

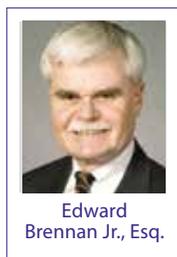


ANESTHESIA RECORD

NEWSLETTER OF THE MASSACHUSETTS SOCIETY OF ANESTHESIOLOGISTS

Volume 44 • 2017 Year In Review

Report of Counsel



Edward Brennan Jr., Esq.

Because this is an election year, the formal session of the Legislature ends July 31, 2018,¹ and our battle to protect patient safety in Massachusetts by opposing efforts of nurse anes-

thetists to practice independently without any physician involvement continues. The next four months will be critical to our advocacy to stop this dangerous legislation.

Nurse Anesthetist Independent Practice

A push for independent practice for nurse anesthetists has come from a number of sources. The Massachusetts Association of Nurse Anesthetists (MANA) filed H.2452 and S.658 which eliminates all physician oversight of nurse anesthetists from the statute, allowing nurses to practice independently. Those bills are before the Legislature's Joint Committee on Health Care Financing, which held a hearing in September in which the MSA testified in strong opposition.

In July, Governor Baker filed legislation aimed at containing health care costs. Under the mistaken notion that expanding scope of practice of so-called "low cost" providers would save money, he proposed independent practice for all advanced practice nurses (APNs), including nurse anesthetists, after 2 years of supervision by a physician or

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FEATURED HOSPITAL

Cambridge Health Alliance and Anaesthesia Associates of Massachusetts

A Partnership of Quality, Efficiency, Education, and Community Engagement

By Omar Gafur, MD

The Hospital

Cambridge Health Alliance (CHA) provides clinical services to over 140,000 patients in Cambridge, Somerville, and Boston's Metro North region. In 1915, the City of Cambridge founded Cambridge City Hospital with the intent to serve and provide medical treatment to indigent Cambridge residents, and soon after the hospital became the "safety net" hospital of the community. CHA formed in 1996 when Cambridge Hospital and Somerville Hospital joined together as an integrated system. The last phase of expansion took place in 2001, when

CHA acquired Whidden Hospital in Everett and its associated health care services in Malden and Revere. Today, CHA is composed of three main

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Bottom two from left to right: Kara Gulezian, SRNA; Feebie Mana, CRNA

Top from left to right: David Joswick, MD; J. Joseph Mackey, MD, Nancy Waywood, CRNA; Annie Woon, MD

MSA COMMITTEES AND APPOINTMENTS 2017–2018

(as of December 2017)

OFFICERS, DIRECTORS, DELEGATES, AND COMMITTEES

Richard D. Urman, MD, MBA, President
Nikhil M. Thakkar, MD, President-Elect
Nicholas Kiefer, MD, Vice President
Maitriyi Shah, MD, Secretary
Daniel O'Brien, MD, Treasurer
Mary Ann Vann, MD, Immediate Past President
David L. Hepner, MD, ASA Director
Selina Long, MD, ASA Alternate Director

DELEGATES: ASA HOUSE OF DELEGATES

Selina Long, MD
Spiro Spanakis, MD
Mary Ann Vann, MD
Sheila Barnett, MD
Fred E. Shapiro, DO
Richard D. Urman, MD
Nicholas Kiefer, MD
Nikhil M. Thakkar, MD
Lee Perrin, MD
Maitriyi Shah, MD

ALTERNATE DELEGATES

Ruben Azocar, MD
Galina Davidyuk, MD
David Feinstein, MD
Nathan Jones, MD
Riki Kveraga, MD
Kay Leissner, MD
M. Richard Pavao, MD
Roman Schumann, MD
Sulpicio Soriano, MD
Lalitha Sundararaman, MD

DISTRICT REPRESENTATIVES AND ALTERNATE REPRESENTATIVES

District 1 Michael Bailin, MD; Timothy C. Abbott, MD
District 2 Spiro Spanakis, MD; Vacant
District 3 Leah Dusett, MD; Vacant
District 4 Jennifer Dearden, MD; Lalitha Sundararaman, MD
District 5 Nathan Jones, MD; Vacant
District 6 Donald Ganim, MD; Vacant
District 7 Satrajit Bose, MD; Cristin McMurray, MD
District 8 Amer Tabba, MD; Vacant
District 9 Vacant

EXECUTIVE COMMITTEE

Richard D. Urman, MD, MBA (Chair); Timothy Abbott, MD; Ruben Azocar, MD; Michael Bailin, MD; Sheila Barnett, MD; Satrajit Bose, MD; Jeffrey Brand, MD; Galina Davidyuk, MD; Jennifer Dearden, MD; Leah Dusett, MD; David Feinstein, MD; Donald Ganim, MD; James Gessner, MD; Alex Hannenberg, MD; David Hepner, MD; Nathan Jones, MD; Nicholas Kiefer, MD; Riki Kveraga, MD; Kay Leissner, MD; Selina Long, MD; Cristin McMurray, MD; Daniel O'Brien, MD; M. Richard Pavao, MD; Lee Perrin, MD; Beverly Philip, MD; Roman Schumann, MD; Maitriyi Shah, MD; Fred E. Shapiro, MD; Sulpicio Soriano, MD; Spiro Spanakis, MD; Lalitha Sundararaman, MD; Amer Tabba, MD; Nikhil M. Thakkar, MD; Mary Ann Vann, MD

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District 1 Bronwyn Cooper, MD; Michael Bailin, MD
District 2 Paul Darcy, MD
District 3 Albert Kalustian, MD; **Jeffrey Brand, MD (Chair)**
District 4 Lena Dohlman, MD; Robert Holzman, MD
District 5 Jeffrey Jackel, MD; Richard D. Urman, MD
District 6 Vacant
District 7 Fadi Farah, MD; Heidi Kummer, MD
District 8 Vacant
District 9 Vacant
Nikhil M. Thakkar, MD; Alan Lisbon, MD; Marguerite Ricciardone, MD; Emily Singer, MD; Robert A. Peterfreund, MD

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COMMITTEE ON NOMINATIONS

Spiro Spanakis, MD (Chair); Sheila Barnett, MD; Mary Ann Vann, MD

COMMITTEE ON PUBLICATIONS

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Website Subcommittee (one-year term): David Feinstein, MD; Chris Quartararo, MD

COMMITTEE ON PUBLIC EDUCATION

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COMMITTEE ON PROGRAMS (CME)

Richard D. Urman, MD (Chair); Sal Basta, MD; Manisha Desai, MD; Lena Dohlman, MD; Lee S. Perrin, MD; Kay Leissner, MD; Sohail Mahboobi, MD; Fred E. Shapiro, MD; Shubjeet Kaur, MD; Roman Schumann, MD; Spiro Spanakis, MD

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REPRESENTATIVE TO THE INTERSPECIALTY COMMITTEE OF THE MMS

Mary Ann Vann, MD (Representative); Fred E. Shapiro, DO (Alt. Representative)

SPECIALTY DELEGATE TO THE HOUSE OF DELEGATES OF THE MMS

Fred E. Shapiro, DO

Report of Counsel

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independent nurse. The MSA testified at a hearing on the governor's bill; pointing out the *fact* that there would be no cost savings because payment for anesthesia services is the same for Medicare, Medicaid, and commercial insurers whether provided by an anesthesiologist, the anesthesia care team or a nurse anesthetist billing independently, but there would be a cost to quality and safety.

In early November, the state Senate took up and passed an omnibus health care reform bill, S.2211, which included expanding scope of practice for all APNs, including nurse anesthetists. The provision is similar to the governor's bill. The MANA-sponsored bills (H.2452 and S.658) are still before the Health Care Financing Committee, which must report bills before it by April 25. In the meantime, the House is developing its own health care reform bill that likely will be taken up at the end of April or early May.

The MSA is working closely with the ASA in a grassroots campaign to defeat nurse anesthetists' independent practice as part of any legislation taken up this session. It is critical that all MSA members step up to the plate and engage with your legislators and advocate for the team approach to anesthesia, patient safety, and opposition to nurse independent practice. Ensuring that anesthesia continues to be provided safely with physician oversight for the protection of patients is dependent upon you to step up and reach out to your legislators.

For your information, attached to this report is the MSA Fact Sheet in opposition to nurse anesthetist independent practice legislation.

Out-of-Network Billing

Out-of-network (OON) surprise billing, in which a patient may receive a bill for medical services provided at an in-network hospital by an out-of-network physician; such as, emergency department, radiology, anesthesia, pathology (ERAPs), has become a major issue this

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Report of Counsel

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year just as it has in other states. Earlier this legislative session, insurers filed legislation to ban out-of-network billing of a patient for emergency treatment and force OON physicians to accept payment at the Medicare rate level. The MSA opposed the bills and noted the devastating impact on anesthesia if Medicare is used as a benchmark for OON services (Medicare payments are 80% of the average commercial payment rates for most medical services. For anesthesia services, which is on a different type of payment system, the Medicare payments are 33% of the average commercial insurance payment rates).

The MSA supports legislation developed by the Massachusetts Medical Society (MMS) that addresses the OON surprise billing issue by calling for greater transparency, so that patients and referring physicians have up-to-date information as to whether hospital-based physicians (ERAPs) are in the patient's network or not, and the patient can make an informed decision as to whether to have treatment at that

hospital or not. In the case of emergency services where the patient cannot choose an in-network provider, a reasonable rate would be determined for the OON provider based on an independently recognized data base such as FairHealth, similar to the New York and Connecticut laws, that place OON payments at the 80th percentile of all charges for the particular service provided in the same geographical area. The proposals take the patient out of the middle for surprise OON billing and bans balance billing, other than applicable co-pays and deductibles.

