

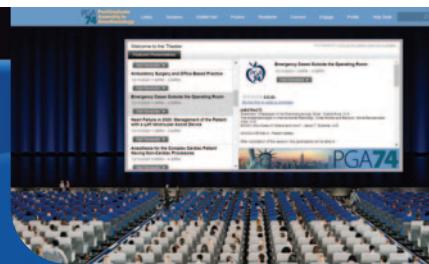
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Quarterly Publication

The New York State Society of Anesthesiologists, Inc.



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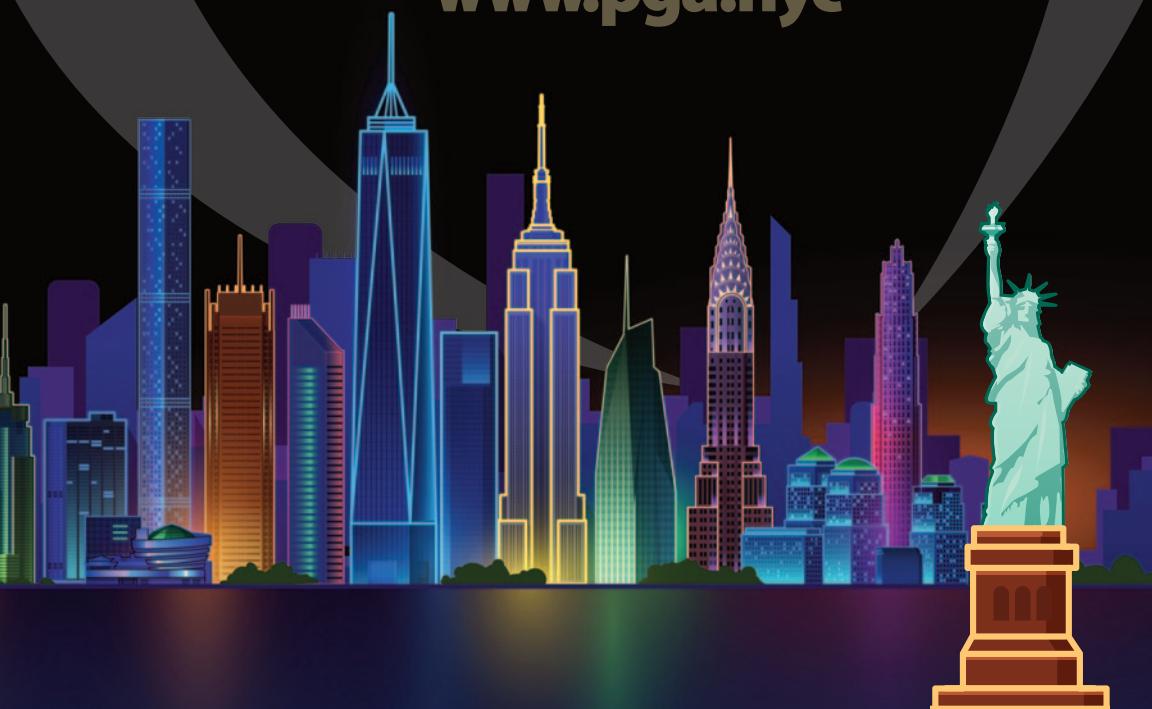


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Inside This Issue:

- 3 Looking Back on an Interesting Year**
Farewell Address to the NYSSA House of Delegates
RICHARD N. WISSLER, M.D., PH.D., FASA
- 9 President's Message**
Reimagining Our Future Direction
Inaugural Address to the NYSSA House of Delegates
CHRISTOPHER L. CAMPESI, M.D., M.A., M.S., FASA
- 13 Editorial**
Adapting to a Virtual World
KIRI MACKERSEY, MBCHB
- 15 Professional Diversity in the NYSSA**
NYU Langone Health Makes Diversity a Priority
UCHENNA O. UMEH, M.D.
- 19 Critical Care Corner**
Utilization of the PACU/Recovery Room
as an Adjuvant Overflow for Critical Care
in the Era of COVID-19
MICHAEL AARON CHYFETZ, M.D., M.SC.,
AND NATALIA S. IVASCU, M.D.
- 23 Virtual Conferences: Challenges, Lessons**
Learned and New Opportunities
JUNE M. CHAN, M.B., B.S., FANZCA
- 33 Rebecca S. Twersky, M.D., M.P.H., FASA, Honored**
With the NYSSA Distinguished Service Award
HANAE TOKITA, M.D., FASA
- 41 Going Virtual Is the New Reality**
TAZEEN BEG, M.D.
- 45 CMS and OIG Move to Expand Exceptions and**
Safe Harbors to Stark Law and Anti-Kickback
Statute
MATHEW J. LEVY, ESQ., AND MAURO VISKOVIC, ESQ.
- 49 Albany Report**
Legislative Update
CHARLES J. ASSINI, JR., ESQ.
- 53 Case Report**
Ketamine for the Treatment of Pain, Delirium
and Wean of Sedation in a Critically Ill
COVID-19 Patient: A Case Report
ANNA SROUJI, D.O., NIGEL KNOZ, M.D.,
MAUREEN COONEY, DNP, FNP-BC, AND
NITIN SEKHRI, M.D.
- 59 Membership Update**

On the cover:
Screenshots from the 2020 virtual PGA

SPHERE

Editors

Paul M. Wood, M.D.	
1948	Vol. 1
Morris Bien, M.D.	
1949-1950	Vol. 1-2
Thomas F. McDermott, M.D.	
1950-1952	Vol. 2-4
Louis R. Orkin, M.D.	
1953-1955	Vol. 5-7
William S. Howland, M.D.	
1956-1960	Vol. 8-12
Robert G. Hicks, M.D.	
1961-1963	Vol. 13-15
Berthold Zoffer, M.D. (Emeritus)	
1964-1978	Vol. 16-30
Erwin Lear, M.D. (Emeritus)	
1978-1984	Vol. 30-36
Elizabeth A.M. Frost, M.D.	
1985-1988	Vol. 37-40
Alexander W. Gotta, M.D.	
1989-1990	Vol. 41-42
Mark J. Lema, M.D., Ph.D.	
1991-1996	Vol. 43-48
Douglas R. Bacon, M.D., M.A.	
1997-2000	Vol. 49-52
Margaret G. Pratila, M.D.	
2000-2006	Vol. 52-58
James E. Szalados, M.D., M.B.A., Esq.	
2007-2011	Vol. 59-63
Jason Lok, M.D.	
2011-2015	Vol. 63-67
Samir Kendale, M.D.	
2016-2019	Vol. 68-71
Kiri Mackersey, MBChB	
2020-	Vol. 72-

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Looking Back on an Interesting Year

**Farewell Address to the NYSSA House of Delegates
December 19, 2020**

OUTGOING PRESIDENT

RICHARD N. WISSLER, M.D., PH.D., FASA

2020 was a watershed year for most people in this country, including all of us in anesthesiology.

It was my privilege to serve as your NYSSA president in 2020. I've learned a lot, and I've done my best to represent the best interests of the NYSSA. We have a great team supporting us in this society, and I would like to take a minute to recognize the team members. The cornerstone of the NYSSA is the administrative team led by Executive Director Stuart Hayman, probably the best executive director in the country. Stuart, you do a wonderful job and you are very much appreciated. We also have a very talented and hard-working staff: Kelly Mancusi, Lisa O'Neill, Will Burdett and MaryAnn Peck. Everyone does a great job, and I'm very appreciative of all their help this year and in years past as well.

We have outstanding advocacy partners in the Albany area: One of these partners is Bob Reid and his team at Reid, McNally and Savage. They are acknowledged as one of the top advocacy groups in Albany, and they have a wealth of knowledge that they share easily with the officers of the NYSSA. I am very appreciative of the mentoring and education about politics that I have received from Bob Reid and his team. We also have Chuck Assini, Esq., in Schenectady, who is the NYSSA legislative counsel. Mr. Assini prepares incredibly thorough lobbying documents and provides lots of advice behind the scenes.

Our NYSSA member volunteers are paired with these staff members and advocacy professionals. The members of the NYSSA are really the most important part of the team. You do an incredible job with lots of effort and time invested in the organization. This includes district participants, committee members, House of Delegates members, Board of Directors members, and NYSSA officers. I appreciate all your efforts and acknowledge that many times your contributions are behind the scenes.

I appreciate the mentoring I received in the past few years from all of my NYSSA teammates, especially the officers, who have gone out of their way and taken extra time to teach me how to do a better job. I also appreciate the support and encouragement of my home department at the University of Rochester and my department chair, Dr. Mike Eaton. Finally, I owe a special thank you to Stuart Hayman for his friendship and guidance.

In retrospect, coming to the end of 2020, we have some accomplishments and some areas of concern for the NYSSA.

Obviously the coronavirus pandemic is on everyone's mind and it's crushed many lives inside and outside of anesthesiology. So many of our neighbors have had their businesses and jobs ruined, many of them have gotten ill, and some of them have died. Those who have survived the coronavirus infection are at risk for long-term physical impairments and/or psychological scars. This pandemic is a terrible thing that has happened to the world.

Beyond the current pandemic, we do have some NYSSA accomplishments to highlight this year. One is the establishment of the Committee on Professional Diversity. This is a very important declaration by the NYSSA. Sometimes our focus on the viral pandemic can deflect our attention away from other important events and issues in our society. I'm very pleased to say that the NYSSA has moved in



Dr. Richard Wissler addresses the House of Delegates as president for the final time.

an important direction by establishing this committee so that our support of diversity and social justice is clear to our members and the public.

We are also planning for the future in specific ways. We own office space in midtown Manhattan. Under the capable leadership of Dr. Chris Campese, the NYSSA's incoming president, there's now an ad hoc committee that has been exploring whether we should keep that real estate, rent it out or sell it, given the dynamics of commercial real estate in New York City. This decision is in good hands. Part of the underlying motivation for looking at our real estate is that the NYSSA's staff members have been working virtually from different locations for more than eight months now and likely will continue to do so.

Speaking of changes, we just hosted a very successful PGA meeting in a virtual format, a change necessitated by the pandemic. Going forward, one of the questions the leaders of the NYSSA will have to answer is, "How should the PGA be structured in the future?" Maybe it needs to transition to a hybrid format in 2021, or maybe it will go back to the same format as in the past. The answer will depend on where the pandemic goes in the next six months and what we learned from the virtual format. I have heard from many NYSSA members that they miss the camaraderie of the on-site conference, including opportunities to network and speak directly with their colleagues and old friends. I want to thank the leadership of the PGA for the tremendous time and effort spent in crafting an outstanding virtual PostGraduate Assembly in 2020.

In financial terms, the NYSSA currently is in good shape. Due to good planning and financial management in the recent past, we are in a good position to weather the foreseeable financial storms. Going forward, however, our finances will depend on some of the choices we make about our future activities.

There is an old saying that every challenge can be an opportunity to improve. No one would have asked for the pandemic but it happened; now we have some opportunities to reflect and see if we can improve in the future.

One of the issues of concern to the NYSSA this year has been related to state government. In the spring of 2020, the Legislature passed a

bill handing many of the keys to the kingdom to Gov. Andrew Cuomo so that he could respond appropriately to the challenges of the pandemic. This action subsequently led to many executive orders from Gov. Cuomo on issues related to state government. Some of these executive orders negatively impacted physician supervision of nurse anesthetists and were later reversed. Currently, we are concerned about and following very carefully one executive order that still allows unsupervised practice by nurse anesthetists in non-hospital settings.

