

# SPHERE

*Quarterly Publication*



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



The Transition to Practice

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## President's Message

### Growing Future Leaders

DAVID S. BRONHEIM, M.D.

Over the course of the nearly 10 years that I have been sitting on the dais at the meeting of the NYSSA House of Delegates, I have made an observation that has given me pause: There is just way too much gray hair in the room. This is not just true for the House of Delegates, but also for leadership positions throughout the NYSSA and PGA.

It does not appear to me that the voices and opinions of our younger members are being heard, nor are your energies being properly harnessed. Indeed, I have found that many of our most promising future leaders look at the pathways to leadership within the NYSSA and choose to spend your energies elsewhere. With this in mind, it has been my primary goal the last few years and during my term as president to make the changes necessary to promote more active participation from our younger members and to shorten the pathways to leadership within the society.

To that end, we have already revised the bylaws and administrative procedures governing the NYSSA's board and committees as well as the subcommittees of the PGA. The NYSSA's senior officers such as secretary, treasurer, assistant secretary, assistant treasurer, and speaker are now limited to six-year terms. Chair positions on NYSSA committees are now three-year terms, although committee chairs may be re-elected. PGA subcommittee chairs will now serve for only three years as well. We're also adding vice chairs to all NYSSA committees, and for the PGA subcommittees we are creating chairmen emeritus positions. By establishing term limits and these additional positions within our committees, we preserve institutional memory, maintain a continuum of knowledge and experience, and create a structure properly organized for mentoring and developing our future leaders. We are making room at the table. Now it's time for our younger members to step up and seize from your "gray-haired elders" the reins of your society.

A more inclusive and representative leadership is merely the first step. Organized medicine within the U.S. is facing a changing landscape.

Membership in medical societies and attendance at educational meetings are in decline. The NYSSA and PGA are weathering these challenges much better than many other organizations, but without continuous, organic change, just exchanging older leadership for younger would be the equivalent of rearranging the deck chairs on the Titanic. To prevent sclerosis, we need to hear from all our members about what you need and want from the NYSSA.

One of my first actions as president was to establish a strategic planning committee that will examine and, if necessary, redirect the NYSSA's activities. This committee, chaired by President-elect Dr. Vilma Joseph and Vice President Dr. Dick Wissler, is tasked with evaluating the NYSSA from a longer-term perspective with the goal of better serving the interests and needs of our members. Your input is key to the success of this committee and, ultimately, the future success of the NYSSA. To encourage your feedback, we will be reaching out to all our members to ask how we can better serve you. In the meantime, you don't need to wait to be contacted. We welcome your input now. Tell us what the NYSSA is not doing that you believe we should be doing. Tell us what we are doing well, but also how we could do better. Share your comments with us by contacting me at [david.bronheim@mountsinai.org](mailto:david.bronheim@mountsinai.org) or Executive Director Stuart Hayman at [stuart@nyssa-pga.org](mailto:stuart@nyssa-pga.org).

Over the course of the year, we will be introducing you to the new leaders of the NYSSA's various committees. If you haven't done so already, please consider joining one of these committees and being a more active participant in any or all of our activities. The NYSSA will benefit from your knowledge, energy and desire to make things better for yourselves and your patients. Every committed member makes a difference. ■



## Editorial

# Easing the Transition to Practice

SAMIR KENDALE, M.D.

Life is full of transitions, whether moving to a new town, buying a car, celebrating a birth or mourning a death. Transitions can invoke a wide variety of emotions: excitement, fear, happiness, trepidation. Perhaps one of the most stress-inducing transitions we all have to face is starting a new job. In the field of anesthesiology, this can happen more than once. There is the transition from medical school to internship; from internship to residency; for some, from residency to fellowship; and, finally, from years of training to our first job as an actual attending anesthesiologist.

Each leap involves its own concerns. How do I round on all these patients and write notes and orders? How do I set up for an anesthetic and create an anesthetic plan? How do I focus everything I've learned in residency on something much more specific during a fellowship? How am I supposed to do this all on my own, without anyone telling me what to do or helping me to support my decisions? These are only a fraction of the worries associated with the transition to practice.

One of the major decisions we have to make is whether to work in an academic setting or in private practice. For me, the decision happened to be simple: I trained in a place I enjoyed and lived in a place I wanted to stay. For most people, though, there are far more factors, including family, compensation, work-life balance, and cost of living. As far as the practice goes, there is such a tremendous range of environments — small or big, solo or supervising, bread and butter or complex cases — that it can make choosing the right path seem exceedingly complicated.

In this issue of *Sphere*, we present three articles about the transition from residency to practice. Truthfully, I wish I had this information when I was first starting out, as the authors provide fabulously valuable advice from their own experiences. For me, despite having plenty of support from colleagues and more experienced attendings, the first months working as an attending were very challenging, especially navigating new work sites, relationships with surgeons and nurses, and the



newfound clinical autonomy. Sometimes it is hard to decipher where one fits in the department, the hospital, the specialty, or the entire field of medicine. Hopefully these articles will help our newest generation of anesthesiologists make their transition to practice as easy and seamless as possible, allowing them to focus on patient care and defining their role in the specialty. ■

## 72<sup>nd</sup> PGA Scientific Exhibits, Poster Presentations, Medically Challenging Case Report Posters

If you are interested in submitting applications to exhibit your projects at the upcoming **72<sup>nd</sup> PostGraduate Assembly in Anesthesiology** — **December 7-11, 2018**, please visit **[www.pga.nyc](http://www.pga.nyc)** for instructions to submit online.

*Deadline for filing is August 16, 2018.*  
Submissions are **only** accepted electronically.

## From the NYSSA Resident and Fellow Section Publish Your Case Report in *Sphere*

- If you have an interesting case
- If you are ready to share your experience
- If you are interested in building your CV

You can submit your case report for publication in *Sphere*.  
All cases will be reviewed and the most interesting published.  
Submit your case report via email to [maryann@nyssa-pga.org](mailto:maryann@nyssa-pga.org).  
Subject: Article for Sphere

If you have questions, call MaryAnn Peck at  
NYSSA headquarters: 212-867-7140.





**From the Executive Director**

## **This Is Not the Time for Complacency**

**STUART A. HAYMAN, M.S.**

As a native Washingtonian, I have always been passionate about politics and the Redskins football team. In fact, I used to describe my loyalty as a Redskins fan by saying, “I bleed burgundy and gold” — the team’s colors. After watching the Redskins play in four Super Bowls starting in the early 1980s, I began taking winning for granted. Sadly, the last two-plus decades have not been kind to my football team. This has taught me that victory must never be taken for granted.

Just as we have seen with our favorite sports teams, when it comes to legislative success, there is no guarantee that history will repeat itself. Yet we often allow past legislative trends to influence our perspective regarding the future, especially when those trends are positive ones. While this may be the natural response, I want to stress the importance of not letting previous legislative victories lull us into letting our guard down.

