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I am writing this column on April 14, 2020, during the coronavirus pandemic, the most serious public health crisis in the last 100 years. NYSSA members will receive this message in late June or early July. I cannot accurately predict the state of the pandemic when you read this, but I expect the situation to have improved. The recent data on COVID-19 illustrates that New York state has the highest number of confirmed COVID-19 cases and deaths in the U.S. Within New York state, the majority of cases and deaths so far are clustered in New York City, Long Island, and Westchester and Rockland counties (94%) as opposed to upstate and Western New York.

Many of us are immersed in the front-line medical care of patients at this time. Some of these patients are critically ill with COVID-19, and some have an uncertain coronavirus status that makes them potentially contagious to others, including those providing their healthcare. Physician anesthesiologists, together with their medical, nursing and support colleagues, are working harder than ever. Their stress has been compounded on occasion by well-publicized local shortages of personal protective equipment, coronavirus diagnostic tests and ICU ventilators. The high death toll from COVID-19, most notably in the downstate region of New York, is another source of frustration for front-line providers, including physician anesthesiologists. Many of us worry about the possibility of unintended spread of the coronavirus to our families when we come home after work.

Our society has undergone the most profound daily changes in our collective memory, primarily as a strategy to mitigate continued spread of the virus. Many businesses are closed and the general public has been encouraged to stay home almost exclusively and to avoid any group gatherings. Public and private schools as well as colleges and universities are closed, and virtually all sporting events are canceled. For healthcare professionals, the restrictions imposed by
the viral pandemic have led to the cancellation of many professional meetings around the world.

At least in New York state, the daily data on COVID-19 cases (aka “the curve”) is beginning to flatten and decrease in a manner that suggests that our widespread efforts to mitigate the spread of the coronavirus are succeeding. If this trend continues, there will be great pressure to restart many of our public activities so that we can begin to rebuild our national economy. For physician anesthesiologists, this is likely to result in a shift back to more traditional roles and schedules, including working on the backlog of deferred elective surgical patients. Planning and implementing this reactivation process for our society is likely to be highly politicized given that 2020 is a major election year and that the federal government is so polarized. Hopefully, the intensity of this crisis will keep our government leaders focused on practical solutions rather than discord.

In summary:

1. We are living through the greatest public health crisis of our generation. Physician anesthesiologists have stepped forward and cared for their patients despite personal danger. In every sense of the word, you are heroes in the finest tradition of the medical profession. I salute you.

2. Medical practice was stressful enough before the coronavirus pandemic. Anticipate that the added pressures of the current situation will affect you. Actively plan to deal with these pressures. Examples include consulting the Wellness Initiative on the ASA website, identifying a personal therapist, or planning daily physical exercise. Please remember that these pressures are a classic setup for substance abuse by you, your family members and your colleagues.

3. Although I have focused on the effects of the current pandemic on physician anesthesiologists, many of our neighbors have had a much more challenging time due to employment layoffs. Whenever possible, please thank your neighbors for their sacrifices during the pandemic. Try to patronize local businesses as the economy picks up, as a way to encourage full employment of others where you live and work.
At this point in time, I absolutely expect the 74th PostGraduate Assembly in Anesthesiology (PGA) to proceed on time (December 11-15, 2020) at the Marriott Marquis in New York City. The organizing committees, under the leadership of Drs. Meg Rosenblatt and Linda Shore-Lesserson, have designed a fantastic program and meeting. After everything that we have been through this year, attending the PGA will be an act of professional and personal renewal for all of us. I look forward to seeing you there.

The 74th PostGraduate Assembly in Anesthesiology Call for Abstract Submissions:

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

**Deadline: September 7, 2020 | Electronic submissions only.**

Visit: [wwwpga.nyc](http://wwwpga.nyc)

Questions? Contact MaryAnn Peck at maryann@nyssa-pga.org.
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 31, 2020.

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
To editorialize on a disaster implies having a solution, or at least some superior perspective. I have neither.

Your experience and burdens during the epidemic have been as diverse as the treatment regimens we encountered. For some there was physical danger while for others the risks were financial, psychological or even political. Some moved out of their homes to protect loved ones while others lost child care or elder care and made precarious and frightening decisions to stay home. Some of us received support; others endured stigma. Some of us were ill and others were grieving.

Amidst the chaos, there have also been moments of hope: extubations, recoveries and discharges. Despite our isolation, there was also camaraderie. We saw physicians come together across specialties, across hospitals and even across time zones, as specialists from around the world shared experiences, innovations and research.

As we think about returning to “normal,” there are a multitude of questions for us as a profession and as a society. What will we do with our new connections and our new perspective? How will we rebuild our systems? Can we correct mistakes without being purely reactionary? We will continue to discuss this crisis on the pages of Sphere and welcome your ideas as we try to define what the new normal should look like.
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, 2020.

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Michael P. Duffy, M.D., FASA, Chair  
NYSSA Judicial and Awards Committee
Like many who have been blessed to live as long as I have, until very recently I believed I was prepared for anything life threw at me. What these past few months have taught me is that I wasn’t. Like everyone else in this country, I was not prepared for the COVID-19 pandemic. This crisis has been an important reminder of the need to be willing to adapt on the fly.

I remember the morning of Monday, March 9, because I felt so lucky that I was able to share a three-person seat with only one other person on my 35-minute Metro-North commute to Grand Central Terminal. By the time I walked through a nearly empty Grand Central at rush hour on Friday, March 13, I knew my luck was rapidly running out. In fact, during my commute home that afternoon, my train, which typically had well over a thousand commuters, was nearly empty. It was then when I realized my staff and I were testing fate. As it turned out, the governor’s emergency order shutting down the entire state of New York would be issued in a matter of days.

Gov. Cuomo’s order prohibited all but essential personnel from working in the city. The NYSSA’s staff members are not considered essential workers, so we had to transition quickly from commuting to our office on East 40th Street in the city to working remotely. For a variety of reasons, I decided it was also time to make a temporary move to an area where my wife and I wouldn’t feel that we were contributing to the depletion of scarce resources. We packed our computers and necessities and relocated outside of New York, naively assuming that we would be on our way back to resume life as we knew it within a couple of weeks. I know how very fortunate I am to be in a position where I could make this decision.

The staff and I have now been working remotely since mid-March. Thanks to the wonders of technology, our workspace may have changed but the NYSSA’s priorities have not. We are keeping the important work of the NYSSA moving forward. We participate in multiple FaceTime and Zoom meetings each week, sometimes daily. We are diligently and enthusiastically
preparing for PGA74, which is still scheduled for December, although those preparations are evolving in recognition of the uncertainty surrounding the remainder of this year.

That uncertainty is affecting many similar organizations, all of which must now approach their meetings with a certain degree of flexibility. For example, every four years the World Federation of Societies of Anaesthesiologists (WFSA) hosts one of the largest anesthesia conferences in the world. The WFSA recently announced that its 17th World Congress of Anaesthesiologists, originally scheduled for September 2020, will be delayed a year. This meeting in Prague, Czech Republic, will now be held in September 2021. The European Society of Anaesthesiology also postponed its upcoming meeting. Euroanaesthesia 2020 will now be held virtually on November 28-30, 2020.

The ASA’s ANESTHESIOLOGY annual meeting is still scheduled for October in Washington, D.C., although the idea of approximately 15,000 anesthesiologists crowded into one conference center just a few months from now no longer seems realistic. Will this meeting be live, virtual, or some hybrid of the two? At the NYSSA we are facing the same questions and challenges when planning for the PGA. I admit that I am no longer as confident as I once was that we will be able to host a fully live conference this year. That said, the staff and I remain committed to making the 2020 PGA a successful event; if a prolonged ban on mass gatherings throws us a curve ball, we will adjust in whatever way the leadership deems most appropriate. Stay tuned.

During these unprecedented times, I am grateful for my job and for the talented and dedicated individuals with whom and for whom I work. You are the true warriors who have been fiercely battling this pandemic from the front lines. The citizens of New York are hugely indebted to you. On behalf of all New Yorkers, I thank you for your service.
Caring for COVID-19 Patients: Is This What We Signed Up For?

KIRI MACKERSEY, MBCHB

Among the enormous challenges we have encountered in the past few months (as of late April 2020), there is an ethical dilemma that has risen to the fore: a physician’s obligation to work in the face of avoidable danger. While the coronavirus pandemic has been a striking reminder of our human frailty and our courage, it also presents an opportunity to ask the question, “Is this what we signed up for?”