The Senate passed health care reform bill passed in November took up the OON issue by directing the insurance commissioner, upon recommendation of the Health Policy Commission and after a hearing, to set rates for out-of-network emergency services at a level *not to exceed* the 80th percentile of a recognized independent data base, such as FairHealth (a percentile of all charges for a particular service provided in the same geographic locale). Unlike the NY and CT laws, and the MMS's proposed bill, that sets the rate

at the 80th percentile, it is unknown what percentile the insurance commissioner would use. This process would be in effect until 2020. Thereafter, the commissioner would set the rate for five-year periods of time based on recommendations of the Health Policy Commission and after a public hearing. Balance billing of a patient would be prohibited. With the exception of Medicaid and Workers' Compensation, this would be the first instance of the state setting rates of payments for physician services in the commercial insurance market.

MassHealth

Effective March 1, 2018, MassHealth rates for anesthesia services have increased 5.5%. The anesthesia base unit rate has increased from \$18.86 to \$19.90 per unit, and time units increased from \$1.26 to \$1.33 per one-minute time unit.

1. *The Legislature will continue to meet in "informal" sessions until the end of the year, but only bills that receive unanimous consent can pass. Any member can object to taking up a bill. Thus, controversial bills must be taken up prior to the July 31 end of the formal session.*

MSA PAST PRESIDENTS

2016–2017	Mary Ann Vann, MD	1992–1993	Gerald L. Zeitlin, MD	1968–1969	Robert D. Ouellette, MD
2015–2016	Sheila R. Barnett, MD	1991–1992	Stephen V. Hall, MD	1967–1968	Donald L. Mahler, MD*
2014–2015	Spiro Spanakis, DO	1990–1991	Fred G. Davis, MD	1966–1967	Henrick H. Bendixen, MD
2013–2014	Michael R. England, MD	1989–1990	Leonard S. Bushnell, MD*	1965–1966	Robert N. Reynolds, MD
2012–2013	Selina A. Long, MD	1988–1989	Marcelle Willock, MD	1964–1965	Joseph G. Murphy, MD
2011–2012	Ruben J. Azocar, MD	1987–1988	D. Sean Restall, MD*	1963–1964	Leroy D. Vandam, MD*
2010–2011	Fred E. Shapiro, DO	1986–1987	Joseph R. Beauregard, MD	1962–1963	Peter G. Lehndorff, MD*
2009–2010	David L. Hepner, MD	1985–1986	Dorothy M. Crawford, MD	1961–1962	Carroll Bryant, MD
2008–2009	Beverly K. Philip, MD	1984–1985	John V. Donlon, MD	1960–1961	Francis J. Audin, MD*
2007–2008	Donald G. Ganim II, MD	1983–1984	Kenneth W. Travis, MD	1959–1960	Phillip S. Marcus, MD*
2006–2007	Mark D. Hershey, MD	1982–1983	Bebe K. Wunderlich, MD	1958–1959	James H. Buskirk, MD*
2005–2006	Glynn D. Stanley, MB	1981–1982	Raymond J. Anton, MD	1957–1958	Benjamin Etsten, MD*
2004–2005	Stephen O. Heard, MD	1980–1981	Lawrence A. Simons, MD	1956–1957	John Bunker, MD*
2003–2004	Rosemarie Maddi, MD*	1979–1980	Herbert L. Everett, MD*	1955–1956	Robert M. Smith, MD*
2002–2003	Prasad R. Kilaru, MD	1978–1979	George E. Battit, MD	1954–1955	Dexter R. Branch, MD*
2001–2002	Michael H. Entrup, MD	1977–1978	Richard A. Kemp, MD	1953–1954	Julia G. Arrowood, MD*
2000–2001	Alan M. Harvey, MD	1976–1977	Joseph L. Murphy, MD*	1952–1953	Leo V. Hand, MD*
1999–2000	Daniel F. Dedrick, MD	1975–1976	Franco R. Dinale, MD*	1951–1952	William J. Martin, MD*
1998–1999	Bernard H. Hand, MD*	1974–1975	Russell J. Rowell, MD	1950–1951	Morris J. Nicholson, MD*
1997–1998	Jeffrey B. Brand, MD	1973–1974	John Hedley-Whyte, MD	1949–1950	Jacob H. Fine, MD*
1996–1997	Robert H. Bode Jr., MD	1972–1973	C. Thomas O'Connell, MD	1948–1949	Urban H. Eversole, MD*
1995–1996	Alexander Hannenberg, MD	1971–1972	Frederick McAlpine, MD		
1994–1995	James S. Gessner, MD	1970–1971	Jess B. Weiss, MD*		
1993–1994	Lee S. Perrin, MD	1969–1970	Donald P. Todd, MD*		

*Deceased

Featured Hospital

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hospitals: CHA Cambridge Hospital, CHA Somerville Hospital, and CHA Everett Hospital. Additionally, CHA has 15 primary care practices located in Cambridge, Malden, Somerville, Revere, and Everett.

The combination of three hospitals and multiple primary care practices allows CHA to meet the needs of its patients, serve as a safety net hospital, and fulfill its health mission “to improve the health of our communities.” CHA is an inclusive provider with a commitment to diverse and vulnerable patients who have publicly subsidized insurance and have many barriers to care. CHA helps to decrease cultural and linguistic barriers by recruiting bilingual providers and with a robust interpreter program. Its Volunteer Health Advisor Program brings together local residents from many cultures to engage in helping the community.

CHA trains the health care providers of tomorrow through its affiliation with Harvard Medical School, Beth Israel Deaconess Medical Center, Massachusetts General Hospital for Children, Harvard School of Public Health, Harvard School of Dental Medicine, and Tufts University School of Medicine. It has residency training programs in internal medicine, adult and child psychiatry, psychology, and family medicine. CHA sponsors undergraduate, graduate, and continuing medical education efforts including the Harvard-Cambridge Integrated Clerkship. It also serves as a clinical rotation site for the Boston College Nurse Anesthesia Training Program and paramedic students from ProEMS.

CHA also operates the Cambridge Public Health Department, CHA Physicians Organization, and CHA Foundation. Through its work with the Public Health Department, it addresses other health issues including breast health, tobacco use, obesity, childhood mental health, and depression.

The Anesthesia Department

The Department of Anesthesia is administered by Anesthesia Associates of Massachusetts (AAM). AAM is the



The CHA Cambridge Hospital

Photo Courtesy of Cambridge Health Alliance

largest anesthesia provider in New England with approximately with 225 clinical employees including over 90 physicians and 110 CRNAs. AAM provides clinical service to over 20 locations in eastern Massachusetts. It also administers the Boston University Residency Program, the MEDSIM simulation center, and the Boston College Nurse Anesthetist Program. Dr. Ellison Pierce, the founder of AAM, is also a past president of the American Society of Anesthesiologists and a cofounder of the Anesthesia Patient Safety Foundation. His core values of patient safety and high-quality care guide AAM physicians every day. As the company has grown, it has also become a regional leader in operating room efficiency and practice management. Expanding on this foundation of safety, quality, and efficiency, AAM's stated mission is to be the anesthesia provider that every patient expects, every physician favors, and every client facility prefers.

For the past three years at CHA, AAM has instilled its culture into the Cambridge Hospital Anesthesia department under the leadership of J. Joseph Mackey, MD. The department is diverse of thought and culture, and it functions to provide excellent clinical care, provide value for CHA by improving operating room efficiency, and educate future anesthesia and medical providers. The Anesthesia Department at

Cambridge Hospital consists of 26 physicians, 24 CRNAs, two anesthesia technicians, and one administrative assistant. Leadership of the department includes Dr. Joe Mackey as chief, Dr. Annie Woon as vice-chief, Dr. Lindsey Moore as OB anesthesia director, and Dr. John Wadlington as anesthesia director of CHA Everett Hospital. All anesthesiologists at AAM are required to be diplomats of American Board of Anesthesiology and many are further certified in other areas of perioperative medicine including cardiac, regional, neuro, OB, pain, and critical care.

At CHA Cambridge Hospital, the department runs six operating rooms dedicated to thoracic surgery, major and minor orthopedic surgery, major and minor general surgery, vascular, plastic surgery, urology, ENT, GI, podiatric, and gynecological surgeries. In addition, the department provides services for cardiology and inpatient endoscopy. CHA Cambridge Hospital has a dedicated Maternity Unity with two additional operating rooms for surgical care of the obstetric patient.

AAM provides anesthesia services for three operating rooms at CHA Everett Hospital including general surgery, minor orthopedic, urologic, podiatric, and ophthalmology. At CHA Somerville Hospital, the department delivers

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EDITOR'S WELCOME

"The secret of getting ahead is getting started." — *Mark Twain*

Nikhil M.
Thakkar, MD

As many as one in four people who receive prescription opioids long term for non-cancer pain in primary care settings struggle with addiction. According to

CDC data from 2000 to 2016, more than 600,000 people died from drug overdoses. On average, 115 Americans die every day from an opioid overdose.

This is the 44th year the MSA newsletter is being published and reaching out to our members to bring valuable information and insights to light. In this year's feature article, Dr. Sundaraman discusses management of neuropathic pain and the role of newer therapeutic modalities to treat it. Let's join as a team to take care of pain via model approach and help our community to reduce incidences of opioid addiction.

As usual, this past year was a very busy year for Massachusetts Society of Anesthesiologists in many ways. I would like to thank our administrator, Nathan Strunk, and our design team for putting this newsletter together and for maintaining our informative website, which provides communication in a convenient manner. Keeping you informed on the state and national level in the world of anesthesia is our primary goal.

We would like to welcome Dr. Richard M. Urman as our new president as well

as the new executive committee and officers. Dr. Urman shares his vision of leading this new team for the upcoming year in his message. We will also get an opportunity to learn about our president-elect (2018–2019), Dr. Nikhil M. Thakkar. We would like to thank our past president, Mary Ann Vann, for her excellent contributions. Dr. Vann describes her term in her report.

