

CSA District Director Reports

Gregory M. Gullahorn, M.D.—District 1 (San Diego and Imperial Counties): All our lives are impacted by world events; in San Diego these events have direct effects on the healthcare system. As Operations Noble Eagle and Enduring Freedom have expanded with the start of Operation Iraqi Freedom, our hearts and hopes are with all of those who may be in harm's way. We pray for a swift resolution to conflict, with a minimum of casualties.

Several hundred physicians, nurses and corpsmen are now deployed in support of these operations from Naval Medical Center San Diego and Naval Hospital Camp Pendleton. In response to this, over 200 physicians, nurses and surgical/medical technicians have been mobilized to active duty in the Navy and Marine Corps from San Diego, and many additional members to the other services. As of mid-March, Kaiser in San Diego has had three anesthesiologists and two CRNAs activated, A.S.M.G. has had two more anesthesiologists activated, and Balboa Anesthesia Group has had two of their four full-time anesthesiologists activated.

Although the practice climate and recruiting in San Diego are improving, manpower is still very tight, and it remains to be seen how routine surgical services will adapt. At the same time as staffing is placed under strain, plans are being set in place to accommodate up to an additional 1,000 hospital beds for service members in San Diego as overflow from the Military Treatment Facilities. We hope these will never be needed.

Sharp Healthcare will be opening an ambulatory surgery pavilion this spring, with 20 new operating rooms. The timing presents both opportunity and challenge.

This spring is also bringing changes to the medical leadership landscape in San Diego. Ralph Ocampo, M.D., a general surgeon and former CMA President, is retiring. For more than 35 years, Ralph has been a strong advocate for organized medicine and healthcare, and more importantly an outspoken champion for patients. He will be missed, but I doubt that he will disappear from community and medical activism.

Robert Hertzka, M.D., a San Diego anesthesiologist well known to the CSA and organized medicine at all levels has become President-elect of the CMA. In addition to having an uncanny personal ability to assess political and bureaucratic machinations, and to work within and through the system to effect a positive future for healthcare, Bob has been mentoring medical students at U.C.S.D. for over 15 years with a course he designed on the politics of healthcare policy. Through his leadership and stewardship, Bob's influence and idealism will bridge beyond his personal involvement in organized medicine, to future generations of physicians. I hope we will all support him in his endeavors with the CMA and beyond.

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Rebecca Patchin, M.D.—District 2 (Mono, Inyo, Riverside and San Bernardino Counties): Several Hospitals in the District have made the local newspapers in the last few months. Parkview, the Riverside Hospital that filed for bankruptcy following the multi-agency accreditation survey which resulted in the JACHO withdrawing accreditation for several months last year has made a positive turn. The new administration has made a number of changes, census has increased and stabilized to the extent that Parkview has begun to repay loans made to cover operating expenses during the crisis.

Riverside Community Hospital had completed the transition to a full Columbia HCA Facility. Union organizers were successful in their election, and all of the staff, including the nurses, will now be represented by the same Union.

Riverside County Regional Medical Center has had a change in administration after the Board of Supervisors became involved. An interim CEO, Administrator, has been recruited from Los Angeles. Given the state of California's State Budget with anticipated reductions to the local health care agencies, many opportunities for change will occur.

I wish to thank the Board, our officers and specifically our President for their encouragement and support over the last several years. I will be stepping down after this meeting as the District 2 Director, and Dr. Stanley Brauer will become the new Director. I look forward to continuing to participate actively in the CSA via the LPAD and other activities. I would like to appoint Dr. Thelma Korpman to the open Delegate Position.

Editor's Note: We want to thank Dr. Patchin for her extraordinary contributions and commitment to organized medicine—both the CMA and the AMA—as well as to our specialty. We are pleased that in addition to all of her other duties and responsibilities, she will continue to be active within our Legislative and Practice Affairs Division.

Earl Strum, M.D.—District 3 (Northeast Los Angeles County): Despite growing concerns about staffing shortages, rising costs, and other related issues, construction of new buildings and other expansion projects to accommodate increasing patient loads flourish throughout our district. At City of Hope, a National Cancer Institute-designated 165-bed hospital will open in October 2004. The new hospital will have six ORs, as opposed to the four in the present 150-bed structure, and will replace the current structure. At this time, plans for use of the old hospital are not definite.