I have frequently overheard NYSSA members voice feelings of complacency with regard to our legislative agenda, specifically as it relates to the recurring efforts by nurse anesthetists to gain the title of CRNA and the freedom to practice independently. As part of the newest iteration of their argument, the nurses suggested that they desire to work in a collaborative relationship, and that this really isn’t any different from the way they practice now. This is a lie. A “collaborative relationship” would allow nurse anesthetists to perform pre-anesthesia evaluations, anesthetic induction and emergence, as well as to write prescriptions, without any physician supervision. We know that the medical practice of anesthesia is not a collaborative practice, and that nurse anesthetists are not trained to work collaboratively. Granting them this practice autonomy would be dangerous for patients, as “collaboration” in this instance would simply mean that a physician of any specialty would review their patient records at least once every three months. Where does that leave the patient who experiences a medical emergency in the operating room? Nurse anesthetists are not medical doctors; they are not educated or trained to work autonomously in these situations, providing the medical interventions that are necessary to save lives.

Year after year, Assembly members Richard Gottfried and Amy Paulin have supported legislative initiatives that would grant nurse anesthetists title and autonomy. It is important to note that these two legislators represent very affluent areas of New York (Midtown West in the city and Scarsdale in Westchester). Their constituents will always have access to physician anesthesiologists for their care. However, should nurse anesthetists be granted practice autonomy, this would not be the case for patients in many of New York's less affluent legislative districts. This legislative effort would create a discriminatory two-tiered medical care system where the quality of anesthesia care would be determined by a patient's insurance or other economic considerations. Those with resources would be cared for by physicians while those without would receive care from nurses.

Another fact that cannot be ignored during the debate about nurse anesthetist scope of practice directly relates to the opioid epidemic in New York state. Granting nurse anesthetists expanded authority would result in nearly 1,300 undertrained and unsupervised healthcare providers writing prescriptions, potentially exacerbating this crisis.

Last year we witnessed an escalation in the amount of misinformation coming from the New York State Association of Nurse Anesthetists (NYSANA) and its leaders. For example, their president, Cheryl Spulecki, provided inaccurate information to local news outlets, as well as in testimony at a legislative healthcare hearing. Spulecki claimed that physician anesthesiologists provide only 5 percent of anesthesia services in rural areas of New York, the implication being that nurse anesthetists are needed to provide medical care in these underserved areas. This is not true. In fact, demographic data shows that most of the state's 1,240 nurse anesthetists practice in and around New York City, not in rural areas of the state. What's more, there are currently three times as many physician anesthesiologists practicing throughout the state as there are nurse anesthetists.

The NYSANA leadership also likes to cite biased studies that were commissioned by their national association. Supposedly these studies support their claim that anesthesia care provided by nurses is equally as safe as when that care is provided by physicians. The studies are flawed, misleading, and fail to acknowledge that the care provided by nurse anesthetists was supervised by physicians. These details are conveniently omitted when the information is presented to legislators or members of the media.

Over the last decade, NYSANA members have been ratcheting up their egregious assertions. In response, the NYSSA's lobbyists, members and staff continue to counter the misinformation with the facts. While we have been successful in these efforts thus far, now is not the time for complacency. We must remain vigilant and committed. This means that your proactive grassroots activism is needed now more than ever. Just as I haven't given up on my beloved Redskins, I remain steadfast in supporting access to safe, high-quality anesthesia care for all New York citizens. We must never allow legislators to take your role in this care for granted. ■

*Thank you*

**NYSSA** **Supporter**



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# Distinguished Service Award

## The New York State Society of Anesthesiologists, Inc. Distinguished Service Award

Each year the House of Delegates of the New York State Society of Anesthesiologists bestows **The Distinguished Service Award** on an outstanding member of our Society. The award recognizes significant contributions to anesthesiology and the NYSSA and is the highest honor that our Society can give to any member.

As outlined in the NYSSA Bylaws:

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

Any member of the NYSSA may submit a nomination. There is no nomination form. We only request a letter indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. The candidate's current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., FASA, at NYSSA headquarters (HQ@nyssa-pga.org) before July 30, 2018.

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

# More EQ Than IQ: Transitioning From Residency to Private Practice

ARUP DE, M.D., MBA

In the winter of my CA-3 year, I signed a contract to join an excellent private practice just outside the city where I had trained. The reality of becoming a junior anesthesiology consultant in private practice was at hand. There would be no one to call the night prior to discuss plans for the next day's cases, no one would be pushing induction medications for me, and no one would need to co-sign my charts. I did extra rotations in pediatric, cardiac, thoracic, and vascular anesthesia in an effort to do as many hard cases as I could to make sure that I had seen and done everything before having to face those challenges independently. Clinically, I was well-prepared to join my first practice, but one's view as a resident is very different from one's view as an attending.

## Attitude and Teamwork

I joined a broad-based practice at a busy community hospital. We covered an ambulatory surgery center and an endoscopy center in addition to the hospital's operating rooms and labor suites. While all of the partners did everything, there were things that some people were better at than others. When there was down time in one area, we pitched in and helped out wherever help was needed. "Rounds not done? Sure, I'll take care of that." "Labor epidural needs to be placed? I've got some time before my next case; I'll run down and take care of it." People love a team player, and pitching in early and often is always appreciated.

## Patients, Not Procedures

My partners had done their due diligence before hiring me. They knew I was well-trained. In my mind, the only way I could prove to them that I was decent was through procedures; every procedure that I could not perform took on the added weight of revealing my ineptitude. My partners did not keep a daily scorecard of my performance, and the procedures really did not matter a whole lot. I remember asking a partner for assistance with an epidural that I had struggled with for 45 minutes in the preoperative area. He looked at the patient and confided

to me, “If you haven’t been able to get this in, there is no reason for me to think that I can.” Partners in a group are most interested in taking excellent care of patients. It doesn’t matter if it takes three attempts to place an arterial line, but it does matter that we return our patients safely to their loved ones.

### **Be Kind, Be Social, Be Present**

When you walk into the operating room, everyone may already know who you are — you’re the new person. Make a concerted effort to learn staff names and especially the people and stories behind the names. That shows that you are interested, engaged, and committed to building lasting relationships. The person who sweeps the floors is just as important as the OR charge nurse. Treat them as your equals. Small things matter and go a long way; remember to make eye contact, smile, and be socially open and in the present. Minimize cell phone use and don’t be the person texting in the corner, closed off to break room chatter. The impressions of every individual in the hospital will make their way into your partners’ ears in short order, so be kind to everyone you meet.



