CUA REPORT

January 2005

A POWERFUL VOICE FOR CALIFORNIA UROLOGISTS

If It's California and It's Urology - It's CUA

President's Report by Vito Imbasciani, Ph.D., M.D., FACS

Urology remains a healthy and vibrant profession in California at the end of 2004. And the CUA has had an active and productive year supporting its members and addressing the concerns of the specialty. We continue to send officers to represent the interests of Urology to all State meetings, whose reports (from the Medicare Contractor Advisory Committee and the Council on Legislation) make up the bulk of these newsletters. We will again have representation at the upcoming CAC meeting in Oakland in January, and in Los Angeles in April, 2005. I will represent the CUA at the meeting of the Council on Scientific Affairs, during the upcoming House of Delegates meeting in Anaheim, in March, and Douglas Chinn will be our presence at the upcoming meeting of the Council on Legislation. We have a fully staffed delegation to the Specialty Society section of the CMA for the upcoming House of Delegates. Any urologist in California is encouraged to bring his or her ideas for changes in policy or law to our attention, that we might better shepherd it along to people in positions of power in Sacramento and Washington.

A number of urologists in the State were shocked recently by the arrival of a document that seemed to threaten a class-action lawsuit over Lupron prescribing in the office. I contacted the legal office of the AUA, which was receiving similar calls from urologists in a half-dozen other states. Their investigation revealed that this threatened action was a ruse, and our advice to all California urologists receiving a letter from the firm of "Kline and Specter" is to ignore it completely, and not respond in any way. Instead, alert Michael A. Pretl, AUA General Counsel (tel 410-689-3733; fax 410-689-3909; email mpretl@auanet.org). He is our point of contact, and is tracking this development assiduously.

The CUA endorsed the upcoming "Essentials of Pain Medicine" course, sponsored by the American Academy of Pain Medicine, to be held in Palm Springs, February 26-27. It is designed to satisfy the 12 hour CME requirement mandated by AB 487, which must be completed by the end of 2006. CUA members will receive a discount from the AAPM for taking this course.

Lastly, on a personal note, I want to thank all the CUA members who took the time to send messages and emails to me during my recent deployment to Iraq. I was the Battalion Surgeon to the 1/185th Armored Regiment out of San Bernardino, CA, and was stationed most of the time at a Forward Operating Base 30 miles south of Baghdad, at one corner of the Sunni Triangle. I commanded a medical platoon of twenty medics, and cared for 200 soldiers and 1000 Marines. The last month saw me at a large base north of Baghdad, where I was tasked with the care of

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Jeffery Kaufman talks with CMA President Robert Hertzka and his wife. Dr. Hertzka was the keynote speaker at the Socio-economics Forum and CUA Annual Members Business Meeting in San Diego this past August.

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A Publication of the California Urological Association, Inc.

CUA Mission Statement:

CUA is a political and socio-economic urologic organization whose purpose is to actively represent, organize and integrate urologists into the current healthcare system by means of communication and representation to similar organizations and to maintain the highest quality of urologic care.

CUAction Report

Political, Economic and Medicare Updates

By Jeffrey Kaufman, M.D., FACS, Past President, NHIC Carrier Advisory Committee, Representative to AACU & UROPAC

By the time you read this article, I suspect the holidays will have come and gone, you will all have had a chance to clear your hangovers from too much Christmas cheer and you're probably settling down now to evaluate the condition of your medical practice in the new year. Unfortunately, 2005 may hold some nasty surprises. As of January 1st, we will all begin to feel the major cutback in Medicare payments for LHRH agonist therapy administered in the office. As I write this in early December, we still have not been given the first quarter 2005 fee schedule from CMS even though the data was due from the vendors October 30, 2004. I suspect as the year progresses, we will see major revisions to that reimbursement level until all profit has been completely wrung out and most of us will be forced to decide if we can afford to continue to provide these medications to our patients. To add insult to injury, the 96400 code used for the subcutaneous injection of "chemotherapy" agents up until now-which was increased in value to offset the loss anticipated when the reimbursement was cut to 80% of AWP-has now been done away with altogether in favor of a new CPT code designed to more closely reflect the costs involved with administering Lupron, Zoladex and the rest. While we have not yet seen the fee schedule for this new temporary code, I strongly doubt it will represent an increase in payment. Add to this negative news a letter from the legal firm (and shakedown artists) Kline and Specter received by many last month threatening legal action for what they claim was widespread collusion and conspiracy by urologists to fraudulently inflate profits from delivering LHRH agonist therapy by artificially overcharging for the medication. Their threatened class action lawsuit (which at the time of this article has yet to be filed anywhere in the country) maintains that it was illegal for physicians to mark up the cost of acquired drugs to patients and that we had a fiduciary responsibility to work with CMS to hold down the scheduled reimbursement rates for these drugs. Moreover, the claim insinuates that the practice of charging for injections that were provided free to the doctor as samples was widespread-an unfortunate action taken by a very tiny number of doctors who have been legally pilloried but by no means represent the majority. The letters appear to be an attempt to blackmail physicians into making inappropriate confessions and settling money on the attorneys in an attempt to avoid litigation. The AUA attorneys have indicated that they are actively investigating this issue and strongly believe the allegations are without merit. Moreover, they have strongly advised against individual doctors contacting these plaintiff attorneys. The CMA legal counsel Catherine Hanson has also advised against making any type of concession since payments could be construed as an admission that the allegations have merit and put the physician in jeopardy of much more serious legal complications from regulators who would view the alleged actions with alarm (a payment to these thieves could bring you a call from the attorney general, exclude you from the Medicare program and put your medical license at risk).