Pro: This IS What We Signed Up For

“If not now, when?”¹ We had a choice and we chose medicine. We were not conscripted into this career, and as a profession that was chosen freely, conscientious objection cannot supersede our duty to patients.² Taking a Kantian, absolutist approach: We have a primary ethical duty to participate.

From the beginnings of our profession, medical oaths have described more than simply membership in a guild. Perhaps you did not follow Hippocrates and “swear by Apollo the physician …”³ but the sentiment that the doctor promises to “… benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them … gaining the respect of all men for all time” is echoed in many medical oaths. If you chose Maimonides (12th

Dr. Kiri Mackersey
century physician, Jewish scholar, and philosopher), you were asked that “the love for my art actuate me at all times, may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind …” The ancient Charaka Samhita in Sanskrit instructed practitioners to avoid “… an act of great unrighteousness …” The ancient Charaka Samhita in Sanskrit instructed practitioners to avoid “… an act of great unrighteousness …”

In the U.S. in 1847, the American Medical Association (AMA) created a Code of Ethics delineating expected professional conduct distinct from personal or religious choice. The original Code stated that “when pestilence prevails, it is [physicians’] duty to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives.” The AMA Code has been toned down in the intervening years but still states that doctors have an “ethical responsibility” to place “patients’ welfare above the physician’s own self-interest” (Opinion 1.1.1). Following from this, physicians are obliged to treat patients with HIV and AIDS (Opinion 1.1.2). Even the “Physician Exercise of Conscience” (Opinion 1.1.7), which allows a physician “considerable latitude to practice in accord with well-considered, deeply held beliefs” (such as religious objections to performing abortions), states that the exercise of conscience does not apply in emergencies.

As recently as 1948, the World Medical Association (WMA) Declaration of Geneva Physician’s Pledge instructed that: “A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.” The phrase “must give emergency care” was removed between the 1983 and 1994 iteration and replaced by: “I will maintain the utmost respect for human life from its beginning even under threat …” The most recent version of this pledge begins as follows: “As a member of the medical profession: I solemnly pledge to dedicate my life to the service of humanity; the health and well-being of my patient will be my first consideration.”

From a legal perspective, the Model State Emergency Health Powers Act (MSEHPA) attempted to provide a legal framework for state governors to compel physicians to provide care in emergencies (including epidemics) as a condition of licensure. A Stanford Law Review discussion of why such a law is justified begins with medical history and the Zuger-Miles hypothesis: prior to the 20th century there was no strong or consistent tradition of doctors providing care in epidemics from a sense of professional responsibility. Vivid examples include
Venetian doctors fleeing the black plague in medieval Europe, 17th century physicians escaping London during the bubonic plague, and the retreat of some prominent Philadelphia physicians to the countryside in 1793 to avoid infection from yellow fever. Fortunately for our professional reputation, there are also historic accounts of many physicians who stayed. In 17th century Italy, the societal and ethical pressure to stay during plagues increased with the introduction of early personal protective equipment (PPE): a linen gown covered in aromatic paste. The gown was the invention of French doctors and although it was purported to fight off the illness-causing miasmas, it probably served as a flea-repellant. It is argued that the 1847 AMA Code of Ethics helped create a social contract and sense of professional responsibility. Certainly, the medical response to epidemics of the 20th century (the 1918 Spanish flu, HIV/AIDS, Ebola, SARS) demonstrates that legislation is not required to motivate doctors to provide care in the face of potentially deadly contagion. The legal framework argues that although the Code of Ethics was a successful motivating force behind the change of involvement in the plagues of the 20th century, our non-binding, ethical promises are insufficient in the face of future public health crises. The legal perspective fails to consider as motivation our enhanced understanding of transmission, our (frighteningly recent) ability to actually improve outcomes, and the increased availability of personal protection. Certainly, there were doctors who stepped back during the AIDS crisis, just as there are doctors now who shelter in place behind their desks or in email-lined bunkers. They know who they are. And it doesn’t matter because the vast majority of us will go to work, despite them. The implication that legislation is required is unjustified, dangerous and insulting. Notably, as of April 2020, no state has passed the MSEHPA in its entirety, and New York has passed only limited sections, none of which include a medical draft.

If we are not part of this pandemic, we can’t expect to be part of the change that needs to arise from it afterwards. If we want to be valued as a national resource, then this is our opportunity to prove that the nation needs to invest in us. Perhaps it is time to revisit subsidized training outside of military service, or else we will continue to be saddled with heavy training debt without any acknowledgement of what happens when the country wants to control the right to use something it didn’t
pay for. Likewise, if we don’t participate, we cannot challenge the “galloping regulosis and assessment degradosis” of bureaucracy. Even now we risk administrative triage teams taking decision-making away from the critical care physician. As powerless draftees, will the hospital administration and “unified command” hand us back the reins after this is done?

We were not conscripted into medicine, and I would argue that part of the overwhelming community response in support of New York’s medical personnel is precisely because we are doing this by choice. The reason that people are cheering from roofs, windows and balconies at 7 p.m. every evening is not because we balanced a budget, wrote a cleverly worded contract, or made a deal. It is esteem: the honor and recognition that medicine is somehow different. The esteem that has been tarnished by journalistic doubts and surprise billing, that is frequently questioned by “Dr. Google” and attacked, even now, by the president, is being earned with every step you take down the hospital corridor.

**Con: This Is NOT What We Signed Up For**

While I am learning how to conduct rounds in the ICU, I am also looking for flexible plastic sheeting to make my own splashguard … so that on those rounds, I am able to practice medicine without falling sick myself, creating a gap in the work roster, and taking up another ICU bed. I challenge that “this is what we signed up for.” When the virus-laden dust has settled, when the emperors of administration have put their clothes back on, when we are asked to go back to normal, I am asking you to avoid wishing for a return to the way things were. Elective surgery will start up again; a huge backlog will exist; there will be busy times ahead; and it might seem like we should just knuckle down again. I say: no.

The oaths and pledges taken by the physician were not a personal promise to exchange our life for that of someone else. The oath has to be relative to a given risk, not absolute: If there is a 100 percent chance of dying, how can I be obliged to treat? It’s analogous to a fireman confronted by the prospect of entering a burning building on the verge of collapse. From 100 percent, it follows that we are on a sliding scale of personal risk. While the risk of a fingerstick and transmission of bloodborne pathogens is in the region of a few percent, we now read of
the higher than average death rates among Chinese and Italian health workers\textsuperscript{23,24} side by side with requests that our most vulnerable retired colleagues come back to work. Where on the scale do we draw the percentage risk line? And, more importantly: Who gets to place us on that scale?

When looking back at the history of medical sacrifice, we have just come out of a long nap. While the doctors of previous generations had careers defined by frequent episodes of plague and the risk of infectious disease, most of us entered our training during a period of relative perceived safety. As our comfort and security in antibiotics, sterility and protective equipment increased, the oath-wording, regarding overt self-sacrifice and work during epidemics, died out.\textsuperscript{9,25,22} Plagues became a thing discussed under “global health,” encountered in lecture halls and on medical mission work. The “pax antibiotica” (Arras 1988, page 10)\textsuperscript{25} was interrupted during the AIDS crisis of the 1980s, and a new generation of doctors had to confront the same fears that had accompanied the lives of the unprotected physicians of the past. However, with proper PPE, it was eventually appreciated that the personal risk was also manageable and working with HIV patients stopped being ethically controversial. Forty years later, the fine print of our ethical duties is again under scrutiny and has led panicking officials to discuss conscription.

Why has military language been employed so heavily in this pandemic? Deploy, redeploy, front lines, unified command, furlough?\textsuperscript{20} It gave a sense of battle, but it also implied something more sinister: the absence of choice. Soldiers follow commands: Once they have “signed up” or have been conscripted, they are required to follow orders according to a chain of command. The idealized essence of the military is increased efficiency and subordination of personal interest as part of a relationship with an organization that has your back. Front-line soldiers are trained for battle and join a group built on trust of their fellow soldiers and trust in the decision-making above them.\textsuperscript{26}

In this medical crisis, we were put into situations that were beyond our usual practice. Our training consisted of PDFs and webinars; we were split from our teams and sent to areas where we had never worked, with no map and no compass; we were sent out without PPE,\textsuperscript{27} or, in other words: untrained, alone, and unprotected. The military analogy is apt,
but not the idealized military machine — rather, the one that sent troops to Iraq without armor and had families begging to send them the equipment they needed.28

Mayor Bill de Blasio raised the question of a military draft as part of a wider discussion on procurement of equipment: “I am urging the president to do something no president has had to do in our modern history: to create an enlistment effort for our medical personnel all over the country…”29 Mayor de Blasio said the city needs 15,000 ventilators, 45,000 clinical staff and 85,000 hospital beds, including 20,000 intensive care unit beds. The irony is not lost that our medical lives were sandwiched between ventilators and beds.