We also have been working with MSSNY, the AMA and the ASA on safe scope of practice by nurse practitioners. The scope of practice issue is an important topic for all physician specialties, not just anesthesiology. Many non-physicians, not just nurse anesthetists, are interested in expanding their scope of practice beyond physician supervision. The motives are unclear beyond the egos of individual practitioners. Looking at the evidence, I do not believe that weakening physician supervision either improves patient safety or lowers healthcare expenditures. We are cooperating with MSSNY, the AMA and the ASA on this issue, and we'll see where it goes.

The New York state budget crisis will provide some pressure to eliminate physician supervision of nurse practitioners, nurse anesthetists and physician assistants. Chuck Assini has prepared some written materials for our state legislators, pointing out the evidence that it's not cost-effective for Medicaid to move to unsupervised nurse anesthetists. Actually, it's more cost-effective to have direct physician supervision of nurse anesthetists. However, it remains to be seen who in Albany is going to consider the evidence. Your contributions to the NYAPAC enable us to deliver our message about safe scope of practice efficiently to our state legislators on a continuing basis. Please contribute now.

In closing, I want to share with you a very different idea for the future. Once the scope of practice issue is resolved and direct physician supervision is free from attack, we need to start thinking about building more bridges with the nurse anesthetists. In the long run, my dream is that anesthesiologists and nurse anesthetists will be allies. If you put aside your usual mode of thought, you'll realize that physician anesthesiologists and nurse anesthetists could be very powerful allies in

deciding the future of perioperative care and developing collaborative models of patient safety and professional education. There may be other players in the healthcare arena who would like physician anesthesiologists and nurse anesthetists to remain antagonists because it weakens our overall impact. My hope for the future is that the scope of practice issue can be resolved in favor of patient safety, and then physician anesthesiologists and nurse anesthetists can learn to work together to build collaborative alliances for the benefit of both the patients and ourselves.

Thank you again for the opportunity to serve as your president and full speed ahead with Dr. Campese. ■

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President's Message

Reimagining Our Future Direction

Inaugural Address to the NYSSA House of Delegates
December 19, 2020

CHRISTOPHER L. CAMPESE, M.D., M.A., M.S., FASA

It is a tremendous pleasure to be granted the opportunity to address this first virtual meeting of the NYSSA House of Delegates as your president-elect. To say that we are living through interesting times would certainly be the understatement of the year. If I have learned anything during this period of Zoom meetings and teleconferences, it's that there is a real value in brevity — so my comments will be appropriately brief.

I often try to think of life in terms of grander themes, and in considering not only where the NYSSA currently is but also the direction in which we want it to go, I came upon the idea of **yesterday, today and tomorrow**.

Yesterday, like all the days since early 2020, was without question among the most professionally and personally challenging that we have ever witnessed. Certainly, many people have experienced situations and seen and done things in the maelstrom of this pandemic that we never dreamed we would ever encounter in our lives. We are the professional organization representing a medical specialty that is among the front line of the “front-line workers,” at an epicenter of the outbreak, and all of you have risen to these extraordinary demands with expertise and selflessness.

I remember in the days after September 11, on the side of the Long Island Expressway entering the Midtown tunnel, fashion designer Perry Ellis erected a billboard that simply said, “Welcome to the City of Heroes.” In this unparalleled time of pandemic, facing an unseen infectious disease, each and every one of you and our colleagues have earned the title of “hero” and it is truly one of the honors of my life to serve you in the leadership of the NYSSA.

Today, we continue to marshal our efforts against COVID-19, knowing far more now about its effect on the patients we care for than we did

in the dark days of March and April. We will always live up to the highest ideals of our profession in every encounter and show our cities and nation what it means to be a physician anesthesiologist. However, the problems that we faced before the pandemic began have not gone away or become insignificant. Executive orders written in a moment of crisis extended rights and privileges to other care providers that we as physicians earned through education and extensive training. And we know that once these privileges are granted, it can often be difficult to return to the life and roles we knew before. We will always advocate for and insist on the highest level of care and safety for every one of our patients. This is our mission and our duty.

Tomorrow, we will face a world that is different in many new and unforeseen ways. We will be expected to adapt and grow, and this is often uncomfortable and challenging. We will reimagine the NYSSA to meet the needs of this new order and each of us will be a critical part of this transformation. We will reach out to our colleagues in anesthesia to join us in our efforts and to our political leaders to support this work. This will not be a moment for fear and paralysis but, rather, one made for bold and dramatic success. I believe that, to paraphrase Winston Churchill, our “finest hours” are truly yet to come.



Dr. Christopher Campese takes control of the president's gavel.

One personal plea, if I may, at this time: This pandemic and its consequences have come with great costs, most certainly in the emotional toll it has taken on many of us and our co-workers. I would ask all of you to take a moment when you return to your workplaces and colleagues, to check in with each other and to seek out help and support yourselves if the burdens become too great. If doing this, and breaking through the culture of silence that so often surrounds mental health issues for physicians, can save even one of our sisters or brothers from a tragic outcome, then we will have truly lived our oaths and helped to make the world a better place.

I would like to take a moment to personally thank Stuart Hayman, Lisa O'Neill, Kelly Mancusi, MaryAnn Peck and Will Burdett for all their extraordinary efforts in making the virtual PGA and House of Delegates meeting a successful reality. You are beyond amazing and I will continue to lean on you for support and guidance in the year ahead. There are no words to adequately describe your efforts.

Finally, I would like to offer thanks to all the other members of the leadership of the NYSSA and, most especially, to our outgoing president, Dr. Richard Wissler. Dick, I know that to tell the story of your quiet strength and leadership during this unprecedented crisis would take the entire time allotted for the business of the House of Delegates. Please know that I am in awe of your amazing efforts on behalf of your fellow anesthesiologists and that in a “society of heroes,” you, my friend, are truly a superhero. I will be asking for your help more than you probably want, and I promise you that when we all meet again in person, the members of this society will give you the recognition and sustained standing ovation that you have so richly earned and deserve.

I thank you all for your support throughout this upcoming year, and I sincerely look forward to serving as your NYSSA president. Thank you. ■

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Editorial

Adapting to a Virtual World

KIRI MACKERSEY, MBCHB

Thank you to PGA General Chair Dr. Meg Rosenblatt, Scientific Programs Chair Dr. Linda Shore-Lesserson, and the dedicated NYSSA administrative team for an excellent PGA. The transition to a virtual conference was a challenge — technically and intellectually — and the PGA organizers not only rose to the occasion but excelled!

While our spring edition traditionally highlights the PGA through photographic spreads, this year must be different. Without the on-site meetings, lectures and social events (and without an actual site), we have exchanged the photographic feature for the opportunity to explore the virtual aspect of the conference. Our spring feature article takes a look at how the virtual PGA conference came together, and we also hear about virtual conferences from the perspective of a speaker/attendee.

Sphere will also adopt the topic of virtual connection as our 2021 theme: virtual conferences, virtual recruitment and virtual interviews will be covered in subsequent issues. We will examine how the screen both helps and detracts from our professional lives and how we can turn the challenges of virtual learning and networking into advantages.

This year we will also be continuing our focus on diversity, as our regular contribution from the Committee on Professional Diversity will include a look at how specific institutions have worked to become more inclusive. We welcome input from our readers about how hospitals around the state have been addressing the issue of discrimination and what positive changes they are making.

On January 6 of this year we witnessed an alternate, rather than virtual, reality unfold on Capitol Hill. Let us hope that the tragic and destabilizing events of that day will not be repeated and that we can look forward to a kinder and more rational 2021. We at *Sphere* wish all our readers a peaceful, tolerant and unified year. ■



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Professional Diversity in the NYSSA

NYU Langone Health Makes Diversity a Priority

UCHENNA O. UMEH, M.D.

Diversity has been a focus for many organizations and companies over the past few years. At NYU Langone Health, diversity has long been a priority; it is actually one of the five NYU Langone Health core values, which include “Performance, Respect, Integrity, Diversity and Excellence (PRIDE).” Under the guidance of Dean Dr. Robert Grossman and our current CMO, Dr. Fritz Francois, NYU began a diversity initiative through its Office of Diversity Affairs (ODA) in 2014. During this time, the chairman of each department/institute was instructed to appoint a diversity ambassador to oversee recruitment, retention and support of minority candidates within the department.

Since 2014, I have served as diversity ambassador for the anesthesia department, acting as a liaison between my department and the ODA. In this role, I meet quarterly with Dr. Joseph Ravenell, NYU Langone Health’s associate dean for diversity affairs and inclusion, other members of his office, and fellow diversity ambassadors within NYU’s departments/institutes to assist in building the ODA’s “vision of an inclusive culture of medicine, positioned to lead the fight for health equity.”

The dehumanizing death of George Floyd last May and the subsequent protests that followed thrust racial injustice and police brutality into the national spotlight. Immediately preceding Floyd’s death was the emergence of the novel coronavirus in the U.S. and the realization that the virus disproportionately affected African Americans and Latinos in comparison to their white counterparts. Although disparities in healthcare have always existed, COVID-19 once again highlighted them and provided the impetus for departments to make changes to address the needs of the underrepresented minorities within their institutions as well as the diverse patients we all serve.

While COVID ravaged New York City and the Black Lives Matter movement’s supporters marched the streets decrying racial injustice,

I received a gentle reminder from my chairman, Dr. Andrew Rosenberg, to form a diversity committee within our department. This had been planned but, with the onset of the COVID pandemic, it was delayed. By summer, when the institution returned to our “new” normal and with racial unrest still boiling over in response to police brutality, COVID-19 and other societal ills, it finally seemed like the perfect time to form our department’s diversity committee.

The Department of Anesthesiology, Perioperative Care and Pain Medicine at the NYU Grossman School of Medicine spans multiple campuses, including the main campus (Tisch/Kimmel hospitals), Bellevue Hospital, NYU Langone Orthopedic Hospital, NYU Langone Brooklyn and NYU Langone Long Island. Dr. Rosenberg envisioned a committee with members that included residents, attendings and nurse anesthetists, and well as staff from all campuses. A list of diverse faculty and staff who would be interested in joining and contributing to the committee was generated. The committee comprises seven attendings, four residents, a CRNA, and a research coordinator. The committee also represents our diverse faculty and staff, including African Americans, Latinos and members of the LGBTQ communities.

This past summer, Dr. Ravenell described four pillars of sustainable change within the institution:

- Optimizing Organizational Culture
- Promoting Inclusive Community
- Increasing Diversity, Equity, and Inclusion Capacity
- Developing and Implementing Equity-Related Knowledge

Our committee mission plan parallels these four pillars as we develop strategies for achieving our goals. So far, we have met twice virtually via Zoom, once in July 2020 and a second time in November 2020, and we have formulated the following goals:

1. Develop a strategic plan for diversity, equity and inclusion goals and regularly report back to the chairman regarding these initiatives.
2. Facilitate our department to make progress on the goals of diversity, equity and inclusion.
3. Develop a method for cultural sensitivity and mindfulness training for our department.

