CSA District Director Reports

CSA Board of Directors Meeting, October 2, 2004

Gregory M. Gullahorn, M.D.–District 1 (San Diego and Imperial Counties)**:** Anesthesia "personpower" seems to be returning to adequate and steady state levels in the San Diego area. Although a positive development, this may be associated with shifting of the balance of power in negotiations between health-care providers and payers/hospitals.

Such a conflict has developed at Pomerado Hospital, part of the Palomar-Pomerado Hospital system in Northeast San Diego/Escondido. Associated Service Medical Group (ASMG) has provided anesthesia services at Pomerado Hospital since it opened, including coverage for a low volume OB service. A new CEO at Pomerado opted to decline renewing/continuing the OB stipend at a level considered adequate by the anesthesia group, and instead, negotiated a new stipend for OB with Anesthesia Consultants of California (ACC), the group which covers Palomar Hospital. This coincided with an offer from ACC for coverage by ASMG for capitated patients for which they were at risk, having surgery in the main operating rooms at Pomerado, which ASMG allegedly felt was inadequate. This has resulted in an overall change with most of the coverage at Pomerado now being provided via ACC. The situation is still in flux, as is the long-term source of physician resources and the disposition of individual anesthesiologists.

Studies conducted by the San Diego County Medical Society show that San Diego has a strongly perceived physician shortage, as well as continuing difficulties recruiting new physicians for reasons well known to us: low reimbursements/income, high cost of housing/living, high managed care penetration, encroachment by payers on physician-patient relationship. A follow-up study looked at physician to patient ratios in San Diego County, and projected them forward to 2006 using results from the earlier manpower study. Using three models to establish physician need, the Graduate Medical Education National Advisory Committee (GMENAC) figures from the early 1990s, average HMO staffing figures, and staffing figures from a non-profit San Diego area HMO, 29 specialties and subspecialties were inspected. A significant and growing shortage was found in OB/GYN, General Surgery, Orthopedics, Ophthalmology, Urology, ENT, Emergency Medicine, Allergy-Immunology and Primary Care. The models used found an oversupply of anesthesiologists; however this is likely due to differences in practice patterns. The baseline figures look at practices across the country, many of which use the Anesthesia Care Team model, as compared to California, which is predominantly anesthesiologist only care. In fact, a

manpower survey from 2002 found anesthesiology to be experiencing the greatest shortfall.

Adding to concerns are data showing that growing numbers of physicians are limiting their practices. Thirty percent of San Diego physicians overall, and 34 percent of surgeons say they either do not accept Medicare or will stop doing so by 2006. For Medi-Cal, the numbers are even more staggering, with over 40 percent of surgeons opting out by 2006. On top of this, current estimates show approximately 450,000 San Diegans are without health insurance. When the underinsured are added to this, the numbers are well over 600,000.

These issues are not unique to San Diego, or to California. They certainly may color public perception of physicians and specialists–either to our advantage or disadvantage. It is up to us to use this information to advocate and protect our patients. Inherent in that is the preservation and promotion of medicine and anesthesiology.

A recent Public Broadcasting Service special included a segment on California physicians who were undertaking humanitarian medical missions within California to perform needed services and surgeries for the unserved and underserved. I think it is important to identify and support such efforts. The benefits extend far beyond the individuals receiving care and their families, beyond the sustenance and re-energizing of those providing the care. Our true strength is in the relationships we have with our patients and the trust which they place in our hands. Emphasizing and enhancing that base may give us the tools and strength with which to shape our future.

I have been involved in international humanitarian medical missions for the last 10 years and have seen firsthand the exponential growth and progress that can evolve from simple but well-founded efforts. We can change lives, and with concerted and ongoing effort, we can change the world. In a time when the role and image of the United States has been challenged or changed in much of the world, it is vitally important that we continue to reach out. We need to reach out across borders and barriers, across countries and cultures. Using the bonds of medicine to build on, we can help shape a better and safer world for our children.

