

# ANESTHESIA RECORD

NEWSLETTER OF THE MASSACHUSETTS SOCIETY OF ANESTHESIOLOGISTS



## Report of Counsel

Edward Brennan Jr., Esq.



On the health care front on Beacon Hill, Governor Baker is expected in mid-March to file a healthcare reform bill emphasizing primary care and behavioral health. The Senate has passed and sent to the House a bill addressing behavioral health, including mental health parity for insurance coverage and coverage for annual mental health exams. They also passed a bill dealing with prescription drug costs. The House has passed a bill designed to help struggling community hospitals. This controversial bill would place regulatory barriers through the Determination of Need process and Health Policy Commission analysis on expansion by large health care systems into the service areas of community hospitals. Such barriers could be reduced if the large systems do a joint venture with community hospitals. Working with Rasky Partners, the MSA will closely monitor these issues. The governor's bill could prove to be an omnibus vehicle that may include areas the Senate and House have separately acted on.

In February, the Legislature passed a Covid-19 spending bill, Chapter 22 of the acts of 2022 which expands testing, increases youth vaccination, and provides funds to purchase masks for schools. Due to recent Department of Public Health (DPH) restrictions on non-essential, non-urgent scheduled

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## Report of Counsel

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procedures due to COVID-19 and variants the bill includes civil liability immunity protection for health care providers and facilities. Also included is a delay in implementation of the State law imposing patient notification and disclosure responsibilities on health care providers relating to out-of-network services.

### Civil Liability Immunity

The immunity would apply to acts and omissions that occurred from the November 22, 2021 date that the DPH issued its order restricting non-urgent medical services at hospitals which will end on February 28, 2022.

The immunity provisions of the bill are similar to the immunity law passed at the outbreak of the COVID pandemic in March 2020, when Governor Baker issued an emergency declaration. That immunity expired in June 2021 when the Governor rescinded his emergency declaration. The immunity then and now is for (i) medical services provided pursuant to a COVID-19 rule; (ii) provision of service to a patient was impacted by the provider's decision or activities in response to treatment conditions resulting from the outbreak of COVID-19 or COVID rules during the effective period of the statutory immunity; and (iii) the provider acted in good faith.

### Out-of-Network Surprise Billing

The federal No Surprise Act (NSA) took effect January 1, 2022, and covers all group and individual health plans and insurance products whether regulated by the federal ERISA law or state insurance laws. (If a state, like Massachusetts, does not have its own out-of-network payment law, the NSA applies to state-regulated insurance products here.)

The NSA protects patients from surprise medical bills when they receive unanticipated out-of-network (OON) care in an emergency and some non-emergency settings; such as from certain OON physicians in a patient's in-network hospital; i.e., hospital-based physicians including anesthesia, radiology, pathology, emergency, and assistant surgeons as examples, who may not bill the patient directly. Such physicians may elect not to provide care to OON patients or accept payment under the NSA. There can be no balance billing of a patient except for applicable co-pays or deductibles.

### Payments for OON Providers Under NSA

For OON providers, the patient's insurer will make an initial payment to the provider, likely the median in-network rate for the particular procedure or service. If the provider disputes the payment, there is the ability to negotiate an acceptable fee before the provider can elect to go to arbitration through an independent dispute resolution process. There is no threshold to enter into arbitration and disputed claims can be bundled. The arbitration is "baseball-style" where each side makes an offer and the arbitrator chooses one as the final fee.

### Factors for Arbitrator to Consider

Offers by both parties; and Qualifying Payment Amount for the same service in the same geographic region (likely median in-network rate).

#### Arbitrator can also consider

- Training, experience, quality, and outcomes measurements;
- Market shares of parties;
- Acuity of patients/complexity of cases;
- Teaching status, case mix, scope of services of a facility;
- Good faith efforts by parties to contract and contracting rate history from last four years.

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## ➤ MSA Past Presidents

2020-2021 Maitriyi J. Shah, MD  
 2019-2020 Nicolas Kiefer, MD  
 2018-2019 Nikhil M. Thakkar, MD  
 2017-2018 Richard D. Urman, MD, MBA  
 2016-2017 Mary Ann Vann, MD  
 2015-2016 Sheila R. Barnett, MD  
 2014-2015 Spiro Spanakis, DO  
 2013-2014 Michael R. England, MD  
 2012-2013 Selina A. Long, MD  
 2011-2012 Ruben J. Azocar, MD  
 2010-2011 Fred E. Shapiro, DO  
 2009-2010 David L. Hepner, MD  
 2008-2009 Beverly K. Philip, MD  
 2007-2008 Donald G. Ganim II, MD  
 2006-2007 Mark D. Hershey, MD  
 2005-2006 Glynn D. Stanley, MB CHB  
 2004-2005 Stephen O. Heard, MD  
 2003-2004 Rosemarie Maddi, MD\*  
 2002-2003 Prasad R. Kilaru, MD  
 2001-2002 Michael H. Entrup, MD  
 2000-2001 Alan M. Harvey, MD  
 1999-2000 Daniel F. Dedrick, MD  
 1998-1999 Bernard H. Hand, MD\*

1997-1998 Jeffry B. Brand, MD  
 1996-1997 Robert H. Bode Jr., MD  
 1995-1996 Alexander Hannenber, MD  
 1994-1995 James S. Gessner, MD  
 1993-1994 Lee S. Perrin, MD  
 1992-1993 Gerald L. Zeitlin, MD\*  
 1991-1992 Stephen V. Hall, MD  
 1990-1991 Fred G. Davis, MD  
 1989-1990 Leonard S. Bushnell, MD\*  
 1988-1989 Marcelle Willock, MD  
 1987-1988 D. Sean Restall, MD\*  
 1986-1987 Joseph R. Beauregard, MD  
 1985-1986 Dorothy M. Crawford, MD  
 1984-1985 John V. Donlon, MD  
 1983-1984 Kenneth W. Travis, MD  
 1982-1983 Bebe K. Wunderlich, MD  
 1981-1982 Raymond J. Anton, MD  
 1980-1981 Lawrence A. Simons, MD  
 1979-1980 Herbert L. Everett, MD\*  
 1978-1979 George E. Battit, MD  
 1977-1978 Richard A. Kemp, MD  
 1976-1977 Joseph L. Murphy, MD\*  
 1975-1976 Franco R. Dinale, MD\*  
 1974-1975 Russell J. Rowell, MD  
 1973-1974 John Hedley-Whyte, MD

