

District Director Reports:

April 2008

The district director reports that appear below contain personal views expressed by each director, rather than statements made by or on behalf of CSA.

Michael H. Verdolin, M.D.—District 1 (Imperial & San Diego Counties)

I practice pain management in a solo practice four days a week. The fifth and sixth days are spent as a per-diem pain management physician with Kaiser Permanente. I also maintain collegial contact with my old institution at the Naval Medical Center and academic contacts with UCSD.

The central issues faced by the military anesthesiology community continue to be deployment-related pressures, with more than two anesthesiologists deployed for a year overseas at any one time. San Diego County houses the second largest naval medical center and the Camp Pendleton hospital facility. The Naval Medical Center has the most sought after anesthesiology residency in the Navy. The naval hospital has pioneered ultrasound-guided regional anesthesiology programs to benefit returning war wounded. There are 19 residents in the program, and there appears to be a continual supply of eager applicants for at least the next five years. Additionally, recruitment of physicians to attend to the growing list of casualties has expanded to a full complement of five dedicated acute and chronic, fellowship trained, pain management specialists. Captain John Shapira, District 1 delegate, continues at the helm of this dynamic department.

The University of California, San Diego, Department of Anesthesiology is the major academic program in the district. Dr. Ed Mariano, District 1 delegate, continues to develop and expand an innovative regional anesthesiology program and fellowship. He coordinates with Dr. Tobias Moeller-Bertram at the Veterans Administration center, and is planning on forging further links with the Naval Medical Center, beyond the yearly, and highly successful, regional anesthesiology course. The department is headed by interim chairman, Dr. Gerard Manecke.

The Kaiser Permanente Foundation hospital system comprises another large contingent of anesthesiologists. The staff now has a new chief of service in Dr. Chor Eng.

The private practice landscape in District 1 is varied, but it clearly has the stamp of managed care systems upon it. The plans continue to adversely impact individual physician practices with meager, diminishing reimbursement

District Director Reports (cont'd)

rates compared to other major metropolitan areas in California. The absurd designation of this district of 4 million residents as a “rural county” also continues to depress fee-for-service contracts.

My goal is to bring our diverse group of physicians and practices together and flesh out some ideas to address each of the challenges facing us.

Stanley D. Brauer, M.D.—District 2 (Mono, Inyo, Riverside & San Bernardino Counties)

Hospital construction and buyout activities continue. The physician investor group-owned hospital in Loma Linda named “California Heart and Surgical Hospital” should open by summer 2008. Rumors circulate in regard to a possible sale, but nothing has actually occurred. The partnership owning the facility includes Cirrus Health, based in Trophy Club, Texas, a nationwide healthcare development and management company specializing in ambulatory surgery centers and specialty surgical hospitals. Redlands Community Hospital opened a new wing in December with additional maternal beds and new operating room facilities. Kaiser continues its construction of new facilities in Redlands.

In Moreno Valley, voters nixed selling financially troubled Valley Health System to Select Co. Instead, hospital district trustees in February 2008 voted to sell to Kaiser (for \$47 million) the 101-bed Moreno Valley hospital and adjacent office building to operate as a community hospital, leaving the district with hospitals in Menifee Valley and Hemet, where the district also owns a skilled nursing facility. Since the Kaiser deal was announced, Chino-based Prime Healthcare has sent an unsolicited offer to purchase the Moreno Valley hospital and its assets for \$52 million. Most bets are on the Kaiser deal to go to completion.

Concerns from around the district are similar to anywhere else in regard to how the state could consider cutting Medicaid payments even further. California anesthesiologists average about one-third of the payment received by physicians in the three adjacent states for identical services. Imagine the uproar if Medicare payments were that discordant.

Wayne Kaufman, M.D.—District 3 (Northeast Los Angeles County)

The new L.A. County–USC Medical Center’s opening date has been postponed until probably September. This is partially to allow the new residents and interns to get acclimated prior to having to get used to working in a new institution. It will also allow time for negotiations between LAC and USC

District Director Reports (cont'd)

about a potential increase in anesthesiology services, which could help shorten the number of days a patient would have to wait until they had surgery. The LAC-USC anesthesiology residency program matched all 17 spots this year with excellent candidates. In the meantime the graduating class of residents are having a great deal of success with their job searches.