What is the problem with conscription? Firstly, it implies that an external force is required; so far, nothing in the COVID-19 pandemic has suggested that doctors need to be forced to come to work. Secondly, in the military, someone has your back: soldiers trust the ranks above them to do a risk/benefit analysis and conclude that the benefits outweigh the risks. The military authority is ultimately accountable for the decisions that took their troops into danger. Who was doing these analyses for medical staff in our current “campaign”? Who organized screening tests for incoming patients and decided that our protective gear was adequate? The answer is a disturbing and revealing look at the relationship between regulatory authorities, the federal government, and private hospitals.

The Centers for Disease Control and Prevention (CDC) decided against using a pre-existing World Health Organization (WHO) COVID screening test and delayed the start of testing by producing their own.30 They produced a faulty screening test, shipped hundreds of tests that produced false positives to state laboratories, and then took weeks to produce another.31 When the new test was available, the criteria for being tested were narrow, such as recent travel to China (at a time when infection was growing both in Europe and in Asia) or contact with someone known to be infected (how many people can be known to be infected in a country without widespread testing? Joseph Heller would be having a field day). Sadly, it doesn’t stop here; the CDC not only failed to Control but also to Prevent.

The CDC website lists descriptions of recommended PPE.32 The advised protective equipment standards changed based on supply in situations
described as “surge capacity” (Table 1). Unfortunately, “there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity.”

A hospital can therefore self-designate a situation as a surge and be held to lower standards for protection of its workers.

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<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tr>
<td>Conventional capacity</td>
<td>Measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls, should already be implemented in general infection prevention and control plans in healthcare settings.</td>
</tr>
<tr>
<td>Contingency capacity</td>
<td>Measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of HCP. These practices may be used temporarily during periods of expected N95 respirator shortages.</td>
</tr>
<tr>
<td>Crisis capacity</td>
<td>Strategies are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known N95 respirator shortages.</td>
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Rather than setting a standard that medical institutions aim for, and possibly fail to achieve, the CDC back-filled a narrative of PPE supply failure by trying to reduce demand. In downplaying the importance of masks, they lost public and professional trust. The federal government, via the surgeon general, downplayed the importance of masks and then announced that lack of PPE was a demand problem. Surgeon General Dr. Jerome Adams, speaking to the ASA on March 26, 2020, said: “Please always remember supply and demand. We will not supply our way out of this problem; and if that’s the only part of this we lean in to, then we are always going to be behind the curve.” Unfortunately, the goal of reducing demand by preventing healthcare workers from contracting COVID was not addressed. In the future, when one sees the CDC listed as a definitive authority, visions of headscarves and bandanas will be difficult to separate from claims of scientific rigor.
It is the responsibility of a professional society to challenge inappropriate adjustment of PPE standards. In the United Kingdom (UK), the Faculty of Intensive Care Medicine, the Intensive Care Society, the Association of Anaesthetists and the Royal College of Anaesthetists have actively challenged standards based on supply rather than safety. In a joint statement from April 19, 2020, they challenge the WHO and CDC guidelines for PPE reuse as lacking evidence for adequate protection and ask whether reuse recommendations represent an erosion of PPE standards.\textsuperscript{35} By comparison, the Anesthesia Patient Safety Foundation (APSF) initially made standard-based recommendations for PPE from international experience, including Toronto’s experience with the SARS epidemic.\textsuperscript{36,37,38} The APSF later modified its website to reference only the CDC and FDA in a joint position statement with the American Society of Anesthesiologists (ASA) on March 22, 2020; an updated ASA statement on April 19 still deferred to CDC guidelines.\textsuperscript{39} Why is a safety standard important? Beyond the obvious issue of personal safety, it is about liability and responsibility. Doctors have been put in a position where we are CDC compliant in our protection but, in practice, exposed. We have been subjected to gag orders, threats and harassment while trying to do our jobs safely.\textsuperscript{40} The threats were so widespread and publicized that the U.S Department of Labor’s Occupational Safety and Health Administration (OSHA) released a statement reminding employers that it is “illegal to retaliate against workers because they report unsafe and unhealthful working conditions during the coronavirus pandemic.”\textsuperscript{41} All this while crowdsourcing our masks (#getmePPE) and accepting donations from actors who play doctors on TV.\textsuperscript{42,43} The PPE authority was no longer the CDC; it was someone with a key to a storeroom.

The surgeon general also suggested that our PPE problem was a “misalignment,”\textsuperscript{34} implying a trove of masks — if only we could find them! It is more likely that the move toward hospital efficiency produced a lean practice model that did not support the storage of adequate protective gear, anywhere.\textsuperscript{27,22} While the clock was ticking for preserving gear, training personnel in PPE, and creating ICU areas and decontamination buffer zones, elective surgery was still taking place. Instead of preserving the interests of the community and employees, it took a City Hall mandate to stop elective surgery in some institutions.\textsuperscript{44} A private, revenue-generating institution that is able to include a
combined CEO/CFO/EVP/VP salary package in the eight-figure range is an institution that should be able to protect its own employees. It should be financially capable of creating a supply stockpile (especially of items with a long shelf life like PPE) and of having a disaster plan that is created well in advance of the first infected patients arriving. The current model of efficiency and “just enough” ordering and hiring has not been tested under conditions of external stress. The lean business approach was adapted from the Toyota car company production line and focused on continuous system refinement using structured inventory management, waste and clutter reduction, and quality improvement.

In fine weather, it didn’t take long to see the consequences of using a car factory as a hospital model: burnout. In rough weather, the other, traditionally disposable, element of the lean model is apparent: empty boxes. We were asked to fix the burnout ourselves (using resilience and wellness committees), so it should come as no surprise that the empty boxes of masks fell to us to fix as well. A system that only functions in good weather is not a good system; it is a tent. The lack of PPE was initially treated as a public relations problem — staff who brought their own were accused of non-compliance with hospital policy or of spreading panic. If an institution has no ethical ear for the value of human life and needs a financial value to work with, put a dollar amount on the loss of an expert revenue-generating unit. Each hospital must publish the number of workers who were sick, confirmed positive, hospitalized or died. Even this level of transparency will be difficult, as testing for hospital employees is heavily gated within a hospital system.

Perhaps my greatest objection to military terminology is the fact that we are actually risking our lives by choice, not because we signed up to do so. The implied subjugation to authority based on a premise of loyalty to an institution denigrates the many individuals who just said “yes.” We didn’t get the military protections or the military promises; we had our leave canceled, our benefits reduced, and our overtime pay stopped, and yet we still took part. It’s the opposite of war; it’s a fight that cannot be won. We are paddling in an ocean with waves lapping at our noses. It’s the opposite of an act of violence; it’s an act of love.

Conclusion
From both the pro and the con perspective, our current system needs to change. What could change look like? Firstly, authority must be based on science and not on expedience or politics. Secondly, it must be
recognized that safety, efficiency, and education do not comprise an intersecting Venn diagram whose center we have yet to reach. In light of this crisis, pure efficiency must be reevaluated, because an efficient system is by definition built without adequate buffers and is less safe. Most importantly, staff must not be treated as if they are disposable. Richard Branson of Virgin Airlines built a business empire of pickles and then planes on a premise that put employees first. He understood that a happy employee would make the customer happy. Perhaps change means recognizing that happy and non-distracted doctors make patients healthier.

“If I am not for myself, who is for me? When I am only for myself, what am I? If not now, when?” (Rabbi Hillel in Ethics of the Fathers [Pirkei Avot 1:14]).

Kiri Mackersey, MBChB, is an attending cardiothoracic anesthesiologist at Montefiore Medical Center and the editor of Sphere.