1972-1973 C. Thomas O'Connell, MD  
 1971-1972 Frederick S. McAlpine, MD\*  
 1970-1971 Jess B. Weiss, MD\*  
 1969-1970 Donald P. Todd, MD\*  
 1968-1969 Robert D. Ouellette, MD\*  
 1967-1968 Donald L. Mahler, MD\*  
 1966-1967 Henrick H. Bendixen, MD\*  
 1965-1966 Robert N. Reynolds, MD\*  
 1964-1965 Joseph G. Murphy, MD\*  
 1963-1964 Leroy D. Vandam, MD\*  
 1962-1963 Peter G. Lehnndorff, MD\*  
 1961-1962 Carroll Bryant, MD\*  
 1960-1961 Francis J. Audin, MD\*  
 1959-1960 Phillip S. Marcus, MD\*  
 1958-1959 James H. Buskirk, MD\*  
 1957-1958 Benjamin Etsten, MD\*  
 1956-1957 John Bunker, MD\*  
 1955-1956 Robert M. Smith, MD\*  
 1954-1955 Dexter R. Branch, MD\*  
 1953-1954 Julia G. Arrowood, MD\*  
 1952-1953 Leo V. Hand, MD\*  
 1951-1952 William J. Martin, MD\*  
 1950-1951 Morris J. Nicholson, MD\*  
 1949-1950 Jacob H. Fine, MD\*  
 1948-1949 Urban H. Eversole, MD\*

**Report of Counsel**

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Arbitrator cannot consider usual and customary rates; billed charges; payment rates by public payers, including Medicare, Medicaid.

The Biden administration has published rules regarding the factors an arbitrator can consider, which puts more emphasis on the median in-network rate and less on the other factors an arbitrator should be able to consider under the NSA. Organized medicine groups, including the ASA, are objecting to these rules and are working to have the rules reflect the intent of Congress and the statutory language, as well as filing suit. Separately, the Texas Medical Association has won a court case that invalidates portions of the rule.

**OOB Required Notice to Patients**

The federal NSA has patient notification provisions such as posting in provider offices and facilities public notices of protection under NSA, good faith estimates of the cost of services through the patient’s insurer by way of an advanced explanation of benefits (AEOB). For Massachusetts, the Legislature enacted Chapter 260 of the Acts of 2020 that imposes patient notification beyond the NSA requirements and are stricter. The Massachusetts law went into effect on January 1, 2020, and applies to all health care providers, including physicians, hospitals, nurses, dentists, pharmacists, chiropractors, psychologists, mental health providers, etc.

In early January, the Department of Public Health (DPH) issued a bulletin “Health Care Provider Obligations”, which outlines the patient notification provisions of Chapter 260. The Medicine Board sent the bulletin out to all physicians. The DPH moved forward with issuing the bulletin without hearing any input from the medical and hospital communities, which has resulted in considerable administrative responsibilities for providers who are already overburdened by the COVID-19 surge, unprecedented burnout, and workforce shortages. In addition, portions of the state law conflict with NSA notification requirements which now creates two sets of requirements that can be inconsistent and confusing not only for providers but patients as well. Adding to the concern are the penalties the Massachusetts law imposes on providers for violation of any of the patient notification provisions: \$2,500 for each instance and enforced by DPH and the applicable provider boards of registration.

Medical, hospitals, and other provider organizations, including the MSA, have sought legislative action to delay the implementation of the state requirements in order to see how the federal notification provisions work out, and how the federal and state notice and disclosure laws can be reconciled. The Legislature recognizes the problem and included, in the COVID-19 spending bill, Chapter 22 of the Acts of 2022, **a provision that delays implementation of the state’s notice and disclosure law from January 1, 2022, to July 31, 2022**, which is good news.

MSA will join with the medical society, hospital association, and other provider organizations to work with the Legislature to reconcile the differences between the NSA and state notice requirements.

**MSA Appointments  
2021-2022**

**Officers**

Nathan T. Jones, MD	<i>President</i>
Cathie T. Jones, MD	<i>President Elect</i>
Jennifer Dearden, MD	<i>Vice President</i>
Galina Davidyuk, MD	<i>Secretary</i>
David M. Feinstein, MD	<i>Treasurer</i>
Maitriyi J. Shah, MD	<i>Immediate Past President</i>
David L. Hepner, MD	<i>ASA Director</i>
Nicholas Kiefer, MD	<i>ASA Alternate Director</i>
Beverly K. Philip, MD	<i>ASA President</i>

**Delegates: ASA House of Delegates**

Sheila R. Barnett, MD
Nathan T. Jones, MD
Nicholas Kiefer, MD
Fred Shapiro, DO
Jennifer Dearden, MD
Nikhil M. Thakkar, MD
Maitriyi J. Shah, MD
Ruben Azocar, MD
Cathie T. Jones, MD
Mary Ann Vann, MD

**Alternate Delegates**

Robert Canelli, MD
Galina Davidyuk, MD
David M. Feinstein, MD
Sohail Mahboobi, MD
Roman Schumann, MD
Balam Sharma, MD
Spiro Spanakis, MD
Lalitha Sundaraman, MD
Richard D. Urman, MD, MBA
Bistra Vlassakova, MD