I would like to take this opportunity to welcome our new delegates and alternate delegates: Drs. Tawfik L. Ayoub, Gligor V. Gucev, Steven M. Haddy, and Jeffrey D. Parks.

Christine A. Doyle, M.D.—District 4 (Southern San Mateo, Santa Clara, Santa Cruz, San Benito & Monterey Counties)

District 4 includes the bulk of five counties but does not include Daly City or South San Francisco. The list of state-certified practice locations includes 934 throughout the state. Of note, none of the Veterans Administration facilities is included. Within that list, District 4 includes:

- 25 hospitals (including Stanford and Lucile Packard Children's Hospital, both teaching centers, and **not** including the Palo Alto VA)
- 43 free-standing surgical centers (not including any office-based settings)
- 303 active and eight life members
- 56 residents
- 74 retired

Paul B. Coleman, D.O.—District 5 (Kern, Tulare, Kings, Fresno, Madera, Merced, Mariposa, Stanislaus & Tuolumne Counties)

Within District 5, a coalition of Central Valley politicians and business and community leaders are joining forces to lobby University of California leaders to build a medical school at UC Merced. The region has a physician shortage and lack of adequate healthcare resources. The entire state of California is expected to face a shortage of up to 17,000 physicians by 2015, and the Central Valley is already experiencing this shortage. Valley residents are medically underserved, with 87 primary care physicians per 100,000. The number of medical specialists per capita is even lower when compared with other parts of the state. These statistics highlight the seriousness of the problem, and community leaders feel the best way to address this shortage is to promptly establish a medical education program at UC Merced.

District Director Reports (cont'd)

To that end, the University of California's Health Sciences Advisory Council has recommended a 34 percent increase in medical student enrollments by 2020. The Council also recognized that medical education programs need to develop in the Valley, where projected population growth rates are twice that of the rest of the state. There exists strong evidence that new physicians choose to settle into full-time practice near where they trained. Establishment of a medical school in the Valley would produce benefits for the health of the region.

The medical school will be founded on a community-based distributed model of medical education, utilizing current medical facilities in the Valley, as well as the resources of UC San Francisco and UC Davis. The first two years of medical education will be on the UC Merced campus, and the second two years of medical education will be in a clinical setting, with the first clinical campus slated to be at the UCSF Fresno Medical Education Center. More than 20 of the largest community hospitals and community health centers in the Valley are eager to collaborate with UC Merced.

Emanuel Hospital in Turlock has been feeling the pressures of this physician shortage, with its population increasing by over 60 percent since 1990 to 69,000. This has resulted in over 40 percent of emergency room patients treated for conditions that could otherwise be cared for in a doctor's office. In an effort to deal with the situation, Emanuel Hospital has recently opened the Emanuel Physician Center, with plans to open additional care centers within a 30 km radius.

District 5 continues to make inroads with our congressmen, including attendance at a breakfast fundraiser in Modesto for Representative Radanovich for which the ASAPAC sponsored a table. The fundraiser gave the CSA an opportunity to meet and get to know the congressman's local field office staff. Representative Radanovich also had a smaller get-together breakfast in downtown Modesto. Once again, we met with the field office staff as well as the congressman's Washington, D.C., Chief of Staff. This gathering, being a more intimate affair, permitted an opportunity to speak one on one with the congressman and thank him for his support of HR 2053, the Anesthesia Teaching Rule.

Steven J. Younger, M.D.—District 6 (San Francisco & North San Mateo Counties)

Several significant events came to pass late in 2007 and early 2008 that raise concerns about the future of healthcare delivery. In November, California Pacific Medical Center (CPMC) was rocked by a two-day nursing strike

District Director Reports (cont'd)

brought about by the California Nurses Association. What is more, the nurses' union announced that it would stage even more brutal 10-day walkouts. The push to strike against Sutter Health comes from union leaders who, according to the President and CEO of CPMC, continue to ignore contract offers despite the implementation of "wage and benefit enhancements." The union's mantra is that strikes are about patient care, yet the walkouts continue to disrupt the elective surgery schedule and necessitate the temporary hiring of outside nursing staff unfamiliar with the CPMC's workload and patient population. Labor union-related problems allegedly also continue to perturb CPMC's efforts to create a new medical center in downtown San Francisco. California's newest building regulations for seismic preparedness soon will render the physical plants at the five campuses obsolete. The most recent problems arose when construction plans were shelved by the San Francisco's Board of Supervisors, allegedly after pressure from the Service Employees International Union.