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## Life Happens

On interview day, you may have given the impression that you would be with your private group until the day you retire. Life has a way of taking the best-laid plans and mixing things up. Family circumstances may necessitate moving to another state and finding another practice. You may feel drawn to a fellowship after several months. It's all good, and your partners will likely understand what you are going through — they may have gone through similar experiences themselves. Be open and truthful about what is happening and the possible impacts to the practice. Remember, your new partners aren't just resources and supports while you are in the same practice, but also friends and colleagues you will seek counsel from and see throughout your entire career, no matter where you end up. Life happens, and allows you to connect with and make new friends throughout your journey. Focus on building bridges, not burning them.

My first practice was not my last, but it was a very important part of my professional development as an anesthesiologist. I gained independence, confidence, and matured tremendously as a clinician. Those partners were like family, and we still seek each other out at conferences and meetings. Remember, the world of anesthesia is very small; your actions will reverberate much farther than the walls of the hospital where you work. Ultimately, we are all part of one big, connected anesthesia family! ■

*Arup De, M.D., MBA, is the vice chairman for anesthesia systems integration at Albany Medical Center in Albany, New York. He previously worked in private practice, both in small groups with as few as 12 partners as well as in larger groups of more than 50 partners.*



## The Transition to Private Practice: Learning From Those Who Came Before You

JENNIFER E. HAYES, M.D.

I vividly remember my first Friday night as an anesthesiologist in private practice. I got sign-out from my partner and knew she was heading out for the night ... and the closest help would be 30 minutes away. *Gulp.*

This is when you rely on your training, previous experience, and faith in yourself that your education and skills will lead you to “do the right thing.”

When you leave the cushions of an academic hospital — with mounds of support, other attendings, residents, and CRNAs who could assist in times of need — this is when you really learn what you know, and what you don’t know. The transition to private practice is also the time to build confidence in yourself. It is as if with each decision tree, you are standing in a courtroom defending your decision, or sitting in a hotel room answering your oral board questions. *Why? How? Is there evidence to support that, Dr. Hayes? And now you can’t intubate and the patient’s oxygen saturation is 89 ... 88 ... 85 ... what next?*

Occasionally I would imagine who I could call if I really couldn’t intubate and couldn’t ventilate. Could the ER doc help? Was there anyone besides me in this hospital who could get an airway? I would go through the “what next” in my head before inducing. Then there was the fear of performing a general anesthetic on someone who *really* needed a spinal if I couldn’t get it. The pressure was on and, once again, I needed to rely on my skills and sometimes figure out new tricks to best serve my patients.

During *daylight* hours, reliance on your seasoned elder partners is a key to success. You may think that you’re the hottest new thing on the anesthesia scene, but, remember, your elder partners have been doing this for far longer, probably in more diverse practice settings than you have. More than likely, their 20- to 30-plus years of clinical experience in the trenches can teach you a thing or two. A few more hints:

## Know When to Say 'No'

Remember to follow your gut. If something doesn't feel right, talk it over with a senior partner, and don't do things that you can't justify ethically. Some of the best advice I received from a partner was, "You can always get a new job. You can't get a new license." In other words, don't be pressured into something that you feel isn't safe. If a surgeon in a free-standing office wants you to do a case in his office-based OR that hasn't been used for years, and there is no dantrolene present, JUST SAY NO! Even if he tells you that the patient is "perfectly healthy" and there's dantrolene across the street at the main hospital. Do you really think that when a patient is having an MH crisis there will be a free person to run across the street and grab dantrolene? Always stay within ASA guidelines. Have (non-expired) dantrolene and intralipid available, no matter what the cost, and check the expiration dates frequently. There's no defense in a court of law for using expired drugs.

## If It Sounds Too Good to Be True, It Probably Is

I once interviewed for a job in a desired West Coast location. Great town, incredible compensation package, but after only a half day in the OR there I felt like I needed a vacation. The stress between partners and



between anesthesiologists and surgeons was so palpable that you could cut the air with a knife. In fact, even during my brief interview speaking to different partners, I could easily tell that they didn't even like each other. The bottom line was that it just didn't feel right. Something was off. Trust your judgment and move on.

### **Know When You Need Backup**

When an obese patient is sitting in pre-op waiting for his lap chole and you can hear his stridor before you walk into the room, perhaps you should call a senior partner before you induce. Especially if it's Saturday and you're completely alone. Of course, you try to protect your partners from coming in unnecessarily, but know the times when you really need someone there because proceeding alone could put patient safety in jeopardy.

### **Don't Just Be a Warm Body**

Offer something to your group. Don't just show up, push the good stuff, slam your locker, and go home. Show your group that you have a valuable contribution to make — a new block, echo experience. If you can't think of anything immediately, at least be cheerful, helpful, and a team player. No one wants to work with a whiner, especially someone who states how “state of the art” and “amazing” the technology was where you came from. Don't complain. Instead, take the necessary steps to change things in a thoughtful manner. If you are continually frustrated that you are unable to change things after a reasonable period of time, then look for a new job, taking the above advice along with you! ■

*Jennifer E. Hayes, M.D., is the director of orthopedic anesthesia at Albany Medical Center. She practiced in both private and academic settings in the Seattle area prior to moving to the East Coast.*

## Reflections on Academic Practice

**JAMES MCKEEVER, M.D.**

There is an anesthesiologist on staff at our academic practice who spent most of his decades-long career in private practice. He likes to say, “A career in anesthesiology, whether in private practice or academics, is like running a marathon. In private practice, the pace is a six-minute mile, whereas in academics, it’s more a 12-minute mile.” I have never run a full marathon but on most days, at least as a new attending, I feel like the clip is faster than a 12-minute mile. Feeling out of breath is not uncommon. When I get a few moments to catch my breath, here are a few of the aspects of academic life I reflect on:

### **Bigger Is Tricky**

The demands an academic center places on its anesthesiology staff can be enormous. At our institution, more than 130,000 anesthetics are administered each year by 198 anesthesiologists, 70 residents, 52 CRNAs, and 34 technicians across 25 New York City locations. The size of such an operation keeps things interesting, as all types of pathologies, operations, patient populations, and personalities are encountered. This diversity makes each day feel unique and offers the benefit of keeping skills fresh and relevant across multiple subspecialties: regional blocks one day, epidurals the next, transplant surgery overnight, off-site endoscopy suite to round out the week.

The logistical challenges associated with running such a large department demand flexibility on the part of its members, as resource allocation needs across time and place are often unpredictable. Residents often lament the result of this unpredictability as “getting stuck.” As an attending, it is more zen to adopt a different lens: We are here as a group to field the demands of patients, surgeons, and the hospital. Most of the time, if not all of the time, it’s just not about us.

Moreover, to meet this unpredictable demand, it is often beneficial to have a surplus of providers around, which means taking days off or vacations during certain times of the year can be difficult.

## **We Don't Do Bread and Butter**

Patients in an academic center tend to be sick, very sick. Patients undergoing face transplants, liver transplants, and lung/heart transplants don't lend themselves to tried and true anesthesia "recipes." Moreover, competing priorities in an academic center place value on making anesthetics unique and educational, whereas in private practice the emphasis tends to be on efficiencies, quick inductions and wake-ups, and rapid turnover between cases. For example, an academic practice is more likely to experiment with opioid-free anesthetics and study their impact on ameliorating the country's current opioid epidemic.