REFERENCES


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Stories From the Trenches

From the earliest stages of the coronavirus crisis in the U.S., NYSSA members have worked tirelessly and selflessly caring for the tens of thousands of New Yorkers who required hospitalization as a result of this deadly illness. Risking their own health and the health of their family members, these physicians and their hospital colleagues have gone above and beyond to save as many lives as possible. As part of the NYSSA’s effort to cover this crisis and to better support the membership during this time, we asked members to share some of their experiences for publication on the NYSSA’s website. We are pleased to highlight these stories and photos on the pages of Sphere as well, and we welcome future submissions.

Finding Strength and Hope on the Front Lines at SUNY-Downstate Medical Center

DENNIS DIMACULANGAN, M.D.

It’s Good Friday (April 10, 2020) and I’m on call today. Going in at 5 p.m. Back to the trenches. I’ve never posted on social media before, but this is serving as a cathartic and therapeutic outlet for me. All the prayers and well wishes I get from you, my friends, give my colleagues and me on the front lines strength and hope to continue what we are doing. Thank you all!

Until we have a vaccine, an antiviral, plasma antibodies, hydroxychloroquine that has been proven to work, there is no cure. Treatment of COVID-19 patients will largely remain supportive — with oxygen therapy. As pneumonia progresses and shortness of breath and
hypoxemia ensues, oxygen treatment will be mainly delivered through nasal cannulas, then facemasks, then 100% non-rebreathers, then non-invasive ventilation (NIV) via CPAP or BiPAPs. If the patient continues to deteriorate, tire out and spiral down into respiratory failure, the last resort is endotracheal intubation and oxygenation through a ventilator. This is when we anesthesiologists are called in.

Our role as airway management experts is to intubate. We are the ones who will come when patients are at the end of their rope. In non-emergencies, standard intubation is straightforward, especially in patients with good airway anatomy. You have a relaxed, non-distressed patient that you will anesthetize smoothly in a controlled stepwise manner: Pre-oxygenation, hypnotic, muscle relaxant, bag-mask ventilation, laryngoscopy, endotracheal tube, ventilator, anesthesia.

Intubation in an emergency, when a COVID-19 patient is in extremis, is totally different. You have a patient who is in severe respiratory distress, anxious, and severely hypoxic. The clinical picture is like someone in status asthmaticus. You will see the patient desperately gasping for air, in pain, in distress, and with terror in his/her eyes — a heartbreaking sight. Add to this scenario your own fear knowing the risk you face because you will be moving in close, mere inches from the patient’s mouth and nose that are laden with the highest viral load.

To start with, the NIV being administered as a means of delivering oxygen is already generating aerosols around your patient. As you approach, expect that the air around you is already dense with a mist of viral aerosols, especially if you are situated in a non-negative pressure room that does not suck the dangerous mist out. Endotracheal intubation is an aerosol generating procedure. In the process of intubation — when you bag-mask and when your patient bucks or coughs — you are at risk of getting showered with virus straight to your face. This is akin to looking straight down the barrel of a locked and loaded shotgun.

Most people get infected by accidentally getting fomites rubbed over their eyes, nose or mouth. This is exposure with a small viral load, which oftentimes is possible for the body to overcome. For most
infected persons, as you might have heard, about 80% to 85% will recover. It is a different story if you get directly hit by a massive viral load in your face, such as during intubation. If you get infected this way, this will not be easy to overcome, even if you are in the peak of baseline health. This is probably why infected healthcare providers who deal very closely with their patients — ER docs, ENT docs, ophthalmologists, pulmonologists and anesthesiologists — have such a high mortality rate, because they often get infected with a high load of virus that gets shot straight into their faces. So, understand the risk we have to face and the fear that we have to overcome as anesthesiologists when we try to rescue our COVID-19 patients. Sometimes I question if it is even worth the risk if the current outcome is already grim for patients who get intubated. Every hospital setting is different, but ours does not have the best outcomes after intubation because we generally have sicker patients who have a lot of co-morbidities. Currently at our institution, only 10% to 15% of those who get intubated make it out, get extubated and recover fully. Most succumb after three or four days on the ventilator. This is why we do the intubation in the COVID-19 patient differently. We modify our intubation technique to prevent any aerosol generation as much as possible. We do this by avoiding bag-masking or ambu-bagging without a HEPA filter, by making sure the patient is completely paralyzed with muscle relaxant so he/she does not cough during intubation, by using video-laryngoscopy so that we can avoid facing the patient’s mouth directly — and, of course, by relying on level 4 PPE.

Thank God that currently we are good with our supplies of PPE. But I worry with all this talk about PPE shortages that we will finally run out; we can only continue with our work while our PPE supplies last.

So, friends, this is the cross that we anesthesiologists have to bear this Good Friday. But alas, recognize that our patients carry a heavier cross! Please do not be a patient. Follow the guidelines! I know most of you already are. I just want to re-emphasize this because I don't want to be in a position where I will need to intubate you.

Praying for everybody’s health and safety.
Recognizing the Amazing Team at NewYork-Presbyterian/Weill Cornell

SHANA HILL, M.D.

The Anesthesiology Airway Team at NewYork-Presbyterian Hospital/Weill Cornell Medicine has taken on management of all COVID-19 patient airway-related procedures across the hospital. We travel to the ED, all the ICUs, and the COVID wards to perform emergency and urgent intubations and endotracheal tube exchanges, as well as elective tracheostomies. Our team of anesthesiologists, CRNAs, and anesthesia techs has been integral to the expert management of these patients. We are grateful for our amazing team and the collaboration we have had with the emergency department and intensive care teams!
NewYork-Presbyterian’s team of anesthesiologists, CRNAs, and anesthesia technicians.

Stony Brook University Medical Center
Photos submitted by Dr. Tazeen Beg

The Proning Team at Stony Brook Medical Center: A team from the OR and the Airway Team assist the nursing staff in the ICUs to “prone” the patients for better oxygenation.

The Airway Team at Stony Brook Medical Center: (Left to right) CRNA Melissa Day, Dr. Tazeen Beg, and CA-2 resident Dr. Adam Taft.
Mount Sinai Health System
Photos submitted by Dr. Jonathan Gal

Dr. Subin Varghese moves an anesthesia machine to the COVID ICU to be used as a ventilator.

Dr. Zevy Hamburger, a COVID-19 survivor who has been helping treat other COVID patients in Mt. Sinai’s ICUs, donates his plasma.

Drs. Carlos Plata-Martinez and Patrick Maffucci in a PACU serving as a MICU

Dr. Zevy Hamburger, a COVID-19 survivor who has been helping treat other COVID patients in Mt. Sinai’s ICUs, donates his plasma.

Department of Anesthesiology Chair Dr. Andrew Leibowitz
“The Innovation Team”: Drs. Ronak Shah, Erica Kane, Martin Chen, Matt Levin, George Zhou, Anjan Shah, Chang Park, Dan Katz, and Garrett Burnett

“The Line Team” members Drs. Benjamin Salter and Menachem Weiner

Drs. Kishan Patel, Asif Javed and Natalie Smith in a PACU serving as a TICU

Drs. Giana Bernheim and Kevin Chung on the med/surg floor turned into a COVID ICU

Drs. Christian Piña and Zevy Hamburger in the COVID ICU

Dr. Marc Sherwin prepares for a COVID intubation.
Montefiore Medical Center

Montefiore anesthesiologists and anesthesia residents don their PPE.

Photos submitted by Dr. Kiri Mackersey

Dr. Sujatha Ramachandran

Dr. Mohammed Al-Samrrai

Dr. Daniel Wong

Dr. Felix Dailey Sterling

Dr. Margaret Sagsveen
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Understanding Private Equity Transactions in Healthcare

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

Introduction
When healthcare providers consider their options with respect to selling their practices, many consider the idea of selling to a private equity firm. While this may seem very enticing, as the purchase price is often higher than that offered by another buyer (usually a multiple of earnings before interest, taxes, depreciation, and amortization [“EBITDA”]), it is important to understand how these deals are structured in order to comply with applicable law, as well as to evaluate the risks and benefits associated with entering into such transactions.

How Private Equity Works
Private equity firms raise money from investors and pool that money in order to buy privately owned businesses. The goal is to increase the value of the business beyond the purchase price by generating greater earnings and then to sell the business to a third party for a larger multiple while returning a portion of the profits to the investors. Private equity often looks for a threefold to fivefold return on investment over a three- to five-year period. With respect to healthcare transactions, many private equity firms attempt either to combine multiple practices in the same specialty or to create a large multispecialty practice in order to control a region, compete for contracts, and drive rates.