Barriers and borders between economic classes and cultures exist, however, not only on an international stage. It seems that we are moving towards having more and more Americans whose general healthcare is near a Third World level, even as we continue to expand the limits and frontiers of First World healthcare. We must continue to push these limits, but we must also continue to advocate for all

our prospective patients. We must not squander resources, but we should question limits placed on healthcare–economic or otherwise. By being the voice of our patients and supporting efforts to provide care through humanitarian efforts, we strengthen our voice as physicians when we seek to be heard across the full range of our agenda and concerns. Working together, we can look to improving our practice environments, improving our ability to provide care, and improving all our lives.

Stanley D. Brauer, M.D.–District 2 (Mono, Inyo, Riverside and San Bernardino Counties): Hospital news includes rumors that Chino hospital has been purchased by Kaiser. Kaiser has opened a new outpatient surgery facility in Ontario, with six operative suites.

San Antonio Hospital has posted a loss in operations the past year and is renegotiating many of its health plan contracts, giving out retirement packages and doing some layoffs to try to turn things around. They also gave the CEO a retirement package and are currently searching for a new CEO.

Angel's Hospital in Rancho Cucamonga closed and reportedly was sold to a for-profit company that is attempting to reopen it.

An interesting small hospital with 40 beds is being proposed for Loma Linda. A private group of cardiac and orthopedic surgeons are the chief investors. Critics allegedly have suggested that the small ER may be intended to avoid specialty hospital regulations, and that the ER could close after the hospital is open.

Reports from many anesthesia groups include the ability to capitalize on the relative shortage of anesthesiologists by renegotiating managed care contracts to higher, more acceptable levels. Several groups have received increased hospital subsidies for Medicare/Medi-Cal. Obviously, this comes at a greater dependence on them financially.

Robert Martin, M.D., Secretary of the CSA for many years, has been appointed as Chairman of the Anesthesiology Department at Loma Linda University. Congratulations on that new position.

Earl Strum, M.D.–District 3 (Northeast Los Angeles County): Construction projects continue to abound throughout the district. The new hospital at City of Hope, which will replace the current one, is now scheduled to open in mid-

December this year. The ORs will expand at that time. The $820 million LAC-USC Medical Center Replacement Facility–which is cited as the largest capital construction project ever undertaken by the County of Los Angeles, and the largest in terms of square footage and cost currently underway in the country–is pointed at March 2007 for completion. Already up and running for several months now, USC's new Healthcare Consultation Center II houses anesthesiology's pain management program. The new tower addition to USC University Hospital continues on schedule for opening in January 2006, when 12 new ORs will become available.

Tenet's problems are being reflected throughout the district. Whittier Hospital has been sold by Tenet to a practitioner representing a group of investors. Although there is discussion about the hospital becoming a convalescent home, its ultimate disposition is unknown. Nearby Presbyterian Intercommunity Hospital (PIH) undoubtedly will pick up much of the displaced volume and will be getting a new CEO. The anesthesiology group at PIH allegedly has dropped its Blue Cross contract due to poor reimbursements. Tenet has also sold Garfield Medical Center, a 210-bed Monterey Park hospital that has been part of Tenet since 1969.

On July 1, Dr. Brian E. Henderson spent his first day as the new dean of USC's Keck School of Medicine. Dr. Henderson took on this role following the resignation of Dr. Stephen J. Ryan, who had filled that position since 1991. Dr. Henderson, in a letter to all faculty, emphasized that the transformation of the physical campus with the ongoing addition of four new buildings, plans for the development of a biomedical research park and plans for other new facilities all will continue smoothly. He also stated that one of his first priorities is to focus on developing a new strategic plan for the school's clinical mission. All of the construction work, openings of new facilities, changes in numbers of rooms, beds, and personnel needs, et cetera, will require extensive planning and preparation–especially for the opening of the new County Hospital facility in 2007. To address these and other complex problems, Dr. Henderson has created a strategic planning group.

Another important personnel change at USC, also effective last July, was the return of Ted Schreck as CEO of USC University Hospital and USC/Norris Cancer Hospital. He first joined Tenet in April 1998 as CEO of University Hospital and was promoted to regional vice president of operations in June 2001, and then to senior vice president of operations in September 2002. He faces Tenet-related financial problems and has stated that there undoubtedly will be cutbacks in the near future.