The MSA continues to work hard for the Massachusetts anesthesia community at multiple levels. The MSA along with the ASA has always been and continues to be at the forefront of dealing with the political aspects that affect our anesthesia community. Government affairs at the state and national level are very well documented in reports by Dr. Hepner, Dr. Long, and MSA legal councilman Ed Brennan. New MSA bylaw changes are reported by Dr. Perrin.

It was a pleasure to host Dr. James Grant, ASA president-elect, as a guest speaker during our MSA annual meeting in May 2017. He visited many institutions and shared his thoughts and vision for the future of the ASA with faculty and residents.

It has been a tradition to cast light on a hospital and an affiliated anesthesia group that provides care to our valuable patients in different areas of Massachusetts. I would like to thank Dr. Gafur for his efforts to bring Cambridge Health Alliance (our featured hospital)

and Anesthesia Associates of Massachusetts to the spotlight.

The MSA provides educational tools via CME courses, as mentioned in the report by the program committee. Take note of the courses and the dates offered for the upcoming events. The MSA also continues to enhance capabilities of resident anesthesiologists to prepare them to become strong future leaders in the field. MSA Committee on Resident and Fellows Affairs (CORFA) Co-Chairs Michael Schoor and Cranstons Gray explain it very well in their report.

I hope that this edition will highlight ample opportunities to inspire you to participate and get involved with activities at the MSA and ASA. We also would like your active participation and contribution to MSA PAC and ASA PAC. Finally, please mark your calendars so that you can participate in many upcoming events including CME courses, MSA annual meeting, ASA legislative conference, and our MSA executive committee meetings.

I hope you enjoy reading this edition of the *MSA Anesthesia Record*. A copy of our newsletter will also be on our website (www.mass-anesthesiologists.org). If you have any questions or comments or are interested in contributing an article, please contact Nathan Strunk at nstrunk@mms.org or me at nikhil.thakkar@baystatehealth.org.



President's Report



Richard D.
Urman, MD

The MSA has had a busy year so far with various administrative, educational, and advocacy initiatives. Most of all, I would like to encourage all of our members — whether you're an ac-

tive, resident, student, or retired member — to participate in MSA activities and support our mission. For example, there are many leadership positions available for our members — I encourage you to apply for one or more of the following opportunities as it is a great way to get involved to advance our specialty on both local and national levels: district representative, ASA delegate, MSA committee member, and MSA officer. We also have a very active Committee on Resident and Fellow Affairs (CORFA), and this is a great way to get an early introduction to what we do and how you can contribute, no matter how little time you have.

I want to thank Mary Ann Vann for her service as past president and for serving in her current role as chair of the Committee on Governmental Affairs.

Please see her report for legislative updates. Our Economics Committee, chaired by Dr. Peter Panzica, has been very active on several issues important to MSA members, and he has been particularly effective in working with the state's insurance companies and other organizations on addressing reimbursements for gastroenterology procedures.

The Committee on Bylaws is working on revising our current document, and Lee Perrin has been leading this effort. Physician Anesthesiologist week has been a great success, based on what I've heard from many institutions. I want to also thank Dr. Fred E. Shapiro for his work as chair of the Public Education Committee.

We are participating in the ASA/MSA joint dues renewal initiative pilot, and you will be receiving more information about it in the near future. Thanks to Secretary Dr. Maitiyi Shah for her efforts. Our organization remains on a sound financial footing, thanks to our members and the systems we have put in place to increase transparency and fiscal responsibility.

The MSA is also actively planning several educational opportunities for

our members. We have an upcoming course on Basic Ultrasound-Guided Regional Anesthesia and a Point-of-Care Ultrasound Workshop scheduled for May 19, as well as the third International Perioperative Medicine Symposium in Cartagena, Colombia, on March 22–24, and the ninth Annual Update in Sedation and Analgesia on December 1, as well as the New England Anesthesia Resident Conference. Please take advantage of these excellent courses and tell your colleagues about it!

Please check out our website for periodic updates and please give us feedback about what kind of information you would like to receive and/or be posted so that you're kept well informed. Please let Drs. Feinstein and Thakkar know if you have any ideas or feedback. Please note that our Annual MSA meeting is scheduled for Friday, May 18, at the Westin in Waltham. Dr. James Grant, MSA resident, will be our special guest. I hope to see you all there!

Again, it is truly an honor to serve as your president. Please let me know if you have any questions and/or interest in getting involved with the MSA. Thank you.

CME COURSE — ENHANCED RECOVERY AFTER SURGERY

The 2018 US-Guided Regional Anesthesia (USGRA) workshop on May 19, 2018, will use a new revised course curriculum, including the addition of some elements of point-of-care ultrasound (POCUS) relevant to all anesthesiologists practicing regional anesthesia.

The MSA has partnered with the UltraSound Airway Breathing Circulation Dolor (USABCD), a group of experts with an international reputation in the field of regional anesthesia and POCUS. Course participants will be provided access to a comprehensive

e-learning suite of teaching modules in USGRA and POCUS upon registration for the course.

Come join us! Register today at mass-anesthesiologists.org.



Massachusetts Society of
Anesthesiologists, Inc.

mass-anesthesiologists.org

MSA Basic US-Guided Regional Anesthesia and Point-of-Care Ultrasound Workshop Activity



Saturday, May 19, 2018

Waltham Woods Conference Center
Waltham, MA

Gustavo Angaramo, MD, Course Director
M. Richard Pavao, MD,
Associate Course Director

President-Elect Profile



Nikhil M. Thakkar, MD

Nikhil M. Thakkar, MD, became president-elect of the MSA in May 2017. He is also currently the president of the Hampden District Medical Society.

Nikhil is an assistant professor of Anesthesiology at UMMS-Baystate, Springfield, Massachusetts. He also serves as a faculty adjunct at Tufts University School of Medicine.

Nikhil completed his undergraduate and postgraduate medical education in Anesthesiology in India. In 1999 he relocated to Western Massachusetts, where he completed his residency in Anesthesiology and his fellowship in Critical Care at Baystate Medical Center. He joined the group immediately after his fellowship. During his tenure at Baystate, Nikhil has continuously

played a vital role and showed his leadership skills by contributing in various committees within the department of Anesthesiology and at Baystate Health. Some of these roles include but are not limited to Chief of PACU and Coach for the Culture of Safety program.

Nikhil has been a member of MSA since he arrived in Western Massachusetts. He has been an active member of the MSA executive committee since 2012 and has played different roles like District 1 representative, the Committee on Publications chair, alternate delegate, and now delegate to the ASA House of Delegates. Nikhil also contributes to ASAPAC on a regular basis.

Apart from his involvement at the MSA, Nikhil also is a member of the Hampden District Medical Society executive committee and serves as a delegate to the Massachusetts Medical Society House of Delegates.

Nikhil's interests include pediatric anesthesia, patient safety, quality control, and standardization of practices. These interests led him to get involved at the various ASA committees such as the committees on Pediatric Anesthesia, Occupational Health, Standards and Practice Parameters, and Patient Safety and Education.

Nikhil also volunteers in the local community as a volunteer physician for the Annual Health Fair, Open Pantry, and Akshaya Patra. He continuously serves as a committee member of the Gujarati Association of Western Massachusetts and Western Massachusetts Association of Physicians of Indian Origin. He has also served as vice president and then as president of the Gujarati Association of Western Massachusetts for multiple years.

Featured Hospital

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anesthetic care for the outpatient CHA Somerville Endoscopy Center.

Each of the three locations is staffed with anesthesia technicians, modern anesthetic machines, and equipment that provide the highest level and quality of care. Through its scope of practice, the anesthesia department has delivered over 10,000 anesthetics at CHA per year.

OPERATING EFFICIENCY

The anesthesia department has been instrumental in building perioperative initiatives to improve operating efficiency, improve patient experience, and deliver quality care. Using data driven metrics, CHA and AAM have improved multiple aspects of perioperative care: improved case throughput, increased surgical volume and on-time first starts, reduced turnover time, improved teamwork and patient satisfaction,

decreased anesthetic costs, and added new surgical procedures.

EDUCATIONAL EXPERIENCE

The anesthesia department provides educational experiences to Harvard Medical School students, Boston College student nurse anesthetists, and ProEMS paramedic students. HMS students rotate through the CHA anesthesia department for their first exposure to anesthesiology. The Boston College School of Nursing, with AAM, graduates up to 16 nurse anesthetists a year. Lastly, paramedic students rotating through the department gain hands-on learning on airway management.

COMMUNITY INVOLVEMENT

The CHA Department of Anesthesiology and AAM understands that our specialty not only requires delivery of quality care to patients but also participation in hospital activities, professional organizations and the society. CHA anesthesia physicians serve on numerous

hospital committees throughout the Boston area. Further, many physicians hold leadership positions in the Anesthesia Business Group, Massachusetts Society of Anesthesiologists, the Massachusetts Medical Society, American Society of Anesthesiologists, American Board of Anesthesiologist, and other philanthropic organizations.

Future

CHA and AAM/CHA Anesthesia Department create an effective partnership. The result has been an efficient and quality-driven anesthesia department delivering quality care, remaining a steward to the community CHA serves, and educators of future providers. Future goals of the department include delivering on new perioperative initiatives, decreasing anesthetic costs, and helping CHA Perioperative Services maximize efficiency, safety, and quality potentials.

FEATURE ARTICLE

Newer Therapeutic Modalities in the Treatment of Chronic Neuropathic Pain

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Introduction

Chronic pain is a significant public health-related problem that negatively impacts quality of life among millions of individuals.¹ It is estimated that one out of every three individuals will experience chronic pain at some point in their lifetime.² An estimated 1.5–8% of patients suffer from severe neuropathic pain in the United States; estimates of the total annual costs for chronic pain (including treatment, lost work days, disability payments, and legal fees) range from \$550 to \$625 million per year. Hence chronic pain and, in particular, neuropathic pain pose a considerable burden to both personal quality of life and the national economy. Treatment of neuropathic pain is undergoing considerable advances with many new medications in the horizon in various stages of clinical trials. In this review, we shall consider some of the newer medications available and to be available in the market for the treatment of neuropathic pain.