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At USC University Hospital, construction on the new tower addition is proceeding as planned. Scheduled to open in 2004, the tower will house an additional 14 ORs and will be connected directly to USCUH. This expansion will increase the need for anesthesiologists.

In what has been called the largest construction project awarded in Los Angeles County history, a new L.A. County Hospital will replace the 70-year-old landmark hospital that has served the area so well for so long. The new 1.5 million-sq. ft. hospital is scheduled for completion in 2007 and is expected to open to new patients sometime in 2008.

Other construction throughout the USC Health Sciences Campus includes a Neurogenetics Institute that opened recently and a new Health Consultation Center II that will augment the existing one.

In the overall financial picture for Los Angeles County hospitals, however, there is doom and gloom. Faced with a \$500 million health care deficit last June, the County Board of Supervisors voted to eliminate 5,000 medical workers, close 12 of 14 public care centers, and four school-based clinics. Closure of the clinics was completed by October 1. In addition, severe cuts and continuing closures are certainties throughout the entire state and nation as a result of vanishing state and federal funding.

The residency match in anesthesiology at LAC/USC was a great success this year. We matched all of our spots with American medical graduates, with eight states being represented (two from Florida; three from New York; one each from Kentucky, Massachusetts, Oklahoma, Texas, and Wisconsin; and three from California). In addition, the Residency Review was successful, and we received full accreditation for two years.

The critical shortage in anesthesiology providers remains throughout the country, a problem that undoubtedly will not be alleviated for several years. Hospitals throughout the district continue to address this problem as aggressively as possible, recruiting additional anesthesiologists whenever possible.

Although Tenet Healthcare occupied the media for some time because of the questionable practices at some of its hospitals, no negative fallout from the events has filtered down to the Tenet hospitals in this district.

Michael W. Champeau, M.D.-District 4 (Southern San Mateo, Santa Clara, Santa Cruz, San Benito and Monterey Counties): The most interesting recent event in District 4 involves an attempt by a local hospital administration to replace its

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existing anesthesia group with Premier Anesthesia, a national provider of anesthesia services headquartered near Atlanta, Georgia. As many readers know, Premier has facilitated the replacement of entire anesthesia groups/departments in several locations around the country by supplying replacement providers when hospitals have made the decision to replace their existing anesthesiologists. Regional Medical Center would have been the company's fourth hospital. The company's ability to take over entire departments has enabled hospital administrators to essentially "clean house" with respect to anesthesiology services.

The recent situation in District 4 involves the Associated Anesthesiologists Medical Group in San Jose and the Regional Medical Center in that same city. The Associated Anesthesiologists Medical Group (Group) currently consists of 21 physicians who provide essentially all the anesthesia services at Regional Medical Center of San Jose and San Jose Medical Center, as well as working at Good Samaritan Hospital, O'Connor Hospital and a variety of outpatient facilities. Regional Medical Center represents approximately 40-45% of the Group's overall activity.

For many years the Group has had a contract with the hospital, renewed annually, which confirmed the right of the Group to provide anesthesia services at Regional, and outlined the stipend paid to the Group in return for provision of otherwise uncompensated services.

In mid-January, less than three weeks prior to the expiration date of the then-current contract, the Group's leaders were notified by Regional Medical Center's administrator that the contract with the Group was not going to be renewed. According to the Group, this news came as a complete surprise. The Group's leaders were informed that the contract had instead been awarded to Premier. Care apparently was taken to point out that this was not a reflection on the quality of care provided by the Group; it was simply a "business decision." When asked about the possibility of negotiation, the Group was told that this was a "done deal" and that no negotiation was possible.

Shortly thereafter, a meeting was held between hospital administrators, surgeons, and three executives of Premier. The administrator again stated that this was a business decision, and that the advantage to the hospital was that Premier would essentially do whatever was asked of it. Representatives from Premier reassured the surgeons regarding the planned changes.

