification and credentials. It is important to keep a copy of this information, including the individual’s name, title, agency and contact information, including phone, fax, address and email (i.e., a business card), as well as the date and time the investigator arrived at the office. This information should be kept in a safe place for future reference.

Limit Communication
Physicians must remember to live by the golden rule: NEVER speak to, or allow anyone in your office to speak to, any investigator! Although these investigators are often friendly, their intention is to obtain as much information from you and your staff as possible with respect to your practice. Other tactics often used by investigators are intimidation and promises of leniency. It is especially important never to speak with an investigator without your legal counsel present, as anything that is said to the investigator can and will be used against you. Unfortunately, many physicians and their staff members speak freely and recklessly with investigators without the benefit of having counsel present, and they often share information that is detrimental to the practice. Even if legal counsel is retained after the discussions, the information initially shared will always remain in the record.
Because you and your staff are not obligated to speak with anyone without your counsel present, you should explain to any visiting investigator that you would be more than happy to speak with the investigator once he/she has spoken with your attorney. Government investigators do not possess subpoena power or have other legal authority by which to compel you to speak with them. Once counsel is obtained, you, the investigator and your attorney can set up a mutually convenient time to speak. Prior to this meeting, your attorney can often ascertain from the investigator why your practice is under investigation and the specific areas of concern. This can often help you formulate an appropriate response. Furthermore, you will be able to make certain that the meeting does not disrupt the continuity of patient care and office operations generally.

**Ask That the Request for Records/Documents Be Made in Writing**

In most instances, visiting investigators will make a request to obtain a copy of medical records and other documents involving the practice, including contracts and corporate documents. Your staff members should be informed that they should not release any records without first speaking with you. Furthermore, do not provide the investigator with the requested records immediately upon his/her request. Instead, you or your attorney should stipulate that the request for information be provided in writing so that you and your attorney can ensure that the requested records are within the appropriate scope and that the investigator is entitled to such records. Furthermore, by providing the records directly to the agency, you are in control of what is provided, and you can ensure that complete copies of the records are provided. Unfortunately, when investigators make copies upon an initial visit, oftentimes the investigators do not make complete copies of the records, or they copy additional information that may not be part of the initial request. It is best either to provide the records directly or to set up a time for the investigator to come back after hours to make the copies. In addition to controlling the information disclosed, this will limit disruptions to your office.

Prior to turning over such information, specifically medical records, you also need to confirm that such disclosure is compliant with HIPAA and state privacy rules and regulations, and that the appropriate authorizations have been obtained.
Conclusion
A visit from an investigator can be a daunting experience. Therefore, even the most informal initial contact by an investigator should prompt an immediate and well-coordinated response. It is important to be prepared and to educate your staff about the practice’s protocols with respect to responding to a visit from an investigator. Have a written policy in place outlining the specific steps that your staff should take in such instances, including contacting legal counsel and providing medical records. These protocols are extremely important and can often mitigate any consequences associated with an agency’s findings. Physicians must ensure that they protect their interests and limit their exposure while cooperating with investigators, as the results of any investigation can be detrimental to a practice.

Mathew J. Levy, Esq., is a partner and Stacey Lipitz Marder, Esq., is senior counsel at Weiss Zarett Brofman Sonnenklar & Levy, P.C., the NYSSA’s general counsel. Mr. Levy can be reached at 516-926-3320 or mlevy@weisszarett.com. Ms. Marder can be reached at 516-926-3319 or smarder@weisszarett.com. The firm can be found on the Web at weisszarett.com.

The 73rd PostGraduate Assembly in Anesthesiology Call for Abstract Submissions:

- Poster Presentations
- Medically Challenging Case Report Posters
- Scientific Exhibits

Deadline: August 4, 2019 | Electronic submissions only.

Visit: www.pga.nyc
Questions? Contact MaryAnn Peck at 212-867-7140 or maryann@nyssa-pga.org.
KEYNOTE SPEAKER

Abraham Verghese, M.D., MACP

Dr. Verghese sees a future for health care which marries technological innovation with the traditional doctor–patient relationship. He grounds his vision of technological progress in a humanistic commitment to listening to the patient’s story and providing what the patient most wants—a true caregiver. This dual-pronged approach makes Dr. Verghese a leading voice in the discussion about what quality care means now and in the future.
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Supporting New York Legislators

Gov. Andrew Cuomo and Dr. Vilma Joseph

New York state Senate Majority Leader Andrea Stewart-Cousins addresses attendees at the Democratic Senate Campaign Committee (DSCC) Spring Reception.

Deputy Majority Leader and DSCC Chair Sen. Michael Gianaris makes remarks.
Mt. Sinai Residents Raise Funds for NYAPAC

Assembly Speaker Carl Heastie Fundraiser

(Left to right) Drs. David Wlody, Vilma Joseph, Sergey Pisklakov, Amaresh Vydyanathan, and Sandy Malhotra with Assembly Speaker Carl Heastie

(Left to right) Drs. Melinda Aquino, Sergey Pisklakov, Tracey Straker, Vilma Joseph, and Marina Mogulevitch
MSSNY House of Delegates

Drs. Vilma Joseph and Rose Berkun with Dr. Malcolm Reid, former president of MSSNY

Dr. Rose Berkun becomes MSSNYPAC co-chair as Dr. Joseph Sellers steps down.