New York Limitations
It is well-established that New York law includes a prohibition on the “corporate practice of medicine.” This prohibition reinforces the basic principle that only persons licensed to provide medical services are permitted to engage in the practice of medicine. Thus, a physician may practice medicine only in his/her individual capacity or as a member of a solo or group practice (either in the form of a professional corporation [PC] or limited liability company [PLLC] where all members or shareholders are licensed physicians themselves). Limited exceptions to this rule apply only to hospitals, clinics, and certain other entities licensed under the New York Public Health Law. In any circumstance not prescribed by New York law, a physician is prohibited from being
employed by a non-physician and partnering with a non-physician in a medical capacity. Note that while New York has a rote prohibition on the corporate practice of medicine, this does not hold true across all states. States such as Delaware, Hawaii and Montana, for instance, have no laws or other guidance barring physicians from being employed by non-physicians.\textsuperscript{2}

New York law also has a prohibition on fee-splitting whereby it is deemed to be professional misconduct to permit “any person to share in the fees for professional services, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice medicine, or a legally authorized trainee practicing under the supervision of a licensee. This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice, except as otherwise provided by law…”\textsuperscript{3}

Based on these limitations, private equity is unable to invest directly in professional practices in New York state. However, private equity can invest in management companies that manage the non-professional aspects of healthcare practices. These management companies can own the non-professional assets of a healthcare practice, including, for instance, equipment, furniture, fixtures and supplies. Management companies can also hold the lease for space, as well as employ the non-professional staff. The professional practice would have to be owned by a healthcare professional licensed to practice that profession in New York state. The private equity firm can designate a professional who would be the owner of a professional practice. A management arrangement would then be established between the management company and the professional entity whereby the management company would be paid a fair market value flat fee for managing the entity.

\textbf{Benefits and Risks}

In addition to a higher purchase price, healthcare providers often reap tax benefits as the sale of assets results in capital gains tax rates that are lower than ordinary income taxes. Additionally, healthcare providers are often given equity in the management company as part
of the purchase price, which allows healthcare providers to participate in the growth of the business and partake in the profits when the entity is sold to a third party. While there can certainly be a benefit to having an equity interest, there are often limitations with respect to how the equity can be converted to actual cash.

In addition to an equity interest, healthcare providers are also generally offered an employment agreement with the professional practice in order to continue to render professional services. Although the initial purchase price for the assets may be high, the compensation offered is generally significantly less than what the provider was making beforehand. Therefore, at the end of the day the healthcare provider is often just getting funds up front with a potential tax benefit, in addition to the potential to profit when the entity is sold to a third party. Providers need to study the numbers in order to ensure the deal works for them in the long term.

Providers also need to be cognizant of the employment terms. For instance, employment is often not guaranteed and can be terminated pursuant to the terms of the employment agreement at any time. Healthcare providers also need to be mindful of the type of malpractice insurance to be maintained, as well as potential restrictive covenants.

Although it can be a huge benefit to no longer have to deal with the administrative burdens of running a practice and making investments in technology platforms, providers need to understand that they will be losing autonomy and decision-making and must be comfortable with the private equity leadership team and the culture of the private equity firm. Providers should do their due diligence with respect to looking at the private equity firm’s track record with similar practices.

**Conclusion**

While a transaction with a private equity firm can be very exciting and lucrative for healthcare providers, these arrangements must be evaluated in order to ensure that they make sense for the provider and are compliant. To that end, it is in the provider’s best interest to retain a team of professionals specializing in healthcare — attorneys and accountants — to ensure that the details of the private equity transaction are appropriate and favorable to the provider. While an
offer may be suitable for some providers, it may not be as desirable for others. Providers also need to recognize that if an offer seems too good to be true, it generally is.

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.

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to see our newly transformed website!

The New York State Society of Anesthesiologists, Inc.

Renew Your Membership
The New York State Society of Anesthesiologists (NYSSA) is a community of 3,696 New York’s anesthesiologists. We advocate on legislative, regulatory and clinical issues to safeguard and advance the provision of anesthesiology on behalf of both patients and physicians.

A message from our President...
Hello from the COVID-19 pandemic. Last fall, I thought that 2020 would be challenging for us due to the upcoming elections and the political polarization at state and federal levels. With the current virus threat to the health of our citizens and the safety of our nation, the politics still exist but have receded in visibility. The NYSSA has an experienced, energetic team watching the events in Albany very carefully. I encourage you to contribute to the NYANCC today, as the Legislature considers the details of the budget and new legislation, so your NYSSA team has the resources to publicize our perspectives on patient safety and equitable care. Many of you have already planned for the upcoming clinical challenges of widespread illness associated with COVID-19. Physician anesthesiologists have many clinical and administrative skills to share in their home institutions to help our society weather the coming storm. As you are aware, the actual impact of the viral pandemic on our capacity to provide critical care will depend on the maximum number of cases and their distribution across time. The viral pandemic is a significant disruptive stress on each of us as well as
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I want to begin this column by extending my sincere appreciation to all the physician anesthesiologists who are on the front lines taking care of critically ill patients as part of the COVID-19 intubation teams, ERs, ICUs, and throughout the hospital. As I write this article (April 8, 2020), 731 New Yorkers have died of COVID-19, the deadliest single day in the state. I cannot imagine the burden on all those who are coping with the loss of patients’ lives. I am honored to be associated with the NYSSA’s incredibly skilled and dedicated physician anesthesiologists. You are doing an amazing job each and every day during this pandemic. Stay safe and stay well!

On March 4, 2020, which now seems like an eternity ago, the NYSSA leadership (including President Dr. Richard Wissler, Immediate Past President Dr. Vilma Joseph, President-elect Dr. Christopher Campese, NYSSA ASA Director Dr. David Wlody, and NYAPAC Chair Dr. Rose Berkun), Executive Director Stuart Hayman, Bob Reid (the NYSSA’s Albany lobbyist), and I conducted a series of legislative visits to address the nurse anesthetists’ scope of practice/independent practice initiative rumored to be included in the Medicaid Redesign Team II (MRT II) recommendations. We did not know that when our group visited the Capitol building on March 4, 2020, COVID-19 had already infected legislators and staff, including some with whom we met. As you may recall, the report from the Medicaid Redesign Team I (MRT I) several years ago included, as a preliminary recommendation, a nurse anesthetist scope of practice proposal, but the NYSSA successfully lobbied for its exclusion in the final report. Our group presented a memorandum setting forth the following arguments:

- The executive budget estimates a $2.5 billion Medicaid gap, and the governor proposes that the Medicaid Redesign Task Force develop a plan to address the Medicaid deficit. We are presenting testimony consistent with the governor’s message to
ensure there will be zero impact on the anesthesia care for Medicaid recipients. We reject a two-tier system of anesthesia care, and we are concerned that the redesign of Medicaid in New York state may lead to the following situation: one tier for the poor and disabled, wherein the physician anesthesiologist is eliminated as the anesthesia care provider or direct supervisor of a nurse anesthetist; and another tier for everyone else, with the physician anesthesiologist as the anesthesia care provider or supervisor. We do not support any fiscal or policy proposal that would sacrifice patient safety, especially when it is likely to have an unequal impact on our most vulnerable patients. On the basis of education and training, physicians are the most capable healthcare professionals for providing rapid diagnoses and decisive actions when adverse events arise during the perioperative period.

- Past proposals to weaken the supervisory link between physicians and nurse anesthetists have been defeated repeatedly in both houses of the New York state Legislature as well as by the Veterans Health Administration under the Obama administration.

- In addition to the patient safety and justice concerns, we want to submit facts that demonstrate that weakening immediate physician supervision of nurse anesthetists will not result in savings for Medicaid.

The entire memorandum can be found on the NYSSA website at www.nyssa-pga.org/legislativeregulatory-issues (under “MRT II”).

Many significant state and federal government developments have been implemented in order to address the novel coronavirus (COVID-19) pandemic and several impact nurse anesthetists’ scope of practice.

