

CSA District Director Reports

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

CSA Board of Directors Meeting, April 1, 2006

Stanley D. Brauer, M.D.—District 2 (Mono, Inyo, Riverside and San Bernardino Counties): Building physician-owned specialty hospitals in our district has generated a lot of controversy as it has everywhere else. This issue has divided not only the physicians in our area, but CSA members in District 2 as well. The AMA has alienated many of the physicians who don't favor specialty hospitals since the AMA actively endorses and advocates for them. I believe the CSA has been wise not to advocate a position since this issue is so divisive and there are good arguments on both sides.

Economically, the picture in our district is mixed. Better contract rates have been seen from various private insurers. However, the hospitals with large Medi-Cal and Medicare populations took a double hit with rate reductions at the beginning of the year. At Loma Linda University, as with all teaching hospitals, the failure to change the Medicare concurrency penalty has resulted in a per unit rate of approximately \$8. As a result, a typical two-hour-duration, four-unit base rate case will gross \$96. After billing and insurance costs, there is probably a net loss before any salaries are paid. The financial ability to train anesthesiologists is really at stake. The AANA, unfortunately, effectively lobbied CMS and Congress against correcting this cut.

For many years there has been an interest at UC Riverside to start a medical school at Riverside. The discussions are moving forward on many levels and collaborative efforts are ongoing with UCLA. If it were to occur, it would place two medical schools, Loma Linda University and UCR, less than 10 miles apart. There would be many pros and cons that would have to be considered. It is true that USC and UCLA are similar distances apart, but they obviously serve a much larger population base.

Kaiser Permanente has recently announced plans to open clinics in Palm Springs, Palm Desert and Indio by June 2006, a move that will affect 18,000 patients in the area. Contracts with 180 area physicians will end June 30, and patients will have to choose one of 14 Kaiser doctors at the clinics or change their insurance coverage. Long term, Kaiser is targeting a hospital for the Coachella Valley as this area continues to grow.

Mammoth Lakes Hospital continues to grow and expand services. Besides a busy orthopedic practice, other surgical services are growing, and a new wing with additional OR suites is planned.

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Wayne Kaufman, M.D.—District 3 (Northeast Los Angeles County): It is still an open job market, as is evidenced by the multiple offers received by this year's graduating USC residents. While it is only February, many of the residents are trying to choose between positions at the various facilities in Los Angeles. The starting offers are high enough to create some difficulties for academic programs to recruit these residents.

USC University Hospital's Norris Tower is on track to open by May 2006. While the new Tower has 10 new operating rooms, the current plans entail opening them in a controlled fashion, and not to open new operating rooms until there is a demonstrated need for more operating time. It is hoped that this will allow the USC Department of Anesthesiology to make the necessary recruitments to run the new operating rooms. The operating rooms at Norris Cancer Hospital will remain open for at least one more year.

The ongoing transplant issues at St. Vincent Hospital and at UC Irvine continue to impact USC University Hospital. Liver transplants have tripled in number (almost three per week), and kidney transplants have also increased. The rapid rise in transplants is taking a toll on providers, which USC is trying to address through recruitment.

City of Hope Hospital, now in its new home, reports that work has caught up with the increased number of operating rooms. Dr. Michael Lew, Chief of Anesthesiology at the City of Hope, managed the transition to the new operating rooms and the increased growth required to run them without difficulty.

One of the problems currently being reported in District 3, as well as in other districts, is addressing the new Blue Cross policy of not paying for the routine use of an anesthesia provider for colonoscopies. For groups that receive a stipend from the hospital, the question remains whether that means the group will provide a service for which no reimbursement is expected.

Christine A. Doyle, M.D.—District 4 (Southern San Mateo, Santa Clara, Santa Cruz, San Benito and Monterey Counties): Demand for anesthesia services seems to be stable or slightly increased over the past few months. There is one new surgery center in San Jose, and one in progress in Morgan Hill. Stanford residents and fellows seem to be staying in the Bay Area.

Paul B. Coleman, D.O.—District 5 (Kern, Tulare, Kings, Fresno, Madera, Merced, Mariposa, Stanislaus and Tuolumne Counties): As the new Director of District 5, there will be a learning curve involved in understanding the policies and procedures inherent to the position and the CSA. Work over the last

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six months in assisting our previous director, Dr. Sufi, will expedite this process.