MSSNYPAC Fundraiser

NYSSA members show their support for MSSNY’s political action committee.
COPA 2019
São Paulo, Brazil
ASA Legislative Conference

New York’s delegation to the ASA gather in front of the U.S. Capitol

(Left to right) Drs. Gregory Yanez, Jason Lok, Michael Duffy, David Bronheim, and Richard Wissler


Drs. Samantha Lomando, Kashmira Chawla, CT Lee, Brittany Reardon, and Jonathan Gal with a representative from U.S. Rep. Jerrold Nadler’s office and Stuart Hayman
New York’s delegation to the ASA Legislative Conference

Drs. Alexander Movshis, Erica Fagelman, Morgan Montgomery, Gregory Yanez, Oden Tal, Jonathan Gal and David Bronheim

Dr. Michael Simon with U.S. Sen. Ted Cruz (R-Texas)

New York’s delegation to the ASA Legislative Conference

NYSSA/ASA Memorandum of Understanding

NYSSA Executive Director Stuart Hayman and ASA CEO Paul Pomerantz sign the NYSSA/ASA memorandum of understanding.
NYSSA Legislative Day in Albany

(Left to right) Dr. Ayesha Arif, Sen. Anna Kaplan, and Drs. Mark Kim, Kimberley Schuller, Alexander Mazerov, Christopher Campese, and David Bronheim

Dr. Steven Schulman, Assemblyman Michael Montesano, and Stuart Hayman

NYSSA members take time for a photo.
Drs. Mark Kim, Alexander Mazerov, Ayesha Arif, and Kimberley Schuller

New York state Sen. Michael Gianaris (center) with Drs. Brian Mayrsohn, Brittany Reardon, Jonathan Gal, Vilma Joseph, Dahlia Townsend, and Erica Fagelman

A representative from Assemblyman Harvey Epstein’s office (third from left) with Drs. Jung T. Kim, Ansara Vaz, and Sudheer Jain
(Left to right) Drs. David Bronheim and Christopher Campese, Assemblyman Anthony D’Urso, and Drs. Daniel Sajewski and Steven Schulman

Drs. Brittany Reardon, Erica Fagelman, Vilma Joseph and Dahlia Townsend, New York state Youth of the Year finalist Christopher Samuel, and Drs. Jonathan Gal and Brian Mayrsohn

Bob Reid and Charles Assini, Jr., Esq., speak to NYSSA members.

Dr. Vilma Joseph

Drs. Sudheer Jain and Jung T. Kim with New York Assemblywoman Rebecca Seawright

Dr. Jonathan Gal addresses NYSSA members.
Euroanaesthesia 2019

The NYSSA was well represented at the conference in Vienna, Austria.
SPAIN I BARCELONA
Euroanaesthesia
30 May - 01 June
THE EUROPEAN ANAESTHESIOLOGY CONGRESS
2020
esahq.org
Anesthesia SimSTAT

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This activity contributes to the patient safety CME requirement for Part II: Utilizing Learning and Self-Assessment of the Annual Span of Anesthesiology (ASA), reclassified Maintenance of Certification in Anesthesiology Program (MOCA®), known as MOCA 2.0. Please consult the ASA website, for a list of all MOCA 2.0 Part II requirements and their associated point values.

Accreditation and Designation Statement:
The American Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates these enduring material for a maximum of 6 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Comparison Chart of Bichotte (A.7100)/Gaughran (S.5885) Bills and New York State Health Code

Legislation introduced by Assemblywoman Rodneyse Bichotte (Assembly District 42) and state Sen. James Gaughran (Senate District 5) preserves, and is consistent with, existing statewide minimum New York state health code standards (as illustrated below) governing the delivery of anesthesia by preserving the patient’s right to be guaranteed that a physician anesthesiologist or operative physician must accept the legal and medical responsibility for the care of the patient undergoing a procedure, including the supervision of a nurse anesthetist. Without the current statewide requirement, hospitals would be free to permit nurse anesthetists to administer anesthesia independently — a decision the hospital could make based on the patient’s payor status or other economic considerations.

Contrary to assertions and positions advocated by the New York State Association of Nurse Anesthetists (NYSANA) and the American Association of Nurse Anesthetists (AANA), physician anesthesiologists personally deliver anesthesia and assume a critical role in the delivery of anesthesia services in accordance with the physician-led anesthesia care team for the great majority of New York patients, regardless of the patient’s payor status or the location of the surgical site.

Bills A.7100/S.5885 accomplish the following:
- Establish a scope of practice consistent with the physician-led anesthesia care team or the operative surgeon accepting responsibility for the administration of anesthesia, including the supervision of the nurse anesthetist.
- Define terms such as “immediately available” and “physically present.”
- Are consistent with the Legislature’s responsibility to grant title to a professional who serves the public.
- Are consistent with existing statewide minimum standards.