4. Promote mentoring and equality in advancement for underrepresented medical students, residents, fellows and faculty.
5. Assist in recruiting diverse faculty and work to recommend effective strategies for outreach and recruitment of candidates from underrepresented backgrounds.
6. Work with our residency program director to achieve optimal resident performance and to groom underrepresented residents for future leadership positions.

We are a fairly new committee and are learning as we go along. Discussing inequities and setting goals are part of the solution but, ultimately, achieving change is the goal. Implementation of the above-mentioned goals is a process that will be discussed in a future issue of *Sphere*. I will address what went well and the challenges we faced. I will also offer advice on how to establish your own committee within your institution. Although we are a fairly young committee, we are dedicated to the challenge to help meet some if not all of these goals within our department to promote diversity, equity and inclusion for our staff and patients. ■

Uchenna O. Umeh, M.D., is an assistant professor in the Department of Anesthesiology, Perioperative Care, and Pain Medicine and the Department of Orthopedic Surgery at NYU Grossman School of Medicine, associate director of the Regional Anesthesiology Fellowship Program, and co-director of ambulatory anesthesia at NYU Langone Orthopedic Hospital.

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Review Your Membership

A message from our President...

Christopher Campese, M.D., M.A., M.S., FASA, CHCOM
President, NYSSA

2020 was a challenging year for each and every one of us. We hope and pray that you and your loved ones are safe, healthy, and managing as best as possible in the face of this resurgent global pandemic. As we prepare to end this year and welcome the better days to come, we at the NYSSA would like to wish you all a healthy and Happy New Year. May the spirit of this holiday season, although different from years past, refill your home with joy, your heart with love, and your life with laughter and peace.

Utilization of the PACU/Recovery Room as an Adjuvant Overflow for Critical Care in the Era of COVID-19

MICHAEL AARON CHYFETZ, M.D., M.SC., AND NATALIA S. IVASCU, M.D.

This is the first article in a new Sphere series from the NYSSA's Critical Care Medicine Committee, a group of academic and private anesthesiologists from around the state who dedicate a portion of their clinical time to the practice of critical care medicine. This series will focus on anesthesia critical care topics and discussions applicable to all NYSSA members. The committee meets virtually on a bimonthly basis and welcomes new members.

"If you build it, they will come" is a statement synonymous with ICU growth and expansion over the years. Not so long ago, every major surgical case was pre-admitted to the "unit" for overnight observation and optimization. The growth of surgical volume saw decentralization of ICU care into separate medical, surgical, burn, cardiac, and neuro-surgical units. In an ideal hospital workflow scenario, complex cases should proceed directly to the "unit," with the Post-Anesthesia Care Unit serving as an intermediary destination pending perioperative bed availability. The COVID-19 pandemic has given new meaning to percent available ICU capacity and the functionality of the recovery room.

During the initial coronavirus surge in New York state, cancellation of elective procedures was deemed the logical choice for conservation of critical care resources. This had little overall impact on surge capacity, as elective cases account for a small percentage of ICU admissions.¹ The advent of ERAS and preoperative clinics has resulted in a shift away from the doctrine of perioperative ICU admission for elective surgical procedures. A recent article in *Anesthesia & Analgesia* demonstrated that roughly one-quarter of total ICU beds are consumed by emergency, urgent and trauma surgical procedures and one-half for medical admissions, leaving a small minority for elective cases.¹ Despite the cancellation and postponement of elective procedures, our experience from the first surge continued to show surgical emergencies requiring ICU admission.

An ideal ICU space is an isolated negative pressure room with capabilities for hemodynamic monitoring, mechanical ventilation, and end-organ support (dialysis, CVVH, and ECMO). Most hospital rooms in the New York City area are not private and, with the exception of certain procedural areas, do not offer the ability to achieve negative pressure isolation. In addition to the physical space requirements, all intensive care patients require a unique subset of critical care nursing, support staff and physician coverage. It is the recovery room in most hospital settings that check most of these boxes. While certain procedure rooms like the GI suite may contain isolated negative pressure rooms, the proximity to the operating rooms and anesthesia personnel make the recovery room the ideal extension to critical care.

The outbreak of COVID-19 placed renewed awareness on infection control of airborne, contact and droplet pathogens. During the first wave, all COVID-positive patients were isolated to single ICU rooms and dedicated hospital units (including step-down units). The necessity for a “clean” ICU required careful and thorough screening of all patients. It may not be feasible to separate beds in a PACU setting by more than a few feet, providing obstacles for a patient who may develop drug-resistant bacteria or Clostridium difficile. Unpredictability of patient census strains nursing and support staff, who may be required to care for multiple patients during a pandemic. Whereas the addition of a bedside curtain may provide limited infection control, it is imperative that careful screening and safety precautions be instituted and reinforced.

Management of the postoperative patient in the recovery room is a direct extension of intraoperative anesthetic management. The modern-day ICU traces its roots to Bjørn Ibsen, a Danish anesthesiologist who practiced during the 1952 Copenhagen polio epidemic.^{2,3} During training, anesthesiologists are required to rotate through cardiac and neuro-anesthesia and become well-versed in managing patients of any age, in any condition, and who may present with past medical histories listing comorbidities only seen in a medical encyclopedia. The American Board of Anesthesiology embraced the anesthesiologist as a true perioperative and critical care physician, mandating a minimum of four months of critical care medicine following internship — more than any other primary medical or surgical residency.

Critical care services may be provided by a variety of physicians, including those without specific critical care training. When providing care that is beyond usual post-operative expectations, another physician in the same

billing group may charge for critical care services rendered on the same day as anesthesia services. The definition of critical care encompasses “high complexity decision-making to assess, manipulate, and support vital system function(s),” which sounds pretty close to intraoperative management of an unstable patient! When surgical volume is reduced during a national pandemic, an anesthesiology staffing model is a logical and feasible way to provide additional staff coverage of critically ill post-operative patients. In extreme circumstances, many hospitals expanded ICU capacity to treat COVID-19 patients by utilizing a pyramid hierarchy with an intensivist consultant overseeing several anesthesiologist-led teams.⁴

The COVID-19 pandemic has strengthened and united anesthesiologists across the country and the world. We have continued to demonstrate our resilience as a specialty and our versatility managing patients from the emergency department to the critical care units. As a specialty, anesthesiologists were early pioneers in the field of critical care; now may be the ideal time to reclaim that momentum and show our versatility as a profession. Even with the distribution of the vaccine, we must embrace the current calling and be prepared for the next looming pandemic. Good luck and Godspeed. ■

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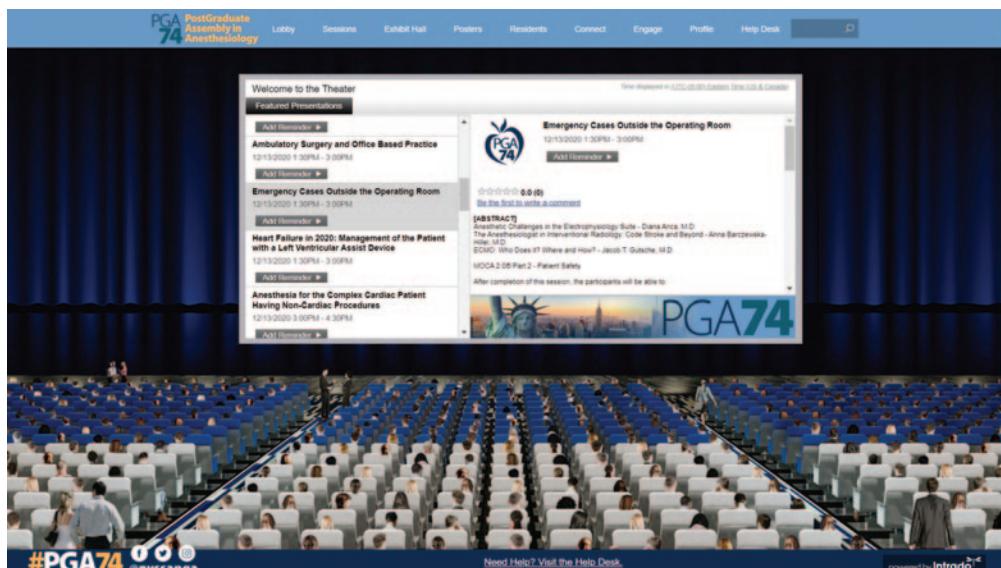
Virtual Conferences: Challenges, Lessons Learned and New Opportunities

JUNE M. CHAN, M.B., B.S., FANZCA

2020 was the year we all learned to connect in the virtual realm. Medical conferences had to adapt in the face of restrictions on social gatherings and travel, while continuing to deliver their key learning objectives and providing opportunities to network and connect as a profession. In the aftermath of a resoundingly successful and fully virtual 74th PostGraduate Assembly (PGA74), General Chair Dr. Meg Rosenblatt, Scientific Programs Chair Dr. Linda Shore-Lesserson, and NYSSA Director of Events & Education Kelly Mancusi share their experiences and lessons learned as key stakeholders in the meeting.

Logistics in a Changing World

The COVID-19 pandemic posed enormous challenges for virtual conference organizers globally. Major anesthesia conferences, including those hosted by the American Society of Regional Anesthesia and Pain Medicine (originally scheduled for April 2020) and the European Society of Anaesthesiology and Intensive Care (originally scheduled for May 2020) were forced to cancel their meetings within weeks of their

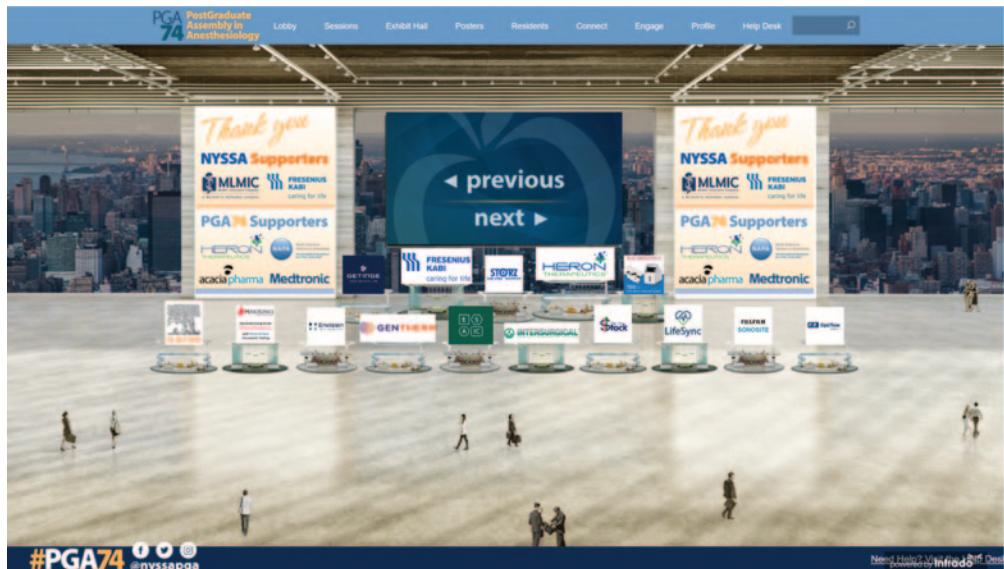


The session theater allowed attendees to select from featured presentations.

session opening dates, with significant disruption to the organizations and their members. Fortunately, the PGA74 timeline allowed for some contingency planning for what became the first virtual PGA in the NYSSA's history.