**District Representatives & Alternate Representatives**

Timothy Abbott, MD; Jacob Schauer, MD	<i>District 1</i>
Dinesh Jagannathan, MD; Vacant	<i>District 2</i>
Daniel O'Brien, MD; Vacant	<i>District 3</i>
Karolina Brook, MD; Wenxi Gao, MD	<i>District 4</i>
Nita Sahani, MD; Tomas Walsh, MD	<i>District 5</i>
Balam Sharma, MD; Vacant	<i>District 6</i>
Ami Karkar, MD; Vacant	<i>District 7</i>
Amer Tabbba, MD; Vacant	<i>District 8</i>
Ben Kaon, MD; Vacant	<i>District 9</i>

**Committee Chairs**

Lee S. Perrin, MD	<i>Committee on Bylaws</i>
Ross Musumeci, MD	<i>Committee on Economics</i>
Jeffry B. Brand, MD	<i>Committee on Ethical Practice and Standards of Care</i>
Nathan T. Jones, MD	<i>Committee on Governmental Affairs</i>
James S. Gessner, MD	<i>Judicial Committee</i>
Nikhil Thakkar, MD	<i>Nominations Committee</i>
Richard D. Urman, MD MBA	<i>Programs Committee</i>
Dinesh Jagannathan, MD	<i>Steering Committee</i>
Fred E. Shapiro, DO	<i>Committee on Public Education</i>
Nikhil Thakkar, MD	<i>Committee on Publications</i>
David M. Feinstein, MD	<i>Sub-Committee, Website</i>
Danielle Levin, MD; Elena Madan, MD	<i>Committee on Resident &amp; Fellow Affairs (CORFA), Co-chairs</i>



## Legislative Update

Provided by Rasky Partners

### Legislative Deadline - Joint Rule 10

February 2nd marked an important deadline in the Legislature. Most legislative committees had to make a decision on every bill within their committee. Committees had to either (1) Give a bill a favorable report, (2) Send the bill to a study, which means the bill is dead for the remainder of the session, or (3) Give the bill an extension order, which means the committee will decide to give the bill a favorable report or send it to study at a later date.

MSA's two pieces of priority legislation were in the Joint Committee on Public Health. The Committee sent HB2356 - An Act relative to anesthesiologist assistants to a study and gave an extension order to HB2241 - An Act relative to health care transparency.

More than 7000 bills were filed, and hundreds were assigned to the Joint Committee on Public Health. Due to the fact that such a large amount of bills were filed, the Committee did not have enough time or bandwidth to analyze most of the bills before it, particularly new ones that have opposition. So, although MSA spent time with the Committee Chairs, met with all the members of the committee, and had MSA members reach out through grassroots advocacy, that is why HB2356 - An Act relative to anesthesiologist assistants was sent to a study. It is not uncommon for a new bill to be sent to a study in the first session. MSA must continue to educate the Committee on this issue.

MSA should be particularly proud that HB2241 - An Act relative to health care transparency was given an extension order, as it is a huge accomplishment for a bill to be granted an extension order during the first session it is introduced. The Committee now has until December 31, 2022, to decide what happens to the bill. MSA will work with the Committee on hopefully getting the bill a favorable report.

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*MSA's two pieces of priority legislation were in the Joint Committee on Public Health.*

### Covid-19 Spending Bill

In February, the Legislature passed a Covid-19 spending bill that would allocate \$76 million to expand testing, increase youth vaccination, and provide funds to purchase masks for schools. It also allots another \$25 million in available federal funds to the state's COVID emergency paid sick leave program.

Included in the bill are the following provisions to benefit physicians and all health care providers:

- **Civil liability immunity protection for health care providers and facilities** due to recent Department of Public Health (DPH) restrictions on non-essential, non-urgent scheduled procedures due to COVID-19 and variants. The immunity would apply to acts and omissions that occurred from the November 22, 2021 date when the DPH issued its order restricting non-urgent medical services at hospitals and would end statutorily on Feb. 28, 2022. The immunity is for (i) medical services provided pursuant to a COVID-19 rule; (ii) provision of service to a patient was impacted by the provider's decision or activities in response to treatment conditions resulting from the outbreak of COVID-19 or COVID rules during the effective period of the statutory immunity; and (iii) the provider acted in good faith.
- **Delay implementation of the state's notice and disclosure law** that was issued as a DPH bulletin "Health Care Provider Obligations", which outlines the patient notification provisions of Chapter 260. Implementation is delayed until July 31, 2022. The delay gives the medical and hospital community the time to work with the Legislature to see how the federal notification provisions under the No Surprises Act work out, and how the federal and state notice and disclosure laws can be reconciled.

On February 12th, Governor Baker signed the bill into law. The Governor returned some portions of the spending bill and vetoed a couple of sections, however, the liability immunity protection and the delay in implementation of the notice and disclosure law were signed into law.



## Editor's Welcome

Nikhil Thakkar, MD, FASA

*Chair, Committee on Publications*

"It is not the strongest of the species that survives, nor the most intelligent that survives, it is the one that is the most adaptive to change." – Charles Darwin

**Change...**Let's embrace it

It's happening at many levels, in many places, and all around us. We all have changed many aspects of our lives in the last couple of years. Some are for the better, some are

temporary while others are forever. We are bringing an exciting change to our newsletter format. With many energized committee members and their extraordinary efforts, we are able to bring together this digital version of the MSA newsletter. For years, MSA members have enjoyed the paper version of the newsletter but from now onwards this new and convenient digital version can be accessed from anywhere. Our website committee is also working hard to update our website content. Slowly but surely, we are increasing our digital presence and reducing our carbon footprint.

**Changes...**many lives have changed, many families lost their loved ones during the last couple of years due to the surprising, sudden attack by the coronavirus, affecting the entire world. We were told to give distance but at the same time, we found newer ways to get connected. We all connected to solve the same problem all across the world, we found different solutions according to our resources, we found different ways to protect ourselves while serving affected patients, we found innovative ways to tackle our patients' symptoms, and we changed our primary serving location from the operating room to all across the hospital in order to save people's lives.

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*We should be proud of this positive change.*

Media and the common man definitely know about the importance of our specialty more than ever. We should be proud of this positive change.