YOUR SUPPORT OF BILLS A.7100 (Bichotte) and S.5885 (Gaughran) IS CRITICAL
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<td>4(b) The practice of professional nursing by a registered nurse anesthetist, certified under section sixty-nine hundred twelve of this article, shall (i) include the administration of anesthesia to a patient but 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 and who is authorized by law to administer anesthesia, to the extent such person is qualified by law, regulation or hospital appointment to perform and supervise the administration of anesthesia; and (ii) include the execution of medical regimens prescribed by the supervisory physician, dentist, oral surgeon or podiatrist who is authorized by law to prescribe; and (iii) be consistent with policies and procedures approved by the medical staff and governing body of the health care facility, or free-standing</td>
<td>10 NYCRR §405.13(a)(1) (Hospitals): ... Anesthesia shall be administered in accordance with their credentials and privileges by the following: (i) anesthesiologists; (ii) physicians granted anesthesia privileges; (iii) dentists, oral surgeons, or podiatrists who are qualified to administer anesthesia under State law; and (iv) certified registered nurse anesthetists (CRNAs) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA; or (v) a student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs may administer anesthesia as related to such course of study under the direct personal supervision of a certified registered nurse anesthetist or an anesthesiologist. 10 NYCRR §405.22(l)(6)(vi) (Critical Care and Special Care Services; Live Adult Liver Transplantation Services): Anesthesia Requirements: (c) These teams shall each be directed by a separate attending anesthesiologist for the live donor and the recipient procedure. In addition to the attending anesthesiologist, who shall be present as specified in clause (a) above, at least one member of the anesthesia team who is an anesthesiologist, chief resident, fellow (postgraduate year 3, 4, or 5), and/or qualified certified</td>
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| ambulatory surgical center defined under article twenty-eight of the public health law, where applicable, and as legally authorized under this title and in accordance with applicable regulations of the commissioner of health. | registered nurse anesthetist shall be present and responsible, under the direction of the attending anesthesiologist, for the evaluation and care of the patient through all phases of the procedure pertaining to the administration of, and recovery from, anesthesia. All team members shall have ongoing education and training in liver and/or cardiac surgery and have had anesthesia responsibility for major liver resections. 10 NYCRR §755.4 (Free-Standing Ambulatory Surgery Centers): The operator shall ensure that:  
(a) an anesthesiologist, licensed by and currently registered with the New York State Education Department, and who meets the definition of a qualified specialist, is responsible for the anesthesia services and may fulfill the requirement for medical director;  
(b) administration of anesthesia is in accordance with current standards of professional practice;  
(c) anesthesia is administered by only a qualified anesthesiologist, or a physician or dentist qualified to administer anesthesia, or a certified registered nurse anesthetist;  
(d) when nonphysicians administer anesthesia, the anesthetist must be under the direct personal supervision of a qualified physician, who may be the operating surgeon;  
(e) the person administering the anesthesia, other than local anesthesia, is not the operating surgeon; and  
(f) a physician examines each patient immediately prior to surgery to evaluate the risk to anesthesia and the procedure to be performed. |
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<td>“Administration of Anesthesia”</td>
<td>(i) “Administration of anesthesia” in the hospital or ambulatory surgical center means anesthesia services shall be directed by a physician who has responsibility for the clinical aspects of organization and delivery of all anesthesia services provided by the hospital or ambulatory surgical center. That physician or another individual qualified by education and experience shall direct the administrative aspects of the service, and shall be responsible, in conjunction with the medical staff, for recommending to the governing body privileges to those persons qualified to administer anesthetics, including the procedures each person is qualified to perform and the levels of required supervision as appropriate. Administration of anesthesia in office-based surgery venues means the anesthesia component of the medical or dental procedure shall be supervised by an anesthesiologist, physician, dentist or podiatrist qualified to supervise the administration of anesthesia who is physically present and available to immediately diagnose and treat the patient for anesthesia complications or emergencies, and nurse anesthetists with the appropriate training and experience may be permitted to administer unconscious or deep sedation, and/or general anesthesia, regional anesthesia, and/or monitor the patient.</td>
<td>10 NYCRR §405.13(a) (Hospitals): Organization and direction. Anesthesia services shall be directed by a physician who has responsibility for the clinical aspects of organization and delivery of all anesthesia services provided by the hospital. That physician or another individual qualified by education and experience shall direct administrative aspects of the service. 10 NYCRR §405.13(a)(1) (Hospitals): The director shall be responsible, in conjunction with the medical staff, for recommending to the governing body privileges to those persons qualified to administer anesthetics, including the procedures each person is qualified to perform and the levels of required supervision as appropriate. 10 NYCRR 405.13(b): Operation and service delivery. Policies governing anesthesia services shall be designed to ensure the achievement and maintenance of generally accepted standards of medical practice and patient care.</td>
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"Supervision" (xiii) “Supervision” means that a physician, dentist, oral surgeon or podiatrist shall perform a pre-anesthetic examination and evaluation, prescribe the anesthesia, including post-operative medications as needed for pain and discomfort, including nausea and vomiting, remain physically present during the entire peri-operative period and immediately available for diagnosis, treatment, and management of anesthesia-related complications or emergencies, and assure the provision of indicated post-anesthesia care.