What Is Neuropathic Pain?

Neuropathic pain is **pain** caused by damage or disease affecting the somatosensory nervous system. It is characterized by the following:³

- Allodynia: Painful perception of non-noxious stimulus
- Hyperesthesia: Increased perceived intensity of painful stimulus
- Hypoesthesia or anesthesia: Decreased or absent sensation over a particular area
- Dysesthesia: Abnormal sensation over a particular area like tingling, etc.

Some common clinical conditions presenting with neuropathic pain are the table above.

Clinical Conditions Producing Neuropathic Pain		
Stroke	Diabetes	Chemotherapy
Spinal cord injury	Herpes zoster	Mechanical irritation
Peripheral nerve injury	CRPS	Nutritional deficiencies (e.g., B12)
Nerve root compression	Surgery	Trauma
Epidural fibrosis	Multiple sclerosis	Amputation
Arachnoiditis	HIV	Trigeminal neuralgia

Brief Overview of New Neuropathic Pain Medications

The field of neuropathic pain medications has grown by leaps and bounds with many new medications on the horizon. Unfortunately, many of the medications, though having shown promise in in-vitro trials, have failed in clinical trials. Some of the ones that still hold promise are these:

Prostatic Acid Phosphatase

Prostatic acid phosphatase (PAP) is an ecto-nucleotidase that dephosphorylates extracellular AMP to adenosine, which then has endogenous antinociceptive properties. PAP is a classic histochemical marker of small-diameter dorsal root ganglia neurons. PAP knockout mice were proven to have increased hyperalgesia and allodynia in response to nociceptive stimuli. In another study, when injected intrathecally, PAP can cause analgesia lasting much longer than morphine — as long as three days.⁴

Spinal adenosine decreases hypersensitivity and central sensitization of pain. However, PAP injection causes spinal analgesia even when adenosine no longer is detected intrathecally. Hence PAP is thought to be very promising in the treatment of neuropathic pain. However, further clinical trials are still awaited.⁵

T-Type Calcium Channel Antagonists

T-type Ca calcium channels are found on peripheral and central endings of primary afferent neurons involved in nociception. Preclinical studies with ABT-639 (a peripherally acting, highly

selective T-type Ca v 3.2 calcium channel blocker) showed dose-dependent reduction of pain in multiple pain models, including arthritic, neuropathic, and capsaicin-induced pain. Antagonism was also devoid of sedation and hence preferred. However, clinical studies in diabetic patients with neuropathic pain were not successful. A phase 1 study using a healthy volunteer pain model and comparison with pregabalin was also negative. Hence clinical efficacy remains under question.

N-Type Calcium Channel Blockers

N-type calcium channels are voltage-gated calcium channels composed of alpha-1B subunits. They are most commonly linked to therapeutic treatment of chronic pain. Studies have shown that the intrathecal injection of calcium channel inhibitors such as Ziconotide, to block the N-type calcium channels, have produced alleviation of intractable neuropathic pain. It is one of the few drugs approved by the FDA for intrathecal pump usage. Of note, other commonly used drugs such as pregabalin and gabapentin may also have some N-type calcium channel antagonistic activity.

Angiotensin II Type 2 Receptor Antagonists

Angiotensin II type 2 receptors (AT2R) are present in the lumbar dorsal root ganglia (DRG). These undergo increased expression in the face of sustained nociceptive stimulation. Khan et al. proved that there is increased expression of angiotensin II in the

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presence of nociceptive stimuli in rats. Rice et al. further established the pathogenesis pathway of angiotensin mediated pain and the mechanism of action of AT2R antagonists in a phase 2 study. He administered a twice-daily oral administration of EMA401, a peripherally restricted AT2 receptor antagonist, and demonstrated significant analgesia in a randomized, double-blind, placebo-controlled clinical trial involving 183 patients with postherpetic neuralgia. Further trials are awaiting.⁶

Selective Sodium Channel Blockers

Sodium channel blockers such as lidocaine, mexiletine, carbamazepine, and its derivatives such as oxcarbazepine have been proven to be effective in the treatment of neuropathic pain. However, their use is greatly limited by side effects such as cardiac and central nervous system effects including arrhythmias, dizziness, and even seizures. Priest et al. found that nociceptive neurons express several Nav 1 channel subtypes that may contribute to the hyperexcitability characteristic of chronic pain states.⁷ In his review of selective sodium channel receptor blockers, he states that the selective blockade of the Nav 1.7, Nav 1.8, and Nav 1.3 receptors may improve on the therapeutic index of sodium channel modulators. Nav 1.3 is an embryonic channel that is upregulated in damaged neurons and contribute to neuropathic states. An intrathecal agent is currently under development for the treatment of neuropathic pain but clinical trials are still in their infancy in this area.

Voltage-Gated Potassium Channel (KCNQ) Openers

Voltage-gated potassium channels are involved in regulating neuronal excitability and have been long established to have the potential to affect a variety of neuronal pathological states such as epilepsy, neuropathic pain, cardiac arrhythmias, and deafness. M channels are a subtype of KCNQ channels that are of particular interest. Celecoxib is a



potent activator of voltage-gated potassium channels/M channels expressed in the DRG. A selective M channel opener of particular interest is retigabine. Introduced in the market as an anticonvulsant, it is an agonist of GABA-A receptors. However, Wen et al. found it to be effective in animal studies in the treatment of chronic pain with central sensitization causing neuronal hyperexcitability. Retigabine may be effective in the management of seizures, anxiety-related behaviors, and neuropathic pain, the common factor being neuronal hyperexcitability. In initial studies by Wen et al., no tolerance, dependence, or withdrawal potential had been reported, although adverse effects could include mild dizziness, headache, nausea, and somnolence. However, further studies are needed for this promising new drug.⁸

Transient Receptor Potential Vanilloid Cation Channels, Subfamily V1 (TRPV1) Antagonists

Transient Receptor Potential Vanilloid 1 (TRPV1) is a non-selective, Ca²⁺ permeable cation channel activated by noxious heat and chemical ligands, such as capsaicin and resiniferatoxin (RTX). Recent studies have found that some forms of endocannabinoid-dependent synaptic plasticity in the hippocampus are mediated through activation of transient receptor potential vanilloid (TRPV) receptors instead of cannabinoid receptors CB1 or CB2. Kitagawa et al. demonstrated that a

selective oral TRPV1 antagonist could have a benefit in the treatment of severe arthritic and postherpetic neuralgia pain refractory to oral nonsteroidal anti-inflammatory drugs. Many pharmaceutical companies are developing TRPV1 antagonists of promise. Many TRPV1 antagonists including ABT-102 (Abbott), SB-705498 (GSK), AMG-517 (Amgen), MK2295 (Merck/Neurogen), and GRC-6211 (Lilly/Glenmark) are in the final stages before phase 2 and 3 trials. A high dose capsaicin patch is available for the treatment of post herpetic neuralgia (Qutenza®).⁹

Mirogabalin

Mirogabalin is a new N-type calcium channel regulator binding to the alpha 2-delta 2 subunit of calcium channels just like gabapentin and pregabalin but having fewer side effects, which could potentially mean higher doses and better therapeutic efficacy. Recent studies have shown a good side-effect profile and comparable efficacy to pregabalin. Further studies to prove any superiority are awaiting.¹⁰

AMPA/Kainate (AMPA/KA) Antagonists

Animal studies suggest that alpha-amino-3-hydroxy-5-methyl-4-isoxazole propionic acid-kainate (AMPA-KA) receptors present in the dorsal horn augment incoming pain signals in the pain pathway. Sang et al. worked on AMPA antagonist LY293558 and Wallace et al. worked on NGX426, an

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orally bioavailable analog of LY293558 to prove benefit in capsaicin induced neuropathic pain. However, no trials have proven any benefit whatsoever in any other type of neuropathic pain so far.^{11,12}

Cannabinoids

Massachusetts has legalized medical and recreational marijuana and cannabinoids are reemerging as promising agents for the treatment of a wide variety of conditions. The endocannabinoid signaling system includes cannabinoid receptors (e.g., CB1 and CB2), their endogenous ligands (e.g., anandamide and 2-arachidonoylglycerol), and the synthetic and hydrolytic enzymes that control the bioavailability of the endocannabinoids. Both CB1 and CB2 receptors are G-coupled protein receptors that are negatively coupled to adenylate cyclase. Activation of CB1 receptors suppresses calcium conductance and inhibits inward rectifying potassium conductance, thereby suppressing neuronal excitability similar to calcium channel and potassium channel modulators discussed earlier. CB2 receptor activation stimulates MAPK activity again discussed earlier to be promising in the neuropathic pain management. Fatty-acid amide hydrolase (FAAH) is the principle catabolic enzyme for fatty-acid amides involved in endogenous cannabinoid activity. Pfizer developed an FAAH inhibitor that failed trials, but other companies are continuing development. The National Institute of Health (NIH) has encouraged the study and development of endocannabinoids for treatment of a wide variety of pain conditions. Some common cannabinoids that have been evaluated are the following:

Natural cannabinoid ligands and synthetic analogues

- 9-THC (Dronabinol/Marinol)
- Cannabidiol (CBD)
- Cannador (cannabis extract, Δ^9 -THC:CBD, 2.5 mg:1.25 mg)
- Cannabis

- eCBD (Cannabis with high CBD content)
- Nabilone (Cesamet, Δ^9 -THC analogue)
- Sativex (oral-mucosal spray, has failed cancer pain trials)

Further result analysis by the NIH and FDA are awaited.¹³

p38 Kinase Inhibitors

p38 mitogen-activated protein kinases (MAPK) are serine/threonine protein kinases, which modulate cellular responses to external noxious by affecting expression of genes controlling and hence production of inflammatory mediators. However, clinical trials of these medications have found prolongation of QT intervals by these agents and have largely been unsuccessful.