Speaking about the planning process for PGA74, Dr. Rosenblatt recalls a changing landscape starting in early 2020. "All through the spring we were still hopeful that a smaller in-person PGA might be possible," she says. "We knew we wouldn't have the European attendance we usually expect." Nonetheless, planning for a potential virtual meeting was well underway, thanks to the collective expertise of the NYSSA's administrative team: Ms. Mancusi, Stuart Hayman (executive director), Lisa O'Neill (director of operations), Will Burdett (exhibits & marketing manager) and MaryAnn Peck (administrative executive). Notified during the summer that the city would not be allowing gatherings, the staff began to pivot to an all-virtual platform. Throughout the planning process, one thing was clear: "The NYSSA had to put on a CME event for our members," says Dr. Rosenblatt. "As a huge member benefit, the show must go on!"

One of the greatest challenges for the PGA74 organizers was adapting the full in-person program by cutting it down into the truncated version that was ultimately delivered in December. Dr. Rosenblatt recalls: "We were



The exhibit hall

aware of Zoom fatigue, and [so we] decided to confine PGA74 to just the weekend, and just present some of the panels. We had a full [in-person] program ... so many committees worked countless hours to put together a meeting with breadth of topics and learning style options, and it was devastating to tell everyone that with the compressed format, their curricula wouldn't be presented."

Connecting Across Screens

Inevitably, technology infrastructure takes over the logistic considerations that traditionally centered on physical venues, lodging and transportation. Virtual event management packages offer integrated solutions that address issues such as secure livestreaming, attendee interface, enrollment, virtual meet-and-greet forums and exhibit halls, but much remains that requires direct input from organizers. For Ms. Mancusi, PGA74 required "100% immersive engagement. Since this was an entirely new process, there were a lot of unknowns and surprises." The scope of the new technology, coupled with the usual work of planning a major conference, can quickly become daunting. For future virtual event organizers, she suggests "[keeping] it simple and streamlined — less is more! Embrace the perpetual evolution of the virtual space. While it can be overwhelming to consider all the digital platforms available, the technology is also a tool to help engage the audience.

The screenshot displays the agenda page of the PGA74 website. At the top, the PGA74 logo is visible along with navigation links for Lobby, Sessions, Exhibit Hall, Posters, Residents, Connect, Engage, Profile, and Help Desk. Below the header, a blue banner features the text "Featured Presentations" and "MY AGENDA". A search bar with a "Filter" dropdown, a "CLEAR" button, and a "MORE" button is present. The main content area is divided into two sections: "Sunday, December 13, 2020" and "Saturday, December 12, 2020". Each section lists presentations with their times, titles, speakers, and action buttons. The "Sunday" section includes a thumbnail image of an audience in a lecture hall. The "Saturday" section also includes a thumbnail image of an audience. The bottom of the page features the hashtag "#PGA74" and social media icons for Twitter, Facebook, and LinkedIn. A "Need Help? Visit the Help Desk" link is located in the bottom right corner.

An attendee agenda/schedule

The specter of technical failure looms over every virtual conference. To prevent this, our PGA74 organizers all emphasize the need for additional time and planning to create contingency plans. Real-time presentations are the most sensitive to connectivity problems that may be beyond the reach of event technical support to solve. Prerecorded presentations can guarantee a predetermined level of quality but require increased preparation time for speakers, and risk losing more of the already-tenuous interpersonal connection between the online presenters and their audience. That said, creating backup recordings presents an opportunity to build a lasting resource that can be accessed by members into the future. In addition, speakers — freed from the attention needed to deliver their presentations — are now able to follow along with their own sessions live while actively scanning the interactive chat for questions and engaging with attendees. The former advantage is one that Dr. Rosenblatt is particularly enthusiastic about for NYSSA members: “I want to remind our PGA attendees that they can access sessions they haven’t seen through November 2021, for CME credit and at **no extra cost!** This is a huge member benefit!”

Presenters for PGA74 were asked to submit prerecorded presentations, which required changes in how organizers and speakers prepared. To help organizers plan for what is likely to be the new norm in virtual

The screenshot displays a virtual conference interface. On the left, a presentation slide titled "More recent changes related to anesthesia utilization" is shown. The slide includes a link to a PubMed study and a bulleted list of changes. On the right, a video call window shows a man in a suit. Below the video are a chat window and a Q&A section. The chat window contains messages from attendees.

SLIDES 1 / 1

2020 PostGraduate Assembly in Anesthesiology

More recent changes related to anesthesia utilization

Projected increased growth rate of anesthesia professional-delivered sedation for colonoscopy and EGD in the United States: 2009 to 2015 - PubMed [nih.gov]

- Increase from 23% (2009) to projected 53% (2015) screening procedures in CMS patients.
- Growth rates of 145% in NE. More growth in areas of older patient populations, more affluence, more hospital admissions.

<https://bulletin.facs.org/2016/05/coding-and-reimbursement-for-colonoscopy/>

Endoscopy reimbursement reduced 9% by CMS and the Relative Value Scale Update Committee (RUC) in 2016 as a result of decreased time for the average procedure due to Propofol increased usage nationally.

VIDEO

CHAT Q & A

Shashi Goel:
good mornings far day 1 has been very good

Mauro Faibischer:
Is recent history of nausea and vomiting an indication for intubation?

Gregory Fiasconaro III:
Good Mourning Dr Malhotra

Enter Message Here

SEND

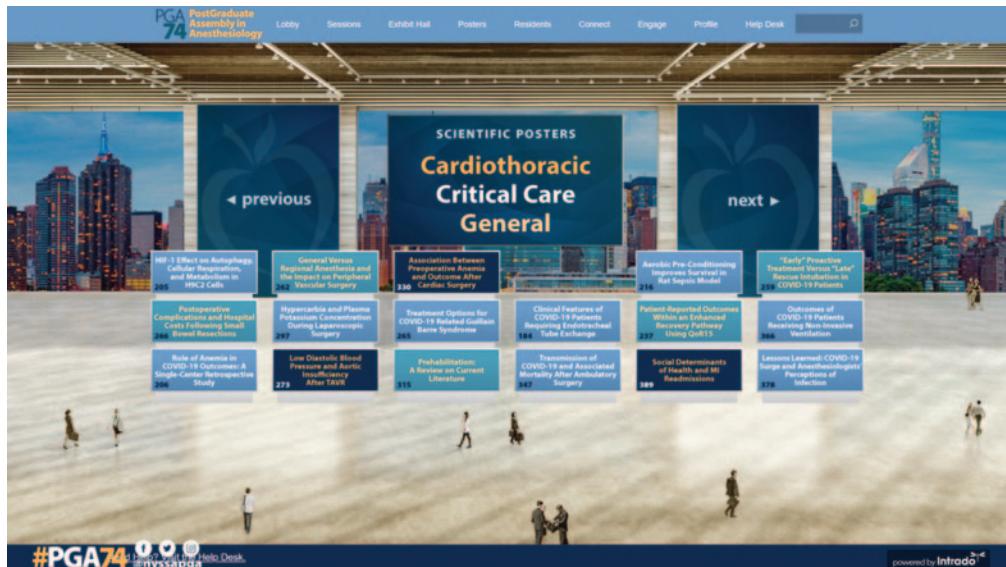
**Dr. Kevin Glassman presents “Economics of Routine Anesthesia Care for Endoscopy”
as part of the session on providing anesthesia in the endoscopy suite.**

conferences, Dr. Shore-Lesserson recommends factoring in not just additional time for speakers to prerecord their materials, but also careful coaching for speakers to ensure the recordings remain engaging for their audience. “[It takes] a lot of preparation and coaching of the speakers to ensure that prerecorded video would have the feel of being live,” she says. Simple rules, such as “don’t read your notes,” “look at your audience (the camera),” and “keep any notepapers out of view of the camera” can improve the quality of the prerecorded presentation. For virtual panels, an explicit script that informs speakers how to transition smoothly from one portion to the next enhances the simulation of a live presentation. For Dr. Shore-Lesserson, the careful efforts paid off: “I was surprised by how seamless the transitions were.”

For speakers, Dr. Rosenblatt advises them to be “meeting-ready much earlier than they did in the past. No longer can speakers be making slides on the airplane on the way to the PGA!” In addition, she cautions, “Now that we are creating enduring materials, slides must be checked to ensure there are no conflicts of interest or commercial interests within them.”

Connecting Across the Globe

The inability to gather attendees in one location created new considerations for organizers. As Dr. Shore-Lesserson recalls, “The



The scientific poster hall

fact that our speakers and participants were not all in the same time zone made scheduling and management a challenge.” Multi-speaker panels, even with prerecorded material, require synchronized presence of all presenters to participate in the discussion with attendees. The same concern extends to accessibility for attendees. Although prerecorded talks can be made available for asynchronous viewing, this solution deprives the attendee of the opportunity to network and participate in the discussion. One strategy to maximize attendance from multiple time zones, particularly for featured or keynote presentations, is to schedule them at non-traditional times (for example, 2 p.m. Eastern Standard Time is 11 a.m. Pacific Standard Time, 8 p.m. Central European Time, and 7 a.m. the next morning in Australian Eastern Standard Time).

Nonetheless, there is no doubt that virtual conferences create new opportunities that ultimately enhance access for attendees. Aside from the obvious benefit of not requiring the time and expense of travel, the relative anonymity and ease of real-time interactive chat and Q&A functions during presentations enables attendee discussion that is often much livelier than in-person conferences. Dr. Shore-Lesserson recalls this aspect of the virtual format as one of the most engaging



The New York and PGA trivia contest

experiences during PGA74: “The live Q&A sessions (in which participants conversed with one another and answered questions that were asked by a live audience via chat) felt as close to ‘in person’ as I could have envisioned.” This interactivity extended to the exhibit halls and poster sessions, which were highly successful despite their traditional dependence on face-to-face contact. “I was very pleasantly surprised by the exhibit hall and how interactive it could be,” says Dr. Shore-Lesserson. “This was one of the best virtual exhibit halls that I have experienced in the last year of virtual meetings.”

Dr. Rosenblatt shares another benefit of the virtual format: “Here is a huge secret: You can open multiple simultaneous presentations on different devices — so you can be listening to a wonderful session while waiting for your colleague to present an abstract or medically challenging case.” The ability to be in multiple places at once — something that is impossible to do in person — offers new and flexible options for attendees to engage with conference content.

Virtual Meetings: The Way of the Future

For our PGA74 organizers, it is clear that the virtual platform offers new and exciting possibilities that can enhance conferences in the



The networking lounge for residents and fellows

future, even when in-person attendance resumes. Ms. Mancusi welcomes including virtual elements into all future PGA meetings. “Our goal was to deliver value to our members,” she says. “By offering an online component, we will be able to reach and engage more of the membership as well as the national and international audience.” Dr. Shore-Lesserson concurs: “There are so many attributes to the virtual meeting that I would retain for an in-person meeting: The ability to text questions into the chat was an advantage, and the ease with which we could visit the virtual exhibits was a pleasure.”