10 NYCRR §405.13(a)(1) (Hospitals):... Anesthesia shall be administered in accordance with their credentials and privileges by the following:

   (iv) certified registered nurse anesthetists (CRNAs) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA; or ...

10 NYCRR §755.4 (Free-Standing Ambulatory Surgery Centers): The operator shall ensure that:

   (d) when nonphysicians administer anesthesia, the anesthetist must be under the direct personal supervision of a qualified physician, who may be the operating surgeon;

   Additionally, the Health Department takes the position that, in the hospital and ambulatory surgical center settings, if the operative physician is supervising the delivery of anesthesia, that physician must satisfy the following basic requirements:

   (1) Appreciate the risks of anesthesia;

   (2) Possess the medical knowledge and judgment with respect to the administration of anesthesia required to supervise the process; and

   (3) Accept legal and medical responsibility for the supervision and for the patient.
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<td>(x) “Physically present” by a physician means the ability to react and respond in an immediate and appropriate manner so as to make possible the continuous exercise of medical judgment throughout the administration of the anesthesia. “Physically present” by a dentist, oral surgeon or podiatrist means the ability of such person who is performing the procedure requiring the administration of anesthesia to react and respond in an immediate and appropriate manner so as to make possible the continuous exercise of professional judgment throughout the administration of the anesthesia.</td>
<td>10 NYCRR §405.13(a)(1)(iv) (Hospitals): ... certified registered nurse anesthetists (CRNAs) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician ...</td>
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Case Report

Balloon-Occluded Retrograde Transvenous Obliteration (BRTO) Procedure Balloon Rupture

SULTAN AHMED GHUMAN, M.D.

Summary
BRTO procedure balloon rupture intraoperatively resulted in systemic spread of sclerosing agent and pulmonary embolus with resultant drop in both end-tidal carbon dioxide (CO₂) and oxygen saturation (SPO₂) with subsequent spontaneous resolution.

Case Report
HPI: A 46-year-old woman with a history of chronic alcohol abuse (10 drinks/day) presented with multiple episodes of bright red hematemesis and melena. Her vital signs were initially stable, but later she developed tachycardia and a drop in hemoglobin from 9.4 to 7.0. She received 2 units of packed red blood cells in the emergency department and was started on octreotide, pantoprazole and antibiotics. An upper GI endoscopy was performed, which showed non-bleeding gastric varices and portal hypertensive gastropathy. A decision was made to perform a balloon-occluded retrograde transvenous obliteration (BRTO) procedure in order to treat the gastric varices by interventional radiology (IR).

PMH: Alcohol abuse, cirrhosis, obesity

PSH: None

Physical Exam: 95 kg (BMI 38) BP: 130/75, HR 109, SPO₂ 95% on 2L oxygen via nasal cannula

OR Course: The patient was induced with a rapid sequence induction and intubated uneventfully. She was maintained under isoflurane anesthesia with rocuronium for neuromuscular blockade. During the procedure, a sudden drop of end-tidal CO₂ from 40 to 15 and SPO₂ from 96% to 90% (FiO₂ of 100%) was noted, with subsequent report from IR team of rupture of the occlusion balloon and systemic spread of sodium tetradecyl sulfate (STS) sclerosing agent. Mild hypotension was noted. This episode of instability lasted approximately two minutes, with spontaneous improvement of ventilation and oxygenation. The procedure was aborted
by IR team and the patient was transported to the medical ICU, intubated, as a precautionary measure. There were no further episodes of desaturation or hypotension in the ICU and the patient was extubated the following day. Five days later, she returned to IR and underwent successful BRTO.

**Discussion**

Balloon-occluded retrograde transvenous obliteration (BRTO) is an endovascular technique that was developed in Japan as an alternative to the TIPS procedure in the management of gastric varices. The classical BRTO procedure requires a portosystemic shunt, usually a gastrorenal shunt. The afferent and draining vessels are identified ahead of the case to ensure favorable anatomy and define technical difficulty. Access to the caval venous system is either via the right femoral or internal jugular vein. From the caval system a balloon occlusion catheter is advanced into the shunt — such as into the left renal vein and then into the gastrorenal shunt. Once cannulated, the balloon occlusion catheter is inflated to occlude the shunt. After venographic confirmation of occlusion, the sclerosant material is injected retrograde to fill the gastric varix. In order for the sclerosant material to remain in the varix and create a thrombosis, the occlusion balloon remains inflated. This can take from four to 24 hours. The sclerosant material denatures the endothelial lining of the varix and causes it to thrombose. After successful thrombosis, the balloon is deflated and withdrawn. In the U.S., the sclerosant material used is STS (ethanolamine oleate was the original agent used in Asia, but it is not available in the U.S.). STS is mixed with lipiodol and gas (air/CO₂) in a ratio of 2 ml 3% STS to 1 ml lipiodol to 3 ml air. The mean total volume of sclerosing mixture used during the BRTO procedure ranges from 10-65 ml with an average of 20-34 ml of mixture injected.