Several members in the district who were Board-certified before 2000, when the ABA introduced Time-Limited Certificates (TLC) that must be renewed every 10 years, have expressed some concern regarding the somewhat ambiguous explanation of ABA's new Maintenance of Certification in Anesthesiology (MOCA) program. MOCA, which went into effect in January 2004, is designed to allow an ongoing, somewhat self-maintained process of recertification over 10-year cycles. The mechanics of the process for those certified after 2000 are relatively clear. However, those whose certificates have no expiration date are told that "externally imposed federal, state and local initiatives…may require documentation of updated qualifications." There is no definition of what those initiatives "may" be, and no clear explanation of what will happen if updated qualifications are not met. Explanations of voluntary programs that are already in progress or newly established within MOCA describe options; however, there is no clear statement that participation in MOCA is either mandatory or voluntary for the pre-2000 diplomates. (See a more detailed article on MOCA by Dr. Strum on page 25.)

Christine A. Doyle, M.D. – District 4 (Southern San Mateo, Santa Clara, Santa Cruz, San Benito and Monterey Counties): As the new District Director, I have spent the past couple of months learning more about the District. I consider the demographics and other information interesting, and feel that the other members of the Board will be interested as well.

There are currently 307 members in all categories of District 4. One hundred twelve of those members list Stanford as their primary hospital affiliation, and 37 are resident members. There are 23 separate facilities, with the bulk being inpatient hospitals.

The major district event is that San Jose Hospital will be closing on December 9th. After the hospital's purchase by Columbia/HCA several years ago, there has been long-standing speculation that this centrally located trauma center would be closing. However, the announcement made on September 8, 2004, was abrupt. Approximately 450 employees are facing the loss of work, although because of HCA's ownership of two other area hospitals–Regional (formerly Alexian Brothers) and Good Samaritan–and seniority rules within the union, it is unclear if the lost jobs will be solely from San Jose Hospital employees. The press release cited a $16 million loss over the past fiscal year as one of the underlying reasons for closure. In addition, the building requires significant seismic retrofitting. Regional has stated an intention to form a trauma center, but it is unclear if they will be able to do so in a timely fashion. Still unclear is the

effect that this will have on Associated Anesthesiologists Medical Group that provides anesthesia services at five facilities, including both San Jose and Regional hospitals.

Other events of note in the district include one hospital's recent bylaws voting, which included a proposed change to allow the CEO to grant privileges, as well as guidelines relating to disruptive behavior. The disruptive behavior has not been defined, although administration has already changed the handling of physician complaints by having the Chief Medical Officer (a member of the administration) review such complaints before notifying the alleged disruptive physician's department. Most physicians queried indicated that they did not support either of these proposed changes. Although the voting has been closed for some time, no announcement has been made about the results.

J. Renee Navarro, M.D. – District 6 (San Francisco and North San Mateo Counties): The workforce continues to fluctuate within the district. However, the UCSF 2004 resident graduates had little trouble finding jobs. Nine of the graduates found jobs within California (seven Bay area, two southern California) and three in other states (two Washington, one Colorado) and one-third of the graduates have gone into fellowship training programs (two Pediatrics, two ICU, two Cardiac). Many of the recent graduates have changed their membership within the CSA and we welcome them.

All of the district's hospitals continue to develop plans for rebuilding of their hospital facilities.

Some of the anesthesia groups have been very successful in working with their hospital administration to provide increased financial support for those services rendered that previously have not been reimbursed. This includes compensation for physician participation in the organized medical staff activities as well as the physician administrator.

Helen T. O'Keeffe, M.D. – District 7 (Alameda and Contra Costa Counties): Overall, District 7 remains unchanged–population and employment are fairly steady, and the area is still attractive to young physicians. However, within this larger picture of no big change, there has been a rearrangement of delivery of services, namely a medium-sized OB service at Summit, one of the Oakland hospitals, has been closed, and the service merged with Alta Bates to form a consolidated large delivery service at this hospital.