Chemokine Receptor Type 2 Antagonists

CCR2 is a chemokine receptor that mediates monocyte chemotaxis and hence is thought to play a crucial role in inflammatory states, such as osteoarthritis, and many chronic pain states. Its antagonism results in reduced monocyte infiltration and hence thought to have potential in diseases such as rheumatoid arthritis and other inflammatory arthritis.¹⁴

However, many trials, including a recent one by AstraZeneca, have failed. Also, its potential in neuropathic pain is still unproven and theoretical.

P2X Purinoreceptor 3 Antagonists

Studies have proven that activation of purinergic P2X3 receptors localized on nociceptive neurons occurs in chronic pain conditions. P2X purinoreceptor antagonists include 2',3'-O-(2,4,6-trinitrophenyl)-ATP (TNP-ATP), an ATP analogue whose inhibitory activity on P2X receptors has been previously reported. Recent studies have shown potent and reversible inhibition of these receptors in trigeminal ganglia without any effect on trigeminal GABA_A and 5-HT₃ receptors, whose membrane currents were unaffected by the tested compounds.¹⁵ This could hence be clinically applied in the treatment of

trigeminal neuralgia refractory to gabaminergic and serotonergic agonists and applied to a wide variety of chronic neuropathic pain states. Only molecular models have been proven and clinical studies are awaited.

Newer Opioid Derivatives for the Treatment of Chronic Pain

NKTR 181

NKTR 181 is a new drug that is a full μ -opioid receptor agonist. It is an oral agonist that binds μ -opioid receptors with moderate affinity (K_i 237 nM). However, unlike conventional opioids, it has a polyethylene glycol (PEG) polymer attached that modulates the rate of entry across the blood brain barrier (BBB). Pharmacokinetic studies show a 2.8-hour delay in miosis (a measure of BBB penetration) compared to oxycodone (11 minutes) as the PEG is strongly linked, making it difficult to modify for faster BBB penetration and hence dramatically reduced abuse liability and CNS side effects. Initial abuse studies have shown the high feeling is comparable to placebo and abuse potential is low. Phase 3 studies have just concluded and are yet to be fully evaluated.

Cebranopadol

Cebranopadol (developmental code name GRT-6005) is a novel opioid analgesic of the benzenoid class that is currently under development internationally by Grünenthal, a German pharmaceutical company, and its partner Depomed, a pharmaceutical company in the United States, for the treatment of a variety of different acute and chronic pain states. As of November 2014, it is in phase 3 clinical trials. Cebranopadol shows highly potent and effective antinociceptive and antihypertensive effects in a variety of different animal models of pain and more effective in chronic neuropathic pain than acute nociceptive pain compared to selective μ -opioid receptor agonists. Relative to morphine, tolerance to the analgesic effects of cebranopadol has been found to be delayed (26 days versus 11 days for complete tolerance). In addition, unlike morphine, cebranopadol

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has not been found to affect motor coordination or reduce respiration in animals at doses in or over the dosage range for analgesia. As such, it may have improved and prolonged effectiveness and greater tolerability in comparison to currently available opioid analgesics.¹⁶

Oliceridine

Oliceridine (developmental code name TRV-130; tentative brand name Olinvo) is an opioid drug that is under evaluation in human clinical trials for the intravenous treatment of severe acute pain. It is a μ -opioid receptor biased agonist developed by Trevena. Oliceridine elicits robust G protein signaling, with potency and efficacy similar to morphine, but with far less β -arrestin 2 recruitment and receptor internalization — thus, it displays fewer adverse effects than morphine. Clinical trials are ongoing and seem promising so far.¹⁷

Nerve Growth Factor Inhibitors

Nerve growth factor (NGF) was originally discovered as a neurotrophic factor essential for the survival of sensory and sympathetic neurons during development. However, in the adult, NGF has been found to play an important role in nociceptor sensitization following tissue injury. It acts by combining with a tropomyosin kinase receptor, activating it and regulating a host of molecules and receptors involved in signaling in acute and chronic pain.¹⁸ Research involving these molecules has been mixed. While improved analgesia for bony pain by acting on the innervating nerves has been established, earlier than expected joint replacement has also been necessary in a small subset of NSAID dependent patients, further causing an FDA hold on human trials that has now been lifted. Tanezumab and fulranumab are mostly effective in inflammatory pain, though recent studies in diabetic nerve pain are emerging. Tanezumab, however, has

failed earlier studies for herpetic and diabetic neuralgia.

Short Interference Ribonucleic Acid (RNA) Therapeutics

RNA interference (RNAi) is an evolutionarily conserved mechanism for silencing gene expression by targeted degradation of messenger RNA (mRNA). In recent years, RNAi has become the most widely used technology to suppress gene expression. Getting the SiRNA to the target molecule is the main problem, and currently transfection agents are being used intrathecally. With evolution of stem cell technology, these agents show great promise.¹⁹

Stem Cells

Stem cells offer a multipotent cellular source for replacing injured or lost neural cells and for delivering trophic factors to lesion site. However, their antinociceptive goes beyond their regenerative effect. There are three main types of stem cells used for neuropathic pain: neural stem cells, mesenchymal stem cells, and bone marrow mononuclear cells. Neural stem cells seem particularly promising and show increased efficacy with repeated injections with effects seen in as little as 3 days and lasting up to 28 days, decreasing allodynia and hyperalgesia by altering cytokine profile at the target site.²⁰

Conclusion

Many newer drugs have emerged and disappeared from clinical trials evaluating efficacy in the treatment of neuropathic pain. Neuropathic pain remains a challenge to be overcome, though age old drugs such as cannabinoids show new potential and new therapies such as SiRNA therapeutics and stem cell therapy show great promise. Much is eagerly awaited and hope remains on the horizon.

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MSA Annual Reports

Outgoing President's Report



Mary Ann Vann, MD

I don't think it would be an exaggeration to say that my term as MSA president was the busiest year ever. There were radical changes that occurred within the organization. Also, the

role of the MSA president has changed, and now advocacy issues require more time and resources.

As I reported last year, the first months of my term saw the transition from a private MSA office to professional management by the Massachusetts Medical Society (MMS). Our chapter administrator, Nathan Strunk, and the MMS have provided a wealth of resources to MSA members and officers. The surprise I had near the end of my term was that this new management reduced costs for the MSA. Clearly, this move, which was initiated and negotiated by my predecessor, Dr. Sheila Barnett, was a tremendous success.

Over the course of my term, I focused on finances. As part of the transition to the MMS we needed to set up a relationship with a bookkeeping firm. I worked closely with our new bookkeepers to modernize our payment methods and increase responsibility and transparency about our costs. They also helped us to frame a working budget. Certain expenses for the MSA have risen, as our advocacy required a public relations firm to assist with messaging as we prevented the advanced practice nursing bills from becoming law. Also, unexpected expenses can occur, as the hacking of our website illustrated when we were threatened with enormous bank fees for the hacker's transactions. Fortunately, the bank never pursued collection of those fees. I hope that my focus on frugality set a precedent that will allow the MSA to function for years to come without raising dues.

In the wake of the hacking, we developed a new website. This has provided us with tools we didn't have before and

will become an even more important means of communication in the future.

In early 2017, I worked to increase our state government's awareness of physician anesthesiologists. I was able to obtain a proclamation from Governor Charlie Baker in recognition of Physician Anesthesiologists week. We were also recognized by the Massachusetts House of Representatives. As part of this acknowledgment, the governor arranged a meeting for me with the Commissioner of Public Health Dr. Monica Bharel. I was able to introduce her to our specialty and our concerns as physician anesthesiologists. This was an important connection I have recently reaffirmed.

In the spring of 2017 the new two-year legislative session began. We messaged MSA members to contact their legislators to discourage them from signing on as sponsors of the nurse anesthetists' independent practice bills, which was met with much response and success. This year, the nurse anesthetists have separated themselves from other advanced practice nurses. Also, they are not using the term "independent practice" and have instead aimed at changing statutes and regulations on prescriptive authority to remove requirements for physician supervision.

I worked with the ASA State Affairs office during my term, which not only

helps us with updates on issues in our own state, but also informs us of what is occurring in other states. In May, the MSA was involved in discussions regarding out-of-network billing, including a conference call with the Emergency Room Physician organization in the state.

My term ended at the MSA Annual Meeting at the Westin Waltham on May 31. Dr. James Grant, ASA president-elect, visited several Massachusetts hospitals and addressed the annual meeting. We realigned MSA districts to correspond to Congressional districts and elected new district representatives. I was thrilled to welcome new and younger anesthesiologists who were elected to office in 2017 and hope they will be excellent leaders for the MSA for years to come.

Overall, I had a successful and exhausting year as MSA president. I know that when my term ended, the MSA was in a better position than the year before. I was most proud of my achievements in advocacy. In my opinion, future presidents will see this as a significant part of their job. I feel it is important to maintain the contacts and utilize the knowledge of the issues I gained while president. I am continuing my work in advocacy for MSA as chair of the Committee on Governmental Affairs.



From left to right: Nikhil Thakkar, MD; Mary Ann Vann, MD; James Grant, MD, MBA

Secretary's Report



Maitriyi Shah, MD

The active membership of the Massachusetts Society of Anesthesiologists slightly decreased below 1,000 members resulting in a reduction of ASA Delegates from 11 to 10 for

MSA representation in the House of Delegates at the ASA Annual Meeting this year. The MSA is identifying the

reasons for this decrease in membership in order to develop a campaign to encourage members to renew and participate in MSA. Unified billing through ASA makes it easier for members to renew. With educational courses, opportunities to network with colleagues, and advocacy activities that help promote anesthesiologists' and their patients' interests in Massachusetts, there is hope that MSA members and anesthesiologists in Massachusetts

will continue to find value in their membership and support the MSA.