## **Thinking Aloud Is Important for Patient Care**

An academic center is ostensibly a place of learning, a place to exchange ideas. It is obvious to anyone who walks into the lobby of an academic hospital center — the walls are lined with posters advertising grand rounds lectures, M&M conferences, and basic science talks. In addition to making continuing medical education credits easily obtainable, these frequent and accessible meetings provide important, cutting-edge information that improves patient care.

Equally important though is the more informal exchange of ideas that occurs between medical student and scrub tech, surgeon and administrator, anesthesiologist and surgical resident. It quickly becomes apparent that few people in the operating room understand what we, as anesthesiologists, do on a daily basis and where our heads are most of the time. To improve this lack of understanding, it is best to lose the inner monologue and think aloud, all the time. While certainly annoying to some, the habit is not only helpful for oral boards preparation, but also improves understanding and communication across specialty and provider level.

In academic practice, thinking is encouraged in many forms — thinking aloud (teaching), thinking on paper (writing), and thinking in response to another's thoughts (reading). When a bunch of human beings engage in such activities, magical things often happen.

## **You Will Rarely Walk Alone**

An academic practice can sometimes feel like an embarrassment of human riches, like you are swimming in resources. You and the junior resident have an emergent ex-lap in a patient with a non-reassuring

airway and a BMI of 55? Let's wake up the senior resident for some more hands. You have a pediatric inhalation induction? Have the resident take the airway while you find an IV. You're having difficulty with the IV? Let's invite the pediatric fellows and pediatric-trained anesthesiologists to come poke around.

If you're on faculty at the same academic institution where you trained, the riches are even greater. You know first names and which specialized skill each name represents. You have a difficult airway, I have a guy for you. You have a question about epidural management, I have a woman for you. This is not to say that staying at the same institution where you trained comes without difficulties. Most significantly, it is challenging to shed the "resident" label and have others identify you as the "responsible provider."

The final observation in my short year of academic practice pertains to the default setting of one's Epic, or electronic records, screen. I have noticed that, when giving breaks to colleagues, all residents have saved as their default screen preference the "My Cases" view, where the computer screen only shows the cases to which that particular resident is assigned. In contrast, attendings uniformly have the entire board displayed as their default. The cynic will say this screen better allows the attending to calculate the likelihood or timing of relief. I prefer to view it as recognition that academic practice is a team sport, an understanding that we are all in this together as we try to meet the demands of the hospital, to help each other out, and to best serve our patients.

One more thought: Obviously, whether in private, community or academic practice, be nice — to everyone. That is, until nice is not getting the job done. In that case, channel your inner cardiac anesthesiologist. ■

*James McKeever, M.D., is a first-year attending and instructor in the Department of Anesthesiology, Perioperative Care, and Pain Medicine at NYU Langone Health. He served as chief resident in the department from 2016-2017 and does not enjoy running marathons at any pace.*

## The New York State Society of Anesthesiologists, Inc.

### Joseph P. Giffin Wall of Distinction Award

The House of Delegates of the New York State Society of Anesthesiologists will bestow **The Joseph P. Giffin Wall of Distinction Award** on an outstanding member of our Society. The award recognizes significant contributions to anesthesiology and the NYSSA.

As outlined in the NYSSA Bylaws:

1. The recipient must be an anesthesiologist who had been an active member in good standing of the NYSSA for a minimum of 10 years.
2. The recipient must have provided significant service to the NYSSA by playing an active role in anesthesia education and/or an active leadership role in the NYSSA.
3. The Wall of Distinction award can only be conferred posthumously and is not required to be awarded annually.

Any member of the NYSSA may submit a nomination. There is no nominating form. We request only a letter from you indicating why you believe your candidate deserves this honor. Please stress his/her significant contributions to anesthesia education, research, or political/administrative activities. If available, the candidate's current curriculum vitae should also be included. Please send your nomination to Michael P. Duffy, M.D., FASA, at NYSSA headquarters (HQ@nyssa-pga.org) before July 30, 2018.

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 EUOs and New Guidance Involving Corporate Structure

**MATHEW J. LEVY, ESQ., AND STACEY LIPITZ MARDER, ESQ.**

Providers who render services under “no-fault” coverage most likely are familiar with “examinations under oath” (EUOs). As per applicable no-fault regulations, an insurance company may demand that a provider who accepts a patient’s assignment of benefits appear before an EUO in order to verify the no-fault claims. Accordingly, an insurer is entitled to deny payment for services rendered under no-fault if a provider fails to comply with an insurer’s timely and valid request for an EUO, so long as the request strictly complies with the governing regulations.

The scope of an EUO often includes a provider’s billing practices and determination of treatment, as well as the provider’s corporate structure. However, insurance companies can ask about anything during an EUO. Therefore, it is imperative that providers seek advice from an attorney prior to attending an EUO in order to limit potential exposure.

Per the corporate practice of medicine doctrine in New York state, a professional practice must be owned by an individual authorized by law to practice the profession the entity is being organized to practice. For example, a medical practice cannot be owned or controlled by non-physicians. This concept was incorporated into no-fault law, whereby a healthcare provider is not eligible for reimbursement under no-fault if the provider fails to meet a licensing requirement or is “fraudulently incorporated.” This issue was raised in the Court of Appeals decision in the landmark case *State Farm Mut. Auto. Ins. Co. v. Mallella*.

This issue was further addressed in a recent Appellate Division case known as *Carothers v. Progressive Ins. Co.* In this case, the Appellate Division upheld the lower court’s decision in favor of the insurers, who claimed that the physician owner of the medical practice was the nominal owner and that the medical practice was actually owned and controlled by non-physicians, and therefore should not be compensated for services billed and rendered under no-fault. In reaching its decision, the Appellate Division upheld a list of factors that the jury was instructed to consider when determining whether the non-physician owners were in fact de-facto

owners or exercised substantial control over the medical practice and its assets. It is important to note that the court clearly indicated that the totality of the circumstances must be evaluated when determining whether a medical practice is “fraudulently incorporated,” and therefore a decision cannot be made based upon one factor alone.

As noted by the court, there are 13 factors to be evaluated, including (but not limited to) the following: Whether the non-physicians’ dealings with the medical practice were arm’s length or were instead designed to give the non-physicians substantial control over the medical practice and channel profits to the non-physicians; whether the non-physicians exercised dominion and control over the medical practice’s assets, including bank accounts; whether and to what extent the medical practice’s funds were used by the non-physicians for personal rather than corporate purposes; whether the non-physicians were responsible for the hiring of, firing of, and payment of salaries to the medical practice’s employees; whether the day-to-day formalities of corporate existence were followed, including the issuance of stock, elections of directors, holding of corporate meetings, keeping of books and records, and filing of tax returns; whether the medical practice shared common office space and employees with the non-physicians’ companies; and whether the physicians played a substantial role in the day-to-day and overall operation and management of the medical practice.