This underlines the fact that OR/OB-based anesthesiology is essentially a specialty primarily responsive to other specialties rather than a direct patient service. So, when such consolidations are made, the anesthesiologists involved necessarily must be affected by–and responsive to–the surgeons' or obstetricians' relocations. There are many downstream events, in anesthesiologists' lives and business arrangements, set in motion by an upstream economic decision.

Denise Bogard, M.D.–District 8 (Alpine, Calaveras, Amador, Sacramento, San Joaquin, Placer, Yuba, El Dorado, Yolo, Sutter, Nevada, Sierra and East Solano Counties):

Private Sector:

- There seems to be some difficulty with recruiting in some hospitals as reimbursement continues to be low in the Sacramento area.
- Kaiser continues to grow and expand in the Greater Sacramento area.

Academic Sector:

- The Center for Virtual Care is operating and has been found to be a useful tool for anesthesiology residents, emergency room residents, surgical residents, internal medicine residents and medical students. It is a state-of-the-art facility consisting of a variety of medical scenarios to play out, the outcome of which depends on actions taken. The Center for Virtual Care is in the forefront of a national trend in medical education to supplement the traditional "see one, do one, teach one" approach. Dr. Peter Moore, professor and chair of the Department of Anesthesiology and Pain Medicine, is the medical director of the Center for Virtual Care.
- The workload continues to increase at UC-Davis as the need to supply anesthesia in remote places such as radiology and cancer centers is on the uprise.
- Plans for a Pediatric Surgery Center for the UC-Children's Hospital are underway.
- Plans for a Surgical Services Pavilion with 32 operating rooms are underway.
- Claire Pomeroy, M.D., Department of Infectious Diseases, was named Vice Chancellor of Human Health Affairs and Dean of Medicine for the Medical School at UC-Davis.

Peter E. Sybert, M.D.–District 9 (Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskyou, West Solano, Sonoma, Trinity, Colusa, Glenn, Butte,

Plumas, Tehema, Shasta, Lassen, and Modoc Counties): The property tax measure voted on to support Healdsburg Hospital has passed. A reprieve has been extended there. The facility, however, needs to define further its direction regarding whether it will have 24/7/365 operating room coverage, concentrate on day/elective surgery only–or something in between.

The situation in Redding continues to evolve. Tenet has sold its facility, which now has been under "new management" for the last few months. The anesthesia community continues to respond to the various stresses, working in different locations and some having left the area. A steady state has not yet been reached.

Office practices in many areas continue to expand and so more work locations are available. This also means more anesthesiologists are needed to staff either these locations or those vacated by current staff. As the healthier patients have procedures in offices or in newly opened surgery centers, the traditional hospitals have sicker and sicker patients.

More locations, however, also mean more employment options. There is currently more locums activity in the district than for quite some time, and multiple practices are looking to add anesthesiologists. This is a nice change from the practice contractions of just a few years ago.

Daniel M. Cosca, M.D.–District 10 (San Luis Obispo, Santa Barbara and Ventura Counties): Community Memorial Hospital in Ventura continues to be of interest. The major differences between the administration and the medical staff seem to have been resolved. As mentioned in the previous report, the long time CEO left in 2003. The new figurehead appears to be more reasonable in the doctors' view, and a settlement seems to be at hand, but must be ratified by the medical staff via bylaws change. Under the agreement, the physicians have more control over their hospital activities and politics. Mechanisms are to be put in place to handle differences with administration. The suit the doctors were waging against administration has been suspended pending follow-through on the agreed-to agenda.

St. John's Regional reports a continued increase in surgical volume as a result of the Ventura Memorial situation. However, St. John's may have some tough negotiations with the union representing nursing and other employees.

In Arroyo Grande, the new surgery center for the area has not yet opened due to delays with inspection and licensure.

From the northern part of our district, Catholic Healthcare West and a group of approximately 100 doctors have formed an alliance whereby the physicians are purchasing hospital properties in San Luis Obispo and Arroyo Grande, and leasing such to the corporation.