Apart from our staple “featured hospital” session, you will also enjoy an article compilation from members across Massachusetts expressing the changes in their lives.

We have learned to overcome obstacles and bring positive changes for the betterment of our patients, ourselves, and our specialty.

"Just when the caterpillar thought the world was over, it became a butterfly."





## Featured Hospital

**Sturdy Memorial Hospital, Eastern Mass Surgery Center, New England Surgical Suites, Shields ASC & Atlantic Anesthesia, PC**

**Amer Tabba, MD**

*Practice Management and the Challenges of Running a Successful Private Anesthesia Group in 2022 and Beyond.*



Atlantic Anesthesia, PC (AAPC) was founded in 2006 by a small group of anesthesiologists and certified registered nurse anesthetists (CRNAs) operating out of a small ambulatory surgery center in Norwood - Eastern Massachusetts Surgery Center (EMSC). Since then, AAPC has grown and now covers, in addition to EMSC, Sturdy Memorial Hospital (SMH) in Attleboro, New England Surgical Suites (NESS) in Natick, and Shields ASC in Medford. AAPC is one of the very few successfully private, medium-sized, anesthesia groups remaining in Massachusetts that is now operating at four very successful service locations. These service locations are strategically located to the north, west, and south of the Greater Boston Metropolitan area allowing the group to be very attractive to many excellent anesthesia providers and surgical facilities.

AAPC has over 30 board-certified anesthesiologists and 28 CRNAs at a part-time or full-time capacity. The department is also supported by 3 anesthesia technicians, one administrative assistant, and two accountants. AAPC engages Change Healthcare to handle all billing and revenue cycle management responsibilities as well as assist in third-party payor contract

negotiations, RFP responses, and facility negotiations. Change Healthcare also has an accountant and CPA assigned to the practice.

### Partner Facilities

Sturdy Memorial Hospital (SMH) is their flagship location. Since 1913, SMH has been dedicated to providing its community with a wide range of both inpatient and outpatient services. What started as a 15-bed facility, over 100 years ago, has grown into a thriving 128-bed facility. SMH admits over 7,000 individuals per annum and treats nearly 50,000 patients annually. SMH and Sturdy Memorial Associates combined have over 2,000 total employees. As a community hospital, SMH is committed to providing top-notch health care to the vast geographic location of southern Massachusetts and nearby Rhode Island.

*"Atlantic Anesthesia, PC is poised to have great success in the years ahead. Having survived the dreaded COVID-19 pandemic with all its parts mainly intact and strengthened, the future looks very bright."*

Atlantic Anesthesia provides services at over 15 Sturdy Memorial Hospital locations alone and 24 anesthesia locations in total.

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## Featured Hospital

*Continued from page 6*

Throughout the partner facilities, AAPC has services dedicated to a wide range of clinical areas including thoracic surgery, major and minor orthopedic surgery, major and minor general surgery, vascular, plastic surgery, urology, ENT, GI, podiatric, gynecological surgeries, and a very aggressive outpatient surgical spine program. In addition, AAPC provides services for cardiology and inpatient and outpatient endoscopy. SMH has a dedicated Maternity Unit with two operating rooms for surgical care of obstetric patients. Also, it operates and oversees a dedicated Perioperative Testing Clinic (PAT) designed to improve surgical scheduling and quality as well as eliminate unplanned, same-day cancellations, maintain on-time starts, and overall patient experiences and safety.

Another highlight of their partner's facilities can be seen at the New England Surgical Suites and Shields ASC locations. These newly renovated suites are equipped with more modern up-to-date operating rooms that include brand new anesthesia machines as well as other equipment needed to provide patients with the best quality of care.

### Dedication and Planning

Surviving as a private anesthesia group in the last decade came with many challenges and struggles along with growth and success. From the outset, however, AAPC implemented a successful strategic plan, allowing them to survive and expand in the ever-changing healthcare environment. This plan included:

- To achieve the very best in excellence in anesthesia delivery status.
- The highest in professionalism by its providers.
- The ultimate in skill level and knowledge and be involved on multiple levels in the hospital and ASC settings.
- To be diverse in practice (inpatient vs outpatient).
- To be diverse in affiliated partners (hospital vs ASC).
- To be diverse in geographic locations (Greater Boston Metropolitan area)
- To be a trusted partner and offer solutions to very urgent issues.



The amount of skill and dedication, requiring effective communication, needed to be unsurpassed. To be able to convince everyone that they are part of the team, and a very valued member of the group is paramount. Beyond that, they must professionally conduct themselves. This proves that no mission is completely impossible. No new frontier is not ever explored.

### Growth and Development

AAPC is very prominent and deeply involved with multiple, very important, administrative committees throughout their partners' organizations. One example of this is Dr. Amer Tabba who, in addition to being the Chief of Anesthesia at this facility, is the Director of the Operating Room Committee, a member of both the Credentialing Committee and the Medical Executive Committee at SMH. Additionally, Dr. David Carp is a member of the Clinical Advisory Committee at New England Surgical Suites in addition to being the Anesthesia Medical Director of the ASC. Dr. Lorraine Foley is a member of the Clinical Advisory Committee at Shields ASC in addition to being the Anesthesia Medical Director of the ASC. Dr. Thomas Curtin serves as the Anesthesia Medical Director at Eastern Mass Surgery Center. AAPC also takes the time to meet monthly with upper management at all locations to discuss problems and formulate innovative solutions.

Throughout the many service locations, they are hitting record highs every year by the sheer number of anesthesia cases and the high acuity procedures performed in the ambulatory settings. This year they are expected to hit another ground-breaking record of 26,000 to 30,000 cases. In addition to these high case numbers, they are pioneering the ambulatory joint replacement procedures program in all practice locations to be the mainstream practice for most of the patient population. Having done more than 150 total hip, shoulder, and knee replacement surgeries on an

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## Featured Hospital

*Continued from page 7*

outpatient basis just in the last 12 months alone, this program proved invaluable during this COVID-19 pandemic. Surgeons were able to move their patients' procedures, who endured a long wait, to the ASC versus being canceled or delayed at the hospital. On daily basis, AAPC work to improve and finetune their operation to better serve customers, the facilities, the surgeons, and their patients.