The first realization I have come to appreciate is how geographically large our district is and how problematic it is to bring the district together. My first goal is to make contact via phone and/or e-mail with our present delegates in an effort to learn their concerns and those of the members in their region.

To further the involvement of members throughout the district, I have developed a listing for hospitals and respective anesthesia department chairs. Regular contact with these chairs not only provides direct sources of information for newsletter contributions, but also permits a direct dialogue between the CSA and the physician members in practice.

Involvement in the political process is a CSA priority, and being part of this process is important to the well being of our members. To that end, I have made an effort to contact Congressman Cardoza, whose district includes my medical center and Congressman Radanovich from my home district. In coordination with their local healthcare staffers, we are working toward these congressmen individually accompanying me during a cardiac anesthetic. The objective of these OR invitations is to build relationships for the future and to provide a window into a world they may not otherwise experience. The logistics have been approved by a cardiac surgeon with whom we work closely and the hospital administration.

Helen T. O'Keeffe, M.D.—District 7 (Alameda and Contra Costa Counties): District 7, as described before, consists of the East Bay counties of Alameda and Contra Costa. These are primarily residential and light industry areas, essentially a conurbation, with Oakland being the most metropolitan/inner city area.

The local medical centers are across the bay at San Francisco and Stanford, with residents in some specialties (not anesthetic) rotating through District 7 hospitals. There is a graduate nursing school at Samuel Merritt College in Oakland providing CRNA training, with clinical rotations through District 7 hospitals.

The Kaiser Permanente hospitals have a large presence in District 7, particularly because Oakland/Richmond is their point of origin. Neither private practice groups nor Kaiser Permanente anesthesiology groups are reporting any difficulty with recruiting. However, we cannot escape awareness that we are like people living inland. We may not be directly devastated by coming bad

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weather, but our lives will not escape impact. Appropriately, District 7 has a high proportion of CSA members, aware that we need this voice.

Jeffrey Uppington, M.D.—District 8 (Alpine, Amador, Sacramento, Placer, El Dorado, Nevada, Sierra, Yuba, Yolo, Sutter, San Joaquin, Calaveras and part of Solano Counties): The Sacramento area continues to sustain heavy pressure on its bed capacity. Hospitals are regularly “full,” which leads to pressures to close ERs and divert patients. Unfortunately, there are few places to which to divert them because everywhere is full, and local agreements limit the time diversion can occur, so ERs largely stay open and hospitals do what they can to move patients through the system. This puts great pressure on the elective services, and great pressure on the operating rooms.

The influenza season so far has been mild, but a worrying outbreak of whooping cough has occurred in the Sacramento area. We continue to be a chronically under bedded region, presumably partly because of the rapid population growth and partly the time it takes for hospitals to generate money and agreement for expansion. While there are new facilities being built and proposed to be built, it is anticipated that these pressures will remain for some considerable time.

The topic of the appropriateness of the role of physicians, and particularly anesthesiologists, at executions has been front, center, rear and every other part of the stage. After the reports of two anesthesiologists initially agreeing to—and then withdrawing from—being present at the execution of Mr. Morales, the media frenzy began.

I was asked to be a spokesman for our area, and I agreed, thinking maybe a phone call or two would suffice. I was also approached by the News Service Manager of the hospital's Public Affairs department because they were inundated with media requests for interviews. I did manage to restrict the *Sacramento Bee* interview to a telephone call but was unable so easily to manage the television channels. I had a taped interview for the local affiliates of ABC and UPN, but NBC's affiliate, KCRA-Channel 3, wanted me live.

I spoke for the CSA and ASA, firmly stating the Society's position that it is unethical for a physician to take any part, either active or passive, at an execution. It will be interesting to see if the AMA will push for legislation forbidding any physician presence at an execution.

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

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Butte, Plumas, Tehama, Shasta, Lassen, and Modoc Counties): Since the last report, things apparently have been relatively quiet. Blue Cross has caused significant consternation with its position on review of medical necessity for endoscopies. How many patients this will actually affect and how Blue Cross's form advising patients of their potential responsibility for payment of anesthetic services will actually work out, remain open questions.

Santa Rosa Memorial Hospital has announced that it will break ground on a consolidated cardiac care facility in 2007. The plan is to have two dedicated operating rooms in that facility as well as the cath, EP labs, postop care, et cetera. This would represent a significant consolidation of the service that is currently spread across the facility. Additionally, it sets the stage to accommodate service line expansion.