On a personal note, this director would like to recognize Mark Richman, one of our district members, formerly a district delegate. Doctor Richman is a military reservist and was called to the Middle East for several weeks earlier this year. He is scheduled to go back again in the Fall. As other physicians in the reserve, he has unselfishly disrupted his private practice to serve his country.

Johnathan L. Pregler, M.D.–District 11 (West Los Angeles County [western portion]): There has been good news and bad news regarding medical facilities in District 11. Tenet Healthcare Corporation's attempt to sell several hospitals has moved forward with the negotiation of the sale of Centinela Hospital, Daniel Freeman Memorial Hospital and the Daniel Freeman Marina Hospital. The buyer is a private investment group that is led by the current chief executives of the facilities. According to a report in the *Los Angeles Times*, 70 doctors contributed to a fund that paid for the group's due diligence prior to making the purchase offer. All 1,400 physicians who practice at the hospitals will be invited to invest in the operating company. The group has pledged to keep open the emergency rooms at all three facilities after the sale which is certainly good news. Hopefully the new owners will be able to make the hospitals financially self-sustaining so that the bed shortage in the western area of Los Angeles is not exacerbated.

Developments at Martin Luther King Jr./Drew Medical Center, although not in District 11, will have a negative impact on hospitals over a broad region including western and central Los Angeles. On September 13 the Los Angeles County Board of Supervisors voted to shut down the trauma unit at the hospital. The closure is expected to take effect 90 days after a hearing process is completed. King/Drew is the second busiest trauma center in the region next to Los Angeles County-USC Medical Center. The trauma centers in District 11 will probably see an increase in volume if the closure occurs.

Construction of renovated and new hospital facilities continues to move forward. St. John's Medical Center is starting to open sections of their new hospital. Some anesthesia services are being provided in the new building already. Construction of the UCLA Westwood Replacement Hospital and the new Santa Monica UCLA Medical Center & Orthopedic Hospital is continuing. The opening of these facilities is scheduled for the end of 2005 or early 2006.

Construction will also begin on a renovation and expansion project for the UCLA Surgery Center to be completed around the same time. Cedars-Sinai Medical Center is also in the process of building a new wing to their facility that will house new ICU beds and should be completed at the end of 2005. Except for the UCLA Surgery Center expansion, all of these projects are providing replacement beds for older facilities and won't add to hospital capacity in the region.

Demand for anesthesiologists continues to be high in West L.A. All of the department representatives that I spoke to stated that they are currently hiring. Facilities are running operating rooms later than they ever have in the past. With operating room capacity tight, hospitals are trying to meet the demand for surgical procedures by extending operating room hours. This has put increased production pressure on the hospital staff and our surgical colleagues. It has also pressured Anesthesiology Departments to provide more services after hours. Several commented that they are finding that new graduates are not as willing to participate in evening and weekend coverage of the operating rooms as have graduates from previous years. As a result several groups are preferentially hiring physicians who have been out in practice for 10 years. One department head commented that new grads want to work only when it's convenient. This pattern is disrupting the traditional model of transitioning weekend and night shifts away from senior members of groups to the more junior physicians. Groups have been forced to reconsider their exit strategy for older physicians who want to continue to practice but don't desire–or can't participate equally in–call and evening obligations.

These trends are going to continue to shape the practice of our specialty in the western area of Los Angeles for the foreseeable future. Hospital operating room capacity will be limited and won't expand in the near future. The demand for operative resources will continue to increase as will the demand for anesthesia services out of the operating room. The new generation of anesthesiologists has trained in an era of limited hours and protected time away from the hospital that has changed their expectations of workload upon graduation. Academic and private groups will need to develop new ways to provide incentive for weekend and evening coverage and new models of staffing to keep operating rooms functioning around the clock. This will be the ongoing challenge for the next several years.

Finally, I would like to write a few words to introduce Dr. Jim Moore, who has just been elected to be the new District Director for District 11. He is an Associate Clinical Professor at UCLA and Director of the Acute Pain Service.

He has been a CSA delegate for the past three years. He has served on the ASA Local Anesthesia and Pain Committee, and Co-Chairs the UCLA Medical Center Pain Committee. Please join me in welcoming Dr. Moore to the CSA Board of Directors.