Outlined below is a chronological sequence of events and the efforts undertaken by NYSSA leadership, Stuart Hayman, Bob Reid, and me to be proactive and strive to preserve the existing statewide requirement of physician supervision of anesthesia care that has been in existence for nearly 30 years. The objective was, and will continue to be, to present to the governor, lawmakers, and members of the MRT II compelling
arguments, grounded in fact, in an ethical manner during the pandemic crisis.

**March 11, 2020**: Bob Reid notifies the NYSSA leadership that the MRT II report included, as part of the Team’s healthcare workforce proposal, scope of practice to “codify the practice of nurse anesthesia.” Similar to the prior MRT I recommendation to codify a nurse anesthetist's scope of practice, there were no details outlining the parameters of the proposal. Obviously, we had strong reason to believe that the objective was to create an advanced practice registered nurse (APRN) status for nurse anesthetists, to allow independent practice.

**March 13-18, 2020**: The NYSSA sends letters to the governor, key legislators, and MRT II members. An example of these letters can be found on the NYSSA website at [www.nyssa-pga.org/legislativeregulatory-issues](http://www.nyssa-pga.org/legislativeregulatory-issues) (under “MRT II”).

**March 23, 2020**: Gov. Cuomo issues an executive order temporarily eliminating physician supervision of nurse anesthetists.

**March 24, 2020**: A letter is sent to the governor (and, with appropriate amendments, to all legislators) from NYSSA President Dr. Richard Wissler:

> On behalf of the nearly 4,000 members of the New York State Society of Anesthesiologists (NYSSA), I want to thank you for your leadership and your dedication to the citizens of New York during this critical time. We support you, the Legislature, and all of government during this current crisis, and we wish you and your family good health. The NYSSA stands with you in this difficult time.

> Our member physicians and all our colleagues (physicians, nurses, physician assistants, and other hospital workers) are working 24/7 to bring the highest-quality medical care to all New Yorkers. We understand the need to issue a drastic, albeit temporary, executive order (expiring April 22, 2020) in response to the pandemic.

> We do not support eliminating physician supervision of nurse anesthetists but we do support your emergency order and your commitment to ensuring the availability of enough
healthcare personnel and equipment to meet the needs of all New Yorkers during this pandemic. We feel strongly, however, that the temporary suspension of the requirement for direct physician supervision of nurse anesthetists must be reversed immediately after the crisis has passed. This will restore the longstanding patient safety requirements in New York state and ensure that the safety of our patients is not jeopardized indefinitely.

March 30, 2020: We work with the Medical Society of the State of New York (MSSNY) to coordinate a message to the Legislature regarding the budget. We express our view that the budget bill should not include any permanent changes to nurse anesthetist scope of practice or regulatory standards for anesthesia care.

April 1, 2020: The budget bill is approved.

April 2, 2020: Bob Reid states, “Despite temporary emergency orders by the governor, the Legislature rejected any permanent changes to New York state law regarding the current health code requirements and codification of nurse anesthetists’ scope of practice. The current emergency order will remain in effect for the duration of the emergency as determined by the governor. The vast majority of other MRT II changes were enacted. The Excess Medical Malpractice program was extended. ... With respect to additional resources on COVID-19 on the federal level, guidance, and webinars on practice management issues featuring Dr. Rosenberg and Dr. Schulman, please visit the ASA website.”

I would like to extend my personal gratitude to Bob Reid, who has kept us informed on an almost hourly basis throughout these challenging weeks. Bob, THANK YOU! Your ability to represent the NYSSA is outstanding and a tribute to your dedication and skill.

Charles J. Assini, Jr., Esq.
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**App Review**

**ASRA Anticoagulation Guidelines: An App Review**

ANDRÉ SAVADJIAN, M.D.

**Application Name:**
ASRA Coags (Latest Versions: 2.2 for iOS and 2.3.1 for Android)

**Cost:** $3.99 (one time)

**Platforms:** Apple App Store and Google Play Store

**Developer:** American Society of Regional Anesthesia and Pain Medicine

**Overview:** The ASRA Coags application, designed as a quick and easy reference to the ASRA anticoagulation guidelines, has become widely known among anesthesiologists. The target audience has evolved and this application will be very useful to both practicing anesthesiologists and anesthesiologists in training.

**How to Use:** As with most apps, there is a concise and informative tutorial. You then begin by choosing either regional or pain guidelines. Most non-pain physicians will choose regional (you have the option to make this your default). You start by selecting an anticoagulation or antiplatelet medication (generic or brand) and then choosing either neuraxial or peripheral nerve block. The next screen provides a very simple selection of four interventions to choose from: hold medication before procedure/catheter removal, or restart medication after procedure/catheter removal. The application then provides the number of hours needed to wait for your intended intervention based on the specific published guidelines. The guidelines can also be found at the bottom right of the screen by clicking on the information icon.

**Review:** As an anesthesiology resident, I have referred to this app countless times to answer an orthopedic or surgery resident’s very common question, “When should I hold the _____?” The app provides easy, drug-specific published and validated guidelines from both American and international societies (especially for anticoagulants that are less commonly encountered).
The pain guidelines allow you to search by medication (anticoagulation, antiplatelet or herbal supplement) or by procedure. There are options to receive recommendations for low-, intermediate-, and high-risk procedures. The app includes an extensive list of interventional spine and pain procedures as well as a modifier if the patient is at high risk for bleeding. These options similarly provide information on how long to hold the medication before the procedure and when to restart it.

The application is updated, very simple to use and intuitive. The color scheme makes it easy to follow and the screens are well organized. In addition, the app provides easy access to more detailed information such as the mechanism of action and the executive summary for each medication as well as full access to the 2018 ASRA regional and pain guidelines.

**Bottom Line:** The ASRA Coags app is well worth the cost. It is simple, easy to use, and increasingly popular. It is particularly useful for those practitioners who do not regularly perform blocks and need a quick reference.

Andre Savadjian, M.D., is a CA-1 resident at Mount Sinai Morningside and Mount Sinai West hospitals in New York City.
The 9th Global Conference on Perioperative Care of the Cancer Patient will take place December 10-11, 2020, in New York City. The conference precedes the NYSSA’s PostGraduate Assembly in Anesthesiology (PGA).

Cancer has become one of the most devastating diseases worldwide. The causes and types of cancer vary in different geographical regions. Today, cancer accounts for about one in every six deaths worldwide. In 2018, there were an estimated 17 million cases of cancer diagnosed around the world and 9.5 million cancer deaths. By 2040, the global burden is expected to reach 27.5 million new cancer cases and 16.2 million cancer deaths solely due to the growth and aging of the population. The disease burden is immense, posing considerable challenges for healthcare systems in poor and rich countries alike, as well as for the affected individuals and their families.

As the incidence of cancer and cancer survivorship grows, there is an increased need for anesthesiologists, surgeons, interventional radiologists, nurses and other perioperative healthcare professionals to provide their services for the multiple diagnostic and interventional procedures in this patient population. The 9th Global Conference on Perioperative Care of the Cancer Patient is geared specifically to address these issues. Due to COVID-19, this year’s meeting has been creatively transformed into a live virtual experience. We are confident that our virtual conference will be an outstanding educational event. More details will be forthcoming about accessing the virtual interactive sessions.

It is an honor to have Memorial Sloan Kettering Cancer Center (MSK) host this year’s international meeting. MSK has been a leading institution in cancer treatment and research since its founding in 1884. It is consistently rated one of the top three cancer centers in the country by U.S. News and World Report and its physicians treat more than 400 different types of cancer. This conference will focus on the key elements needed to deliver value-based, patient-centric perioperative care to cancer patients. There is a continuous influx of new research being published and new practices being tested every day. Our goal is to deliver some of these
novel approaches to the forefront of perioperative medicine while presenting them in an interesting and accessible format. The conference program chairs include Eric Kelhoffer, M.D., Anahita Dabo-Trubelja, M.D., Rebecca Twersky, M.D., M.P.H., and Gregory Fischer, M.D., all of whom are widely known in their fields of expertise and have been actively involved in the production of this world-class event.

This meeting is the work of a collaborative group of international researchers and clinicians who are passionate about improving perioperative care of cancer patients by integrating the science and art of the practice of medicine through mutual learning and shared experiences. The multispecialty international consortium gathers leading anesthesiologists from cancer centers of excellence worldwide to promote patient-centered, team-based, high-value care aimed at improving oncologic outcomes by enhancing functional recovery and reducing symptom burden. Participants will include MD Anderson in Houston, The Royal Marsden NHS Foundation in London, the Peter MacCallum Cancer Centre in Melbourne, The Mater Misericordiae University Hospital in Dublin, and the VU University Cancer Center in Amsterdam, among others. Past meetings have taken place at leading cancer centers around the globe, including in Shanghai, London, Houston, Melbourne and Amsterdam. We look forward to the opportunity to host an outstanding educational event.