In a Mayo Clinic study, chest x-rays performed shortly after procedures using sclerosant agents (including STS) for esophageal varices were abnormal in 85 percent of the cases, but this was rarely found to be of clinical significance. After the procedure, fever, chest pain and difficulty swallowing were commonly reported but were rarely serious. A pleural effusion was seen in 25 percent of patients, mediastinal widening in 33 percent, atelectasis in 12 percent, and pulmonary opacities in 9 percent. The risk of balloon rupture and systemic spread of STS is real, with one study reporting balloon rupture during 14 percent (six out of 41) of BRTO procedures after sclerosant material was administered. One likely cause of balloon rupture is the size of the balloon relative to the gastrorenal shunt.
being occluded; with undersized balloons being overinflated to create an occlusion.¹

Anesthesiologists caring for patients undergoing a BRTO procedure must be aware of and ready to treat the potential hemodynamic instability that may result from systemic spread of sclerosant material secondary to balloon rupture.

The procedure may be performed under sedation or local anesthesia alone. In this patient, general endotracheal anesthesia was chosen to secure the patient’s airway due to concerns for further hematemesis and hemodynamic instability.

Sultan Ahmed Ghuman, M.D., is a resident physician in the Department of Anesthesiology at NYU Langone Health/Bellevue Hospital Center.

REFERENCES


Help the NYSSA Maintain Patient Safety: Support Physician Supervision of Anesthesia

Patient-Centered, Physician-Led Care
Case Report

Going Retro for a Better Outcome: An Appreciative Inquiry Case Report

ARUP DE, M.D., MBA, AND LINDSAY GENNARI, M.D.

This is the second case report in a new Sphere series. We hope that these case reports and discussions will encourage other medical systems to consider reevaluation of their focus in the QA process.

Most medical and surgical specialties, including anesthesiology, maintain rigorous, structured and privileged peer-review programs through which untoward clinical outcomes and complications are presented, discussed and debated, with the goal of improving future practice performance. The discussion can degenerate into punitive, fault-finding expeditions that focus on failures and shortcomings, both provider- and system-related. Through the business management lens, the M&M process is a form of change management, as it is an effort to recognize current shortcomings and prevent future poor outcomes.

The overall tone of the morbidity and mortality process is often negative. We are focusing on “bad” outcomes that require “corrective” actions, with the blame laid with the clinicians or care delivery systems. Overall, it is often a subjectively heavy, anxiety-provoking process, requiring us to defend our care decisions. This process, although not intended to do so, can lead to low morale and fear.

Appreciative Inquiry (AI) is a method of change management that has been utilized in the business world for some time. The fundamental belief in AI is that work systems (organizations, personnel, anesthesia care teams) are inherently good and driven to become better. AI recognizes that there is enormous talent, energy and drive within the core of a care team, and through selective recognition and focus on the good, the team can become even better. The quest to improve care delivery in the M&M perspective — “What have we done wrong?” — differs from the AI view — “What can we do even better?” AI is a positive, energizing process. We present the following case from the AI perspective.

Case Report

A 46-year-old man with multiple recurrent episodes of cholelithiasis and recent cholecystitis was scheduled for a laparoscopic cholecystectomy. The patient had severe bronchiectasis requiring home oxygen at 4 liters/minute.
by nasal cannula and was awaiting a double lung transplant. Cholecystectomy was required to remain on the lung transplant waiting list. All other medical problems were noncontributory. On physical exam the patient was dyspneic with use of accessory muscles. Breath sounds were markedly diminished bilaterally. The oxygen saturation was 93% on 4 liters/min, respiratory rate was 18, heart rate 94 and blood pressure 150/88. FEV1 six weeks prior to presentation was 30% of predicted, and a recent chest x-ray showed a flattened diaphragm with increased AP diameter.

The pulmonologist recognized that the patient was at high risk for postoperative respiratory failure. Postoperative mechanical ventilation was planned and the likelihood of prolonged ventilation, with likely tracheostomy, had been discussed. It was hoped that in the stable postoperative intubated state, organs might become available, thus minimizing the time the patient would have to remain intubated. Given the clear risks of long-term ventilation and the unpredictability of procurement of suitable tissue- and size-matched organs for transplant, the anesthesiologist approached the surgeon with an alternative course of therapy.

In discussion with the surgeon, it seemed reasonable to consider an alternative anesthetic technique, but this would necessitate a change in the surgical approach: an open technique. The carbon dioxide load from laparoscopy could be avoided by having the surgeon use a minimally-invasive open technique. In an open procedure, the patient could be anesthetized using a thoracic epidural anesthesia. The perioperative team decided that removing the gallbladder via a subcostal mini-laparotomy approach under epidural anesthesia with a spontaneously breathing patient would be the best option to avoid mechanical ventilation. The patient was very motivated to proceed with this alternative approach.