Sutter Santa Rosa is reevaluating its Family Practice Residency Program and the role it will have in the facility's future. The residency case mix is primarily Medicare, Medi-Cal or uninsured. The derivative operative cases tend to be performed at the same facility. Options would include shifting portions of the residency and its case load to other hospitals in Santa Rosa, primarily Kaiser Permanente's facility and Santa Rosa Memorial Hospital. The options apparently are only in draft format at this point, but the topic has been in the local newspaper, and spirited discussions undoubtedly will follow before any final conclusion is reached.

Owen Shea, M.D.—District 10 (San Luis Obispo, Santa Barbara and Ventura Counties): A common theme facing anesthesiologists and anesthesia groups in District 10 is the rapid increase in free-standing surgery centers. The hiring and retention challenges facing our district have eased in the last few years. This has been offset by an increase in demand for anesthesia services without a concomitant increase in surgical caseload. This trend has placed many groups in an undesirable business predicament, creating tensions among all parties involved.

Hospitals are demanding continued, full anesthesia coverage for documented less surgical volume. Simultaneously, developing surgery centers are requesting services to staff rooms that have less than ideal case volume. The struggle to maintain economic viability is shared by anesthesiologists throughout our district and the entire state. The developing tensions to cover all cases are clearly being felt by the anesthesia providers, who are made to feel unsupportive of the institutions for which they provide services. Some hospitals and surgery centers have used these "support" issues to pit competing providers against each other for access to cases.

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Many hospitals in District 10 now “support” anesthesiologists to ensure obstetrical and emergency services at their hospitals. Patient access to VBACs remains problematic in our district. Sierra Vista Hospital in San Luis Obispo is one of the few hospitals offering this service in a district that extends from King City to Thousand Oaks. The return of VBACs to this community occurred only after Sierra Vista agreed to “support” an in-house, available anesthesiologist.

District 10 shares many of the same issues facing all members of the CSA. Fair and appropriate reimbursement will continue to challenge anesthesiologists in perpetuity. Our unified voice is heard only through a financially viable GAS-PAC and ASAPAC. I urge all members in our district to donate yearly to both of these PACs.

James M. Moore, M.D.—District 11 (West Los Angeles County [western portion]): In November, a district meeting was held for District 11 at the Maple Leaf Restaurant in Beverly Hills. The meeting was well attended, and the program consisted of an educational lecture on postoperative pain management as well as a presentation on CSA matters, followed by a pretty lively and thoughtful interactive discussion on district events and concerns. Equally important, the food was excellent.

The clinical workload at many facilities has been slowly increasing, perhaps in part due to a greater demand for off-site anesthesia services. Nevertheless, at hospitals throughout the district, workforce demands have for the most part been well met, although with a significant proportion of part-time anesthesiologists in some practices.

Several hospitals in the area have either gone through—or are preparing for—JCAHO visits for reaccreditations. Many physicians continue to find this a burdensome process that detracts from patient care.

Optimizing patient care sometimes involves moving services within a health-care system. The Centinela Freeman Health System recently shifted some resources among its hospitals. The obstetric anesthesia services from both the Memorial Campus (formerly Daniel Freeman Hospital) and the Centinela Campus were consolidated at Centinela. Also some operating rooms were closed at the Memorial Campus, with the caseload moved to both the Centinela and the Marina Campuses. The Centinela Freeman system has seen an influx of cases since the opening of a new spine center and, according to a recent announcement, the Kerlan-Jobe Orthopaedic Outpatient Clinic will soon become part of Centinela Freeman Regional Medical Center.

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Cedars-Sinai Medical Center opened its new Saperstein Critical Care Tower in January, offering 126 new intensive care and acute care beds. In addition, the labor and delivery suite soon will be renovated. A cardiac anesthesia fellowship will be offered at Cedars-Sinai starting this year.

St. John's Health Center and Century City Doctors Hospital both promote new facilities that offer luxury hotel-style amenities. At St. John's, the new North Pavilion offers in-room features, such as plasma televisions and wireless Internet access. Meanwhile construction is underway on a new four-story diagnostic and treatment center at St. John's, to be opened in 2009.

Century City Doctors Hospital recently reopened under the direction of the physician-owned Salus Surgical Group. The 178-bed facility recently underwent the first phase of an ongoing renovation, including construction of seven operating rooms. The boutique-style hospital began performing surgical services again, and the next phase of renovation is to include an additional five operating rooms. Operating room services began in October, and the emergency room should open in March.