John A. Lundberg, M.D.–District 12 (Southeast Los Angeles County): We have seen the progressive evolution and growth of the physician surgeon owned surgicenter here. Pain management dominates most of the surgicenters here but there are others which cater to gastrointestinal endoscopy, ophthalmology, orthopedics, urology, podiatry, and ENT. A few surgicenters have been doing lumbar discectomies utilizing minimally invasive surgical techniques, a procedure done only in the hospitals until recently. Time will tell which procedures can be done in the outpatient surgicenters.

It's not unusual for the surgeons to take their better reimbursing patients to the surgicenters, and their Medi-Cal and poorly reimbursing patients to the hospitals. The economic base at the hospitals is beginning to erode and attracting anesthesiologists to the hospitals has become increasingly difficult. Why would one want to work in the hospital and take call when one could work in the surgicenter at better recompense and not take night call? Of course this is not the whole story, and as things change, other issues likely will become important.

The nursing shortage seems to have stabilized, or at least the nursing administrators have developed strategies to minimize the effect of the nursing shortage. It's very common here to use nursing registries on a daily basis and employ nurse "travelers" on a contract basis. This has been such a chronic issue that we have become accustomed to it.

We have not seen any HMO bankruptcies or HMO Ponzi scheme bankruptcies lately. However, there has been a gradual erosion of anesthesia units paid by payers. Payers are often disallowing submitted units billed–in effect discounting anesthesia fees. Payer negotiation has been intense and some anesthesiologists have cancelled contracts with major insurance payers because they feel they have been treated unfairly.

Anesthesiologists are still in short supply here. Graduating residents should find handsome employment opportunities in District 12, and this is expected to continue for the foreseeable future.

Kenneth Pauker, M.D.–District 13 (Orange County): As more freestanding surgical facilities continue to open, it is becoming apparent that operating room staff who have long felt overworked and under-compensated are migrating to these facilities which often offer better working conditions and no call. Hospitals seem increasingly to be staffed by "travelers," nurses who may actually be better paid than permanent staff, and even given housing allowances. Many of these "temporary staff" are quite competent and well-trained, but some may not have enhanced the quality of the service rendered to the patients and doctors who rely upon them. Some permanent staff have elected to become "travelers" in order to get paid more while still continuing to work in their same jobs. The implications of this evolution in employment relations in the surgical suites remain to be seen. There seems to be a relatively fixed supply of staff available in some locales, and some hospitals–and now even some of the older outpatient centers–are experiencing issues with respect to having adequate staff to run the number of operating rooms desired.

Western Medical Center is one of the Tenet hospitals to be sold. A long list of suitors have participated in what has become an extremely convoluted negotiation. This has apparently produced a very tumultuous ride for the medical staff, who have felt disenfranchised by the process. The hospital had been "in the black" until Tenet's recent legal problems. Some suggest that the hospital is now losing money because of Tenet's unwillingness to seek appropriate compensation for outliers, and because of their signing some very unfavorable contracts, at least some of which may relate to their trying to heal public relations. Since February 2004, the medical staff has been on a path to try to purchase the hospital outright, or to do so in partnership with another entity, such that the medical staff has a substantial equity stake and decision-making voice. The medical staff has been concerned that some of the entities Tenet has considered may not be the strongest players, and that there may be motivation for Tenet not to sell to the most viable player because it will be in competition with its other local hospitals such as Irvine Medical Center and Fountain Valley Medical Center. Apparently what has prevented this from happening already is the medical staff, which has vocalized its ability to compound Tenet's problems with additional bad publicity. Excellent relations with the local hospital administrators continue.

At Saddleback (SMMC), planning continues for the hospital to build, in partnership with physicians, four (five when last reported) new outpatient operating rooms in the Medical Office Building, perhaps opening in part in January 2006. SMMC announced an agreement for it to purchase Samaritan Hospital in San Clemente from the physician group who now owns it and to run it under the

Saddleback license. There is, hence, a discussion about merging the medical staffs. The stated intention is to keep this hospital as an acute care facility, at present 72 beds with three ORs (using one to two each day). There is a history of some difficulty ensuring anesthesia coverage because of a poor insurance mix and low volume.