Using standard monitors and supplemental oxygen at the patient’s normal settings, the patient was placed in the sitting position. After premedication with midazolam 1 mg and fentanyl 10 mcg, the epidural space was identified using the loss of resistance to air technique with an 18-gauge Tuohy needle at the T10-T11 interspace. A 20-gauge epidural catheter was secured 4 cm cephalad beyond the needle tip. A test dose of 3 ml of 1.5% lidocaine with epinephrine (1:200,000) was given to exclude intravascular or intrathecal catheter migration. After confirmation of negative test dose, 5 ml of 0.5% bupivacaine was injected. The height of the block was tested.
by pinprick every five minutes. Another 5 ml of 0.5% bupivacaine was given to achieve a T4 to T10 level. Surgery began once a T4-T10 level was established. The patient received a continuous epidural infusion with bupivacaine 0.5% and fentanyl 2 ug/ml at a rate of 5 ml/hr intraoperatively and for 24 hours postoperatively (postoperative concentration was changed to 0.1% bupivacaine). A propofol infusion was begun during the procedure at 50 mcg/kg/min, and end-tidal carbon dioxide was monitored through the nasal cannula. The intraoperative course was uneventful, and the gallbladder was removed through a 3.5-inch subcostal incision. The epidural catheter was removed 24 hours postoperatively and the patient was discharged home shortly thereafter. The patient underwent successful double-lung transplant four months following the open cholecystectomy.

**Discussion**

Laparoscopic cholecystectomy is generally deemed superior to an open approach due to shorter hospital stays, reduced morbidity, reduced intraoperative and postoperative pain, rapid return to work, lower mortality, and significant cost savings. However, the physiological effects of intraperitoneal carbon dioxide insufflation combined with variations in patient positioning can have a major impact on cardiorespiratory function, particularly in patients with co-morbidities. Laparoscopic cholecystectomy necessitates general anesthesia and endotracheal intubation to prevent respiratory decompensation secondary to the pneumoperitoneum, as well as to reduce the risk of aspiration, and enables better control of ventilation and ongoing analysis and management of carbon dioxide. Although epidural anesthesia has been described in the literature for healthy patients undergoing laparoscopic cholecystectomy, this was not deemed feasible because this patient would not have tolerated the reduction in pulmonary compliance with gas insufflation, the steep Trendelenburg position, and hypercarbia from CO₂ absorption. The anesthesiologist suggested performing a mini-laparotomy as an alternative to laparoscopic surgery. This produces less trauma than a classical open cholecystectomy and is believed to have a similar level of invasiveness to the laparoscopic approach. In this case, the placement of the epidural eliminated the decrease in functional residual capacity and vital capacity from incisional pain, eliminated considerations of carbon dioxide insufflation altogether, and avoided committing the patient to prolonged postoperative mechanical ventilation.

In this case, the entire team — including surgeon, pulmonary physicians, and patient — was ready to accept the seemingly unavoidable postoperative
respiratory failure that would result from a laparoscopic procedure. As anesthesiologists, we are consultant physicians first and foremost, and our duty is to examine every aspect of our patients’ care and provide our opinion. The idea that there was an alternative surgical approach had escaped the consideration of the entire team. Communication between the anesthesiologist and the surgeon allowed the surgeon to agree that the alternative surgical (and anesthetic) approach would vastly alter the postoperative patient course. In an era of patient care that views newer technologies as a wellspring of continued advancements, the anesthesiologist can remain the lighthouse that bridges the future and the past, navigating the best course for optimal patient care.

There are myriad positive attributes derived from this case that we can hope to remember and emulate in the future. Anesthesiologists are not merely technicians playing a trivial role in patient care. We can communicate articulately with other members of the team to bring clarity and a unified, goal-oriented approach to the patient care process. We need to free ourselves from the production pressures of first case starts and turnover times, to view the perioperative process from a holistic patient perspective. It is important to cultivate relationships with our surgical colleagues so that they are open to considering the advantages of our perspective. This type of trusting and respectful relationship requires years to nurture. The communication between professionals requires the obliteration of thought and vocation silos. Finally, not all our surgical colleagues may possess the requisite skills to perform an open cholecystectomy through a small subcostal incision, especially in an era when robotic and laparoscopic procedures are rapidly becoming the accepted clinical norm.

Arup De, M.D., MBA, is vice chair of anesthesia systems integration and an associate professor of anesthesiology at Albany Medical Center. Lindsay Gennari, M.D., is an assistant professor of anesthesiology and a member of the division of obstetrical anesthesiology at Albany Medical Center.

REFERENCES
Jeopardy Night at the New York Academy of Medicine

ELIZABETH A. M. FROST, M.D.

The annual Jeopardy contest at the New York Academy of Medicine, held on May 13, 2019, attracted contestants from nine departments of anesthesiology in New York and New Jersey. Following a reception, the competition was hosted by Dr. Adam Lichtman from Weill Cornell. Eighteen residents battled each other to earn the coveted trophies and bragging rights for their hospitals. Seven attending anesthesiologists acted as scorekeepers. The winners this year were New York Medical College (Drs. Cynthia Wong and Joon-Hyung Kim); Columbia University Medical Center (Drs. Harry Wanar and Woojin Lee); and Robert Wood Johnson, Rutgers New Jersey Medical School (Drs. Maksim Ptushko and David Convissar). Dr. Farida Gadalla, co-chair of the New York Academy of Medicine Section on Anesthesiology, presented trophies and medals at the conclusion of the evening.