More and more, AAPC's revolutionary new and innovative anesthesia techniques improve the safety and quality of their patients. Some physicians had no official training during their anesthesia residences on how to use ultrasound-guided regional nerve blocks but now they are well-versed experienced sonographers. This highly successful team is continuously learning from each other as well as reaching out to other successful institutions throughout the country to explore ways to improve and excel.

Atlantic Anesthesia believes in community advocacy and offers all its providers fully paid membership to the American Society of Anesthesiologists (ASA) and the Massachusetts Society of Anesthesiologists (MSA). They encourage all anesthesiologists and CRNAs to be more involved both locally and nationally. AAPC is always seeking to recruit the best anesthesiologists and CRNAs to join and improve. Dr. Uttara Bhimani is an AAPC anesthesiologist emeritus having served at Sturdy Memorial Hospital uninterrupted as a pediatric anesthesiologist since July 1st, 1976. She just recently retired from her full-time position but continues to support the group on a per diem basis. She continues to be a role model and inspiration for everyone through her dedication and vast experience and knowledge.



*From left to right: Emily Bouley MD, David Carp MD, Brook Napolitano CRNA, Amer Tabba MD*

*"...took on the mission of self-advocating, improving efficiency, reducing waste, and assisting its service partners to achieve their goals"*

## Anesthesiologists

For decades, anesthesiologists made the operating room theaters their home and rarely ventured out unless perhaps to visit the cafeteria. However, those days are long gone and forgotten. Now, anesthesiologists are required to be very visible, not only as complete well-rounded perioperative physicians but also assist with administrative responsibilities. If you don't have a seat at the table, there would be no one would speak on your behalf. AAPC, empowered by dedicated anesthesiologists and CRNAs, took on the mission of self-advocating, improving efficiency, reducing waste, and assisting its service partners to achieve their goals.

This required AAPC to self-correct and required the group to do the additional leg work that was needed to achieve the desired outcome.

Working hand in hand with the busy surgeons to help them do their cases in the best conditions possible and in the most efficient way, make anesthesiologists transition from being a hindrance to an equal and trusted partner.



*From left to right: Thomas Curtin MD, Dipak Kumar MD, Nancy Poblador MD, Amer Tabba MD*



# President's Report

Nathan T. Jones, MD, FASA

The Massachusetts Society of Anesthesiologists (MSA) had a busy year in 2021. We saw the ups and downs of case volumes as COVID-19 surged and retreated. One of our own, Beverly Philip, MD, successfully served as ASA President. Compensation for both Physicians and CRNAs was a hot topic of discussion around the water cooler. Unfortunately, CRNAs gained prescriptive authority after 2 years of supervision. The MSA has been very active on the legislative front, with the help of Rasky Partners, supporting two bills that directly impact us.

The first is House Bill 2241, An Act Relative to Health Care Transparency. This bill would require individuals to identify themselves to patients based on their credentials and license. The goal of this bill is to make it easier for patients to know whom they are talking to and what that individual's role is on the healthcare team. This bill has had widespread support with little opposition.

The second is House Bill 2356, An Act Relative the Anesthesiologist Assistants. This bill would allow AAs to practice within the team model and could eventually help with staffing shortages. This bill has gained support for offering a group of individuals a high-paying career in the state, that does not currently exist. The American Academy of Anesthesiologist Assistants has been supportive of our efforts and I cannot thank them enough for testifying on this bill and meeting with our state representatives.

The MSA is committed to helping with staffing our member institutions. To this end, the Executive Committee voted to allow a monthly email to members with potential short and long-term career opportunities. If your group has an available position, please reach out to the MSA for advertising assistance.

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*The MSA has been very active on the legislative front...*



## MSA Annual Meeting 2022

MAY 19th 2022 | WESTIN WALTHAM BOSTON | 6:00-9:00 PM

As part of an effort with the ASA to encourage membership from new and recent graduates, there will be reduced dues for the first 3 years after completion of training for both the ASA and MSA. A unified bill from the ASA will reflect these changes.

Over the coming year please be on the lookout for Grassroots emails at the State and Federal levels on these above mentions issues as well as the surprise medical billing legislation. I hope to see you all at the annual meeting in May. Thank you.



From left to right: Drs. Brendan O'Donovan, Lester Chua, Nathan Moriarty, Thomas Lambert, Samuel Tate, Nikhil Thakkar (Displaying Intubation Box and Scuba mask with filter)

## Featured Article

### COVID-19 in Massachusetts: Through the Looking Glass

Compilation by Ami Karkar, MD

**Ami Karkar, MD, Department of Anesthesiology  
Melrose Wakefield Hospital**



In early 2020, breaking news came out of China about the rare new SARS-CoV-2 virus. We could not anticipate the havoc it was about to wreak on our daily lives, friends and families, economy, and of course our work as anesthesiologists. Across the U.S., each state and region had varying challenges with COVID-19, depending on population, supplies, manpower, and support. Surge after surge, we would gear up for another taxing period where hospital workers would rally to support one another, only to get hit with another wave of COVID. Still, so many similarities fighting the war against this virus tied us anesthesiologists and critical care physicians together and made us a stronger united front.

I had just moved to Boston from the South in January 2020. Come late February, my group at Melrose-Wakefield Hospital, a small community hospital, jumped into action and did our best to ride the waves of the tsunami that was headed our way. We created a surge schedule that entailed 3 person teams with 1 team off for 5-7 days in case a team member got sick. We had an intubation team for both day and night shifts and, as most hospitals did, only performed emergency surgeries. April and May brought new difficulties: adjusting to breathing through N95 masks, managing a limited number of masks which we rotated keeping old ones to air out in paper bags, adopting new mask/shroud cleaning techniques, and employing PAPRs which

we had never used before. There were moments early on when we felt like we were “being sent to the frontlines without the right armor.” We even had people develop new intubation apparatuses made from PVC tubing that would create an isolated box to contain the aerosolization. Normal three-minute intubations turned into high-stress thirty-minute ones, involving the new complexities of donning and doffing. We would watch patients profoundly desaturate after intubating, knowing there was not much more we could do. This was going on all over the US and the world, some places with far fewer resources than my hospital.