In keeping with a national trend, there is increasing concern over so-called "Horizontal Scheduling" around San Francisco, that is, the increase in the number of "anesthetizing locations" that need to be covered each morning, coupled with the dwindling number of rooms running longer than two to three hours per day. As hospitals and surgery centers strive to attract more business, there is increasing pressure to provide more opportunities for cases to get started first thing in the morning, rather than being scheduled consecutively. Clearly, some balance will need to be struck in the future to provide for adequate workloads for anesthesiologists.

One result of the increasing caseload is the growth of CPMC's group at an unprecedented rate, a 25 percent increase over the last five years (we now total 50 anesthesiologists). My colleagues at Kaiser San Francisco report a substantial increase as well.

Just as I often feel isolated from my partners only one or two rooms away, we often remain isolated from other groups practicing in the same locale. I always find it educational to watch my partners in action, and I think it would be beneficial to learn what life is like in other practices as well.

Uday Jain, M.D.—District 7 (Alameda & Contra Costa Counties)

The Kaiser Permanente anesthesiologists constitute a large proportion of District 7 anesthesiologists, which has a high proportion of CSA members. Alameda County Medical Center and Kaiser Foundation Hospitals employ a significant number of CRNAs, and the relationship between physicians and

District Director Reports (cont'd)

CRNAs appears to be positive. A new Kaiser Foundation Hospital opened in Antioch (the northeast part of the district).

There are no M.D. anesthesiologist training programs in this area. Samuel Merritt College, Oakland, has a CRNA training program. One of the problems facing District 7 hospitals is the difficulty in recruiting qualified nonanesthesia personnel for perioperative care.

District 7 held a meeting on March 20 with a lecture and discussion by Edmund I. Eger, M.D., sponsored by Baxter.

Jeffrey Uppington, MBBS—District 8 (Alpine, Amador, Sacramento, Placer, El Dorado, Nevada, Sierra, Yuba, Yolo, Sutter, San Joaquin, & Calaveras Counties)

Recently most of my time as district director has been taken up by the issue of the Medical Board of California's decision to sunset the Diversion program. Because it is important that CSA members know what is happening to this program and what will happen in the future, I will use this report to give an update.

The Diversion Program has been under some pressure for a number of years. It has failed a number of Audit Reports, essentially because of problems in monitoring physicians in the program. Senator Ridley-Thomas, a friend of CSA, had sponsored a bill to continue to improve the Diversion Program. However, the last largely negative report from the State Bureau of Audits, again based on the monitoring issue, was seized upon by Julie D'Angelo Fellmuth, the MBC Monitor who has the media's ear, and the MBC quickly voted to let the program die upon its June 30, 2008, sunset date.

The media are important because there is a patient lobby that claims that impaired (alcoholic) physicians caused long-term disabilities from plastic surgery. D'Angelo Fellmuth believes that the role of the MBC is licensing and discipline only. Treatment and rehabilitation she believes is the job of private practice and that drug addicted physicians should not be shielded from public scrutiny and Board discipline. The Board, under its present Chairman Richard Fantozzi, M.D., clearly agrees with her and decided to end the Diversion Program.

In January, the MBC held a summit meeting. A number of people testified, including me, on behalf of the CSA. It was clear from that meeting that the Board's decision to end the Diversion Program was final and irrevocable. It will leave California as the only state in the Union without any sort of Diversion Program.

District Director Reports (cont'd)

The CSA is now working with the CMA to decide how best to go forward. There is more than one way to run a Diversion Program, and about 30 states actually have a program run by the component state medical society independently of the State Medical Board. Ultimately, any ability to protect an impaired physician's confidentiality will have to come from the legislature. Senator Ridley-Thomas recently held a meeting of the Senate Business and Professions Committee, of which he is the Chair. Although CMA testified at that meeting, the MBC has refused to meet with the CMA. The CMA presently is looking at the option of running a Diversion Program itself, but these are early days.