In sum, all providers, including but not limited to those who render no-fault services, should review their corporate structure with an experienced healthcare attorney in order to ensure that they are structured appropriately. This is extremely important, as being improperly incorporated can result not only in the inability to collect payment from insurers, but also in actions against the practice involving licensure and violations under the Stark and anti-kickback statutes. Should you have any questions relating to your corporate structure, or if you are requested to appear for an EUO, please do not hesitate to contact Mathew Levy at 516-926-3320 or [mlevy@weisszarett.com](mailto:mlevy@weisszarett.com). ■

*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](mailto:mlevy@weisszarett.com). Ms. Marder can be reached at 516-926-3319 or [smarder@weisszarett.com](mailto:smarder@weisszarett.com). The firm can be found on the Web at [weisszarett.com](http://weisszarett.com).*



Stony Brook **Medicine**

# Stony Brook Anesthesiology Alumni Cocktail Reception

Saturday, December 8, 2018  
5:00-7:00 p.m.

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

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

Please send your current mailing and email addresses to:  
[SBUH\\_anesthesia\\_alumni@stonybrookmedicine.edu](mailto:SBUH_anesthesia_alumni@stonybrookmedicine.edu).

We will send you a small gift and add you to the department's  
monthly newsletter distribution list.

**A Celebration of Research Excellence.**

**Ranked #6 in 2016 NIH Funding among Anesthesia Departments**  
**Ranked #4 in 2017 NIH Funding among Anesthesia Departments**

\*\*\* ASA Endorsed MOCA Simulation Center \*\*\*



# Mount Sinai Anesthesiology Residency Celebrates 100 Percent Participation in NYAPAC and ASAPAC



(Left to right) Drs. Adam Levine and Andrew Leibowitz, ASA President  
Dr. James Grant, Drs. David Reich, Lawrence Epstein and Jonathan Gal, and  
NYSSA Executive Director Stuart Hayman



ASA President Dr. James Grant (seated, second from left) made a special visit to the Mount Sinai Department of Anesthesiology to recognize the department's leaders, faculty, residents, interns and staff.

# NYSSA Members Meet With New York Legislators



U.S. Rep. Gregory Meeks with NYSSA President-elect Dr. Vilma Joseph



Assemblywoman Alicia Hyndman and Dr. Vilma Joseph



Assemblyman Luis Sepúlveda and New York City Mayor Bill de Blasio with Drs. Lauren Thornton and Vilma Joseph



Senate candidate Chele Farley with Dr. Scott Plotkin



NYSSA President Dr. David Bronheim, Senate Majority Leader John Flanagan, Sen. Catharine Young, and Dr. Jonathan Gal

# NYSSA Annual Legislative Day

A record number of NYSSA members traveled to Albany for the 33rd annual Legislative Day.

NYSSA President  
Dr. David Bronheim



Sen. John DeFrancisco (left)  
with Dr. Jonathan Gal





**Dr. Richard Wissler (left) and  
Assemblyman Joseph Morelle**



**Speaker Carl Heastie (left) and  
Dr. Jonathan Gal**



**Lobbyist Marcy Savage  
with Dr. Michael Simon**



**NYSSA Past President Dr. Rose Berkun  
with Sen. John DeFrancisco**



**(Left to right)  
Drs. Morgan Montgomery,  
Ashley Whisnant, David  
Currie, Matthew Stratton,  
and Sudheer Jain**





(Left to right)  
 Drs. Joey Mancuso,  
 Jasmeet Easwar and  
 Vilma Joseph, Sen. Andrea  
 Stewart-Cousins, and  
 Drs. Matthew Wecksell  
 and Kenneth Saad



Dr. Andrew Rosenberg



(Left to right) Drs. Andrew Rosenberg, James McKeever and  
 David Wlody, Sen. Simcha Felder, and Drs. Lance Wagner,  
 Daniel Sajewski, and Jason Broker



Drs. Rose Berkun and Jason  
 Broker, John Koury from Sen.  
 Chris Jacobs' office, and Drs.  
 Elizabeth Mahoney, Robert  
 Semidey, and Scott Plotkin



(Left to right) Drs. Adaora Chima, Danielle Lindenmuth, Alan Curle, Marjorie Gloff, Richard Wissler, and Melissa Kreso



(Left to right) Drs. Matthew Stratton, Gregory Fischer, David Currie, and Sudheer Jain



NYSSA members held productive meetings with legislators and their aides.



(Left to right) Drs. Daniel Sajewski, Christopher Campese, and Anthony Schwagerl



# ASA Legislative Conference, Washington, D.C.



(Left to right)  
Drs. David Bronheim,  
Vilma Joseph, Colleen Yen,  
Erica Fagleman, Sam Satler,  
Will Tyson, Ashley Whisnant,  
Alex Mazerov, Morgan  
Montgomery, Ansara Vaz,  
David Wlody, and Jonathan Gal



(Left to right)  
Drs. Alexander Mazerov,  
Ashley Whisnant, Jonathan Gal,  
Morgan Montgomery,  
David Bronheim, Erica  
Fagleman, and Colleen Yen



Dr. Rose Berkun shares the NYSSA advocacy experience with ASA legislative conference attendees as a panelist on the “Interactive Session on State Topics.”



**Dr. Ansara Vaz and David Wlody with Rep. Yvette Clarke**



**Dr. Vilma Joseph, David Bronheim, Jonathan Gal, Ashley Whisnant, Erica Fagelman, Morgan Montgomery, Colleen Yen, and Alexander Mazerov meet with Mark Howell from Rep. Adriano Espaillat's office.**



**Dr. Vilma Joseph, David Bronheim, Jonathan Gal, and Ashley Whisnant**



**Dr. Jason Lok and Rose Berkun, Charlotte Pineda from Rep. Chris Collins' office, and Dr. Douglas Sillart and Michael Duffy**



**(Left to right)  
Dr. Kashmira Chawla, Will Tyson and Sam Satler, Erin Meegan from Rep. Brian Higgins' office, and Dr. Rose Berkun, David Currie, and Douglas Sillart**



**Dr. Michael Duffy and  
Rep. Claudia Tenney**



**Dr. Jason Lok,  
Rep. John Katko, and  
Dr. Michael Duffy**



**NYSSA delegates took time for a photo during the ASA legislative conference.**



(Left to right) Drs. David Bronheim, Sudheer Jain, Jung T. (Ted) Kim, Jason Lok, Rose Berkun, Michael Simon, Vilma Joseph and James McKeever, Sen. Charles Schumer's legislative aide Matthew Fuentes, and Drs. Douglas Sillart, Christopher Campese, Michael Duffy, and Ansara Vaz

## The World Congress on Regional Anesthesia & Pain Medicine



NYSSA staff members Will Burdett and Jacqueline Homan at the World Congress on Regional Anesthesia & Pain Medicine



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

Patient-Centered, Physician-Led Care



The New York State Society  
of Anesthesiologists, Inc.