*There were moments early on when we felt like we were “being sent to the frontlines without the right armor.”*

When the vaccine finally reached Melrose-Wakefield Hospital in December of 2020, we had anesthesia manpower to spare due to low surgical volume. Doctors and CRNAs were redeployed to assist in the vaccine clinic and the ICU to help with the deluge of critical care patients that flooded in following the Thanksgiving holiday.

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## Featured Article

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More blows to the already vulnerable hospital systems were to come. June 2020 ushered in the Delta variant, kicking off a third brutal peak. By the fall of 2021, previously triumphant vaccines were losing their potency and those who thought they were protected fell sick. Hospitals were bombarded once again with critical patients who presented too late. We were unable to transfer patients to the inundated tertiary centers in Boston.

The winter of 2021 hit like a fireball. Omicron was 70 times more contagious and still fatal to those who were unvaccinated. Staffing experienced new shortages due to illness and dissent against the vaccine mandate. There was a distinctly eerie feeling on floors with the nursing stations deserted. When we went to intubate, instead of having 5-6 people in the room helping, there was one RN and one RT. For the month of January 2022, we were unable to resume elective surgeries. Having been through a few surges before, this was clearly the worst with less manpower, sick colleagues, and an inability to transfer the sickest ones to other critical care centers.

Alas, we have made it past the latest hurdle and are grasping at normalcy. While Covid may be with us forever, we now move forward with the hope that it will not be as fatal, especially for those who are vaccinated. It's been a challenging 2 years, especially for those who remained in our profession, but we should be proud of our community, which has banded together in the interest of public health.

### **Nathan T. Jones, MD, FASA, Department of Anesthesiology Lahey Hospital and Medical Center**

When news of a new viral infection started to spread the Lahey Anesthesiology Department was ready to respond. Under the leadership of Drs. Sana Ata, Paul Teague, Michael Kaufman, and Kevin Crotty intubating protocols were developed and airway carts were created to safely care for some of the sickest patients many of us had seen. We did not know everything, but we were constantly learning. As the scope of the pandemic started to become clear our services



From left to right: Maitriyi Shah, MD and colleague



Ami Karkar, MD

were moved from the operating rooms to the ICUs. Invasive line teams and intubating teams were staffed around the clock. As a result, we experienced mortality rates lower than what was being reported out of Italy. We were fortunate to have just purchased new ventilators prior to the pandemic so had twice as many ventilators available to care for these patients. Maintaining adequate quantities of PPE was a challenge so Dr. Carl Borromeo researched UV light sterilization and was able to create a sterilizer out of an old file cabinet. Through it all, the ingenuity of our department was utilized to creatively care for these patients. We could not have done it without our CRNAs and nursing colleagues who were willing to go to unfamiliar environments and continue providing high-quality care. This was an uncertain and scary time. I was hearing stories of doctors and nurses dying across the globe and was convinced it could happen to me. The communication and assurances that we got from leadership that they were doing everything possible to protect us gave me comfort as I spent my nights intubating patients. Now we look forward to a post-Covid recovery where adequate PPE is available, safe, and effective vaccines are preventing people from dying. We can learn from this challenging period, and go forward caring for our surgical patients like we were trained to do.

### **Jamel Ortoleva, MD, Cardiothoracic Anesthesiologist, and Intensivist, ECMO Team Member Tufts Medical Center**

The coronavirus infectious disease 2019 (COVID-19) pandemic has upended almost every aspect of life in the world, and the medical profession is of course no exception to this. The most feared manifestation of COVID-19 is severe damage to the lungs to the point of inability to transmit oxygen to the bloodstream. When this happens, even an endotracheal tube and mechanical ventilator are not enough

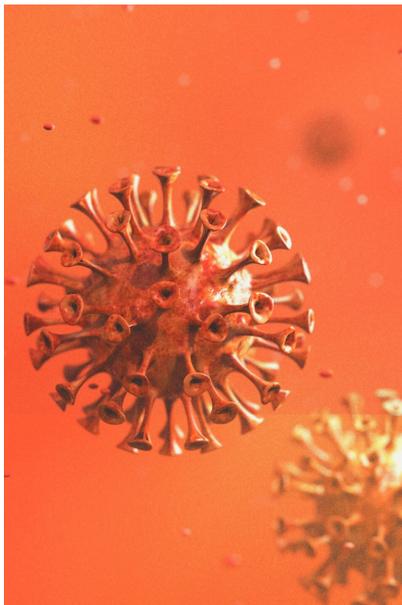
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## Featured Article

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to give patients a chance to survive this illness. In the small portion of patients that enter this phase of illness, a highly advanced technology that allows direct administration of oxygen to the blood, along with the removal of carbon dioxide, may help preserve life while the lungs heal, or in the worst of cases, potentially allow for lung transplantation. This technology is known as Extracorporeal Membrane Oxygenation (ECMO) support. These patients are among the sickest patients in any hospital and for the best chance to survive, a highly trained and motivated team with a special skill set must take over their care. Every patient supported by ECMO for COVID-19 has unique challenges and considerations. Unfortunately, even with this technology, patients sick enough to require ECMO have a very high risk of not surviving- over 40% in the medical literature.