The Health South Ambulatory Surgery Center of Huntington Beach, three ORs at Beach Boulevard and the 405 freeway, closed July 1, 2004, reportedly because of parent company issues. Various entities have bid on the premises with an outcome expected soon.

Throughout the Southern California Permanente Medical Group's Anesthesia Departments, goals for 2004 are being implemented: Peri-operative Patient Safety Briefing during the required pre-incision pause, Patient Controlled Epidural Analgesia with L&D nursing and pharmacy support, and the Pediatric Peri-operative Plan. The Regional Chiefs' Group is also working on IDDM, beta blockers, electronic medical records, and difficult airways.

The report from the Allied Anesthesia Group is that all is on an even keel at St. Joseph's Hospital, but that there is an interesting wrinkle at Children's Hospital of Orange County (CHOC). CHOC, an independent non-profit entity which is not a part of St. Joseph's or Catholic Healthcare West, but which in the past has shared professional services, is at present making a strong push to establish its reputation as one of the "top ten" children's hospitals in the nation. As such, its administration is attempting to establish for all of its hospital-based physicians "professional services standards," and has brought in a non-physician outside administrative consultant to do so, in effect trying to stipulate physician clinical standards without soliciting the expertise and decision-making of its local physician experts. One of the suggestions has been that all anesthesiologists on the staff be fellowship-trained in pediatric anesthesia. It appears unlikely that this approach will be embraced by the anesthesia group which at present services this complicated, largely Medi-Cal patient population.

As District Director, I had been dissatisfied for some time in the relatively low percentage of members in the CSA and ASA within my own large group of 60 anesthesiologists, California Anesthesia Associates (CAA), spanning Saddleback, South Coast, and Long Beach Memorial. Moreover, I was frustrated with my inability to recruit even people I knew well and with whom I spoke often. I submitted a roster of my group to the CSA and found that less than 50 percent were members and that those who did belong were largely the "old-timers." Our

newer and younger members, the very group for whom we labor in our professional organizations in the hope of passing along a vibrant future practice, had very low rates of membership. Armed with this data and also with the knowledge of the kinds of activities presently underway to enhance our practices vis-à-vis government regulation and reimbursement on both the state and national levels, in addition to the extraordinary expense of the development of practice guidelines, I urged our Board to consider how to help stimulate participation in these professional activities. I argued that we should consider membership and participation as our professional responsibility, a kind of civic duty, and quite simply as a cost of doing business. I am proud to report that the CAA Board decided to pay dues for all of its members out of corporate overhead, and this produced 30 new members in Districts 13 and 12. Many large groups in Northern California have mandated CSA/ASA membership for years, and it is hoped that many groups, especially those which are larger and better organized, can be persuaded to adopt this same tack to enhance CSA and ASA participation. A copy of the e-mail sent to all CAA members is available from the CSA office at (800) 345-3691.

Morris Jagodowicz, M.D.–District 14 (Los Angeles County [northwestern portion]): The drop in reimbursement by workers' compensation to surgery centers is taking its toll on San Fernando Valley facilities. A few are at the verge of bankruptcy. Others are cutting back on staff as well as services with poor reimbursements.

Catholic Healthcare West has decided to close the Northridge Hospital, Sherman Way Campus. Staff will be relocated to the main campus at Roscoe and will be absorbed by surrounding hospitals. The anesthesia department will have to find work elsewhere.

William Ko, M.D.–District 15: Resident CSA involvement is crucial to continued involvement and increased membership in the CSA upon graduation. To this end, the resident wing of the CSA aims to continue development of the CSA Web Site to disseminate information deemed relevant to anesthesiology residents across California. I would like to commend Dr. Johnathan Pak for his efforts last year to incorporate valuable information on practice management for residents. We will continue to collect information on this important topic throughout the year and post them on the resident section of the CSA Web Site. Other areas of resident interest include networking for job relocation, the establishment of CSA mentors, volunteerism, and education resources.