At UCLA, the new Ronald Reagan UCLA Medical Center at Westwood is still on schedule to open in 2007, providing over 500 patient beds in private rooms, 70 pre- and post-recovery patient care areas, and 23 operating suites utilizing cutting-edge surgical technologies. The UCLA Santa Monica Replacement Hospital Project is also expected to see completion in 2007. This facility will replace all of Santa Monica-UCLA's current facilities except the Merle Norman Pavilion and will house the Santa Monica-UCLA Medical Center and Orthopaedic Hospital. Over 90 percent of the 266 patient beds will be private rooms, and over one-fifth of the beds will be dedicated to inpatient orthopaedic care.

The surgical caseload at Childrens Hospital Los Angeles has seen an upswing under the direction of a new chief of surgery. The new hospital building currently under construction at Childrens Hospital is scheduled to open in 2009 and will house an Emergency Department, a Cancer Day Hospital, a 40-bed Neonatal Intensive Care Unit (NICU), and over 150 intensive care and acute care beds. The facility will include a state-of-the-art Family Resource Center.

Past trends in the district continue: new facilities continue to arise, just as the available anesthesiologist workforce rises to meet the steadily growing clinical demands.

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John A. Lundberg, M.D.—District 12 (Southeast Los Angeles County): JCAHO will now conduct its hospital inspections without prior notice. One JCAHO methodology utilizes “tracing,” which involves following a patient’s admission and hospital stay through discharge. All documentation, orders, procedures, tests, and records for a particular patient are traced to their origin, examining them for compliance with JCAHO guidelines. Gone are the times when we spent weeks “cleaning shop” in preparation for a JCAHO inspection. For better or for worse, these unannounced surprise inspections should give a better look into the real world at hospitals. Meanwhile there is an increased anxiety level in administrators waiting for their first surprise inspection.

Surgicenters continue to prosper here. Most are founded and started by surgeon owners who sell them to larger corporate entities within a few years. Certification, regulation, and accreditation are less stringent than for hospitals. They have provided exceptionally efficient and good medical care for less complex procedures not requiring specialized equipment. Hospitals are attempting to win back the outpatient surgery business but, so far, have been unable.

Housing prices here continue to climb, making it difficult for newcomers to buy a house they can afford. These exorbitant house prices, along with relatively low recompense, have naturally limited the influx of new anesthesiologists here. Why come to Los Angeles when you can go elsewhere and buy a home at a fraction of the Los Angeles price while also earning higher annual incomes?

Hospitals here employ as much as 50 percent of the night nursing staff with travelers or registry nurses. “Travelers” contract with the hospital to work three to six months. They receive a housing allowance, along with relatively higher wages. Some of these itinerant nurses are locals looking for the added bonuses, but some are from back east, and a few are displaced nurses from the Hurricane Katrina episode.

Martin Luther King Drew UCLA Medical Center has been out of the news since last October. Dr. Thomas Garthwaite quit his post in November as Director of Services for the Los Angeles County Health Department and left for a position in Pennsylvania with Catholic Healthcare East. His plan before leaving was to decrease hospital inpatient services and increase outpatient services.

Little Company of Mary Hospital in Torrance welcomed Michael Hunn as the new COO last month. After only a few weeks, he seems to be on track with a successful dialogue with doctors. Time will tell.

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Kenneth Pauker, M.D.—District 13 (Orange County): “Holding steady” is the phrase which best captures the flavor of current anesthetic practice in Orange County, and what is “steady” is continuing change, controversy, and the evolving forces at work that have been detailed in previous reports.

Change in ownership at South Coast is unresolved. The largest nearby hospitals, Mission, Saddleback, and Hoag, have not made purchase offers. Apparently what remains is an offer to purchase the facility from the Adventist System by a group of physicians who practice at the hospital, in partnership with a management group from out of the area, but one which has never operated an acute care hospital. The hospital enjoys tremendous community support and a poll of Laguna Beach residents has shown considerable support for raising taxes in their city to help fund the \$50 million in retrofit expenses. Details of the negotiation are being held close to the chest, but it seems that the three options are to sell to this group, to share ownership between this group and the Adventists, or for the Adventists to continue to operate the hospital themselves. There is no talk of closing the hospital.