Meanwhile, what happens to those physicians presently in the Diversion Program, and what happens to physicians who become impaired through drugs in the future? The Wellness Committees of various hospitals have been grappling with this. The chairs of the Wellness Committees have been left not knowing how to handle the confidentiality of impaired physicians in the future. The Office of the President of the University of California hospitals drafted a number of questions to the MBC and, rather than try to paraphrase, I will give the questions and answers in their entirety. They are not as clear as one would like! [Note: If you would like a copy, please contact the CSA office at csa@csahq.org.]

Jason A. Campagna, M.D., Ph.D.—District 10 (San Luis Obispo, Santa Barbara & Ventura Counties)

The district has remained relatively stable in terms of issues of great import to the general membership. There are, however, some specific events and concerns for members of this district.

First, I am proud to nominate two wonderful people and talented physicians from Santa Maria to become new District 10 delegates. Dr. Mike Lim and Dr. James Justice. We share very similar thoughts and aspirations for our region and our profession in general.

The southern area of our district, primarily the Ventura/Oxnard area, has been largely event-free, save for an uptick recently in difficulty finding orthopedic surgical coverage. In Santa Barbara, Cottage Hospital has seen the impact of that difficulty in a much larger number of transfers and transfer requests.

The northern areas of the district, primarily Santa Maria through San Luis Obispo and the Twin Cities, continue to be the area of growth for Santa Barbara/San Luis Obispo counties. Not surprising, there have been reports of hiring difficulty. In Santa Barbara, construction of a new \$800 million hospital complex continues.

District Director Reports (cont'd)

We have begun to expand pilot projects, from the large anesthesia group in Santa Barbara to other areas of Santa Barbara County (a large part of our district). Specifically, we have opened up the adjunct appointment opportunities to all anesthesiologists who have an interest in such things. Another expansion is CME credit for “local” departmental grand rounds. My group has implemented this for our monthly program, and we are expanding it to the Santa Maria group in the near future. Our vision is that the region becomes more of an integrated network of private-practice physicians who regularly interact with one another on professional matters.

Our major focus, however, for the next few cycles of this report will be on convening a “working” group of practicing physicians in the district to establish a plan of action to work more closely with insurers to develop “homegrown” metrics for quantifying patient care processes. At present, as is widely appreciated by the general CSA membership, we are confronted with such process metrics largely by fiat, and largely without any input into their design. After talking with many members in this district, we have decided that a more proactive, local approach to the design and implementation of such metrics will better match patient care needs with the realism of cost pressures. Our guiding principles are that the metrics should reflect the actual nature of our patient population, and that they be designed to capture real-world practice in order to determine if that practice can be augmented or modified in such a way as to produce similar or better outcomes in a more valuable or efficacious manner. The project is a pilot and is just getting off the ground, but it is our hope that such effort on our parts will show tangible evidence to our local payer groups that our dedication to patient care includes helping to design the metrics to which we will ourselves be subjected.

My continued gratitude to Dr. Owen Shea, former District Director, for his reliable and vigorous support during my transition to this position.

James M. Moore, M.D.—District 11 (West Los Angeles County [western portion])

Some recent events in District 11 have far-reaching implications that may be of interest to many. Recent Department of Health Care Services inspections, at several hospitals in California, required under Centers for Medicare and Medicaid Services “conditions of participation,” resulted in findings of non-compliance related to the use of selected medications that have FDA-mandated boxed warnings (often called “black box warnings”) in their package labeling. Medications implicated included droperidol, haloperidol, and fentanyl in transdermal form. The highest level of noncompliance, a finding of “immediate jeopardy,” was cited at one institution in relation to droperidol use. The

District Director Reports (cont'd)

propriety of the FDA boxed warning for droperidol, which recommends pre-treatment ECG analysis and continuous ECG monitoring for two to three hours after treatment out of concern for serious dysrhythmias, has been challenged for years by many experts, as is well documented in the medical literature.

Representatives of the CSA communicated with state officials on this matter, and in November 2007 the California Department of Public Health issued an All Facilities Letter to acute care hospitals regarding FDA boxed warnings. This letter “acknowledges that there may be occasions when a facility has the need to use medications in a manner that is not consistent with manufacturer’s specifications, including those with boxed warnings. In those occurrences, documented evidence should be present of a deliberative, evidence-based process by your medical and pharmacy staff and appropriate hospital committees that support such use while ensuring patient safety.” Subsequently some institutions, including the UCLA Medical Center at Westwood and the Santa Monica-UCLA Medical Center, have adopted policies in accordance with this acknowledgment, allowing the safe use of droperidol in selected settings while not necessarily adhering fully to the boxed warning specifications.