The evening was sponsored by the Weill Cornell and Montefiore departments of anesthesiology. The New York Academy of Medicine provided library space and administrative support, including advertising and programs.

The next meeting of the Academy’s Section on Anesthesiology will be the poster session in the fall.

Elizabeth A. M. Frost, M.D., is chair of the New York Academy of Medicine Section on Anesthesiology.
SAVE THE DATE

The Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai New York, NY, USA presents

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

St. Kitts Marriott Resort
St. Kitts, West Indies
January 19-24, 2020

For faculty information: george.silvay@mountsinai.org
For abstract information: menachem.weiner@mountsinai.org
For general information: margorie.fraticelli@mountsinai.org
Newly Matched Residents Enjoy RFS Brunch

GREGORY YANEZ, M.D., AND BRITTANY REARDON, M.D.

The NYSSA Resident and Fellow Section (RFS) held the inaugural brunch for newly matched anesthesiology residents at the restaurant Farmer & The Fish in New York City on March 30, 2019. All newly matched residents in New York state were invited, and the brunch was well attended, with 21 future residents from programs across the state. Several RFS board members hosted the brunch, which was made possible by insurance company Charles J. Sellers & Co., Inc. in conjunction with the NYSSA.

The gathering provided a forum for incoming residents to network with future residency program colleagues and to introduce attendees to the NYSSA. The RFS board members in attendance included Dr. CT Lee (CA-3, Columbia University), Dr. Erica Fagelman (CA-2, Icahn School of Medicine at Mount Sinai), Dr. Brittany Reardon (CA-2, Mount Sinai West), and Dr. Gregory Yanez (CA-3, University of Rochester), all of whom addressed the attendees. The board members spoke about the array of NYSSA-sponsored networking, academic, and advocacy opportunities that are available to residents, including...
Residents and Fellows

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Send your case report via email to lisa@nyssa-pga.org. Subject: Article for Sphere

Submit your case report for publication in Sphere. All cases will be reviewed and the most interesting will be published.

If you have questions, email Lisa ONeill at lisa@nyssa-pga.org

the PostGraduate Assembly in Anesthesiology (PGA), legislative days, and involvement in the Resident and Fellow Section. Kathleen Sellers of Charles J. Sellers & Co. gave a brief overview of disability and life insurance for anesthesiologists, with tips on what to look for when considering plans.

The RFS leadership is grateful to those who helped organize this successful inaugural event, including NYSSA Academic Anesthesiology Committee Chair Dr. Suzanne Karan (University of Rochester) and RFS board member Dr. Matt Stratton (CA-2, NYU). Program directors from across the state shared contact information for their newly matched residents. We are hopeful that this will become an annual event.

We encourage all residents to continue to engage with the NYSSA through the various academic and advocacy activities. Stay tuned for updates on our involvement in the NYSSA’s spring advocacy events: the NYSSA Legislative Day and the ASA Legislative Conference. The NYSSA RFS also is eager to welcome our new board members, who will begin their terms on June 15, 2019.

Gregory Yanez, M.D., is a CA-3 at University of Rochester and Brittany Reardon, M.D., is a CA-2 at Mount Sinai West.
Membership Update

New or Reinstated Members
January 1 – March 31, 2019

Active Members

**DISTRICT 1**
Kalpana Arya Gupta, M.D.
Krystal Ferreras, M.D.
Ji-Young Hong, M.D.
Moiz Siddiqui, M.D.
Justin Varghese, D.O.

**DISTRICT 2**
Helen Ahn, M.D.
Keisha Benjamin, M.D.
Vikram Bhasin, M.D.
Robert Bohnenberger, M.D.
John Caruso, M.D.
Kevin Chung, M.D.
Timothy Connolly, M.D.
Emad Faragalla, M.D.
Robert Gasalberti, M.D.
Samit Ghia, M.D.
Caroline Gross, M.D.
Thomas Gruffi, M.D.
Qi Jiang, M.D.
Roman Johnson, M.D.
Jonathan Ko, M.D.
Christos Koutentis, M.D.
Jason Lee, M.D.
Zhiwei Li, M.D.
Sha Sha Lu, M.D.
Jeannie Lui, M.D.
Aleksey Maryansky, D.O.
Robert Oldaker, M.D.
Chang Park, M.D.
Alopi Patel, M.D.
Howard Prusack, M.D.
Seyed Safavynia, M.D., Ph.D.
Jacob Schaff, M.D.
Anjan Shah, M.D.
David Shapiro, M.D.
Marc Sherwin, M.D.
Natalie Smith, M.D.
Richard Thalappillil, M.D.
Ansara Vaz, M.D.
John Vullo, M.D.
Robert White, M.D.

**DISTRICT 3**
Lewis Diamond, M.D.
Agapi Ermides, M.D.
Fadi Farah, M.D.
Kevin Fitzmartin, M.D.
Zachary Hoffman, M.D.
Sarfaraz Kabeer, M.D.
Michael Kullman, M.D.
Szabolcs Mandy, M.D.
Victor Marino, M.D.
Bentley Ogoke, M.B.B.S.
David Vent, M.D.
Zsolt Vereczkey, M.D.