Planning but no construction as yet continues for Saddleback, in partnership with physicians, to open its new Outpatient Surgery Center in the adjoining medical office building. Anesthesiologists will not be permitted to own shares, reportedly based upon a careful review of applicable laws and regulations with their hospital attorney. (*Phillip Goldberg, CSA legal counsel, in the Spring 2006 CSA Bulletin discusses in detail why this conclusion is erroneous.*) Scheduled opening date is January 2007. Discussions have also begun at Saddleback on closing the Department of Anesthesiology.

Irvine Medical Center continues to “hold steady.” My previous report apparently misstated the volume of the contracted business from Kaiser Permanente; the correct figure is closer to 30 percent of both obstetric and operating room business. The new KP hospital—a substantial edifice that is already framed out and is now filling in—is basically across the street and a portent of the intense competition to come. Beyond the issue of patients potentially seeking to realign where they get their care, there is a concern that IMC, a Tenet hospital, may face a serious issue of losing employees to a competitor that is known for paying its employees well.

Kaiser-Permanente plans to open its new Orange County Medical Center in Irvine on October 1, 2007. The hospital will have 150 beds, eight ORs, and two Special Procedure rooms. It will connect with the recently opened Sand Canyon Medical Office Building, which itself has four ORs, one Interventional Pain Suite, and two GI rooms. The plan is to staff the new hospital with two in-house anesthesiologists to provide coverage for both the ORs and OB.

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The Orange County Register continues to investigate and feature various problems at UCI. This began in the past with the widely reported Infertility Clinic scandal. More recently the *Register* did an exposé on the Liver Transplant Program, which subsequently lost its certification and now is closed. The *Register* also has reported on the flawed Renal Transplant Program and the Pain Medicine Fellowship, which has been on probation for several years. Faced with mounting pressure and allegations of failure of oversight, the physician CEO recently resigned. The report of the blue ribbon committee is available at http://www.chancellor.uci.edu/lt_committee_report.shtml. This committee was appointed by the UCI Chancellor to conduct an independent review of the closed Liver Transplant Program.

Now the *Register* has turned to featuring problems in the Department of Anesthesiology: a former faculty member claims that he was dismissed because he allegedly complained about problems of quality. Chairman Peter Breen, M.D., could not reply to the specifics because of restrictions in the California Evidence Code (a suit is in process), but he is unequivocal in his statements concerning his department's quality and safety record. Construction on the new hospital proceeds, as does Dr. Breen's efforts to increase faculty salaries and his plans to elevate the department to a world-class status.

Fountain Valley, another Tenet Hospital, had a substantial shake-up in administration in 2005, now with a new CEO, CFO, and COO. The anesthesia group continues to be a work in process, working toward a "face sheet neutral" environment. The group has an excellent relationship with the current administration, although it has concerns about a declining payer mix that includes increasing numbers of indigents.

Hoag continues to "hold steady," now with 42 members in the anesthesia group, and it is waiting to see how things turn out with its new hospital CEO.

At St. Joseph, discussions concerning expanding OR capacity by 50 percent are in process. There is concern that lateral expansion of this degree may, depending on how it is done, substantially affect case volumes for individual anesthesiologists. Negotiations continue concerning stipends to defray the burden of caring for economically nonsustaining programs.

At Mission, matters also are "holding steady." The observation has been made that the substantial growth in Orange County south and east of Mission has, curiously, not produced noticeable incremental business so far.

Dr. Brian Cross, CSA alternate delegate and a participant in the recent CSA meeting with Southern California billers because of his expertise in billing

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matters, is now Chief of Staff at Western Medical Center. The Medical Staff Bylaws, a model of what can be achieved to ensure physician engagement in hospital economic decisions, have at long last been approved by the hospital Board of Directors. Now the physicians have a seat at the table and can insist that resources be provided for appropriate care, but the hospital response now is, "Sorry, we have no money." Defense of a SLAPP suit (Strategic Litigation Against Public Participation) against a former Chief of Staff for speaking out on quality issues is supported financially by both the OCMA and the CMA, and may have national implications.

An encouraging development is that there is lobbying within at least one other large group to require membership for each physician in the CSA and ASA as a matter of professional responsibility. My group, California Anesthesia Associates, Inc., did this at my urging last year. Also, the device of using the automatic "opt in" unless specifically "opting out" has been employed to increase membership in professionally related political action committees and, in at least one case, the funds available almost tripled.