At Tufts Medical Center, we routinely care for COVID-19 patients supported by ECMO with a multi-disciplinary team that includes intensive care physicians, ECMO specialists, interventional cardiologists, pulmonologists, physician assistants, nurses, respiratory therapists, physical therapists, and surgeons. There are several key phases to the care of COVID-19 patients supported by ECMO including deploying the ECMO support (“Cannulation”) which at Tufts is performed by intensive care physicians or interventional cardiologists, the management of the patients while on ECMO (performed by intensivists), the decannulation process (usually performed by intensivists and occasionally performed by vascular surgeons), and the rehabilitation process after ECMO. As a Cardiothoracic Anesthesiologist and Intensivist, I have had the honor of being directly involved in all aspects of ECMO care from cannulation to management to decannulation. I have never been



part of a more challenging or rewarding endeavor in my career as a physician, and I am proud of the outstanding outcomes that our multi-disciplinary team at Tufts has achieved with these patients. Every day I am inspired and humbled by the dedicated, outstanding care delivered by nurses, physician assistants, respiratory therapists, ECMO specialists, and physical therapists, without whom it would not be possible to care for these patients. Our efforts have allowed new mothers that would never have survived to meet their babies, families to reunite with their loved ones, and the incredible stories we are a part of have given us hope as we meet the challenges of the ongoing COVID-19 pandemic.

Anesthesiologists are by nature collaborative and accustomed to working in a team: thus, the team approach necessary for the care of ECMO patients is a natural environment for us. As Anesthesiologists, our advanced understanding of pharmacokinetics, airway and ventilator management, and the interplay of the cardiopulmonary interaction makes us uniquely positioned to play a vital role in the care of COVID-19 patients in need of ECMO. As the pandemic

evolves and hopefully eventually subsides, we must utilize the skill set we have acquired and honed from caring for COVID-19 patients as a tool to combat emerging diseases and optimize the management of existing ones.

**Dr. Robert Canelli, M.D., Clinical Associate Professor of Anesthesiology, Boston University School of Medicine Director, Anesthesia Critical Care, Boston Medical Center**

**Dr. Patricia Haddad, M.D., Resident Physician, CA-2, Department of Anesthesiology Boston Medical Center**

The Covid-19 pandemic has challenged health care systems in ways that seemed unimaginable two short years ago. From inadequate personal protective equipment to the anxiety of contracting and transmitting a life-threatening illness to others, we have been pushed to our limits. Since the start of the Covid-19 pandemic, Boston Medical Center has undergone transformational changes in our approach to prepare and react to the challenges brought on by an ever-evolving viral illness.

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Monica Shook, MD

## Featured Article

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When we confronted the initial Covid-19 wave in 2020, our resources were limited, and the number of unknown factors was overwhelming. As the operating rooms idled, the Department of Anesthesiology at Boston Medical Center began to assign its attendings, residents, and nurse anesthetists to new roles and responsibilities. From the formation of “airway management teams” to dedicated staff for emergent surgical procedures and intensive care teams, the Department adapted and expanded its knowledge with remarkable flexibility and ingenuity. When uncertainty was rampant, our colleagues gallantly rose to the occasion to carry out any role asked of them.

Whether it was obtaining intravenous access in the emergency department, managing anesthesia ventilators in the ICU, or supporting colleagues on the wards, we did it without hesitation. Our professional and mental limits were tested as we worked tirelessly in uncomfortable PPE and witnessed much suffering every day. Though our resilience fills us with pride and a sense of community, some memories remain painful. It is difficult to forget the expressions of patients gasping for air as one prepares to place an endotracheal tube that may only be removed after a patient’s death. The grief expressed by family members over a video call because they were not allowed into the hospital has left an indelible mark in our memories. Indeed, it has been difficult to think about how many people died alone.



Robert J. Canelli, MD

Covid-19 highlighted weaknesses in our health care system and gave us the opportunity to improve. We are now better prepared and trained for the next disaster. We understand where our surge spaces are and how to staff them. We know how to use anesthesia workstations as ICU ventilators, appreciating the major and subtle differences between the two. We have become experts in disease transmission prevention by accurately identifying appropriate levels of precautions, refining our donning and doffing skills, and mastering our checklists and buddy systems. In March of 2020, we were uncertain if our PPE would protect us against SARS-CoV-2. However, only three months later, our intubation and tracheostomy teams reported with great relief zero cases of Covid transmission after 231 intubations and 22 tracheostomies. Particularly important, we reaffirmed the importance of being compassionate and understanding with each other in the wake of so much suffering.

These two years have passed quickly, but the ways in which our health care system currently operates feel vastly different. We are forever changed in the ways we think, feel, and react to public health emergencies. It has become clear how important our flexibility and camaraderie has been to make it through this. Ultimately, the most important factor keeping us grounded and persevering has been hope: the conviction that we will overcome these challenges, the belief we will better care for patients, and that life will soon return to “normal.”

### Timothy Abbott, MD, Vice Chief of Anesthesiology Pioneer Valley Anesthesia

At our hospital, the operating rooms decreased the volume of elective cases starting mid-March 2020, with a transition to performing urgent/emergent cases solely the last week in March. The hospital worked with the group to fit us into functioning roles once the operating room volume became depleted. Half of our department worked to help take care of critically ill patients in the ICU and in overflow areas located throughout the hospital. The endoscopy unit served as an overflow area for example. The other half of our department covered the operating room for urgent and emergent cases and served as an intubation/line team for patients in the hospital. Anytime a patient needed to be intubated, that was suspected to have Covid, we would be paged to intubate and at the same time place a central or arterial line if deemed appropriate. PAPRs were a scarce commodity so I worked with our central sterile department to ensure that everyone in our department returned the PAPRs once used so the units could be sterilized and then put back into circulation quickly.

Manpower never became an issue because everyone in the group, doctors, and CRNAs, worked during vacations and long hours to ensure all shifts were covered. Communication streams were rapid in the age of texting and emailing and we were able to discuss ethical and work considerations expeditiously. Environmental services disinfected all areas in our call rooms daily, and each member of the department has disinfecting wipes available to try to limit the spread of the virus in high traffic areas. Shortages of supplies were an issue. Circuit filters were in short supply. At that time, we were not sure if patients who were infected but asymptomatic would leave the virus behind in the anesthesia machine, infecting any patient who would use the machine subsequently.