**DISTRICT 4**
Sailaja Alapati, M.D.
Igor Galay, M.D.
Alexander Hawson, M.D.
Karthik Hiremath, M.D.
Abigail Rubin-Dembitzer, M.D.
Membership Update

New or Reinstated Members
January 1 – March 31, 2019

Active Members  continued

DISTRICT 5
Sarah Bush, M.D.
Carlos Santa Ines, M.D.

DISTRICT 6
Paul Guadagnino, M.D.
Daniel Kianpour, M.D.
Heather Lander, M.D.

DISTRICT 7
Shawn Cantie, M.D.
Emily Denisco, M.D.
Hussein Elattar, M.D.
Chad Elgersma, D.O.
Anupama Gopinath, M.D.
Cyrus Tanhaee, M.D.
Huseyin Tunceroglu, M.D.

DISTRICT 8
Sandeep Annam, M.D.
Joseph Cardinale, M.D.
Andres Chipollini, M.D.
John Ferguson, M.D.
Betty Hua, M.D.
Kevin Lee, M.D.
Rami Najjar, M.D.
Sunil Prasad, M.D.
Daniel Rogel, M.D.
William Runcie, M.D.
Carl Schmigelski, M.D.
Bonnie White, M.D.

Resident Members

DISTRICT 1
Gregory Smith, D.O.

DISTRICT 2
Michael Balot, D.O.
Rebecca Koscik, M.D.
Shefali Rikhi, M.D.
Andre Savadjian, M.D.

DISTRICT 3
Anish Garg, M.D.
Yusufu Kamara, M.D.
Joon-Hyung Kim, M.D.

DISTRICT 7
Aisha Averyhart, M.D.
Logan Blunk, D.O.
James Chue, M.B., B.Ch.
Vanja Coric, M.D.
Naiman Fenech, M.D.

Ethan Kim, M.D.
Keshar Kubal, M.D.
Peter Magharious, M.D.
Shinae Namkoong, D.O.
Muhammad Shabsigh, M.D.
Membership Update

New or Reinstated Members
January 1 – March 31, 2019

Resident Members continued

**DISTRICT 7 continued**
Michael Ferrante, M.D.
Zachary Fetter, D.O.
John Garfoot, M.D.
Aaron Garza, M.D.
Zishan Hashmi, M.D.
Alex Heller, D.O.
Felipe Juarez, M.D.
Michael Kagan, M.D.
John Knudsen, M.D.
Jennifer Lamb, M.D.
Donald Lee, M.D.
Alexander Levine, M.D.
Ashlee Lybrand, M.D.
Hinna Malik, M.D.
Ashok Manepalli, M.D.
Shalini Mathias, M.D.
Andrew McCulloch, M.D.
Justin McMaster, M.D.
Loué Nassar, M.D.
Huan Nguyen, M.D.
Christopher Ogbuah, M.D.
Caroline Piekos, M.D.
Andrew Podley, M.D.
Cheng Qian, M.D.
Alan Rejonis, M.D.
Siavash Sedghi, M.D.
Andrew Selles, M.D.
Abdul-Haseeb Sheikh, M.D.
Ajit Singh, M.D.
Chavalit Sitapradit, M.D.
Nicole Sprentall, M.D.
Samuel Tillmans, M.D.
Kenneth Todd, D.O.
Anisha Varodan, M.B.B.S.
Nuo Yang, M.D.

**DISTRICT 8**
Saamia Alam, M.D.
Lucas Bracero, M.D.
Chamandeep Brar, D.D.S.
Robert Chojnowski, M.D.
Bryce Farr, D.D.S.
Carlos Figueroa, M.D.
Jae Grymes, D.D.S.
Ramanjot Kang, M.D.
Ishu Kant, M.D.
Benjamin Kim, M.D.
Youngil Kim, M.D.
Shuran Ma, M.D.
Ashley Mathew, M.D.
Julie Mercado, D.M.D.
Josiah Miles, M.D.
Duran Mitchell, M.D.
Jerimarie Pasiliao, M.D.
Ravi Shah, M.D.
Karim Shuaib, M.D.
Ramiz Shuminov, M.D.
Usama Siddique, M.D.
Adam Taft, M.D.
Elizabeth Watson, M.D.
Albert Xiao, M.D.
New or Reinstated Members
January 1 – March 31, 2019

Medical Students

DISTRICT 1
Alexandra Vazquez

DISTRICT 2
Taulun Aman
Jessica Leung

DISTRICT 3
Nicholas Bacher
Sean O’Rourke

DISTRICT 8
Jordan Abrams
Ronald Gutman

Retired Members

DISTRICT 1
Ismael Holipas Jr., M.D.

DISTRICT 2
Subhash Jain, M.D.
Kumkum Singh, M.D.

DISTRICT 3
Yosuke Imai, M.D.
Doreen Wray Roth, M.D.

DISTRICT 4
John Mathews, M.D.

DISTRICT 7
Ralph Hinds III, M.D.

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