Attendees can fully exploit the potential of hybrid meetings by being active participants and explorers of the virtual space. Most conference platforms provide orientation materials to help attendees familiarize themselves with the environment ahead of time. Keeping an open mind and trying out all the features available can offer new and surprising experiences. By engaging in the interactive chat function during sessions, attendees can transform a conventional session into a communal learning experience, harnessing the knowledge not just of the speaker but of the global audience as well.

For Dr. Rosenblatt, the possibilities for the future are endless. “This is a very exciting time for the PGA,” she says. “We have the opportunity to reimagine the whole meeting: How many days should it be? Do we keep all of the current offering types? I would like to see an expansion of the ‘Engaging With the Experts’ format that we introduced at PGA73.” Indeed, the experience of PGA74 can be summarized by Dr. Shore-Lesserson when she says, “I think that a hybrid meeting structure is the way of the future.” ■

June Chan, M.B., B.S., FANZCA, is an assistant professor at Weill Cornell Medical College, where she is also the assistant director of education for anesthesiology and the associate program director for the cardiothoracic anesthesiology fellowship.



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Kahoot Competition for Anesthesia Residents – Pediatric Anesthesia Topics

Wednesday, April 28 • 6:00 - 7:00 pm

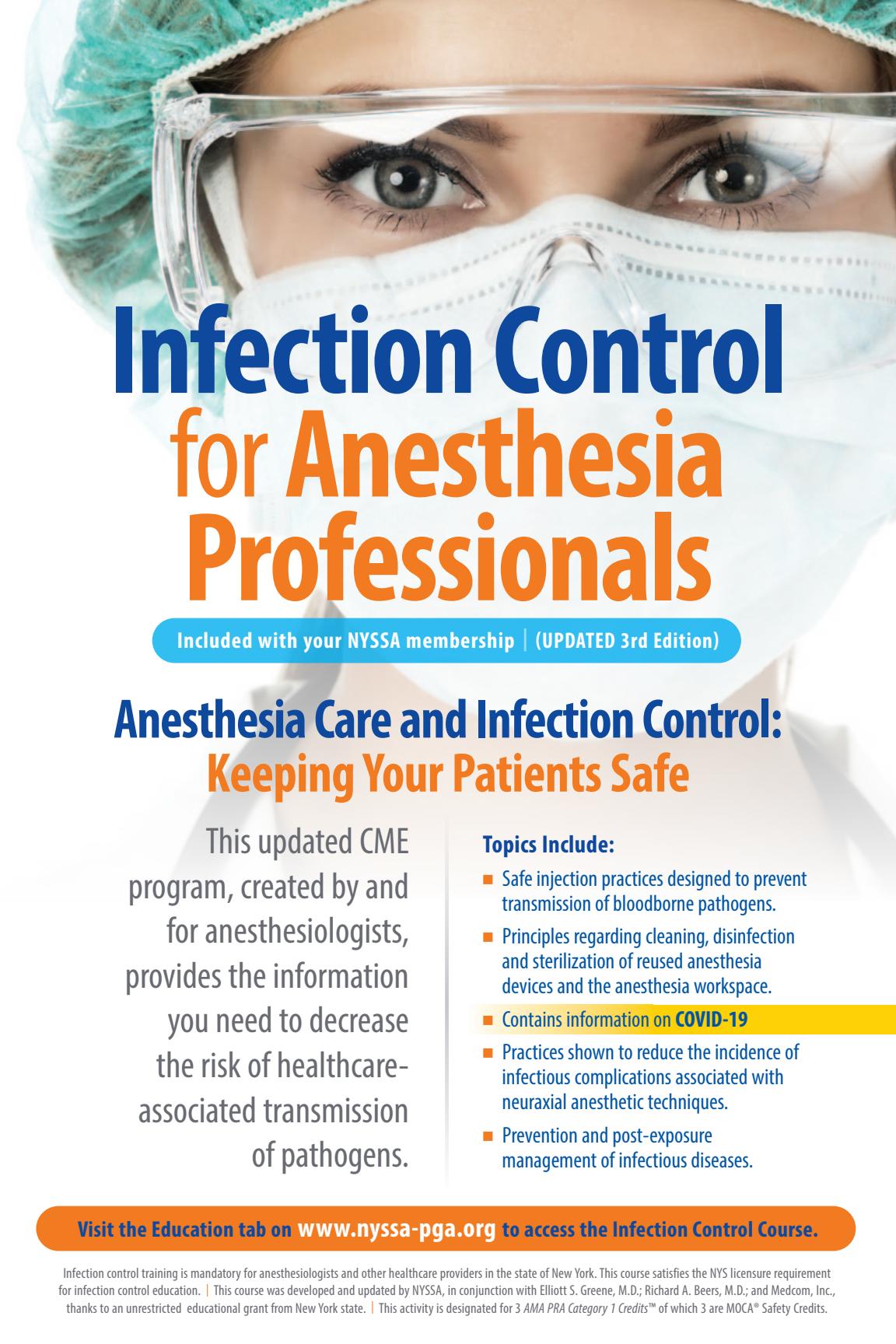
Using the online platform Kahoot, I will test your knowledge of pediatric physiology relevant to anesthesia!



Dr. Melissa Ehlers is the Anesthesiology Program Director at Albany Medical Center as well as Director of Pediatric Anesthesia. She is interested in resident education, pediatric cardiac QI, and loves to waterski at her home on Saratoga Lake (when it's not covered in ice of course!).

Upcoming Topics

- Life After Residency
- Virtual OSCE
- POCUS
- Contract Negotiation 101
- Kahoot Competition
- Diversity in Medicine
- Malpractice 101
- Poster Presentations
- Career Development



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Rebecca S. Twersky, M.D., M.P.H., FASA, Honored With the NYSSA Distinguished Service Award

HANAE TOKITA, M.D., FASA

Dr. Rebecca S. Twersky received the 2020 NYSSA Distinguished Service Award in recognition of her long-standing service to the specialty of anesthesiology, including in the areas of education and research. The award was conferred at the 74th annual PostGraduate Assembly in December.

Dr. Twersky has been an active member of the NYSSA since 1984 and has held many leadership roles, including past PGA chair and active educator at the PGA meetings. She is a well-known authority on ambulatory and office-based anesthesia and remains a strong representative for anesthesiology with the New York State Department of Health.

Dr. Twersky serves as chief of anesthesia at Memorial Sloan Kettering's Josie Robertson Surgery Center (JRSC) in New York City. JRSC is an

SLIDES

1 / 1 New York State Society of Anesthesiologists, Inc.

NYSSA

2020 Distinguished Service Award Recipient

Rebecca S. Twersky, M.D., M.P.H., FASA

innovative freestanding center that provides high-quality, patient-centered outpatient and short stay surgical care for oncology patients. Prior to joining Memorial in 2015, Dr. Twersky spent 30 years at SUNY Downstate where she was a professor of anesthesiology, medical director of the Ambulatory Surgery Care Unit, and chair of the Institutional Review Board. She received her M.D. in 1983 and her M.P.H. in 2005 from SUNY Downstate.

I sat down with Dr. Twersky to discuss her career, life, and involvement with the NYSSA. This interview has been edited for length and clarity.

Tell me a little bit about your childhood. Where did you grow up?

I grew up in Los Angeles in the ‘60s and ‘70s as the third of four children. My father was a rabbi who served the community for many decades after moving to the U.S. from Europe after surviving the Holocaust. My mother was American, and her father was also a rabbi who came to the States after WWI, so I came from two rabbinical families with long lineages tracing back several generations. In those days there weren’t that many Orthodox Jewish families in California. We grew up as the “rabbi’s children,” always having to be on our best behavior and striving to serve as good role models with values that were primarily driven by the Torah and reinforced by good citizenship.

Along with my sister, I attended an all-girls yeshiva; we were actively involved in the student council and excelled academically. I played piano and worked every Sunday in the local Jewish Sunday school. My father was very insistent on us developing ourselves and working, including in the summer and during college.

What was your path to medicine?

I thrived in an all-girls school. My sister and I were always high achievers, graduating as valedictorian and salutatorian, and I ran a campaign to be school treasurer. In 10th grade, I had an influential social studies teacher who was the first one to plant the idea that I could “go to the moon.” But no one in my family was in medicine so I didn’t think of it at the time. I was in 12th grade at the age of 15 and took an exam that enabled me to start UCLA early as a high school senior while still completing my regular high school curriculum,

including my Judaic studies. After high school, my sister and I attended UCLA together and the question was, “what next?” At the time, my father encountered a “medical technologist” and felt that would be a good career path for my sister and me. Against my father’s wishes, however, I decided that I wanted to become a doctor. But there were no women doctors in our Orthodox community. There were a few Orthodox physicians, but they were all males. In my junior summer I was awarded a fellowship from the California Heart Association to spend 10 weeks at the University of California, Berkeley, which was a very liberal place for an ultra-Orthodox young woman. I did research in molecular biology and then applied and was accepted to a medical technology program at Methodist Hospital in Brooklyn. After completing a year of training at Methodist, I was certified as a blood bank and medical technologist, but it wasn’t what I wanted to do. I hadn’t given up on my dream to become a doctor. I began putting away money to apply to medical school by working at an all-girls school in Williamsburg during the day and then the nightshift as a medical technologist at the hospital. I took the MCAT, applied to medical school and was ultimately accepted to Downstate Medical Center. My parents, particularly my father, eventually came around to accept my career path when they saw what I had accomplished and how driven I was.

What led you to the field of anesthesiology?

Interestingly enough, I had very little prior knowledge about the specialty of anesthesiology. I had a distant cousin who was an anesthesiologist but no firsthand knowledge. I was initially headed toward a career in OB-GYN. In my third year of medical school, during a clinical psychiatry rotation at Downstate Medical Center, I was fortunate to encounter the anesthesiologist in charge of the PACU as I accompanied my patient to receive general anesthesia several times a week for a psychiatric condition. During that time, I was tantalized by the breadth, depth and versatility of the specialty, and I signed up for a clinical anesthesiology elective followed by an anesthesiology research elective. The rest is history. I embraced the field and I loved the clinical constellation of how it encompasses all medical disciplines. I even published as a medical student and was ready to commit to an academic career in anesthesiology. That was in 1983, and I would select anesthesiology all over again!

Who were the most influential people in your professional development and why?

After completing my residency at Mt. Sinai School of Medicine in New York City, I was recruited to join the faculty at Downstate Medical Center. Dr. James Cottrell, the chairman, was an amazing mentor: He kept on opening doors for me; there were no glass ceilings. He introduced me to Dr. Bernard Wetchler, Dr. Burt Epstein, and Dr. Beverly Philip, the founders of SAMBA and legendary leaders in the ASA. They recognized my passion to advance the specialty and to help others; they proceeded to appoint me to committees and encouraged me to join cutting-edge research groups, co-author publications, and organize and plan major educational meetings. I excitedly assumed national and international leadership positions.

How have you maintained a work-life balance throughout the years?

Thank G-d I have been blessed with an amazingly supportive husband, David Schreiber, who has partnered with me to raise a family and uphold our strong religious commitment to Orthodox Judaism, which is the foundation for my work-life balance.

What have been some of your favorite pastimes?

Observing the Sabbath every week with family and recharging spiritually still remain my favorite activities. Additionally, we always made it a point to take the family on summer trips (national parks) and winter trips (usually skiing) just by ourselves so we would not dilute the attention the children deserved.

How did you initially get involved in the field of ambulatory anesthesia?