Jeffrey B. Glaser, M.D.—District 14 (Los Angeles County [northwestern portion]): When I became District Director of District 14 I was aware that we were and are a challenged district and many obstacles would lie ahead. That being said, I committed myself to figuring out why my district suffered the lowest membership of any district and how to improve the situation. I have spent many hours speaking with CSA members and nonmembers in my district to learn the answers to those questions. I have enjoyed interacting with my colleagues and have learned a great deal.

There is a perception amongst CSA members and nonmembers alike in District 14 that CSA, as a big tent organization, does not focus solely on issues that directly impact the quality of anesthesiologists' financial affairs. Many anesthesiologists are especially outraged at the egregiously low rates some carriers have bullied us into accepting when compared to the rest of the country and want to know what the CSA has done to address this concern. Many of these rates are \$20 or more per unit less than other states. Furthermore, some carriers don't even use the ASA RVG, but rather their own proprietary system—which they refuse to disclose. This leaves many anesthesiologists wondering what the unit rate agreed to in their contracts really means or reflects.

In November 2005, Blue Cross of California advised that they would no longer cover the routine services of an anesthesiologist for colonoscopy (CPT 00810) or endoscopy (00740). Numerous anesthesiologists in our district have

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practices with a heavy predominance of such cases. Most encouraging is the response by gastroenterologists and patients in our community who are outraged by this new policy and are supportive of the anesthesiologists. Unfortunately, to date the sentiment has been that the CSA was unable to act briskly and strongly enough to prevent or reverse this decision. Fortunately, this issue now is clearly on the radar screen and CSA is attempting to aggressively address this issue and develop an effective position. Furthermore, California State Senator Debra Bowen introduced legislation last month that would mandate all insurance carriers to cover the services of an anesthesiologist when requested for colonoscopy/endoscopy by January 2007.

It would appear that there is widespread sentiment that CSA should be more aggressive regarding economic advocacy to improve the financial well being of anesthesiologists while simultaneously preserving safe and effective patient care.

It is my assessment that we as a society can do several things to boost and retain membership. I believe that we need to regularly dedicate a page in the *CSA Bulletin* that directly shows the great financial benefits, in dollar amounts, of being a CSA member. Additionally, I would like to see a regular e-mail that bullet-points our important active issues and how they help the individual anesthesiologist. Clearly, contracting issues need to be addressed. Lastly, I'd like to see an overturning of Blue Cross's decision not to pay for anesthesia for colonoscopy/endoscopy, and also a commitment to working on increasing low per-unit rates and urging carriers to disclose how they figure their base units and time in this state.

As sad as it is, many of our efforts go unrecognized and unappreciated. Perhaps if we spend more time and effort combating the financial issues at hand to improve the economic livelihood of anesthesiologists, physicians will be more open to look at and positively accept all of CSA's great efforts and accomplishments—such as CME offerings, *CSA Bulletin*, CSA Web Site, legislative advocacy, and legal advice.

Ali Fahimi, M.D.—District 15 (Resident Members): At the CSA board meeting on January 6, 2006, the issue of information distribution was brought up. The issue at hand was that of “push vs. pull” technologies for the dissemination of information. Although we do not hear much about this debate any more, these paradigms still exist. In brief: E-mail and list serves give the sender the choice about what content others receive. In other words, they are entirely “push” technologies. Really Simple Syndication (RSS), news servers (USENET), and the World Wide Web (web sites and blogs) give all of the choice to the recipient. They are entirely “pull” technologies.

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Each of these services has its merits and drawbacks. With “push” technology, everyone gets the information at the cost of bandwidth and information overload. Although “pull” technology allows for information to go to those who are truly interested, it runs the risk that others—who also need to be aware—do not receive the information.

Of course, a happy medium would be nirvana: a technology that ensures everyone who needs to get information gets it, while at the same time avoiding a deluge of information. Although there are certain promising technologies, our current information technology (IT) infrastructure simply does not allow for their use. As such, I would recommend an expansion of our current list serves and web resources to achieve better information dissemination.

At this time we have a number of limited list serves open to every member who subscribes to the list. CSA could perhaps be better served by three large groups of lists:

1. **Closed Lists.** These are lists created by the CSA administration. Subscription to these lists is possible only through the administration. These would be lists set up for particular districts or groups such as the District 15 Delegates/Alternate Delegates, District Directors, or Executive Board.