When Santa Clara County Medical Association's (SCCMA) Medical Executive Bill Parrish heard about the hospital's action, he was concerned enough to approach the hospital administrator. Mr. Parrish arranged a meeting between the Group's President, the hospital administrator and himself. By the end of the meeting, the

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administrator agreed that there was perhaps a small amount of room to negotiate with regard to the contract.

Several days later, the administrator contacted the Group's President, suggesting further negotiations. Apparently, part of Premier's plan for staffing the department was to recruit members from the Group, essentially providing the hospital and surgeons with many of the same anesthesiologists that were currently working at Regional, but under different management. Many members of the Group were offered positions with Premier, but allegedly few, if any, showed interest. Moreover, the difficulty in convincing anesthesiologists from outside the Bay Area to relocate to an area where \$1 million homes are tear-downs can be appreciated by most who work here.

In the end, the administrator and the Group negotiated a new contract. Interestingly, this same administrator apparently had successfully replaced both anesthesiology and radiology departments when previously employed at other hospitals.

Linda B. Hertzberg, M.D.—**District 5** (Kern, Tulare, Kings, Fresno, Madera, Merced, Mariposa, Tuolumne and Stanislaus Counties): Recruiting of new anesthesiologists to groups continues to be an issue in District 5 although the market seems to have improved slightly over the past year. New graduates of residency programs continue to be in short supply, while the major recruiting successes appear to be due to relocation from other practices.

Childrens Hospital Central California laid off a number of staff earlier in the winter. The layoffs affected 14 physicians as well (none anesthesiologists) since the cuts were made in programs in which the hospital supported the physicians through the multispecialty medical group. This could certainly be a wake-up call for physicians in our specialty who are subsidized by their hospitals in some manner. It appears that the only thing protecting anesthesiologists in this sort of situation may have been the current supply and demand issue regarding personnel. In addition, Childrens Hospital closed two urgent care centers which will have an impact on their and other already overcrowded ERs (see below).

Hospital building in Fresno County continues as previously noted here. Both major hospital systems are progressing with their projects. However, as reported in the *Fresno Bee*, when all is said and done, there will be a net gain of only 14 beds due to the eventual closure of University Medical Center. Seemingly there is no relief in sight for the capacity problems that are plaguing this area. Both systems are currently operating at capacity and are holding patients for long periods of time in the ER and PACU on nearly a daily basis.

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Saint Agnes Medical Center is reported to be considering terminating its contracts for the routine care of Medi-Cal patients if it is not successful in renegotiating the rates (article in *Fresno Bee* 03/21/03). Saint Agnes claims this is necessary because it is losing large amounts of money on these patients. Were this to occur there would be a huge impact on the OB population as well as on individual physicians who have a large Medi-Cal component in their practices.

Douglas J. Martin, M.D.-District 6 (San Francisco and North San Mateo Counties): This is the season of recruiting. By now commitments from graduating residents have usually been secured and staffing for the coming academic year is established. Despite the proximity of several high quality anesthesia residency programs, most private practice groups remain on the hunt. Academic practices have it even worse. Many jobs are available in the Bay Area; freelancers are an endangered species.

Fatigue has been a topic of intense discussion not only on the pages of *Anesthesiology* (2002; 97:1281-1294), but also in the hallways of the operating room. Of particular concern is the equivalence between the impairment in psychomotor function seen after 24 hours of sustained wakefulness and that associated with blood alcohol concentrations of 0.1%. If we showed up for work drunk we would certainly be hung by our thumbs; yet working more than 24 hours is not an uncommon practice. Although this has not become an issue in the medico-legal world (personal communication Dave Willett), when we work long punishing hours, we won't be seen as noble by the lay public.

This combination of inadequate staffing plus working long hours is highly problematic. Hospital administrators are petrified at the prospect of losing surgeons to stand alone surgicenters. They kowtow to surgeons who demand 0730 start times and impose horizontal scheduling on the anesthesia staff. Many operating rooms finish near midday, providing anesthesiologists only a half day's work. Although hospitals lose money when OR nursing staff are idle for half the day, their fear of losing surgeons prevails. It will take courage and conviction on the part of anesthesiologists to oppose this scheduling inefficiency.