Among some pain medicine physicians in the district, concerns exist that patients are adversely affected by the state of California’s adoption of questionable practice guidelines for pain management. In 2004 California passed a workers’ compensation reform package in the form of Senate Bill 899, which required that medical treatment must be in accordance with practice guidelines from the American College of Occupational and Environmental Medicine (ACOEM), including guidelines on management of low back pain. A court ruling last year restricted the application of these guidelines to acute low back pain. ACOEM recently revised the Low Back Disorders chapter of its practice guidelines and now has draft guidelines on chronic pain management. Both these practice guidelines have received criticism from pain medicine physicians. In a Joint Position Statement, the American Academy of Pain Physicians, the American Society of Interventional Pain Physicians, and three other professional societies express deep concerns over the new ACOEM guidelines, including inadequate expert review of diagnostic and therapeutic modalities; elimination of approximately 50 percent of all tests, therapies, and interventions; insufficient evidence; and inconsistent ranking of the evidence cited. According to *Pain Medicine News*, several well-established treatment techniques were deemed as not recommended, such as epidural steroid injections for chronic back pain without radiculopathy; intrathecal pumps; and spinal cord stimulators. Timothy Deer, M.D., Chair of the ASA’s Committee on Pain Medicine, stated that adoption of the current form of the ACOEM guidelines

District Director Reports (cont'd)

would adversely affect patient care, and that some patients unable to receive minimally invasive procedures will undergo more back surgery or be on medications indefinitely. “There will be more failed surgeries, an increased potential for addiction, worse outcomes, at more expense.”

ACOEM, formerly known as the Industrial Medical Association, has been criticized for its close ties to business. A recent article in the *International Journal of Occupational and Environmental Health* describes ACOEM as “a professional association in service to industry” and says “ACOEM provides a legitimizing professional association for company doctors, and continues to provide a vehicle to advance the agendas of their corporate sponsors.”

Robert McLellan, M.D., President of ACOEM, refutes the findings of the above article and the criticisms of the Joint Position Statement. In a letter to Dr. McLellan in November 2007, Todd Sitzman, M.D., M.P.H., President of the American Academy of Pain Medicine, states that ACOEM’s new practice guideline “does not present a balanced view of pain management strategies but is clearly weighted toward non-interventional/non-opioid strategies” and advocates that invasive techniques and commonly used medications are to be avoided.

Suffering patients should have access to effective pain management. The impact of the new ACOEM guidelines on patients with work-related injuries troubles pain medicine physicians and others. Two members of Congress, Bart Stupak and Ed Whitfield, wrote a letter to Dr. McLellan expressing their concerns that use of the ACOEM guidelines could deny injured patients needed healthcare services. Even so, a broader concern exists. Just as with the threatened adoption of the Medicare Teaching Rule by private payers, guidelines used by one regulatory body could potentially be adopted more broadly by others and by the private sector as a means for denying payment of service and limiting patient access to care. It behooves the CSA to consider the impact of the ACOEM guidelines and determine whether any action is appropriate.

The Ronald Reagan UCLA Medical Center is scheduled to open in May. This is one of the first total-replacement hospital projects to be built in accordance with the current California seismic safety requirements as a result of the 1994 Northridge earthquake. The one million-plus square foot, 10-story hospital structure houses the operations of Ronald Reagan UCLA Medical Center, Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA and Mattel Children’s Hospital UCLA. The new medical center’s 520 large, private patient rooms feature daybeds for family members plus wireless Internet access for patients and guests. Other facilities include 154 intensive care beds, 23 observation beds, 60 preoperative/recovery spaces, and 23 operating suites

District Director Reports (cont'd)

(one more than the previous facility). Multiple outdoor play areas for children are available.