This allows for a number of benefits:

- Allowing for dissemination of information into “need to know” categories and targeted groups. Since lists are closed, other members cannot join them and are therefore not privy to their content.
- Although all members can set up their own distribution lists, this is time consuming and requires a certain prerequisite knowledge of computer software. Furthermore, each member would then need to constantly update and ensure the integrity of his or her own e-mail distribution list. By having the CSA set up these lists, central maintenance can occur. If members update their contact information with the CSA, only the list serve needs to be updated, at which time all members with access to the list serve will have access to the new address.
- Central maintenance also allows for continuity. If there is a change of director, then the incoming director can just use the list serve and pick up where everyone left off, without needing to set up a new distribution list.

2. **Semi-Closed Lists.** These would be general information lists. They can only be posted to by certain members (i.e., administrators and moderators)

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but can be joined by anyone. This allows for all CSA members to receive information in which they are interested, while avoiding information overload. For example, a list could be set up for “California Legislature News” relevant to the CSA and anesthesiologists. Those who subscribe would then be informed of any issues that the CSA is examining at the legislative level. Since the list is moderated, no discussion occurs; i.e., it is a purely informational list. Hence, people who are not interested in the topic, or do not want hundreds of follow-up discussion e-mails, are kept informed but not flooded.

3. **Open.** These lists would be for discussion. Any member can post and other members can respond.

The current web site can also be expanded to have private, semiprivate and open areas. Again, this allows for compartmentalization of information and allows for securing of sensitive data. Furthermore, the web site can be much more tightly integrated with the list serves to make it easier to reference copies of important articles, CSA news, and other announcements in the future.

Although this provides a workable stopgap measure, the CSA may want to consider expansion of its IT infrastructure. As it stands, our current IT infrastructure is adequate but becoming outdated. For example, one of the current goals of District 15 is the creation of a central database of anesthesiology fellowships in the United States. This could be achieved by sending out e-mails to program directors and asking them to fill out a brief survey on the CSA Web Site. Then using simple scripting and a Simple Query Database (SQL) server, the data can be sorted, cataloged, and made immediately available to users in a searchable and “sortable” database. Furthermore, this would allow for continued updates and maintenance of the database by the residency programs themselves, reducing much of the administrative overhead from the CSA and its staff. Unfortunately, due to our current setup, we cannot automate this procedure at all. Surveys are e-mailed to program directors who fill them out and send them back to the CSA; then they are entered by hand into a static database. The CSA also incurs administrative overhead to ensure that the data has not changed and is accurate to maintain value in the database.

The web site can further be expanded to include the use of forums (bulletin boards) to replace the open list serves. This allows for archiving of discussion threads for future reference and to allow new members to catch up to what has been going on, something that an e-mails list serve does not allow. This can then be combined with RSS technology to allow for distribution of information to those who wish to subscribe for automatic delivery.

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Beyond the web site and list serves, other measures can be taken to decrease our reliance on paper and to reduce costs. For example, the issues of privacy and confidentiality and electronic information distribution were brought up during the last CSA board meeting. Although by providing for closed lists and compartmentalization of the web site we achieve a medium of security and privacy, this is not the ideal for all types of information. However, we can achieve complete electronic distribution and security through the use of encryption schemes, such as Pretty Good Privacy (PGP), which allow for public and private key generation and use of centralized key servers. This allows for ensuring “Eyes Only” communication as well as “fingerprint” and “signature” verification of a sender’s identity.

Not all of these changes or improvements need to be in-house. CSA can also make use of Value Added Resellers (VARs) to improve its member services. (Capitol Advantage at <http://www.capitoladvantage.com/>.) Use of such services is almost mandatory for an organization like the CSA, given our political needs.

In order for the CSA to effectively leverage new technology, it needs to implement a policy of aggressive change. First and foremost, a cost analysis should be performed to determine an effective budget. Second, a dedicated IT department or committee needs to be formed to proactively seek out, study and implement new technology. Finally, a dedicated support infrastructure needs to be implemented to maintain the web site, list serves, and current databases. In the future, this support infrastructure can be expanded to maintain any newly implemented technologies.

The CSA board is small. However, our membership is extensive. We have the need to be able to communicate efficiently with a large and diverse population if we are to organize effectively in order to achieve our objectives. The rapid pace of technological change has been astounding. What only 20 years ago was science fiction is now science fact in the realm of computers. Only by rapidly and aggressively adapting can the CSA continue to remain a model of effective communication, collaboration, and development to other state and national organizations.

**CMA Physician’s
Confidential Assistance Line
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