On the bright side, I am happy to report that anesthesiologist Stephen Lockhart has been appointed Director of Operating Room Services at California Pacific Medical Center (CPMC). This is a significant (full-time) appointment with great promise for improved input to the hospital administration. Dr. Lockhart's appointment addresses, at least in part, one of the major drawbacks of private practice anesthesia that participation in hospital committees means time out of the OR, which means loss of income.

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Helen T. O’Keeffe, M.D.–District 7 (Alameda and Contra Costa Counties): District 7 consists of a mix of community hospitals, county hospitals, private and Kaiser Foundation hospitals. There is no university hospital in the district, but there are several residency rotations for various specialties. In the last year, there has not been any major change at all in the composition of the district. There also has not been much change in population location, though growth has definitely been more in the eastern regions such as Antioch, due mainly to increasing housing prices.

Overall, then, as a result there has not been much change in the structure and composition of the anesthesia community in this district. Recruitment, while impacted by housing considerations, has not been a major problem.

There has been unexpected newspaper publicity in this area on the topic of pediatric anesthesia and post-anesthesia care. The *Contra Costa Times* reprinted information from the *Los Angeles Times* about a serious issue with pediatric anesthesia at a Southern California Kaiser Hospital, as well as another article about nursing concerns about post-op pediatric care at a local hospital. There is an inherent conflict between providing care closer to a child’s area of residence and providing more specialty pediatric care. The issue of how to distribute cases to maintain expertise, whether anesthetic, nursing or surgical is key, and is a springboard for active discussion in many settings.

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

UC-Davis reports:

1. The AGME has okayed an increase to 36 residents; the match results were excellent, matching all 12 residents and only going to number 23 on the list.
2. The Center for Virtual Care is being developed for training medical students, residents, nurses and faculty. Two anesthesiology simulators are available, a child and an adult simulator.
3. UC-Davis is sponsoring a War on Pain CME series. This satisfies the California Assembly Bill number 487, which requires physicians and surgeons to complete 12 hours of CME on the subject of pain management and the treatment of terminally ill and dying patients. There will be meetings in Napa, Sacramento, and Hawaii.

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4. There has been an increase in research funding.

From the private sector:

1. A few anesthesiologists have been called up to the reserves, leaving our short supply even shorter.
 2. There continues to be a shortage of anesthesiologists in the area. Reimbursement is lower than surrounding areas in California.
 3. Staffing is being stretched by the proliferation of free-standing surgery centers being built in the surrounding area.
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Peter E. Sybert, M.D.-**District 9** (Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskyou, West Solano, Sonoma, Trinity, Colusa, Glenn, Butte, Plumas, Tehama, Shasta, Lassen, and Modoc Counties): Evolution affecting the operating room environment continues apace. As in other areas, there is continued growth in outpatient centers owned by plastic surgeons, gastroenterologists or major hospitals. All seem to believe there is a large unmet demand for their specific services. Staffing by anesthesiologists is variably requested at these facilities but the issues of greater horizontal staffing, resulting in shorter work days, yet with attempts at expanding evening availability, continue.

Multiple small hospitals continue to struggle as their cash flows do not cover their costs. To bridge the gap they try to sell assets or borrow from future funding (tax revenues). How long this can continue remains an open question.

The Health Plan of the Redwoods liquidation continues. Currently it appears likely that physicians will receive a final accounting by the end of 2003 and will be paid in the range of 23% to 37% of approved claims amounts.

With the international appearance of Severe Acute Respiratory Syndrome and hospital admissions locally of patients with this diagnosis, some community hospitals are retrofitting ICU rooms to provide negative pressure capability. Background talks are taking place to preplan the OR response should a SARS patient need OR attention. Considerations include coordination with facility infection control staff and infectious disease physicians, portable air filtration systems, respirators for staff where droplet contamination is a possibility.

At the same time several communities are adjusting to physicians and other staff leaving on short notice as they are called to service. Hopefully they will be back with us soon.