MEMBERSHIP TOTALS AS OF MAY 31, 2017

Active	990
Affiliate	20
Resident.....	484
Student	38
Retired.....	193

ASA Director's Report



David L. Hepner, MD

Leaders from the Massachusetts Society of Anesthesiologists, representatives from the majority of the districts, and resident representatives (COREA designees and Alex Hannenberg's award recipient) participated in the annual ASA Legislative Conference in Washington, DC, on May 15-17, 2017. The 2017 Legislative Conference was well attended with physician anesthesiologists from all over the country. We heard from members of Congress, including Congressman Andy Harris, the first physician anesthesiologist elected to Congress, about the latest health policy issues and learned about current regulatory and payment issues. For the fourth year in a row, the Veterans Health Administration (VHA) nursing handbook was one of the major focuses of discussion during our congressional visits on Capitol Hill. Thirteen MSA members and residents attended the Conference and made visits to Capitol Hill. We visited every Congressperson's and Senator's offices from Massachusetts.

Even though after extensive study and consideration and two public comment periods with a record level of engagement, the Department of Veterans Affairs' (VA) issued a Final Rule on

December 13, 2016, that maintained safe, high-quality physician-led anesthesia care in VA facilities, nurse anesthetists continue to seek ways to change how care is being delivered in Veteran Health Administration health care facilities and abandon the VA's proven model of physician-led team-based anesthesia care. Since this new policy authorizes all other APRNs to function as independent practitioners regardless of the scope of practice defined by their licensure, we expect all APRNs to rally around nurse anesthetists in their effort to gain independent practice at VA facilities. Therefore, we continued this year to lobby members of Congress and VA leaders about the importance of physician-led anesthesia care. Furthermore, there is already a bill in the House of Representatives (H.R.1783) that would provide full practice authority for advanced practice registered nurses at VA facilities. We urged all members of congress from Massachusetts not to cosponsor H.R.1783. We must realize that this fight is far from over.

During our visits to Capitol Hill, we emphasized that providing independent practice to nurse anesthetists is a dangerous policy because the health status of our veterans is poorer when compared to the overall surgical population. Many veterans are older with multiple comorbidities that put them at greater risk for complications during and after

surgery. Furthermore, there are independent peer-reviewed studies demonstrating better outcomes with anesthesiologists. Other studies finding that no harm was found when nurse anesthetists work without supervision by physicians did not include VA facilities and were funded by the American Association of Nurse Anesthetists. We were glad to hear Representative Moulton Chief of Staff tell us that he was impressed by this fact and that signing the letter supporting physician anesthesiologist led practice was one of the very first things that Congressman Moulton did upon arriving in Congress. We also emphasized the fact that although there is a shortage of primary care providers, there is no such shortage of anesthesiologists.

Our visits were very successful and we were able to meet Senator Elizabeth Warren and Representative Keating in person. Senator Warren agreed with us that veterans deserve to receive the same state of the art medical care that civilians receive and was interested to hear about the Final Rule. We also emphasized this point in our discussion with the legislative aides of Senators Warren and Markey and of the nine Massachusetts members of the House of Representatives.

In addition to discussing the VHA Final Rule, we also discussed the Medicare Access and CHIP Reauthorization

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ASA Director's Report

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Act (MACRA) that repealed the flawed Sustainable Growth Rate (SGR) formula and created a new Medicare physician payment system for two pathways for participation: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). We emphasized during our visits to the Hill that we need appropriate timeline for implementation, recognition of the role of physician anesthesiologists and access to resources to develop important quality measures. Some of the quality measures that we are going to be held accountable for in 2017 were just approved on May 12! Therefore, we would like to continue having the pick your own pace option not only for 2017 but also for 2018. If this is selected, a minimal reporting requirement effectively protects physicians from a negative payment adjustment. We also asked members of Congress to ask the Centers for Medicare and Medicaid Services (CMS) to extend the 0% MIPS cost component to 2018 because of challenges in developing the cost component, and to encourage CMS to develop advanced alternative payment models for all specialties, including physician

anesthesiologists. We asked members of Congress to sign the MACRA letter authored by Congressman Phil Roe (an OB/GYN from Tennessee who also spoke at the Legislative Conference). This letter urges CMS to ease MACRA requirements for physicians.

Our own Dr. Alex Hannenberg is the chair of the Ad Hoc Committee on Payment Reform and the Interim Chief Quality Officer of the American Society of Anesthesiologists. Dr. Hannenberg gave a presentation at the Legislative Conference on the state of MACRA ("MACRA's Second Birthday"). Dr. Hannenberg led many of the discussions on easing physician anesthesiologist participation in MACRA with various legislative aides. This was a great opportunity for the residents and even some of the faculty that attended the conference to learn about anesthesia payment and its history over the past quarter of a century.

In addition to MACRA, there was a call for members of Congress to take action to address the prescription opioid abuse epidemic in the United States by implementing strategies to reduce the misuse, abuse, and diversion of prescription opioid medications. Some of these strategies include the institution

of multimodal and multidisciplinary pain management programs, to encourage opioid "take back" programs, and to reduce opioid use in the postoperative period.

We also discussed health care reform, including the American Health Care Act (AHCA), recently passed by the House of Representatives and currently in the United States Senate. The ASA did not take a position on the House AHCA because of the unclear and unspecified impact on our practices. The ASA plans to carefully watch the process to see how it aligns with our principles. In the meantime, we told the Democratic members of Congress and their legislative aides that we visited that we support efforts to make health care more accessible and affordable. We expressed our concerns about the Affordable Care Act (ACA, Obamacare) including the high deductibles and the low number of insurers in exchanges. We also asked members of Congress to support legislation that would repeal the Independent Payment Advisory Board (IPAB) from the ACA.

Dr. Jeffrey Plagenhoef, Mr. Jason Hansen, and Mr. Paul Pomerantz participated in a call with their counterparts

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From left to right: Michael Schoor, MD; Chris Hansen, MD; Maitriyi Shah, MD; Anna Budde, MD; Beverly Philip, MD; Kay Leissner, MD; Selina Long, MD; Senator Elizabeth Warren; David Hepner, MD; Sheila Barnett, MD; Mary Ann Vann, MD, Nikhil Thakkar, MD; Richard Urman, MD, MBA; Alex Hannenberg, MD

ASA Director's Report*continued from page 14*

at the American College of Emergency Physicians (ACEP) at the beginning of March about out-of-network billing (OONB). The American Academy of Orthopaedic Surgeons and the American Society of Plastic Surgeons (ASPS) have signed on to the joint principles and principles developed by the ACEP and ASA with the American College of Radiology. ACEP CEO Dean Wilkerson and ASA CEO Paul Pomerantz also reached out to the Society of Hospital Medicine, the American College of Osteopathic Pediatricians, and the American Academy of Pediatrics. ACEP plans to develop a resolution for the annual meeting of the AMA in June to seek the AMA's endorsement of the principles of out-of-network billing. The ASA and ACEP will follow up with societies representing pathology, hospital medicine, pediatrics, orthopedics, plastic surgery and OB/GYN to confirm their participation. Of note, leadership from the MSA met with State Affairs staff and Ad Hoc Committee on Out-of-Network Payments Chair Sherif Zaafran, MD, at the Legislative Conference concerning OONB legislative initiatives in our state. We have been working very closely with the Massachusetts Medical Society (MMS), and plan to initiate conversations with the Massachusetts chapter of ACEP.

The ASA has conducted a critical assessment of budget items as a follow-up of a request from the Section on Fiscal Affairs (SFA). This was discussed at length at the Board of Directors meeting at the beginning of March. Some initial recommendations that came from that discussion include reduced AMA delegation associated spending by \$35,000, outlined next steps of the AC Subcommittee on Face-to-Face Meetings for committees and editorial boards, reduced the per diem reimbursement rate from \$250 to \$200 effective after March 6, 2017, and reduced the 2017 budget for Public Relations in support of state advocacy by \$100,000. Board of Directors feedback was

captured at the interactive sessions in Chicago, and critical assessment feedback will be shared with the SFA, Budget Committee and the AC Critical Assessment Workgroup, with a planned report back to the BOD in August.

I hope that from this update of ASA activities, you recognize the significant value that you get from your ASA membership. Please remember that since every single anesthesiologist benefits from the ASA's efforts, all anesthesiologists should be ASA members. I urge all of you to support the ASA's legislative/political efforts by contributing to the ASA PAC. MSA member contributions continue to be poor when compared to other component societies. I challenge you to not only contribute to the ASA PAC, but also to recruit five friends and colleagues from the anesthesia community to contribute (the 1+5 approach that worked so well in the Safe VA Care initiative). In addition, if you know of any member in your department who is not a member of the MSA or ASA, please let the MSA office know and urge them to become members and get more involved. We lost one delegate this year as a result of the drop in the number of ASA members from the MSA. Therefore, now more than ever, it is important to increase the number of MSA and ASA members and to contribute to the ASA PAC.

It has been my distinct honor and privilege to serve as your director to the ASA. I am thankful for the help and support that I get from the Executive Committee and other MSA members. I also appreciate the confidence that you have on me to represent you to the ASA.

I look forward to continue serving as your director to the ASA and thank you for your vote of confidence.



**Check out our
website**

mass-anesthesiologist.org

MSA Annual Reports



Richard D. Urman,
MD, MBA, CPE

It has been a productive year working with all of the members of the Committee on Programs to ensure that our programs are well received and continue to meet the require-

ments of our accreditation through the Massachusetts Medical Society (MMS). We have met quarterly through 2016–2017, and during that time we organized two new courses we had never offered before.