This year’s program is packed with world-renowned speakers who will provide the latest education on perioperative care. The program includes a plenary lecture, 11 interactive panels with eight parallel breakout sessions, point-counterpoint debates, real-world case discussions and a medical simulation workshop. Attendees are encouraged to register simultaneously to attend the PGA meeting immediately following this program.

This meeting will help attendees:

- Understand the global impact of cancer.
- Learn the latest advances in cancer therapy and the implications for the perioperative period.
- Incorporate the knowledge of cancer epidemiology and biology to improve perioperative and oncological outcomes for cancer patients.
- Implement a strategy to deliver patient-centric, value-based perioperative care.
- Utilize the appropriate research methodology in perioperative medicine to improve patient outcomes.
• Demonstrate various methods of managing patients with airway compromise, hemodynamic issues, and postoperative pain using regional anesthesia and ultrasound in your everyday practice.

• Learn about the challenges of caring for the chronic pain patient.

Mark your calendar and join us for an interactive virtual experience on December 10-11, 2020. For further information and to register for this conference, please visit our website at https://mskcc.org/periop2020.

Anahita Dabo-Trubelja, M.D., FASA, is in the Department of Anesthesiology and Critical Care Medicine at Memorial Sloan Kettering Cancer Center. Abigail Ziff is project coordinator for the Department of Anesthesiology and Critical Care Medicine at Memorial Sloan Kettering Cancer Center.

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#EA20 Goes Virtual

Due to the COVID-19 pandemic, Euroanaesthesia 2020 will now be held virtually.

Visit our website regularly for more information
www.euroanaesthesia2020.org
Apgars in the ICU: An Appreciative Inquiry Case Report

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

The Appreciative Inquiry case reports are meant to facilitate alternative methods of examining patient care and outcomes. We hope that this series will encourage other medical systems to consider reevaluation of their focus in the QA process.

Appreciative Inquiry (AI) is a method of change management that has been utilized in the business world for some time.\(^1\),\(^2\) We have highlighted an AI approach to challenging cases in previous issues of Sphere.\(^3\),\(^4\) Instead of internalizing blame for bad outcomes, the fundamental belief in AI is that work systems (organizations, personnel, anesthesia care teams) are inherently good and are 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. Recent articles in the surgical literature have highlighted the extent to which teamwork and cooperation across the perioperative care team can result in improvements in team morale and anesthesia provider performance.\(^5\)

The quest to elevate care delivery and the perioperative patient experience moves from the Morbidity and Mortality conference perspective — “What have we done wrong?” to the AI view — “What can we do even better and how can we do that as a high-functioning team?” It is a positive, energizing process that shifts the traditional Morbidity and Mortality approach to one of “Positivity and Praise.”

We present the following case from the AI perspective.

Case Report

A 29-year-old primigravida with Ondine’s curse or congenital central hypoventilation syndrome (CCHS) presented for consultation regarding anesthetic management for labor and delivery. The patient had been managed since birth via tracheostomy with ventilator support needed only when sleeping, through a #6 uncuffed Shiley tracheostomy tube. Her portable home ventilator was an LTV series ventilator with a tidal...
volume of 400 ml and respiratory rate of 20. She denied any other medical problems and her pregnancy was uncomplicated; prenatal genetic testing showed a normal fetus without CCHS. After consultation, we determined that there were no contraindications to neuraxial analgesia and that all sedating medications should be avoided. We also advised that the tracheostomy tube should be changed to a cuffed Shiley upon hospital admission in case the need for emergency general anesthesia arose during her labor or delivery. The patient and her family expressed a strong desire for as normal a delivery process as possible, preferably on the labor and delivery unit.

Given the challenges that this patient’s planned labor and delivery presented, a multidisciplinary meeting was scheduled with obstetrical anesthesiology, maternal fetal medicine, respiratory therapy, critical care medicine, nursing and risk management. All parties were apprised of the patient’s wishes regarding her labor and delivery. During the ensuing discussion it became apparent that there were multiple systems-based challenges to overcome that would require an intensive care unit (ICU) environment. At our institution, all patients on ventilators must be in the ICU even though this patient had managed her own daily ventilatory support at home. There was no logistical way to avoid an ICU admission for intermittent mechanical ventilator support during this patient’s labor and intended vaginal delivery. She would also have to receive her postpartum care in the ICU to ensure adequate patient safety.

The team developed a plan to transfer the patient to the ICU after conformation of the onset of labor. Since she could not remain on the labor and delivery ward because of her need for intermittent mechanical ventilation, a plan was constructed whereby the labor and delivery ward would travel to her in the ICU. Upon arrival for initial labor evaluation, she would first be triaged in labor and delivery and then transported to the ICU once labor was officially declared. This was done so as not to hold up an ICU bed if it was a false alarm. While laboring in the intensive care unit, the patient would have an experienced labor and delivery nurse at the bedside and an obstetrics provider readily available to evaluate the fetal heart rate tracings and for cervical exams. If there was need for a cesarean section it would take place in the main operating room, as that location was physically closer to the ICU. Also, to ensure there was no delay if there was a need for emergent cesarean
section, an operating room would be placed on hold for her. All necessary surgical equipment and a newborn warmer would also be brought down to the main operating room, as this equipment is not normally in the main operating room. The care plan, which was placed with the patient’s prenatal records, outlined every step of her care along with a contact list of physicians who should be notified of her admission.

The largest ICU bed was designated to be available to allow the patient’s newborn baby to room-in with her and multiple family members to visit her. Postpartum nurses and lactation consultants were updated on the plan, as they would travel to the ICU to meet with and care for the patient and newborn. For comfort and technical familiarity, the patient was also allowed to bring her ventilator from home, after inspection and safety assessment by the biomedical engineering team.

The patient presented in active labor at 37 weeks gestation. She herself changed her tracheostomy to a cuffed Shiley upon admission. She strongly desired epidural analgesia. A continuous lumbar epidural was placed at the L2-L3 interspace using the loss of resistance to air technique. The epidural was initially dosed with a total of 8 ml of 0.2% Ropivacaine in divided doses while the patient was still on the labor and delivery floor. After epidural placement, continuous labor analgesia was started using bupivacaine 0.01% at a rate of 10 ml/hour; to avoid possible sedation from systemic absorption, no opioids were added. The patient was then transported uneventfully to the surgical ICU with a labor and delivery nurse. Labor progressed quickly and fetal heart tracings remained category I. She gave birth to a healthy baby. When the patient desired to sleep during her ICU stay, respiratory therapy would place her on her vent. She was discharged from the surgical ICU directly home on postpartum day two. The patient expressed that her experience was overwhelmingly positive and she felt she was treated as “royalty.” The surgical ICU nurses also enjoyed taking care of the patient for such a joyous event.

**Discussion**

Ondine’s curse or congenital central hypoventilation syndrome (CCHS) is a rare disorder resulting from mutations in the PHOX2B gene, characterized by impaired ventilatory response to hypercapnia and
Voluntary breathing is intact while the patient is awake, but during periods of sleep there is no central control of ventilation, resulting in alveolar hypoventilation. Additionally, patients will have lost the perception of high CO₂ or low O₂, and the sense of dyspnea.

Goals of anesthetic management include:

1. Minimize respiratory depressants by utilizing neuraxial anesthesia.
2. Avoid hypoxia and hypercarbia.
3. Provide a safe yet family-centered care environment in an atypical setting.

The PHOX2B gene targets autonomic neuronal development, manifested as impaired pupillary constriction, poor temperature regulation, and other parasympathetic alterations including impaired alimentary absorption and motility. The central mechanisms contributing to failed autonomic processes are readily apparent from fMRI studies, which reveal disrupted functional responses in hypothalamic, hippocampal, posterior thalamic, and basal ganglia sites. Patients with CCHS have lost the perception of high CO₂ or low O₂, and the sense of dyspnea; losing this affective drive to breathe poses serious consequences, unless continually encouraged to breathe. The brain structures mediating this perception of dyspnea, which include the insula, cerebellum and cingulate, are injured in CCHS patients. Additionally, the midbrain and medullary areas, which serve cardiovascular, respiratory and CO₂ sensing roles, are also affected.