Prime Healthcare Services, a rapidly expanding hospital management company founded by Dr. Prem Reddy, recently purchased Centinela Hospital, formerly part of the Centinela Freeman Health System. With the acquisition of Centinela, Prime Healthcare now operates nine hospitals in Southern California. A news article in the *L.A. Times* last year said that Dr. Reddy's recent hospital "buying spree is making his company one of the largest hospital owners in the state, placing it in a position to challenge industry leaders including Kaiser Permanente and Catholic Healthcare West." Reportedly, when Prime Healthcare takes over a hospital, "it typically cancels insurance contracts, allowing the hospital to collect steeply higher reimbursements. It has suspended services—such as chemotherapy treatments, mental health care and birthing centers—that patients need but aren't lucrative. Free of most contracts, Prime Healthcare's hospitals can collect the patient's entire bill, calculated at the higher rate, whether the patient has insurance or not." Under state law, insurers are required to pay the full amount. "Insurers, who have been criticized in recent years for raising patient premiums while restricting care, say they have found a tenacious adversary in Reddy." Some experts assert that "Prime Healthcare's unusual business model reduces patient access to services, significantly raises costs and, as the company grows, could destabilize California's healthcare system." Critics say that "Reddy-owned hospitals routinely turn away uninsured patients, an allegation the company denies." In a lawsuit in which former nurses successfully sued Prime Healthcare's Desert Valley Hospital, one nurse alleged that "during frequent visits to the Emergency Department, Reddy pressured staffers to treat insured patients more favorably and turn away uninsured patients." On a few occasions, "inspectors have found that Prime Healthcare facilities failed to meet minimum federal safety standards, placing their Medicare funding at risk." On the other hand, the *L.A. Times* article states that "doctors and staff members at Reddy's hospitals say he has never tried to influence their medical decisions or cut costs in ways that have affected care."

Recently Prime Healthcare announced recently that it has entered into a multiyear agreement with Aetna to provide managed care services under their PPO, POS, and HMO plans. In a recent press release, Dr. Reddy states, "This dispels the rumor that PHS is averse to managed care contracting and, hopefully, paves the path for other managed care health plans to enter into contracts with fair and reasonable reimbursement." Since the acquisition of Centinela Hospital, the elective caseload decreased by about 50 percent, and some anesthesiologists have been forced to look for work elsewhere. Centinela

District Director Reports (cont'd)

Freeman Health System retains the facilities of the Marina Campus and Daniel Freeman Campus.

A few practices in the district have experienced reduced caseloads, attributed to lower demand for cosmetic surgery correlating with a slower local economy, as well as to reduced coverage of anesthesia payments for endoscopy procedures. The latter effect may be mitigated to some extent by Aetna's recently announced delay in implementing its intended restrictions on coverage of anesthesia for endoscopy procedures. However, in a recent statement the ASA cautions that "this is merely a delay."

At some practices within the district, the push to comply with performance measures such as normothermia goals and preoperative antibiotic administration has been a source of frustration.

At St. John's Medical Center, new hospital construction is slated for completion in May 2009. Anesthesiologists at St. John's have begun using an automated anesthesia record system. At this early stage, the jury is still out as to the benefits of this change. At Cedars-Sinai Medical Center, the new residency program reportedly is going well.

Now I have sad news. Dr. Ann Lofsky, an accomplished physician and long-time CSA member, passed away on March 3, 2008. Dr. Lofsky was a staff anesthesiologist at St. John's Medical Center in Santa Monica. She entered private practice after completing residencies at UCLA in both internal medicine and anesthesiology. Formerly the Director of CSA District 11, Dr. Lofsky was a valued consultant to the Anesthesia Patient Safety Foundation, and for years she served on the Board of Governors of The Doctors Company, a physician-owned medical malpractice insurer. Dr. Lofsky wrote and lectured extensively on issues related to patient safety and risk management. At UCLA we were fortunate to have her lecture to our residents periodically, and she was scheduled to be on the program for this year's CSA Annual Meeting. Friends described Dr. Lofsky as extremely knowledgeable and enthusiastic in her work, quick-witted, and possessing a gentle disposition. She is survived by her two children, her sister, brother, mother and former husband. Dr. Ann Lofsky will be greatly missed by all who knew her.

John A. Lundberg, M.D.—District 12 (Southeast Los Angeles County)

Another freestanding surgicenter opened here recently, although the trend toward opening surgicenters has slowed dramatically. Contracts have kept

District Director Reports (cont'd)

some outpatient surgery procedures at hospitals, but most of those cases go to surgicenters.