American Society of  
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accepted into anesthesia training in Hanover. In Germany in the 1960s, this was quite different from today's structured training system. It was a true apprenticeship — one did cases while being supervised by a senior colleague. In 1967, Dr. Hollinger took advantage of an opportunity to spend a year in the U.S. This seemed like an interesting way to strengthen her English and learn additional skills. At the advice of another European anesthesiologist, she deferred her return to Germany and, after her year in New Jersey, she was accepted into an anesthesia residency at Montefiore Hospital.

After serving as chief resident and then a fellow in pediatrics at Montefiore, another opportunity arose, this time in Canada. Dr. Hollinger's husband was moving to Toronto for work, and she went looking for advanced training nearby. As a newly board-certified anesthesiologist, she had the option of taking a fellowship position at The Hospital for Sick Children, but when she discovered that the fellows did outpatient work while the big cases were actually done by anesthesia attendings and residents she re-enrolled as a resident. During her time in Toronto, she crossed paths with Dr. William Mustard (of the Mustard procedure). He was nearing retirement but could still repair an ASD in three minutes. The following year, she continued her training in the ICU at The Hospital for Sick Children before returning to Montefiore as an assistant professor in 1974. Dr. Hollinger's travels were not yet complete! 1976 also saw her return to Germany to complete her German board certification in anesthesia. Again she was required to return to a residency position and elected to spend the year doing the cases that few people wanted to touch: complex pediatric cardiac surgery. There were only about 300 cases done in the whole of Germany at that time, and Dr. Hollinger did half of them.

In 1978, Dr. Hollinger returned to New York and rejoined Montefiore Hospital and Albert Einstein College of Medicine, becoming an assistant professor in 1983 and then a full professor in 1990. She stayed at Montefiore a total of 26 years before moving to Mt. Sinai Hospital in 1997. Recollections from colleagues of her time at Montefiore abound. She was the go-to person in a crisis who could rapidly assess and manage a chaotic operating room problem. She had the stamina to attend a Monday night Wagner opera at the Met and be fresh in the OR at 6 a.m. the next day. As a teacher, she would hold a room transfixed with her knowledge. Teaching accolades followed Dr. Hollinger at every academic institution, starting with a 1976 Best Teacher Award at Montefiore Medical Center and culminating

in a 2007 Lifetime Achievement Award for Outstanding Contribution to Resident Education. Dr. Hollinger's role in teaching does not end with resident education. She is active in the New York Academy of Medicine, serving as chairperson for the Gertie Marx Symposium in 2002 and the Edith Kepes Symposium in 2004. Nationally and internationally, she has donated her time and expertise to no less than 73 symposia with a focus on transplant, craniofacial, critical care and pediatrics, especially congenital heart disease.

International patients have also benefited from Dr. Hollinger's talents. She has been involved in numerous humanitarian missions to Russia, Romania, Vietnam, Honduras, Guyana and Nicaragua. Dr. Hollinger would provide anesthesia for complex pediatric cardiac cases as well as teach the local doctors about new anesthesia techniques — including regional — so that they could improve both intraoperative and post-operative care of complex congenital heart disease.

Research began at the bench with physiology and the pharmacology of muscle relaxants and narcotics. In more recent years, Dr. Hollinger's research has had a clinical focus, especially in pain relief for the pediatric cardiac surgical patient, enabling fast tracking after pediatric cardiac surgery. She is also co-PI on a study of the utility of cerebral oximetry in pediatric cardiac surgery. She has authored 38 peer-reviewed publications, 35 abstracts and 18 book chapters.

### **NYSSA Involvement**

When Dr. Hollinger joined Montefiore, the chair of anesthesiology at the time (Dr. Francis Folds) was an active NYSSA member. Dr. Folds "strongly encouraged" the department's anesthesiologists not only to join the NYSSA but also to attend the annual PGA meeting. Lack of attendance at important sessions would be duly noted! As a result, Dr. Hollinger became an active District 3 member in 1978 and worked her way up the ranks of the committee structure. When she moved to Mt. Sinai in 1997, she moved to District 2 and her involvement in the NYSSA continued. From taking on positions of leadership to her participation in educational endeavors and administrative functions, it is hard to find an area within the NYSSA that Dr. Hollinger has not touched. Her work on behalf of the PGA is equally impressive.

As part of her contribution to the PGA, Dr. Hollinger campaigned successfully for term limits on the vice chair and chair positions (three years each for

vice chair and chair with an additional three years as an emeritus chair to allow mentorship of the incoming leader). She firmly believes that younger delegates must be allowed to transition into these roles early so that they are able to gain experience from the veterans. Of the many challenges she has faced, the ability to foresee the future must be among the more noteworthy — selection of the next year’s “hot topic” requires her to predict trends in anesthesia a year in advance.

In 2009, Dr. Hollinger became the president of the NYSSA’s District 2, serving until 2012, when she moved to the position of director. Not surprisingly, she has been an NYSSA delegate to the American Society of Anesthesiologists for the past 23 years. Within the ASA itself she has been active on both the pediatric and blood management committees.

It is striking that amongst all the academic and administrative responsibilities she has held, Dr. Hollinger also took time to attend the New York State Fair as an NYSSA representative. She manned a booth where adults could try the monitors, ask questions, and occasionally be diagnosed with a tachyarrhythmia! On children’s day, kids dress up in small scrubs and have their picture taken giving anesthesia to a mannequin. She sees this as important, front-line public relations work — the anesthesiologist as doctor, meeting the community. How could anyone lobby for our profession if they didn’t know what we did?

Over the course of her career, Dr. Hollinger has watched anesthesia become a significantly more sophisticated specialty. When she began, there was no pulse oximeter and she recalls a primitive blood gas machine, the calibration of which was part of her job as chief resident. Although the new technology has clear advantages, she sees a new reliance on the monitoring that takes away from direct observation of the patient. She wants her residents to be excellent clinicians and not just technicians who treat the monitor. If anesthesiologists are perceived as technicians — line, tube and block placers — then physicians are replaceable by technically proficient nurses. Instead, we need to be seen as specialists with expertise in the management of complex medical problems. To be the experts in perioperative disease management, we need to reclaim critical care, an area once dominated by anesthesiologists that now takes mainly pulmonologists, cardiologists and surgeons. We should embrace extra training and embody the reason why physician-delivered anesthesia became safe anesthesia. ■

*Kiri Mackersey, M.D., is a cardiothoracic anesthesia attending at Montefiore Hospital in the Bronx.*

## MLMIC UPDATE

### **HANYS and MLMIC Collaborate to Improve Patient Safety**

The Healthcare Association of New York State (HANYS) and MLMIC are collaborating to conduct an in-depth analysis of claims data. This effort will explore potential linkages between patient safety protocols, patient health outcomes and adverse events.