Since the MSA annual meeting in 2016, we have held two CME programs. The MSA held the second “International Perioperative Medicine Symposium” in collaboration with our host society, Sociedad Antioqueña de Anestesiología, on February 2–4, 2017, in Medellín, Colombia. The MSA also offered a course on “Enhanced Recovery after Surgery (ERAS): A Multidisciplinary Approach to Patient Care”, which was

Committee on Programs

endorsed by the ERAS Society and the ERAS-USA Society and held at the Waltham Woods Conference Center at the Massachusetts Medical Society on March 25–26, 2017. The programs were well received.

The MSA is providing continuing medical education (CME) credits for the New England Society of Anesthesiologists (NESA) 60th Annual Fall Conference through joint providership. The NESA conference will be held at the Ocean Edge Resort and Golf Club in Cape Cod.

Looking ahead, the Program Committee anticipates another excellent year in 2017–2018 and we are currently preparing courses for next spring. In addition to collaborating again with Sociedad Antioqueña de Anestesiología to hold a joint course in Cartagena, Colombia, on March 22–24, 2018, we plan to offer a Sedation course and a Regional Anesthesia course this spring.

At the end of 2017, the MSA decided to forego its accreditation in order to

have each individual event accredited through the MMS. While we anticipate that this will result in some minor procedural, administrative changes for accrediting MSA events, we look forward to delivering outstanding and timely events for our members and care providers throughout Massachusetts, New England, and the United States.



Committee on Publications



Nikhil M.
Thakkar, MD

It is my honor to serve as chair of the Committee on Publications, which has the important role in communicating vital information to our valued members. The goal of the publica-

tion committee is to continue the tradition of publishing a newsletter (*MSA Anesthesia Record*) yearly following the annual meeting. This newsletter is viewed as a very effective communicating tool and a wonderful opportunity to educate our colleagues and peers regarding many aspects of our professional lives. I encourage all MSA members to take advantage of this tool and share their stories, whether it's about a

political movement or changes in clinical practice affecting our profession.

Life is full of changes and challenges. Many times, the challenges in life bring about a better outcome.

This last year was a year of many changes and many challenges for MSA including hacking of our website. The MSA looked into various vendors for the new website to bring the best for their members. Thus, the creation of our new website www.mass-anesthesiologists.org and new interface.

With our new administrator Nathan Strunk and expert infrastructure help from the Massachusetts Medical Society staff, we have flourished in our new way of communication. In the midst of all these changes we continued to strive to do our best with our delayed but newly designed newsletter.

Our primary goal is to improve every year through the various platforms. With the help of a new publisher, we were able to make a different layout for our most current newsletter.

I am thankful to our subcommittee on the new website (Dr. Feinstein, Dr. Spanakis, and Dr. Quartraro) for their leadership and support to enhance our website.

I would like to thank Dr. Mary Ann Van, MSA president, for her continued support to make my work successful along with my committee members. I encourage any feedback and assistance to help us grow together.

“To improve is to change; to be perfect is to change often.”

—Winston Churchill

Committee on Economics



Peter Panzica, MD

As newly appointed chair of the Committee on Economics, I have some pretty big shoes to fill: those of Dr. Alex Hannenberg, who served the society in this role for many years. His expertise in this area, both locally and nationally, is second to none. The major issue that the committee has been focusing on is the updated (November 2016) Harvard Pilgrim Health Care (HPHC) payment policy for MAC anesthesia of endoscopy procedures and its overly restrictive nature. Many practices around the state of Massachusetts have seen significant denials in their billing claims, even when MAC anesthesia is warranted from a procedural or patient condition prospective.

There are several areas that the MSA is contesting with HPHC, and they fall into two major buckets. The first issue is that all current endoscopy CPT codes (diagnostic/screening vs. complex/interventional) crosswalk into only two anesthesia codes:

- 00740 (anesthesia for upper gastrointestinal endoscopic procedures, proximal to duodenum)
- 00810 (anesthesia for lower gastrointestinal endoscopic procedures, distal to duodenum)

For 2018, the Centers for Medicaid and Medicare Services has published new anesthesia endoscopy codes:

- 5 units — 00731 (anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified)
- 6 units — 00732 (endoscopic retrograde cholangiopancreatography [ERCP])
- 4 units — 00811 (anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified)
- 3 units — 00812 (screening colonoscopy)
- 5 units — 00813 (anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum)

Even with the new codes, discrimination between routine and advanced/procedural endoscopy besides ERCP will not occur.

There needs to be a mechanism to allow insurers to better differentiate.

The second major area is the current restrictive and inconsistent nature of the indications for MAC. These currently include:

- Member is under 18 years of age; OR
- Member is over 70 years of age; OR
- Member is pregnant; OR
- Increased risk for complications due to severe comorbidity corresponding to the American Society of Anesthesiologists (ASA) Physical Status Modifier of 3 or greater; OR

- Increased risk for airway obstruction due to anatomic variation, such as:
 - History of stridor;
 - Dysmorphic facial features;
 - Oral abnormalities (e.g. macroglossia);
 - Neck abnormalities (e.g. neck mass);
 - Jaw abnormalities (e.g. micrognathia); OR
- Member has one of the following:
 - History of adverse reaction to sedation;
 - History of inadequate response to sedation;
 - Obstructive sleep apnea;
 - Morbid obesity (e.g. BMI >40)
 - Active or history of alcohol or substance abuse

The MSA is working with HPHC to broaden this list of indications so that patients who would benefit from anesthesia care can be included and practices can be reimbursed. The initial meeting with HPHC over these flaws in this policy was positive. The private health insurance industry has generally coalesced around the practice of specifying criteria for medical necessity. Without trying to reverse this national trend, the MSA seeks to make coverage of our services available for all the patients who can demonstrably benefit from it. There will be more to follow on this issue.



Committee on Resident and Fellows Affairs



Michael Schoor, MD



Cranston Gray, MD

The Committee on Resident and Fellows Affairs (CORFA) is comprised of residents from all Massachusetts training programs and has continued to work together toward fulfilling its mission of:

Bringing the resident “voice” to MSA and ASA meetings

Ensuring residents and medical students gain exposure to opportunities within the anesthesia specialty

Unifying Massachusetts residents and increasing awareness on the state and national issues affecting our specialty

This past year, we have continued the strong tradition of representation and involvement. Since the annual meeting in 2017, CORFA has engaged in the following activities:

- **Expansion of the New England Anesthesia Research Conference (NEARC):** Members of CORFA helped to organize the meeting and its structure. This year, with the continued support of MSA leadership and funding, the conference had a record number of over 60 presentations and 100 participants. Residents enjoyed the opportunity to showcase their research and network with fellow residents from all over the region.
- **ASA Annual Meeting representation:** Members of CORFA attended various meetings at the ASA, held in Boston this year. At meet-and-greet sessions, we answered questions from prospective medical students and discussed pathways for increased involvement. The House of Delegates this year engaged in lively debate on several issues, including the ASA's position on

climate change initiatives and an increase in resident dues. Resident dues for the ASA will only be raised \$5 as a result of resident involvement. Many members of CORFA made testimony on these issues. CORFA had resident representation at each of the ASA reference committees and attended the Committee on Equipment and Facilities discussion on environmental sustainability.

- **Meetings with State Government Officials:** CORFA members joined the MSA in visiting Beacon Hill and meeting with state legislators. Residents gave testimony on the importance of physician led anesthesia care and shared our concerns about how independent practice for nurse anesthetists would negatively impact patient safety in the operating room. Residents also had the opportunity to meet with Massachusetts Commissioner of Public Health Dr. Monica Bharel regarding recent legislation that would impact the care team model.
- **ASA Legislative Conference:** The conference was an amazing experience to gain insight into the national legislative process. Members of CORFA met with senators and representatives from Massachusetts and raised concerns over the expansion of CRNA prescribing privileges, which in Massachusetts is the legislative language that would allow for independent practice. We educated our national representatives on what a physician anesthesiologist does and applauded the defeat of the VA care handbook language that would have allowed nonphysicians to practice anesthesia unsupervised in the operating room at the VA.
- **Other Activities:** Currently, we are planning the post-ITE celebration and Lifebox fundraising event. CORFA members have been hard at work planning and advertising this yearly event, and we are hoping for an even greater turnout than in years past. The party will be a great way for residents

from each of the Massachusetts training programs to meet and learn more about the life-saving work of Lifebox.

Our CORFA team has had a very successful year that would not be possible without the support of our dedicated leaders within the MSA. It has been an honor to lead CORFA this year. Each member has worked hard and brought enthusiasm, creativeness, and political experiences to the table to provide residents and medical student an avenue for activism and engagement within our specialty.

Michael Schoor, Co-Chair
UMass Memorial Medical Center

Cranston Gray, Co-Chair
Brigham & Women's Hospital

Brian Alexander, Treasurer
UMass Memorial Medical Center

Jimin Kim, Secretary
Brigham & Women's Hospital

Brandon Napstad, Social Chair/
Lifebox Coordinator
Brigham & Women's Hospital

Amita Jain, Social Chair/
Lifebox Coordinator
Tufts Medical Center

Sarah Franklin, Social Chair/
Lifebox Coordinator
Brigham & Women's Hospital

Lindsay Sween, Social Chair/
Lifebox Coordinator
Beth Israel Deaconess Medical Center

Kelly Tankard, Program Liaison
Brigham & Women's Hospital

Tori Derevianko, Program Liaison
Beth Israel Deaconess Medical Center

Amanda Xi, Program Liaison
Massachusetts General Hospital

Arunthevaraja Karuppiah,
Program Liaison
St. Elizabeth's Medical Center

Sarah Abbett, Program Liaison
St. Elizabeth's Medical Center

Committee on Governmental Affairs



Mary Ann Vann, MD

I am happy to lead the efforts to advocate for physician anesthesiologists in Massachusetts as chair of the Committee on Governmental Affairs. The committee deals with legisla-

tion affecting anesthesiologists and works with governmental officials. The knowledge and contacts I gained during my term as president will be useful in helping to win the legislative battles we face in the coming months.