The past six months have seen a slow steady increase in Emergency Department visits. With the closure of MLK-UCLA, closure of Robert Kennedy Medical Center and overcrowding at Harbor-UCLA, patients now travel to hospitals in the private sector for their acute care needs. Sometimes admitted patients wait in improvised wards in the ED for inpatient rooms until patient discharges free up inpatient beds.

In February, State inspectors threatened to cite Harbor-UCLA for overcrowding in their emergency room. The investigation was prompted by the death of William Harold Jones, Jr., a 56-year-old dialysis patient who left the ER before treatment was finished. He was found dead in a parking lot across the street. Jones was a diabetic with end-stage renal disease, and toxicologic tests found cocaine in his system. Harbor UCLA's ED saw 82,300 patients last year, with an average wait time of 12.2 hours, and 16.6 percent left without being seen. A Los Angeles County Supervisor said in a February meeting, "I'm very concerned that we are entering a spiral here very similar to what happened at MLK." Talks are continuing between the hospital and the County Board of Supervisors.

Electronic medical records are slowly being implemented here. Kaiser Harbor City appears to be the leader and has been converting to a paperless system. When EMR improves billing and collections for the hospitals, I expect it will be used everywhere. Software is becoming more user friendly and intuitive.

Torrance Memorial Hospital will open five new ORs in July. They plan to build a new hospital from the ground up on property adjacent to the present hospital. Seismic retrofits to the present hospital have been an issue.

Paul B. Yost, M.D.—District 13 (Orange County)

CSA in Orange County held two recent dinner meetings. On December 4, Dr. Hany Samir from Houston gave an excellent talk about "The Management of Acute Hypertension" at Da Vinci Ristorante in Long Beach, sponsored by PDL Biopharma. On February 19, Dr. Thomas Ebert from Wisconsin spoke about "Inhaled Anesthetics in the Morbidly Obese," the dinner was held at the Savannah Supper Club and sponsored by Abbott.

Many facilities in Orange County are experiencing a slight decrease in case loads. The reasons may be economically based. With the economy slowing down, the insurance companies getting stingier about approvals, and the

District Director Reports (cont'd)

patients being unable or unwilling to pay deductibles or co-insurance, it appears as though patients are choosing not to have as many procedures. A couple of exceptions are the large HMOs (Kaiser) and the large high-quality institutes (cardiovascular, ortho-joint and ortho-spine) which draw patients from outside the area. Many facilities are still experiencing “lateral expansion” with more anesthetizing locations without an increase in workload. Many groups are still working to get adequate stipends from hospitals to cover under-funded work requested by the hospitals. The CSA compensation survey, which includes data on stipends, was presented at our February 19th meeting.

One of the most significant anesthesia stories is the arrival of Dr. Zeev Kain at UCI who took over as the Chairman of the UCI Department of Anesthesiology and as the Associate Dean of Clinical Research at the UCI School of Medicine. In a March 5th press release, UCI said the following:

Dr. Kain is recognized as an international expert in the clinical management of surgery-related anxiety and pain and in the management of children undergoing invasive medical procedures. His research triggered a change in the manner in which children are treated during the perioperative period, which includes ward admission, anesthesia, surgery and recovery. As a direct result of Kain's research, significantly fewer children are taken into the operating rooms and sedation suites awake, alone and crying.

His research is supported by \$6.6 million in funding from the National Institutes of Health. In addition, Dr. Kain is a member of the editorial boards of the journals *Anesthesiology*, *Pediatrics*, *Journal of Clinical Anesthesia* and *Journal of Pediatric Psychology*, and he has more than 243 original articles, case reports, book chapters, and abstracts to his credit. In Dr. Kain's own words: “...my vision is to establish national excellence and prominence in clinical care, education, and research. As part of this vision, we are planning for an expansion of the clinical faculty and enhancing the various subspecialty services and pain management services. The scheduled 2009 opening of the New University Hospital and the expected increase in services creates exciting opportunities for the Department of Anesthesiology and UC Irvine Healthcare.

Dr. Kain also served as the secretary of the Connecticut Society of Anesthesiologists and is looking forward to getting involved with the CSA.

CSA Web Site

www.csa-hq.org