Averting the consequences of an adverse event for patients — and the economic and professional impact for physicians, hospitals and all other healthcare provider organizations — is a high priority for HANYS, HANYS members and MLMIC, an insurer of many HANYS practitioners and organizations.

“We are hopeful that this analysis will provide valuable insight and best practices for providers across New York to improve risk mitigation and patient safety. Over time, improvements in patient safety could reduce medical malpractice claims and, in turn, serve to counter medical malpractice premium inflation,” said HANYS President Bea Grause.

“The shared goals of reducing patient harm, advancing patient safety and helping New York providers mitigate risk, coupled with the considerable subject matter expertise and robust data capabilities of both organizations, will serve to advance the interests of New York healthcare physicians, facilities and providers,” said Ms. Grause.

MLMIC President John Lombardo, M.D., in commenting on the collaboration, noted that “MLMIC, since its creation, has always believed in risk management by experienced personnel who truly understand the unique New York medical community. MLMIC can not only improve patient safety but can also assist both physicians and hospitals in their pursuit of quality improvement for all patients. We look forward to working with our new partner, HANYS, in developing many new and cutting-edge vehicles to accelerate these efforts and achieve these worthwhile goals.”

### **Diederich Data: New York Has Highest Per Capita Medical Malpractice Payout**

According to this year’s medical malpractice payout data from Diederich Healthcare, New York is among only three states with total medical malpractice payouts exceeding \$300 million in 2017. In addition, its total

payout of \$617,973,000 earns it the distinction as the state with the highest per capita payout (\$313) in the nation.

This isn't surprising. As Lawsuit Reform Alliance of New York notes, "New York ranked first in each of the last five years, except for 2016, when it was bumped down a spot by New Hampshire." Total payouts in the Northeast, says Diederich, were responsible for 41.95 percent of the U.S. total, illustrating just how far out of line the numbers are in states like New York.

Unfortunately, it's one of the reasons New York is an extremely challenging business and professional environment for healthcare providers. The stakes are very high, and providers need excellent protection. It's why MLMIC operates with the highest level of fiscal responsibility and with business practices that ensure strong backing for the liability coverage offered to policyholders. (In contrast, when companies advance unsustainable pricing practices, the risks are great.)

In addition to offering policyholders this kind of security, MLMIC monitors and, when possible, works to improve the environment for healthcare providers. Find information about some of these efforts in *The Albany Report*, published periodically by MLMIC, which offers a concise, insider's view of pending legislative, regulatory and political developments that have an impact on New York's medical malpractice insurance marketplace. ■

*The Healthcare Association of New York State (HANYS) is the statewide hospital and continuing care association in New York state, representing hundreds of non-profit and public hospitals, nursing homes, home care agencies and other healthcare organizations.*

*Medical Liability Mutual Insurance Company (MLMIC) is the largest writer of medical professional liability insurance in the state of New York and one of the largest companies of its kind in the nation. Across New York state, MLMIC insures nearly 13,000 physicians, 3,000 dentists and dozens of hospitals.*

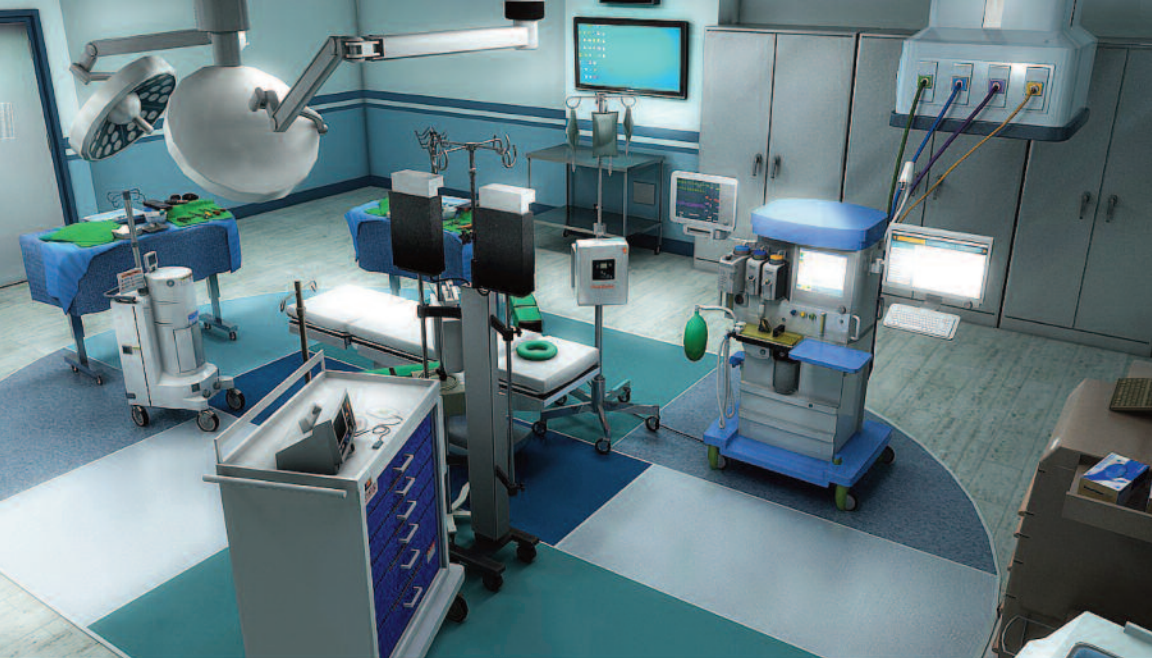
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## **Legislative Update**

**CHARLES J. ASSINI, JR., ESQ.**

### **NYSSA's 33rd Annual Legislative Day in Albany**

#### **Annual Legislative Day (May 1, 2018) - RECORD ATTENDANCE!**

This year's Legislative Day in Albany had the greatest number of participants in recent years and included NYSSA leadership and members from every district. We greatly appreciate the efforts of these dedicated members to attend this annual event. Based on the strong participation of our members, we were able to schedule appointments with 102 legislators (58 Assembly members and 44 senators). During our Tuesday morning breakfast, we had the privilege of having Speaker of the Assembly Carl Heastie address our group. We also recognized Senate Deputy Majority Leader John DeFrancisco, who announced his retirement from the Senate at the end of the year, and Assembly Majority Leader Joseph Morelle, who announced he will be running for U.S. Congress in November 2018. As prime sponsors of the NYSSA-backed safe anesthesia bill for the past 20-plus years, their strong leadership and support was recognized and applauded by our group. Below please find the list of members who registered to attend as well as those who signed in on Legislative Day; we apologize to anyone inadvertently left off this list.