Location, location, location. Ambulatory anesthesia was just sprouting its early buds in the '80s and my chairman was looking for someone to pull together a program at the medical center. I was a young, energetic junior attending. The world was my oyster. Starting from scratch, forging national networks and building on this foundation over the next three decades, our facility and its affiliate modeled themselves on foundations of ambulatory anesthesia and surgery. Ambulatory anesthesia expanded to include hospital-based, freestanding, non-operating room anesthesia and office-based surgery. Together with the ASA, SAMBA, departments of health, and the accrediting agencies, I participated in establishing the foundations: a robust process for

patient selection, multimodal anesthesia techniques for all depths of anesthesia appropriate for a short stay, and high-quality, safe care with measurable outcomes. Over the years, I have conducted clinical studies, lectured and published on all these topics, always looking to further improve care.

Looking ahead, what are some of the relevant issues or current challenges in the field of ambulatory anesthesia?

Since the COVID pandemic has affected all healthcare systems, it's hard to speculate, but assuming at some point there will be a restoration of elective surgeries, it is possible that freestanding ASCs will continue to absorb more cases previously done in hospital-based ambulatory facilities, as hospitals focus on critical care needs. This will include an increase in standard ambulatory cases, and I anticipate more advanced ambulatory surgery cases, including total joint replacements and minimally invasive robotic and laparoscopic procedures.

What do you see as the future direction of ambulatory anesthesia?

Too often clinicians practicing in ambulatory anesthesia venues become complacent with the "routine," making themselves vulnerable to determine marks of distinction. Therefore, I strongly encourage active involvement of anesthesiologists and those serving as medical directors in establishing clinical pathways based on patient-centered outcomes. We need to constantly assess our metrics to determine if they are met and how we can continue to improve.

What are some of your proudest career accomplishments?

I am most proud of authoring the *Ambulatory Anesthesia Handbook*, establishing national guidelines for office-based anesthesia and surgery, and facilitating the promotion and advancement of colleagues.

You have taken on an active role in mentoring me and several junior faculty members at MSK, and you have sponsored medical students who are conducting summer research at MSK for the past five years. Why is mentorship so important to you and why is it so important in our field?

The medical students' clinical research summer program has been favorably associated with establishing positive role models and increasing interest in the field of anesthesiology.

Mentoring junior anesthesiology attendings enables a relationship within which a senior individual provides a junior colleague with invaluable advice, training, and support. The availability of senior colleagues who provide experienced counsel and career guidance, either within an institution or externally through state or specialty societies, may be personally and professionally welcome even when things are going relatively smoothly. The mentor assists the junior staff member in developing productive work relationships, successful clinical or research projects, timelines for promotion, and approaches to time budgeting and conflict resolution. More broadly, a mentor might also assist a junior member in thinking through doubts or ambiguities that commonly arise as one's professional life unfolds. Mentors can provide helpful guidance to help navigate through the ambiguities and rough spots that frequently arise in a complex medical center.

For most physicians, the need for professionally supportive relationships continues for one's entire professional life; over time, the role of the mentor will gradually be replaced by collegial relationships within one's areas of interest. I have been very gratified with the progress of our own department's mentoring program and have extended my interest in mentoring clinicians through the ASA, SAMBA, the NYSSA and other groups.

What has been your proudest accomplishment as chief of anesthesia at JRSC?

Creating a collaborative, multidisciplinary team of clinicians committed to providing innovative care, and continually evaluating and improving the way patients undergo ambulatory complex cancer surgery. Along the way, our faculty members have been able to develop their careers; we have seen an exponential increase in the number of presentations at national meetings and publications, and we now have a sophisticated investigator-initiated clinical trial by one of our junior faculty.

There is still a lack of women in leadership roles in our specialty. What advice do you have for women who are seeking a path to leadership?

Do not let anything stand in the way of your passion to advance your career, and accept opportunities that will enhance your leadership experience. Identify a mentor(s) and engage in professional networking outside your clinical practice. "No" is not an answer!

You have been actively engaged and held leadership positions in the ASA, the NYSSA, and SAMBA. Describe how you initially got involved in these organizations and why.

I was fortunate that in my department, Dr. James Cottrell and Dr. Alex Gotta were very active in the NYSSA leadership as officers. They provided me with my first committee chair appointment, and for the following 20 years I was actively involved in organizing and planning the PGA meeting, serving as scientific and general program chair, as well as serving as annual meeting program chair for the ASA. Through continued networking and sincere volunteering on my part, over three decades I was appointed to various positions in SAMBA and the ASA where they tested me out and saw that I was for “real,” and I ultimately served as SAMBA president and ASA section chair for professional standards. I also served as the NYSSA representative to the New York State Department of Health and still serve on an advisory capacity for their Office-Based Surgery Committee.

Why is it so important for us to be involved in our specialty organizations, and what advice do you have for junior faculty who wish to get involved?

Who is best suited to advocate for our medical specialty than anesthesiologists? Interaction at the governance level can actually be rewarding. We need to get out of our OR comfort zone and enlighten our elected officials and other non-physician citizens about the level of knowledge, training and skill that our specialty entails. Most non-physicians have no clue, and remaining silent will not serve us well. There are so many opportunities to volunteer our time with the NYSSA, the ASA, MSSNY, the AMA, and the multiple specialty societies within anesthesiology, and we have so many talented individuals practicing anesthesiology who can make a contribution. ■

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Going Virtual Is the New Reality

TAZEEN BEG, M.D.

I attended my first-ever virtual conference the weekend of June 6, 2020, when the Society for Ambulatory Anesthesia (SAMBA) hosted their annual conference, SAMBA 2020: A Virtual Experience. It was wonderful that we were able to attend a conference despite all the misery surrounding us.

This conference was very different from others that I have experienced in the past. More than 250 people from the anesthesiology community in the U.S. and around the world registered for the event despite the COVID-19 disruptions.¹ Granting special consideration to the different time zones, the sessions started at a later time of the day. The conference included numerous thought-provoking sessions and panel discussions, which were better regulated through the chat and Q&A boxes. There were virtual networking receptions with sponsors, experts and attendees from different parts of the country and the world, which were facilitated by a newly created app for faster communication. If you registered but couldn't attend virtually, you had access to the lectures for a whole year. We had gone completely digital.

However, it didn't feel as if we were at a conference, as it was bereft of personal interaction. It was missing the enthusiasm and excitement of meeting the author of a classic paper or an editor of a book. There was no opportunity for that casual conversation that starts while you stand in line for a cup of coffee and ends with an exchange of phone numbers, an invitation to do a talk, or a collaboration in research. It lacked the special associations that develop during a discussion at a PBLD or a pro/con debate. While you could post your question in the chat box or "raise your hand" hoping to catch the moderator's eye, your question might never get answered. The hands-on workshops were nonexistent.

From the speaker's perspective, you lectured to the screen on your computer, missing that "connection" with the audience. Your facial expression or that little nod with a tilt of the head acknowledging your point of view on a particular subject wasn't there. As a member of the audience, watching that bobbing head on the computer screen or tablet

for hours is hardly a thrilling experience, even with the creative backgrounds that speakers are striving to present. The burnout and eye fatigue that follow cannot be ignored either.

For researchers, sharing months — sometimes years — of research with colleagues around the world from the confines of their offices or homes doesn't always allow them to get fully immersed or involved. There are numerous distractions, audiovisual disturbances and technological difficulties that must be overcome for a flawless presentation. For some, conferences are a means of retreating from their everyday routines to mingle with the intellectual community for an exchange of ideas and thought processes. They are a learning experience for all but also an excuse to travel and visit new places — sometimes even exotic locations, and with families, to steal some time with them while "working." All that is missing in a virtual world.

While SAMBA 2020 was a smaller conference, the challenges faced by the organizers of larger gatherings could be overwhelming. As one of the speakers invited by SAMBA to present my reflections as a member of my hospital's COVID Airway Team, I was privy to the entire gamut of preparations that take place during the days preceding a virtual conference. We had several virtual meetings, exchanged emails, had IT professionals help us prepare and navigate our presentation slides, and even had a "dry run." The American Society of Anesthesiologists (ASA) annual meeting 2020, held virtually (#Anes20), was a huge undertaking with thousands of attendees and hundreds of speakers and events.

Navigating the virtual event was not an easy task and was more challenging for the not-so-tech-savvy person. It was the first virtual event of mammoth proportions for the largest anesthesiology society, which is usually attended by 14,000-15,000 participants from approximately 80 countries across the globe when in person.² With such a large platform, a few technological mishaps are bound to happen. However, server breakdowns and internet connectivity are some of the hiccups that can be easily amended. The success of such a large conference is, therefore, praiseworthy. The NYSSA's recently concluded PGA74 conference was another such success story. The usual PGA attracts more than 4,500 attendees from around the globe, with presentations on the latest science and technologies in anesthesia. The two-day virtual event this year offered 24 scientific sessions featuring 80 speakers, a virtual exhibit hall and poster presentations, all well

conducted from the confines of participants' offices, homes and even the hospital on-call rooms. Of course, one missed the holiday lights and the delights of New York City.

While a virtual conference may have certain disadvantages, outreach efforts can be even greater and more diverse both for the speakers and the attendees. One could easily reach out to any expert across the globe and request his/her presence at a meeting. The conferences also have become more inclusive, with an enormous exchange of ideas and experiences from around the country and especially with international participation. The individuals who would otherwise be restricted to travel due to childcare issues (mostly female) or a disability can now attend the conferences of their choice without having to step out of their homes.

Financially, too, virtual conferences are more affordable, both for the conference organizers as well as the attendees. The major cost incurred for hosting a virtual event goes toward the technology company or the web platform that hosts the event. Despite travel restrictions due to COVID, there is no barrier for attendees, saving both time and transportation costs, including the need for visas for international travel. If there is an overlap in terms of favorite lectures, there is the added advantage of having them available to watch "on-demand."

While we are discussing the perks of a virtual conference, the decrease in its environmental impact warrants a special mention. With no in-person travel and hospitality venues, there is no environmental waste and energy expenditure, thus providing a more sustainable conference environment. According to a recent article in *Nature*, the carbon footprint of conferences varies from 0.5 to two or more tons of carbon dioxide per participant in travel alone. If each of the estimated 7.8 million researchers in the world traveled to just one conference each year, they would still generate carbon emissions that are roughly equivalent to those of some smaller nations.³

Virtual conferences have been on the rise with the digital revolution, but with the advent of the COVID-19 pandemic their demand skyrocketed. The digital technology companies are definitely making profits, while the huge resorts and hotel chains may be losing out on their clients. There are more virtual event organizing companies now than ever before, and they are coming up with new ideas and ways to

make our events seem more real and “human” with digital avatars. It appears that virtual conferences are here to stay — if not solely virtual, definitely as a hybrid model.

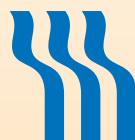
We humans are a resilient species. The loss of lives from COVID-19 cannot be changed. However, this pandemic has allowed us to take a break from the so-called norms and given us the opportunity to reflect on and rethink the way we want our future to look. It has acted as a catalyst for us to come together as a society and work for a better world, sometimes virtually. ■

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CMS and OIG Move to Expand Exceptions and Safe Harbors to Stark Law and Anti-Kickback Statute

MATHEW J. LEVY, ESQ., AND MAURO VISKOVIC, ESQ.