In July 2017, MSA President Dr. Richard D. Urman, MSA Vice President Dr. Nicholas Kiefer, CORFA Co-Chair Dr. Cranston Gray, and I testified before the joint Health Care Financing Committee (HCFC) at the State House. The legislation discussed was the governor's proposal to decrease health care spending by the state. The bill made the incorrect assertion that nurse anesthetists were lower-cost providers. Our testimony was effective in making it clear that nurse anesthetist independent practice would not reduce and, in fact, could increase costs.

In September, the nurse anesthetists' bills were the subject of a hearing before the same committee. The MSA testified at this hearing. The nurse anesthetists' testimony followed ours. Once again, they stated that these bills were not about independent practice but just about prescriptive authority. However, we know that is just a way to remove any language regarding physician supervision in current regulations and statutes. It is important to know that nurse anesthetists want to write prescriptions for patients three weeks before and after surgery. This six-week period would exceed the bounds of perioperative anesthesia care. We have contradicted this concept in testimony by mentioning the rarity of physician anesthesiologists writing prescriptions. This six-week period may actually represent a means for nurse anesthetists to

extend their independent practice to pain medicine, which is especially concerning.

In October, during ASA Week here in Boston, Dr. Kiefer testified against a bill created in the Senate addressing health care costs and incorporating the same false information as the governor's bill indicating nurse anesthetists as lower-cost providers.

At the close of the ASA Annual meeting on Wednesday, October 25, Massachusetts delegates to the ASA and other MSA members visited the State House for scheduled appointments with their senators and representatives to discuss the pending legislation. Prior to the visits, I arranged an informational session at the convention center after the close of the ASA House of Delegates. We were joined by Erin Berry Philip and Jason Hansen from the ASA State Affairs office and members of Louisiana delegation with advocacy

experience, Dr. Kraig DeLanzic and Dr. Joe Kovaleske, and our lobbyist, Ed Brennan. As a group we discussed the issues in the legislation and tactics for communication of our message to the legislators. It was an extremely valuable and useful session, even for those of us with experience in meeting with elected officials. Seventeen of us visited the State House that day to spread our message. The group included Mr. Hansen from the ASA and Dr. Kovaleske from Louisiana, giving support to Massachusetts causes. It was a huge success for all involved as important contacts were made and information was delivered. We may schedule a group visit again in the future.

In November, Dr. Cranston Gray and I had an important meeting with the governor's chief of staff for the Executive Office of Health and Human Services and Commissioner of Public

continued on page 20



From left to right: Mary Ann Vann, MD; Alex Hannenberg, MD; Ann Jablon (Chief of Staff for Congressman Richard E. Neal); Nikhil Thakkar, MD

MSA Annual Reports

Governmental Affairs

continued from page 19

Health Dr. Monica Bharel, whom I first met in January. We made significant progress in delivering the message that preservation of patient safety during anesthesia requires the presence of a physician anesthesiologist. We stressed that there are no cost savings with nurse anesthetist independent practice and no access issues for anesthesia care in this state, while there is a threat to patient safety. We also discussed the misinformation about prescriptive authority for nurse anesthetists.

Since the Senate has passed its bill, our immediate focus is now on the House of Representatives, which will likely craft its own bill in the near future.

The year 2018 will be significant since it is an election year, and patient safety will always be on the minds of the health care savvy voters in Massachusetts. Also, during an election year, legislators are usually more available to their constituents, allowing more opportunity for interactions. However, since the legislative session closes at the end of July, contact must be made well before the election. I hope that all MSA members will make efforts to contact their legislators to protect patient safety and preserve the anesthesia care team in Massachusetts. The state is known in the country and world for high-quality patient care. It would be unfortunate to lose that distinction by becoming only the fifth state in the nation to allow independent practice by nurse anesthetists.

Please contact me through the MSA with any questions about the current legislation or how to interact with your legislators. I am happy to help with information on messaging and tips for communicating our points. Also, please keep an eye out for urgent calls to action from the MSA when we need you to contact your legislators who are set to act on legislation at the State House.

MSA at the State House



From left to right: (back row) Roman Schumann, MD; Nicholas Kiefer, MD; Brian Alexander, MD; Joe Kovaleskie, MD; Jason Hansen, Esq. (ASA Direct of State Affairs); Kay Leissner, MD; Nathan Jones, MD; (middle row) David Feinstein, MD; Nikhil Thakkar, MD; Fred Shapiro, MD; Ed Brennan, Esq.; David Hepner, MD; (front row) Maitriyi Shah, MD; Erin Berry Philip, Esq. (Director, State Government Relations); Richard Urman, MD, MBA; Michael Schoor, MD; Mary Ann Vann, MD



Maitriyi Shah, MD, and Joe Kovaleskie, MD, meeting with a legislator at the Massachusetts State Capitol



Joe Kovaleskie, MD; Maitriyi Shah, MD

2017 MSA Annual Meeting



David Feinstein, MD; Richard Urman, MD, MBA; Daniel O'Brien, MD



Mary Ann Vann, MD; James Grant, MD; Mary Peterson, MD; Beverly Philip, MD



James Gessner, MD; Ed Brennan, Esq.; Lee Perrin, MD



J. Cranston Gray, MD; Jimin Kim, MD; Kelly Tankard, MD; Alex Stone, MD



Tanya Lucas MD; M. Richard Pavao, MD

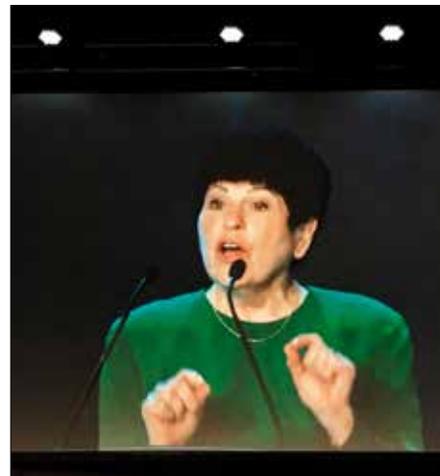


Nikhil Thakkar, MD; Sulpicio Soriano, MD; Stephanie Jones, MD; Ruben Azocar, MD

2017 ASA Annual Meeting



From left to right: Lisa Crossley, MD; Annette Mizuguchi, MD; Monica Sa Rego, MD; Maitriyi Shah, MD



Beverly Philip, MD



Kay Leissner, MD, chief of Anesthesiology at Veterans Affairs Boston Healthcare System, and Ann Walia, MD, chief of Anesthesia at the Veterans Affairs Tennessee Valley Healthcare System — Nashville, presented an award to the Association of Veterans Affairs Anesthesiologists for their leadership and efforts to safeguard veterans and patient safety



David Hepner, MD, presiding over the New England Caucus

A Student's Perspective



Brian Tashjian

I would like to first take a moment to express my gratitude to the Massachusetts Society of Anesthesiologists for providing me with the opportunity to attend my first national medical

conference. My time at ASA Annual Meeting 2017 was a wonderful introduction to all the opportunities Anesthesia has to offer. It was my first experience at a national conference of any type, and it was one I will never forget.

Just walking into the Boston Convention Center was overwhelming. I was immediately compelled to take pictures of the exhibition floor, a

combination of innovation and spectacle. After indulging in my touristic tendencies, it was on to the actual conference. Over the weekend I attended two House of Delegates sessions and one reference committee session, where I got to observe some of the most passionate anesthesiologists in the nation advocate for their patients on the floor. I received first-hand experience of how the MSA functions on a state and national level. At the Environmental Sustainability Subcommittee of the Equipment and Facilities Committee meeting, I learned about all of the ways that the ASA is trying to decrease waste and improve environmental sustainability. I also attended lectures ranging from consciousness to end-of-life care,

all of which were of particular interest to me. My final, and probably favorite, experience of all was presenting a poster with Dr. Michael Schoor as part of the Medically Challenging Cases section. It was exciting to see how the specialty of Anesthesia is constantly evolving.

It was difficult to get acclimated to the whirlwind tour of my first ASA conference, but I am truly grateful for the opportunity given to me by the Massachusetts Society of Anesthesiologists. My experience furthered my interest in Anesthesia, and showed me the importance of being an active member and a steward of the American Society of Anesthesiologists.

2018 Programs and Events

**Jan 28
to
Feb 3**



**Physician Anesthesiologists
Week**

Located in institutions throughout
Massachusetts

**Third International Perioperative
Medicine Symposium**

Hotel las Américas, Cartagena,
Colombia



**Mar 23
to
Mar 24**

**May
18**



**Massachusetts Society of
Anesthesiologists Annual
Meeting**

The Westin Waltham, MA

**Basic US-Guided Regional
Anesthesia and Point-of-Care
Ultrasound Workshop Activity**

Massachusetts Medical Society,
Waltham, MA



**May
19**

**Oct 13
to
Oct 17**



**American Society of
Anesthesiologists Annual
Meeting**

San Francisco, CA

**Ninth Annual Update in
Sedation and Analgesia**

Massachusetts Medical Society,
Waltham, MA



**Dec
1**

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MSA's Chapter Administrator

Nathan Strunk is a specialty society coordinator in the Specialty Management Services department of the Massachusetts Medical Society. He has served as MSA's CME coordinator for about 24 months and as the primary administrator for the Massachusetts Society of Anesthesiologists for about 18 months.

If you have questions or requests for the Massachusetts Society of Anesthesiologists, please send them to Nathan, who can be contacted at MAAnesthesiologists@mms.org or (781) 434-7329.



Nathan Strunk
MAAnesthesiologists@mms.org

Check Out Our Website

Please visit us often at mass-anesthesiologists.org for the latest updates in anesthesiology, both nationally and regionally, for upcoming events, and for opportunities for you to connect with your friends and colleagues.

mass-anesthesiologists.org