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Daniel M. Cosca, M.D.—District 10 (San Luis Obispo, Santa Barbara and Ventura Counties): A general concern throughout District 10 since the last report includes those of healthcare providers (mostly nurses and technicians) departing from facilities due to reservist military needs of the Gulf War. This has left some gaps in staffing of ORs.

Another continuing consideration is the approaching deadline of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as hospitals, ambulatory centers, groups, and offices move toward compliance.

Anesthesiologist manpower in the district seems to have stabilized to some degree; there are no apparent serious excesses or shortages at present.

In the northern area, news includes a firm May 2003 closing date for General Hospital of San Luis Obispo. A news article from March 4, 2003, stated, "A group of local doctors is trying to rally support and raise money to repurchase French Hospital Medical Center once the San Luis Obispo nonprofit is sold to a for-profit group. Universal Health Services was reported to be the leading contender to buy French Hospital and Arroyo Grande Community hospitals along with Corona Regional Medical Center in Riverside County."

In Santa Barbara, Saint Francis Hospital is scheduled to close in late June 2003. Apparently Cottage Hospital has purchased the facility and will possibly be converting the land to a housing project.

In perhaps the most disturbing news items, the *Los Angeles Times* (Ventura Edition) reported on March 16 and 20, 2003, on conflicts and serious differences between physicians and administration. "Numerous past and present physician leaders at Community Memorial Hospital are rebelling against what they consider heavy-handed and perhaps illegal tactics by top administrators and the board of trustees at the Ventura Medical Center... a California Medical Association spokesman said the Community Memorial quarrel stands out and gives physicians cause for grave concern."

Johnathan L. Pregler, M.D.—District 11 (West Los Angeles County [western portion]): Surgical caseload and manpower issues appear to have stabilized in West Los Angeles. Most facilities are reporting either steady or slow growth in surgical caseload. Most are also reporting adequate anesthesiology manpower at this time. One facility reported that it was still short of its ideal number of anesthesiologists and is experiencing some difficulty in recruiting. This group was successful in

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obtaining financial help from their hospital to provide salary support to aid in recruitment.

The news that received the most press in the district has been the engagement of the Hunter Group by UCLA. The consulting group was hired to help improve the bottom line and the cash position of the UCLA Healthcare system. The consultants presented a working draft of their report to an open meeting of the faculty on March 12. It was emphasized at that meeting that the consultants' recommendations were still preliminary and should not be considered finalized. Of interest to the Department of Anesthesiology, the consultants recommended continued physician involvement in the management of the hospital and also the operating rooms. Data was presented that indicated that after the replacement hospitals are constructed, the total number of beds and operating rooms would probably be insufficient to meet patient care needs in UCLA's geographic area.

The projection that the district will experience a future shortage in operating room and hospital capacity has been reported in the local media over the last nine months. The new UCLA hospitals will open in 2005 and will add 13 operating rooms to the existing capacity. The new hospital at St. John's will open in 2004 and will be smaller than the existing facility. Invasive services probably won't move to that new facility until 2007. St. John's may consider building additional outpatient operating rooms in a freestanding facility to add operating capacity to their organization. A new outpatient surgical center opened in Westwood in December. The facility has not been used to its capacity at this point in time. On March 19 Tenet Healthcare Corp. announced that it would close or sell 14 hospitals. No hospitals in West Los Angeles were on the list. It appears that Daniel Freeman Marina Hospital will continue to be kept open because of action by the state attorney general's office.

Several anesthesiologists reported pharmacy issues at their facilities including new attempts at controlling access to ephedrine. At the UCLA Surgery Center and Centinela Hospital the pharmacy departments instituted changes that resulted in ephedrine not being stocked on the anesthesia cart and consequently not being immediately available for patient care. However, the drug was replaced in the anesthesia workroom and on individual anesthesia carts on the same day that it was removed at UCLA after consultation with the pharmacy. After several weeks it was returned to the anesthesia carts at Centinela Hospital.