In January of 2021, we also had a decrease in operating room cases being performed, however, our coverage of the ICU and intubations was not as extensive as it had been in 2020. Morale in our department was high, even under the stress of not knowing how lethal and transmissible the virus was and if we could infect ourselves and our family members. The hospital also offered staff the opportunity to stay at a local hotel after a shift.

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**Featured Article**

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**Thomas J. Lambert III, MD,  
CA2, Department of Anesthesiology  
Baystate Medical Center**

***The Challenges of Residency During  
COVID-19***

Originally identified in the Wuhan region of China during the winter of 2019, SARS-Coronavirus Variant 19 quickly expanded into a global pandemic which continues to plague local, national, and international healthcare institutions. While new variants continue to develop and infection rates fluctuate monthly, the healthcare industry has remained in a state of turmoil for almost 2 years. Unfortunately, medical residents are among the most profoundly affected groups.

The first residency program was developed by William Osler and William Stewart Halstead at Johns Hopkins in the late 19th century and has since evolved into years of highly specialized postgraduate clinical training. Residency has historically been a time to further hone critical thinking and analytical skills learned in medical school. It is through the application of theoretical knowledge that ensures post graduate physicians develop into competent consultants. This is especially true for the field of anesthesiology. Our specialty frequently encounters emergencies which rely on near instantaneous decisions that will determine if a patient survives. The ability to make life saving decisions correctly and repeatedly can only be gained through tutelage and experience as residents.

The most obvious effect of COVID on anesthesia residents has been the widespread reduction of elective surgeries. With fewer cases, there is less opportunity to treat a variety of pathologies. Such reductions can lead to potential gaps in clinical knowledge that cannot be developed solely by studying. Additionally, with fewer cases for residents, the



*Timothy Abbott, DO*

***"The ability to make life saving decisions correctly and repeatedly can only be gained through tutelage and experience as residents."***

development junior residents' operating room awareness is pushed further into one's training. Perhaps the greatest trait of the skilled anesthesiologist is the ability to anticipate problems before they arise. Unfortunately, this requires daily training over thousands of hours that can only be gained in the OR. The COVID pandemic has also presented unexpected educational opportunities for residents. This is especially true in the critical care field. With the devastating pulmonary effects of coronavirus, residents have gained ample experience managing complex respiratory pathologies. Often such management involves ventilated patients who present their own unique challenges. Residents have been required to continually push their clinical skills while keeping up to date on current COVID treatment protocols.

Though the past 2 years have presented considerable challenges, these challenges have allowed for residents to display the resiliency and adaptability required to provide a lifetime of patient centered care. Such skills will assuredly serve us well as attending physicians. I am incredibly proud of all we have accomplished and look forward to residents continuing to personify healthcare excellence.

**MSA ANNUAL MEETING**

*SPECIAL EVENT GUEST SPEAKER*



**Randall M. Clark**

PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS



**THURSDAY, MAY 19**

*THE WESTIN WALTHAM BOSTON*

*6:00-9:00 PM*



## Committee on Resident & Fellow Affairs (CORFA)

Danielle Levin, MD

*CORFA Co-Chair; CA2 at St. Elizabeth's Medical Center*

Hello from MSA Committee on Resident and Fellow Affairs (CORFA)! We are an elected group of resident representatives of the anesthesiology state training programs. We work on behalf of all Massachusetts residents and fellows regarding state and national issues affecting future anesthesiologists. As advocates, we stay active at both the state and national levels and have representatives present at MSA Executive Board Meetings and ASA meetings. Our goal is to also ensure that medical students throughout Massachusetts get exposure to our specialty early on in their careers.

Every year, we select resident delegates to attend the ASA Annual Meeting, with attendance at all House of Delegates meetings and regional caucuses throughout the week. Through this initiative, we help anesthesiology residents network with one another and be more informed on important issues affecting our specialty, both current and future.

Some of our upcoming events include the "Annual ITE Pizza Party." In the past, when CORFA would organize a pizza party after the In-Training Exam, residents throughout the state would gather together to unwind and network. Last year and this year, there will be multiple "Annual ITE Pizza Parties" at each individual residency program to limit the spread of COVID-19. Hopefully, in the future, we will be able to return to bigger gatherings.

Although gathering in-person has been challenging lately, to ensure anesthesiology residents throughout the state are still able to network, CORFA is working on creating an "Anesthesia Resident Network Library." Through this library, we will have one location for the contacts of all the current anesthesiology residents. This way, residents will be able to virtually be in touch with one another throughout residency and continue to have access to their state peers as they graduate and become attending anesthesiologists.

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*Our goal is to also ensure that medical students throughout Massachusetts get exposure to our specialty early on in their careers.*

CORFA has also reached out to all medical schools in the state. We will be working with the Massachusetts Anesthesiology Interest Groups to create Q&A sessions and Trivia sessions where medical students can have their questions answered about our specialty in a relaxed atmosphere. Once the COVID-19 pandemic starts to slow down, we will be having a "Massachusetts CORFA Bowling Event" where medical students, residents, and fellows will be able to further network.

We are excited about our upcoming CORFA events and welcome all medical students, residents, and fellows to reach out to us any time at [massachusettscorfa@gmail.com](mailto:massachusettscorfa@gmail.com).

### FOLLOW US

#### Connect with CORFA!

We invite you to follow CORFA to make connections with your fellow residents in Massachusetts and stay informed of upcoming regional/ national meetings, sponsorship opportunities, advocacy events, resident social events, and much more!



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# MSA ANNUAL MEETING

## Come Join Us!

Discover ways that the ASA and MSA work together to create a better future. Get involved. Connect, learn and share experiences with your fellow colleagues.

Date **May 19th, 2022**

Time **6:00 - 9:00 PM**

Venue **The Westin  
Waltham Boston**

### Guest Speaker



**Randall M. Clark,  
M.D., FASA**  
President, ASA

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