#### **DISTRICT 1**

Dr. Tal Levy  
Dr. Joey Mancuso  
Dr. Lance Wagner  
Dr. David Wlody

#### **DISTRICT 2**

Dr. David Currie  
Dr. Erica Fagelman  
Dr. Gregory Fischer  
Dr. John Foote  
Dr. Jonathan Gal  
Dr. Ingrid Hollinger  
Dr. Sudheer Jain  
Dr. Alexander Mazerov  
Dr. James McKeever

Dr. Morgan Montgomery  
Dr. Andrew Rosenberg  
Dr. Matthew Stratton  
Dr. Will Tyson  
Dr. Ansara Vaz  
Dr. Ashley Whisnant

#### **DISTRICT 3**

Dr. Jason Broker  
Dr. David Bronheim  
Dr. Jasmeet Easwar  
Dr. Vilma Joseph  
Dr. Sandhya Malhotra  
Dr. Kenneth Saad  
Dr. Matthew Wecksell

**DISTRICT 4**

Dr. Ravneet (Sona) Bhullar  
Dr. Scott Chamberlain  
Dr. Robert Eberle  
Dr. Scott Groudine  
Dr. Lawrence Routenberg  
Dr. Kimberley Schuller  
Dr. Michael Simon

**DISTRICT 5**

Dr. J. Robert Calimlim  
Dr. Pratik Desai  
Dr. Michael P. Duffy  
Dr. Jason Lok  
Dr. Benjamin Robele

**DISTRICT 6**

Dr. Adaora Chima  
Dr. Alan Curle

Dr. Marjorie Gloff  
Dr. Suzanne Karan  
Dr. Melissa Kreso  
Dr. Danielle Lindenmuth  
Dr. Sam Satler  
Dr. Richard Wissler

**DISTRICT 7**

Dr. Rose Berkun  
Dr. Elizabeth Mahoney  
Dr. Scott Plotkin  
Dr. Robert Semidey

**DISTRICT 8**

Dr. Christopher Campese  
Dr. Kevin Glassman  
Dr. Daniel Sajewski  
Dr. Anthony Schwagerl

The involvement of Legislative Day participants this year was critical despite our recent victory in defeating the NYSANA-supported independent practice bill that was incorporated in the governor's budget bill (Part H). The governor's budget bill would have given nurse anesthetists independent practice via collaboration and seriously lowered the standard of care. As a result of our good work in defeating Part H of this bill (through the pro-active involvement of many of the NYSSA's members who reached out to their lawmakers to voice their opposition to Part H of the bill), NYSANA is now pushing two alternative bills to permit independent practice for nurse anesthetists: (1) nurse anesthetist title bill: S.1385 (Gallivan)/A.0442 (Paulin), and (2) nurse anesthetist collaboration bill: S.3501 (Bailey)/A.8007 (Gottfried) (this bill is very similar to Part H of the governor's budget bill).

Our primary message to lawmakers and their staffs has been to support equal access to physician supervision of anesthesia. Despite advances in medicine, every procedure and surgery has risks. Given the risks associated with the delivery of anesthesia, we must preserve equal access to the physician-led supervision safety standard for all New York patients, which increases the likelihood of positive patient outcomes and can mean the difference between life and death for some patients.

## Key Points:

- Defeat proposals that remove the physician anesthesiologist from the treatment team, including perioperative assessment of a patient, preparation of an anesthetic plan, and post-anesthesia care. Currently, a physician anesthesiologist must either administer anesthesia or supervise a nurse anesthetist, or the operative physician must accept responsibility for supervising the nurse anesthetist.

- Defeat proposals that create a two-tier anesthesia delivery system. Without the current statewide uniform requirement, hospitals will be free to permit nurse anesthetists to administer anesthesia independently, a decision that would be based on patient payor status or other economic considerations.

- Defeat proposals that allow nurse anesthetists broad prescriptive authority. At a time when New York state is combating a prescription drug and opioid abuse crisis, it defies common sense to give 1,240 nurse anesthetists unrestricted prescriptive authority.

- Defeat proposals that grant nurse anesthetists title without defining their scope of practice. Not defining scope would: (i) create ambiguity in the operating room when clarity is needed for the safety of the patient and (ii) permit the Board for Nursing to define scope of practice without guidance from the Legislature.

- By granting nurse anesthetists independent practice, healthcare costs will increase. Independent studies have shown that the odds of an adverse outcome are 80 percent higher when anesthesia is provided only by a nurse anesthetist as opposed to a physician anesthesiologist. Adverse outcomes lead to higher costs for patients in both monetary and physical terms when patients require longer hospital stays.

NYSANA's lobbying efforts to achieve passage of Part H of the governor's budget bill included the dissemination of factually inaccurate information. Previously, NYSANA circulated a memorandum in opposition to the Morelle/DeFrancisco bill (A.1829/S.4422) that also contained factually inaccurate statements and misinformation. The NYSSA's memorandum, titled "Just the Facts - Answering NYSANA's Memo in Opposition," addresses the misstatements in the NYSANA memorandum. NYSSA members should review how NYSANA is framing this debate, and be prepared to "set the record straight."

Additionally, NYSSA members are urged to review the NYSANA video that was produced as part of their lobbying efforts to achieve Part H of the

governor's budget bill. Go to the NYSANA Facebook page: [www.facebook.com/New-York-State-Association-of-Nurse-Anesthetists-NYSANA-102363509805285/](https://www.facebook.com/New-York-State-Association-of-Nurse-Anesthetists-NYSANA-102363509805285/). Then go to "videos" (listed on the left) and click on "CRNAs ARE PART OF THE SOLUTION."

Listed below are some Legislative Day documents found on the NYSSA website (click on the "Advocacy" tab, then click on "Legislative/Regulatory Issues," and look for "NYSSA's Annual Legislative Day in Albany 2018").

1. Legislative Day trifold brochure.
2. Memo in support of DeFrancisco/Morelle safe anesthesia bill (S.4422/A.1829).
3. A more comprehensive memorandum in support of DeFrancisco/Morelle safe anesthesia bill (S.4422/A.1829), with attachments.
4. "Just the Facts – Answering NYSANA's Memo in Opposition" to A.1829 (Morelle)/S.4422 (DeFrancisco) equal access to safe anesthesia bill.
5. Memo in opposition to Gallivan/Paulin CRNA title bill (S.1385/A.0442).
6. Memo in opposition to Bailey (S.3501) and Gottfried (A.8007) collaboration practice-CRNA bills.
7. Table of bill sponsors indicating those on the Senate and Assembly Higher Education committees.

In view of the foregoing developments, as well as other bills listed in the trifold brochure, your involvement in our governmental advocacy plan is essential. As such, if you are scheduling a district meeting in the near future, please consider:

- Updating your district on these initiatives and inviting Stuart Hayman, Bob Reid, or me to address your district.
- Reviewing the NYSSA website for information, including supporting and opposing memorandums on legislation. ■

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