Another pharmacy issue that was raised by one member of the district is that the appearance of drug vials and the formulation or concentrations of commonly used drugs are constantly and rapidly changing. This presents a potential patient safety issue because the wrong drug or dose may be administered, or there may be a

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delay in preparing the proper drug to treat an urgent clinical problem. The reason for this inconsistency in drug formulation and appearance appears to be the constant switching that occurs when a hospital or a national purchasing group tries to decrease pharmaceutical costs by switching manufacturers. It may be worthwhile to consider initiating a national effort to standardize the color and shapes of drug vials and concentrations for certain classes of pharmaceuticals in order to reduce this hazardous situation.

Finally, the new HIPAA regulations are causing difficulties for individual practitioners and group practices. Some hospitals are instituting policies to comply with HIPAA across their organization and as such have taken care of the needs of their anesthesiology groups. This appears to be the case at Tenet Healthcare hospitals and at UCLA. Other facilities have instructed their departments to develop policies and procedures to comply with the new rules and this has created significant headaches in those groups. The ambiguities that still exist in the federal regulations have not made the process of compliance easy. Several groups report that they have filed for an extension on the implementation date for these rules for their members.

John A. Lundberg, M.D., District 12 (Southeast Los Angeles County): We have seen a proliferation of outpatient surgicenters in District 12. Multispecialty groups consisting of orthopedic surgeons, pain management anesthesiologists, ophthalmologists, podiatrists, and ENTs have successfully opened surgicenters that have displaced outpatient surgery caseload from larger hospital medical centers. So far anesthesiologists have not been included as founding partners of these groups. Efficient convenient utilization by surgeons and economic profitability for founding partners has created a niche for short outpatient surgical cases. Gastroenterologists and urologists have jumped into the game by opening their own single specialty surgicenters.

The nursing shortage is still very apparent although nursing administrators have strategized by hiring and training as many nurses as they can. New nurses working in the OR for the first time endure a six month supervised work-training period before they are allowed to do cases alone.

The HMOs have stabilized, and we have seen no recent bankruptcies. Blue Cross and Aetna have been relentless in seeking methods of decreasing recompense and especially how they determine base units and how they reimburse labor epidurals.

Kenneth Pauker, M.D., District 13 (Orange County): The practice climate in Orange County seems to reflect a continuing trend: anesthesiologists care for

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healthier and often better insured patients in outpatient facilities, while ever sicker, increasingly complicated, and more difficult patients fill the schedules at many larger hospitals. There is mounting pressure to run more late rooms and more elective rooms on weekends, just to be able to get the work done, and sometimes to accommodate the scheduling needs or whims of busy surgeons, but staff are tiring of the workload. Some senior members are leaving to enter less demanding practice settings like outpatient surgi-centers. Many new ones are cropping up, including those in Fountain Valley, Costa Mesa, Irvine, and Laguna Hills, each adding 3-5 ORs per facility. Investors, sometimes businessman from out of state as well as surgeons and anesthesiologists, are still trying to capitalize on a reimbursement structure that rewards entrepreneurial activity. In some of the smaller hospitals, an entrepreneurial anesthesiologist might offer the hospital an exclusive contract, which might displace more experienced physicians, and then employ newer and less experienced staff or new graduates.

Contracts with insurers continue to be negotiated upward in order to be able to pay enough to attract and retain strong new staff.

The large group at Fountain Valley is experiencing the difficult process of organizing itself into an integrated group, consequent to a hospital contract essentially being forced upon them. In order to satisfy the realities of a contract with the hospital, a new corporate structure is emerging.

At Hoag, a very busy schedule with a large number of late rooms and weekend elective rooms leaves many of the group feeling like they have much less personal time than they did in the past, almost feeling institutionalized. New staff is being added and new activities, like providing sedation for many procedures outside of the OR, are being undertaken. An acute pain service continues to be run by Hoag anesthesiologists.

St. Joseph's is not staffed optimally. Issues include: not enough pay, a very complex patient load, and a relationship with a hospital administration that allegedly is less than cordial. It is difficult to be able to pay enough to attract and retain well-trained new staff who are willing to work as hard as is required.

Dr. Breen at UCI reports the imminent approval by the California Board of Regents of a new UCI Hospital with greatly expanded capacity and sophistication and which, over time, will allow UCI to rival the stature of UCLA.