Given the patient’s increased sensitivity to systemic opioids and ventilatory support requirement, she was managed with a higher level of care in a critical care unit. It is recommended to minimize any respiratory depressants such as opioids, anxiolytics, and neuromuscular relaxation in these patients; therefore, a neuraxial technique is preferred for labor and delivery.

From an AI perspective, we took a multidisciplinary approach to develop a management plan for this patient’s rare condition. Goals were to try to meet the patient’s wishes and at the same time provide safe care. During planning it became evident there were systems-based challenges to overcome requiring a critical care admission, as she
would not be allowed to use her ventilator on the labor and delivery and postpartum units. Though not often viewed as a warm and welcoming setting, the surgical ICU provided a comfortable and safe environment for the patient and allowed her to use her home ventilator. Her newborn remained with her at all times, with the only exception being for the required hearing test, and the pediatricians even did their assessments in the ICU. To ensure the safety of both mom and baby, a simple but detailed care plan guaranteed that no steps were missed. In spite of being admitted to the ICU, the planning and flexibility of all staff allowed this patient and her family to experience a joyous occasion on their own terms.

Naldine Isaac is a fourth-year medical student at Albany Medical College. Lindsay Gennari, M.D., is an associate professor of anesthesiology and a member of the division of obstetrical anesthesiology at Albany Medical Center. Arup De, M.D., MBA, is an associate professor of anesthesiology and president of the faculty practice at Albany Medical Center.

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Emerging Into a New Reality

MENA ABDELMALAK, M.D., M.B.F.

It has been tough to put into words the whirlwind that all healthcare workers have faced in this storm of a pandemic. From nurses to respiratory therapists, physicians to janitors, everyone had to come into work with the possibility of contracting a virus that has no regard for human life. Faces are deformed with the indentation of N95 masks, bodies are sweaty from wearing multiple layers of protection, and hands are wrinkled from constant washing and sanitizing. Yet we all knew that if we did not do this, we would lose even more people.

Being in New York City has been especially traumatic, as the city became the epicenter of the outbreak in the U.S. (and eventually the world). Hundreds of deaths became the norm, as did empty streets and subways, shuttered businesses, and the deafening silence in the heart of the city that never sleeps. The claps and cheers at 7 p.m. were uplifting (almost like the martial music before a battle), but you knew that as soon as you stepped foot into the hospital, you were ready to get back into the trenches.

During this time, our entire residency was moved out of our original rotations and redeployed. As the operating rooms were essentially turned into emergency-only mode, bare-bones staff was required to run them. Those not in the ORs were
then sent into a multitude of settings: COVID ICUs, non-COVID ICUs, COVID floors, Obstetrics, Research and Ventilator Development, Airway Team, Rapid Response Team, COVID Line Team, and many other locations. The anesthesia department became the Swiss Army knife for combating this epidemic. As many in our specialty have said before, anesthesiologists are uniquely positioned to treat patients with this disease given our special skill set and experience.

My personal experience has been different from others, having rotated through multiple environments in the hospital dealing with the virus. It was early in March, when I was assigned to obstetric anesthesia, that we were informed there was a patient in our hospital who was infected. My typical duties as an anesthesia resident consisted of epidural placement/management, cesarean section anesthesia, and resuscitation. However, this routine and these duties started to change quickly. Within the next two weeks, we saw policies changed on a daily basis to help adapt to the situation. It started with wearing N25 masks at all times, then N95 masks and negative pressure rooms for all known infected patients, then N95 masks at all times and testing every woman who came into the Labor and Delivery ward. Partners were no longer allowed as the hospital restricted all visitors; however, this policy was shortly reversed by the state of New York. It became apparent that many women who were admitted in March but not tested were actually infected and were asymptomatic carriers. Pregnancy has a way of hiding and disguising symptoms as the body and its physiology change, and this may have played a role in these mothers’ lack of symptoms. In the end of March, I was immediately redeployed into one of our many COVID ICUs.

My transition to a COVID ICU was a vast change from the L&D floor. Every single patient I was responsible for now had COVID and was in critical condition from the disease. Normally only one patient would be in an ICU room; now there were two in each room, no dividers or curtains, and barely enough room to fit the two ventilators required. All the medicine pumps normally at the bedside transfusing an assortment of IV medications required for each patient were moved outside the room, connected to what seemed like miles of tubing, in order to decrease the times anyone had to access a room. All of my 20 patients were intubated. They ranged in age from the mid-30s to the late 80s, with varying medical histories, all fighting one virus. Nurses scrambled from room to room to complete the tasks required for each patient, all while donning and doffing the protective equipment and hand washing every time. Countless
phone calls were made to family members to update them on their loved ones, whom they hadn’t seen since they arrived at the hospital, and to make tough decisions about their goals of care. Providers from all areas of the hospital joined forces to run this ICU, from anesthesiology, to critical care, to cardiology and internal medicine; all were willing to come together to do their best to help these patients.

I experienced many feelings while in this unit, from joy after successfully extubating a patient, to sadness after pronouncing patients dead, to relief after resuscitating patients on the verge of death. In the end, I felt comfortable in my role, having been in ICUs before and discussing end-of-life goals with families, dealing with lung physiology on a daily basis in the ORs, and resuscitating and managing patients in the recovery room. My training up to this point had put me in a place where I was capable of doing anything needed to help these patients. It wasn’t until my last shift that I realized I needed more than my expertise to help my patients. I also needed my health. I had just signed out to the morning team when I began to feel cold. I quickly got home and measured my temperature; surely enough, I was febrile with a 102.5 F fever. Reality set in quickly; I likely was infected.

I began my quarantine at home, called my chair and employee health to inform them of my status, and started what would end up being a 10-day course of fevers, chills, myalgias, and loss of appetite. Tylenol, fluids, vitamins, TV and rest composed the majority of my days while my portable pulse oximeter and thermometer were bedside at all times. I didn’t have any shortness of breath and didn’t lose my sense of taste or smell, but I was confident this was COVID, confirmed shortly by a nasopharynx RNA swab, which isn’t the most pleasant test as many know. Once my symptoms subsided, I was finally cleared for work. At that time I was tested again and found out I had very high anti-COVID antibodies, more than enough to meet the criteria to donate plasma when the opportunity arises.

Upon my return to work, I was deployed to the operating rooms, where we had begun to do more cases, mostly with COVID patients. Precautions were put in place to help protect providers, such as proper PPE, different intubation techniques to help limit the aerosolization of the virus, and equipment cleaning and disinfecting. A case that would normally take one hour became a two- or three-hour ordeal. Patients now recovered in the operating room or were immediately taken back to their ICU, putting
more strain on staff members who were now both performing surgeries as well as working to contain the virus. Our COVID numbers have since peaked and declined and we have begun our transition to a pre-COVID schedule, but with every day I spend in the ORs it has become clear that this will be our new normal for quite some time.

As I begin to reflect upon these past few months, the thought that always comes to my mind is that I would have never predicted this would have happened to me; and now having gone through it, it has certainly made me a stronger person. This pandemic has taken a mental, physical and emotional toll not only on me but also on countless other residents, healthcare workers, essential workers, families, those who stayed at home, and those who lost loved ones. Yet we are emerging from it in a new reality, ready to see what the future holds, whether it’s a vaccine or a second wave or herd immunity. In the end, I’ve never been more grateful to be in my department, working alongside world-class anesthesiologists (residents and attendings) and reinforcing my choice to pursue anesthesiology. During this time, I’m reminded of how the ASA’s lighthouse logo so accurately depicts what it truly means to be in our field:

“The patient is represented as a ship sailing a troubled sea with clouds of doubt and waves of terror, guided by the skillful pilot — the physician anesthesiologist. The stars represent constant and eternal vigilance. The lighthouse acts as a beacon in the night, and symbolizes the physician’s dependable knowledge about the science of anesthesiology.”

- The American Society of Anesthesiologists

I hope we can all continue to be the lighthouses in our patients’ lives, and I look forward to leading you into this next chapter as your new Resident and Fellow Section president.

Mena Abdelmalak, M.D., M.B.F., is an anesthesiology resident in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai and president of the NYSSA Resident and Fellow Section.
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