On November 20, 2020, the Centers for Medicare & Medicaid Services (“CMS”) and the Office of Inspector General (“OIG”) adopted significant changes to regulations regarding the Anti-Kickback Statute (“AKS”) and the Physician Self-Referral Law (“Stark Law”). Among the changes are those that expand and create new AKS safe harbors and Stark Law exceptions.

Background

As a general matter, AKS and the Stark Law prohibit medical providers from paying or receiving kickbacks, remuneration, or anything of value in exchange for referrals of patients who will receive treatment paid for by government healthcare programs such as Medicare and Medicaid, and from entering into certain kinds of financial relationships. There are various exceptions to the Stark Law, together with certain safe harbors to AKS, that permit certain referrals under limited circumstances. The recent changes adopted by CMS and OIG aim to expand those exceptions and safe harbors in order to modernize and clarify regulations that were enacted back in 1989. Summarized below is a general overview of the key AKS and Stark Law changes.

AKS Changes

The main AKS revisions are as follows:

- *Value-Based Arrangements:* Three new AKS safe harbors will be added to protect certain arrangements entered into with, or by, a value-based enterprise (VBE) and its eligible participants for a number of value-based network arrangements, as follows:
 - Care coordination arrangements to improve quality, health outcomes, and efficiency, involving “no risk,” where in-kind remuneration such as technology or services are exchanged between VBE participants used to engage in value-based activities directly connected to care coordination for the target patient population.
 - Value-based arrangements involving both monetary and in-kind remuneration between a VBE and VBE participants

where the VBE assumes “substantial downside financial risk” for providing or arranging for the provision of items and services for the target patient population, and the VBE participants assume a “meaningful share” of that risk.

- Value-based arrangements involving both monetary and in-kind remuneration between a VBE and VBE participants where the VBE assumes “full financial risk” for all items and services covered by a payor for each patient in the target population for a term of at least one year.

These “value-based” safe harbors vary by the type of remuneration protected, the type of entities eligible to rely on the safe harbors, and the types of safeguards included as safe harbor conditions. The value-based safe harbors exclude pharmaceutical manufacturers, distributors, and wholesalers; PBMs; pharmacies that primarily compound or dispense compounded drugs; laboratories; medical device and supply manufacturers; medical device distributors and wholesalers; DMEPOS suppliers; and physician-owned medical device companies. The care coordination safe harbor can be accessed by medical device and DMEPOS manufacturers to protect digital technology arrangements under certain conditions.

- *Patient Engagement:* A new safe harbor will be added for patient engagement tools and supports to improve care quality, outcomes and efficiency, furnished by a VBE participant or “eligible agent” to a patient in a “target patient population,” subject to a \$500 annual cap, with an inflation adjuster. This safe harbor includes the same general exclusions as outlined above but allows medical device and supply manufacturers to provide some digital health technology.
- *CMS-Sponsored Models:* A new safe harbor will be added for CMS-sponsored model arrangements and CMS-sponsored model patient incentives that is expected to reduce the need for separate fraud and abuse waivers for new CMS-sponsored models.
- *Cybersecurity:* A new safe harbor will be added to protect non-monetary donations of certain cybersecurity technology, including both software and hardware, and related services. This safe harbor permits the donation of cybersecurity technology to physician groups or other providers so long as the technology is “necessary and used predominantly to implement, maintain, or reestablish cybersecurity.” The safe harbor limits donors from making donation

decisions considering volume or value of referrals or other business generated between the parties.

- *Electronic Health Records:* The existing electronic health records (EHR) safe harbor will be modified to update provisions regarding interoperability, remove the prohibition on donation of equivalent technology, and provide clarification to protections for cybersecurity technology and services included in an electronic health records arrangement.
- *Personal Services and Management Contracts:* The existing personal services and management contracts safe harbor will be modified to increase flexibility for part-time or unpredictable compensation arrangements, and to provide new protection for outcome-based payment arrangements, with the same entity-exclusions that are applied to the new value-based safe harbors.
- *Warranties:* The existing safe harbor for warranties will be modified to revise the definition of “warranty” and provide protection for warranties for one or more items and related services.
- *Local Transportation:* The existing safe harbor for local transportation will be modified to increase mileage limits from 50 to 75 miles for rural areas, and to eliminate distance limitations for transporting patients discharged home from an inpatient or observation setting.

The AKS changes became effective January 19, 2021.

Stark Law Changes

Many of the Stark Law changes track similar revisions made to AKS, with some distinctions. The main revisions are as follows:

- *Exceptions for Value-Based Arrangements:* As with the AKS changes, new, permanent exceptions for value-based arrangements were adopted to permit value-based arrangements that satisfy certain requirements based on the level of financial risk undertaken (full financial risk, meaningful downside financial risk, or no risk). These exceptions will allow healthcare providers to design and enter into more flexible value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate Stark Law.

- *New Guidance and Clarifications:* CMS provided additional guidance on key requirements of the exceptions to the Stark Law to make it easier for healthcare providers to comply with the law. For instance, compensation provided to a physician by another healthcare provider must generally be at “fair market value.” The new rules clarify how to determine whether compensation meets this requirement. An additional clarification was effected by adding a new definition of “commercially reasonable,” which requires that an arrangement “furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty” and clarifies that an arrangement may be commercially reasonable even if it does not result in a profit for one or more of the parties.
- *Other New Exceptions:* The final rule establishes new exceptions to protect non-abusive, beneficial arrangements between physicians and other healthcare providers that apply regardless of whether the parties operate in a fee-for-service or value-based payment system — such as donations of cybersecurity technology that safeguard the integrity of the healthcare system. In addition, CMS finalized a new exception to protect compensation not exceeding an aggregate of \$5,000 per calendar year, adjusted for inflation, to a physician for the provision of items and services without the need for a signed writing and compensation that is set in advance if certain conditions are met, including that the compensation does not exceed fair market value and is not determined in any manner that takes into account the volume or value of referrals or other business generated.

The new Stark Law regulations became effective January 19, 2021. Certain provisions relating to value-based care arrangements will not be effective until January 1, 2022.

Should you have any questions regarding the foregoing rule changes, please contact Mathew Levy at 516-926-3320 or MLevy@weisszarett.com. ■

Mathew J. Levy, Esq., and Mauro Viskovic, Esq., are partners at Weiss Zarett Brofman Sonnenklar & Levy, P.C., the NYSSA’s general counsel. They have extensive experience representing healthcare clients in transactional and regulatory matters. The firm can be found on the web at weisszarett.com.

Albany Report

Legislative Update

CHARLES J. ASSINI, JR., ESQ.

As highlighted in the winter 2021 Albany Report, the New York State Association of Nurse Anesthetists (NYSANA) is claiming that, as a result of Gov. Andrew Cuomo's executive orders suspending physician supervision of nurse anesthetists (the physician supervision requirement in hospitals was reinstated by Gov. Cuomo effective May 8, 2020), the state Legislature should enact legislation to permanently dismantle the physician anesthesiologist-led anesthesia care team and substitute a loose collaboration arrangement that would permit independent practice for nurse anesthetists. That article also outlined the various reasons why the NYSANA position is without merit.

The NYSSA advocacy team — led by Government and Legal Affairs Committee (GLAC) Chair Dr. Jonathan Gal and including GLAC's members, Albany-based lobbyist Bob Reid, NYSSA Executive Director Stuart Hayman, and me — has met and discussed an advocacy plan for 2021. Some of the activities planned to date include:

1. A virtual NYSSA Legislative Day to be scheduled in May 2021 (look for details to follow).
2. Participation in the Medical Society of the State of New York's (MSSNY) virtual annual Physician Advocacy Day, scheduled for March 2, 2021.
3. Participation in the American Society of Anesthesiologists' (ASA) town hall meetings with other state component societies to compare and share notes.
4. A review and assessment of the New York state executive budget with respect to the practice of anesthesia.
5. A review and analysis of bills introduced in the state Senate and/or state Assembly relative to the practice of anesthesia.

Recently, Bob Reid, Stuart Hayman and I participated in an ASA-sponsored component society meeting. The message was clear: New York state is not alone in gearing up to preserve the physician anesthesiologist-led anesthesia care team. In fact, representatives from the following states highlighted the efforts by nurse anesthetists to

achieve independent practice by either advancing legislation or through lobbying efforts aimed at their governors to approve opt-out: Arizona, Arkansas, Florida, Georgia, Illinois, South Carolina, and Maine. At the conclusion of the session, Jason Hansen, ASA director of state affairs, circulated advocacy fliers from other states. The following, based on a handout from one of the ASA's component societies, will be distributed to New York state lawmakers and contains New York-specific information (e.g., the polling data).

Consequences of Independent Anesthesia Nurse Practice

The consequences of independent practice for anesthesia nurses do not justify a change in New York state's physician supervision requirements, which have been in existence since 1989.

- Unsupervised anesthesia nurses do not save healthcare dollars. In fact, unsupervised anesthesia care leads to higher costs related to anesthesia complications.
- This form of independent practice has not been shown to improve access to care.
- Anesthesia nurses order more tests and require additional physician consultations to manage patients. This increases costs.
- Creating a "collaborative" relationship would create a new, unproven two-tier anesthesia delivery system.

Despite being funded by an anesthesia nurse lobbying group, one study found that unsupervised nurse anesthesia care results in higher mortality rates.

Physician Anesthesiologists: When Does It Matter?

- Physician anesthesiologists have at least twice the education and eight times the clinical training hours of anesthesia nurses.
- During life's most crucial moments, no one can safeguard and protect the lives of patients like a physician anesthesiologist.
- Physician-led teams are proven to be the safest and most cost-effective model to deliver anesthesia care.
- The existing statewide uniform requirement of physician-led anesthesia care protects and guarantees to all New York state patients (regardless of payor status, economic considerations, or ZIP code) that a physician will assume the legal and medical responsibility for the nurse anesthetist.

Prepared for Crisis

During the COVID-19 pandemic, physician anesthesiologists took the opportunity to utilize their unique critical care knowledge and procedural skill sets to provide:

- Dangerous front-line intubation and ICU care.
- Creative fixes for modifying anesthesia ventilators, strategizing surgery reopening timing, and caring for COVID patients in the operating room.
- Clinician and public education.
- Innovative solutions to equipment shortages.
- Critical medical services to gravely ill COVID patients.

It takes the best to lead us through the worst. Physician anesthesiologists are made for this moment.

A Look at the Facts

- Physician anesthesiologists have a broader-based medical education and more clinical training:

Physician Anesthesiologist Clinical Hours: 12,000-16,000

– American Medical Association

CRNA Median Clinical Hours: 1,651

– American Association of Nurse Anesthetists

- Physician-led care teams are the safest model of anesthesia care.¹⁻⁴

A self-funded study by the national nursing lobby clearly shows:

– A 15% increase in mortality rates when anesthesia nurses practice without physician supervision.

- “Opting Out” of physician supervision requirements doesn’t improve access or reduce costs:^{2,5-8}

A 2017 research report concludes:

– “Opt out” has not been effective in increasing two important dimensions of access to anesthesia care: number of procedures performed or decreased travel distances for surgery.