California State Assemblywoman Patricia Bates, Republican, District #73, served a "Mini-Internship" at SMMC on March 21, 2003. This program was originally conceived of by the ASA, has been encouraged by the CSA Board of Directors,

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and is described in the current *ASA Newsletter*. All involved received her visit warmly, and she both enjoyed it and learned a great deal.

Some members who care for large numbers of Medi-Cal patients are extremely concerned about the State's fiscal crisis and the implications for their already less than marginal reimbursements.

There is a new concept called "Sedation Service" being touted in some hospitals. At Children's Hospital of Orange County (CHOC), the Critical Care physicians have proposed to constitute a service which will use propofol to sedate children outside of the Intensive Care Unit, allegedly attempting "to get paid for what they are doing already." In some locales, submissions to insurance companies apparently have produced reimbursements essentially equivalent to those for anesthesiologists who render anesthesia. There was also a continuing education course offered at Hoag recently for gastroenterologists to learn how to use propofol for sedation, presumably in their own offices. The proposed record at CHOC looked very much like an anesthesia record to an anesthesiologist reviewer.

Morris Jagodowicz, M.D.-District 14 (Los Angeles County [northwestern portion]): *Mid-Valley Anesthesia Group (Northridge) vs. Doctors Company* case was dismissed by the court, based on the decision that was handed down during the *Upland Anesthesia vs. Doctors Company* case. To avoid the appeal process a settlement for attorney fees was reached. This case had dragged on for three years.

There has been an increase in applications for Medicare and State Certification for Surgery Centers in the area. New centers are being opened throughout the San Fernando Valley and Burbank. Most of the hospitals in the area continue to have a large population of Medi-Cal, Medicare and uninsured patients.

Everything appears peaceful in the Valley.

Michael Severson, M.D.-District 15: As this quarter comes to a close, we find ourselves in the middle of the annual delegate elections having just finished electing a new District Director for District 15. The new Director is Jonathan Pak, M.D., from UCLA. I have chosen to use this report as a soap box to get some discussion started among the residents about resident leadership election protocol. Although we have not seen much discussion lately on the resident list serve, we did hear some concerns by those who were voting for District Director without having met or spoken with the candidates. This touches on an issue that I think is of critical value with regard to resident involvement in the CSA and will hopefully be the

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legacy of the current CSA resident leadership. With regard to resident District Director elections the current Bylaws read as follows:

For District 15, the District Director, Delegates and Alternate Delegates shall be elected according to the following: The District Director shall be nominated and elected according to these Bylaws from the entire District with the office being filled by the candidate receiving the greatest number of votes; one Delegate and one Alternate Delegate shall be elected from each ACGME approved residency training program by separate nomination and election conducted among the residents of each program according to these Bylaws; for the ACGME approved training program in which the District Director is a resident or fellow, only an Alternate Delegate shall be nominated and elected.

All nominations must be submitted by a CSA member and seconded by another eligible CSA member both within that district. "Eligible members may submit their own names as nominees along with the signature of a seconding CSA member from within that district." (CSA Bylaws) Should only one nomination be received from a district for any vacant office, such nomination would constitute election to that office and the vacancy declared filled.

In the election of the district director, if no candidate receives a majority, a second election shall be held between the two candidates who receive the highest number of votes.

My concern is two-fold. First, as stated before, these elections are conducted without the opportunity for those voting to meet with, speak to, or hear from the candidates running. Of course, we could require the candidates to make a statement on the list serve and answer questions in that format. This is one option. My second concern is that candidates from the larger programs have a distinct advantage over those from the smaller programs. What I propose is that we change the Bylaws in such a way that alternate delegates are elected at the end of the CA-1 year for a 2-year term serving as the delegate in year two. In addition, I propose that the District Director be elected from those delegates. This requires that the candidates show commitment and have an opportunity to develop a "record" to run on. The details about how this is all carried out is exactly what we should be debating on the list server, and we should have a resolution ready to present to the CSA leadership at this year's CSA meeting in Anaheim.

I exhort all California anesthesiology residents to voice their opinion on this subject so that we can make a small step forward toward improving our representation in the CSA.