- Two NYSSA-sponsored surveys of New York voters conducted in 2014 and 2016 by Tel Opinion Research revealed overwhelming public support for a physician-led team model:

89% prefer doctors to administer or respond to anesthesia emergencies during surgery. [2014: 91%]

- 75% said it was safer to have a doctor administer or respond to an anesthesia emergency during surgery. [2014: 74%]**
- 78% said it was very to extremely important that a nurse anesthetist be supervised by a doctor during surgery. [2014: 84%]**
- 91% prefer doctors to respond to an emergency during surgery. [2014: 92%]**
- 85% felt strongly that a doctor should continue to supervise nurse anesthetists. [2014: 84%] ■**

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Case Report

Ketamine for the Treatment of Pain, Delirium and Wean of Sedation in a Critically Ill COVID-19 Patient: A Case Report

**ANNA SROUJI, D.O., NIGEL KNOX, M.D., MAUREEN COONEY, DNP, FNP-BC,
AND NITIN SEKHRI, M.D.**

Background

Coronavirus disease 2019 (COVID-19), a novel virus responsible for a worldwide pandemic, has caused an alarmingly high number of critically ill patients in need of prolonged mechanical ventilation. In order to optimize treatment and recovery, critically ill COVID-19 patients require a combination of sedatives and analgesics, often at higher doses, to ensure proper sedation, ventilator synchrony and pain management. Prolonged exposure to the most commonly used sedatives and analgesics results in critically ill COVID-19 patients having an increased risk of: (i) accumulation and delirium from the use of benzodiazepines, (ii) tolerance, tachyphylaxis, and hypotension from the use of dexmedetomidine, (iii) propofol infusion syndrome due to triglyceridemia from propofol, and (iv) hyperalgesia and/or opioid tolerance from the use of commonly used parenteral opioids. In addition, sedation holidays are often not possible in this population given different circumstances such as use of paralytics, proning or risk of self-harm. Consequently, the increased demand for sedatives and analgesics has resulted in a supply shortage, thus exacerbating the difficulties associated with treating critically ill COVID-19 patients. Given the above clinical difficulties, the authors present a case using ketamine on a critically ill COVID-19 patient.

Case Presentation

In April 2020, a 45-year-old male correctional officer with a medical history of diabetes and hypertension was hospitalized for a syncopal episode. Three to four weeks prior to hospitalization, the patient reported feeling fatigued. The patient believed that his fatigue was a result of being exposed to multiple co-workers who were ill with a viral illness. Two days prior to hospitalization, the patient developed fever, vomiting, headache, and shortness of breath. Given worsening symptoms, he decided to present to the hospital. Upon presentation to

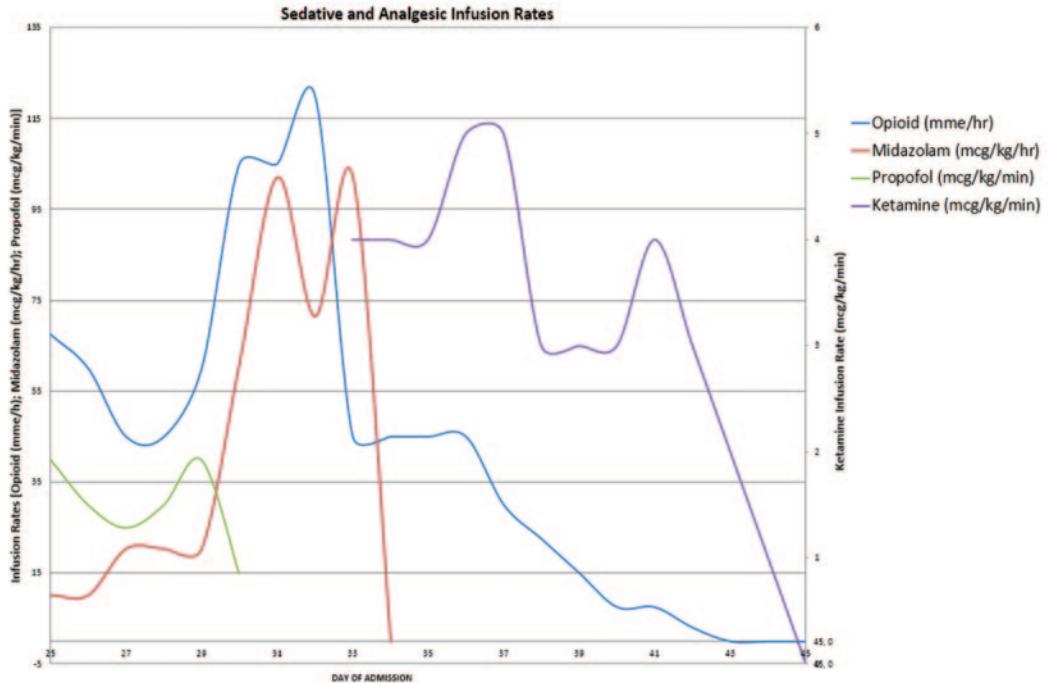
the emergency department, the patient was noted to be profoundly hypoxic and was started on high-flow nasal cannula. Laboratory tests revealed multiple elevated lab values, including: white blood cell count, D-dimer, ferritin, CRP, fibrinogen, and LDH levels. Chest X-ray was performed and showed diffuse parenchymal disease. Patient was tested for SARS-CoV-2 RNA, which determined that he was positive for COVID-19. Patient was promptly started on an array of directed treatment therapies for COVID-19-related pneumonia. Despite treatment, his condition continued to deteriorate and the patient was found to have severe acute respiratory distress syndrome requiring intubation. His blood pressure continued to decrease and the patient was started on treatment for refractory septic shock. After maximal ventilator settings and no signs of clinical improvement by day 19, the patient was transferred to Westchester Medical Center, Valhalla campus, for initiation of venovenous extracorporeal membrane oxygenation (VV-ECMO). While on VV-ECMO, the patient was started and titrated on several infusions: fentanyl, propofol, dexmedetomidine, cisatracurium and norepinephrine. The fentanyl, propofol and cisatracurium drips were adjusted according to the patient's needs and, at maximal values, were (while on VV-ECMO) fentanyl 225 mcg/hr and propofol 40 mcg/kg/min.

On day 28, cisatracurium infusion was discontinued. Subsequently, the propofol infusion was discontinued due to increased triglycerides on day 30. Over the next few days, vasopressors for hemodynamic support were tapered off and the patient's overall pulmonary function improved. As a result, VV-ECMO was discontinued and the patient was de-cannulated. Additionally, his ventilator settings improved and a tracheostomy had been placed. However, despite the patient's overall clinical condition improving, the patient started to become agitated and delirious, and he began having worsening tolerance to the sedative hypnotics and opioids. Restraints were used on multiple occasions in order to prevent self-extubation. During sedation holidays, the patient was unable to follow commands, would often become aggressive and was CAM-ICU positive. Infusions at this time in his clinical course included a fentanyl infusion at 250-300 mcg/hr, a hydromorphone infusion at 2-3 mg/hr, and a midazolam infusion at 6-10 mg/hr.

Concerned about the patient's high requirements for sedation, the hospital's critical care team requested a pain management consultation

on day 33. The pain service team initiated a low-dose adjunct ketamine infusion starting at 3 mcg/kg/min and titrated to 5 mcg/kg/min. This low-dose ketamine infusion was found to maintain adequate sedation and analgesia while allowing for the reduction of other sedatives in order to avoid withdrawal symptoms, including being able to wean the benzodiazepines infusion completely within a few days (Figure 1). While on the ketamine infusion, the patient was closely monitored for adverse effects, none of which were observed. The patient's positive response to the low-dose ketamine infusion resulted in the ability of the critical care team to wean the patient from all other infusion agents that were previously being used to sedate him. During this time, he was able to sit up in bed, communicate via writing, and even videoconference with his family, while weaning from the ventilator. By day 45, the patient no longer required ventilatory support and the ketamine infusion was discontinued. The patient was then transferred to the general floors and only required modest doses of enteral benzodiazepines for anxiety and to help prevent withdrawal. The patient's clinical condition improved and he was ultimately transferred to an inpatient rehabilitation facility.

Figure 1



Discussion and Conclusions

Ketamine is an N-methyl-d-aspartate receptor inhibitor and activates opioid μ - and κ -receptors, which provides both sedation and analgesia. High-dose infusions or boluses of ketamine can produce an alteration in cerebral hemodynamics and increase adverse cardiovascular and psychometric effects; therefore, is not first line for critically ill patients.^{1,2} However, our case illustrates that ketamine, when used in low doses, may provide an alternative to conventional sedatives (and help the patient to taper off of these medications) used in COVID-19-related critical care settings due to its ability to provide analgesia and sedation, reduce delirium, facilitate ventilation, reduce inflammation and improve bowel motility.

In this case, our patient needed high levels of sedatives, opioids and benzodiazepines to optimize recovery and ventilator synchrony, as well as for prevention of self-harm. As a result, the use of ketamine was taken into consideration. It has been previously shown that low-dose ketamine infusions have the benefit of acting as an adjunct sedative-analgesic agent without known adverse effects while also facilitating spontaneous ventilation.^{3,4} We observed that introducing a small-dose ketamine drip (3-5 mcg/kg/min) did indeed facilitate safe and slow tapering of other agents while ensuring adequate sedation and analgesia during ventilator weaning.

Delirium has been linked to an increase in mortality in critically ill patients.⁵ That being said, ketamine's ability to improve mental status, as shown in our case report, makes it superior to many other agents known to cause delirium.⁶ The need to decrease delirium is even more crucial in COVID-19 patients, as current studies have shown an increased risk of delirium in these patients through various mechanisms.⁷

In addition to the positive effects noted above, ketamine, despite possibly causing an increase in secretions, has numerous positive effects on respiratory dynamics, including: (i) a decrease in airway resistance, (ii) bronchodilation, (iii) increased compliance, and (iv) preserved airway reflexes, functional residual capacity, tidal volume, and minute ventilation. The negative effects are dose dependent and typically minimal at low doses. These positive properties may allow ketamine to be superior to other agents during ventilator weaning, as discovered in this case study.

Moreover, ketamine, by comparison to opioids, is also unique in that it does not have as many negative effects on bowel motility. This allows for better nutrient absorption and faster recovery.⁸

Lastly, current data suggests that interleukin-6 (IL-6) and other inflammatory markers are elevated during a cytokine storm that affects severe cases of COVID-19.⁹ Ketamine has been previously shown to reduce IL-6 and C-reactive protein in intraoperative cardiac patients.^{10,11} While there is no current evidence that ketamine's anti-inflammatory properties may help facilitate recovery in COVID-19 patients, it is a unique property of the drug that may warrant further investigation. Ketamine may also decrease lipopolysaccharide-induced lung injury that can be seen in superimposed bacterial infections, not uncommon with prolonged intubations seen with many patients with COVID-19.

Our case study has shown that there may be numerous benefits of a low-dose ketamine infusion in the management of critically ill COVID-19 patients, including but not limited to: (i) limiting other sedative-analgesic agents, (ii) reducing delirium, (iii) facilitating both mechanical and spontaneous ventilation, (iv) improving bowel motility, and (v) reducing inflammation. ■

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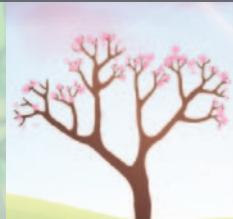
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