In short, our honest efforts to provide appropriate treatment to our patients and our success in keeping those patients alive longer and in better health are now going to bring us no profit, may well cause us to lose money and could possibly result in legal costs and penalties. Boy, practicing medicine in America just keeps getting better and better.

In an effort to offset these anticipated losses to our bottom line, many have advocated looking to other areas of our practices to raise income. One of these suggestions has been to invest in an ambulatory surgical center. Facility payments to the operating room for surgeries performed by us dwarf the surgeon's fees in most cases. Many have sought to share in those costs by utilizing free standing surgicenters. An excellent argument can be made that these centers allow the urologist an opportunity to increase the quality of care provided, improve efficiency and add considerable convenience for our patients. Unfortunately, CMS has begun to take steps to close down or restrict the types of cases performed in these centers. The new list of approved procedures has removed authorization for diagnostic cystoscopy (CPT code 52000), cystoscopy with dilation (CPT code 52281) and prostate biopsy (CPT code 55700). While most of us would perform these in the office with minimal local anesthesia, there certainly are times when a patient's anesthesia needs can't be met in that setting. And yet taking the patient to a full service hospital may be more expensive and much less efficient than warranted. Moreover, for those who quite often perform these as an outpatient with anesthesia, they have been a profitable part of the ASC experience. The AUA and the ASC working group have been actively appealing the removal of these codes from the approved list and we expect a call to the members for letters to CMS demanding that these codes be reinstated. Each of us should become involved in these issues even if it is just to write a forceful letter explaining how this impacts the quality of care you deliver to your patient or his access to care.

At the same time, some urologists have been relying on income from performing their own imaging studies-some with in-office ultrasound and others with CT or MRI partnerships. These are difficult economic times for everyone however and other specialists may be envious of our success. The AUA has responded to a turf challenge from radiologists over who is qualified to perform various imaging studies. Most of us were well trained in almost all aspects of imaging studies as

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CMA Council on Legislation

By Douglas Chinn, MD - COL Delegate

In the beginning of November, the CMA held its annual autumn workshop. There were 4 workshop groups, and a final report will be forthcoming, a copy or summary of which I will provide for the CUA members in the future. This report contains excerpts and complete text taken from reports and documents provided by the CMA, COL and CMA website.

Introduction:

I was involved in the Specialty Hospital Workshop. Basically, the California Healthcare Association (CHA), which represents hospitals' interests, wants to continue federal legislation that bans physician ownership of specialty hospitals. The CHA has openly stated that they will not support legislation to extend this ban to outpatient surgery centers. However, the American Hospital Association has publicly stated that not only do they want the ban to continue on specialty hospitals, but also apply it to physician owned surgery centers.

Background:

In Section 507 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Congress issued a moratorium on physician investment and referral to specialty hospitals pending the outcome of specified studies and recommendations by the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC). Under the moratorium, a physician may not refer a patient to a specialty hospital in which he/she has an ownership or investment interest, and the hospital may not bill Medicare or any other entity for services provided as a result of the prohibited referral. The moratorium became effective when the law was signed on December 8, 2003 and will expire June 8, 2005.

The MMA moratorium expressly applies to hospitals that are primarily or exclusively engaged in the care and treatment of patients with cardiac or orthopedic conditions, patients receiving surgical procedures, and patients receiving surgical procedures, and patients receiving any other specialized type of services that CMS may designate. In addition, the law specifies that the following types of hospitals are not subject to the moratorium: psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals and those cancer hospitals that are not paid under the inpatient prospective payment system. The MMA also prohibits construction of new specialty hospitals for 18 months from November 18, 2003. There is grand fathering in this moratorium.

Pending Studies:

Congress directed the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (DHHS) to conduct studies of the whole hospital exception during the moratorium and to recommend legislative and administrative changes.

Preliminary results of the MedPAC study were released September 10, 2004. Basically, although the hospital lost some surgeons and patients to specialty hospitals, the overall volume declined only slightly and most had recovered. The FTC and Department of Justice independently created a report, and concluded that more competition, not less, "promotes the delivery of high-quality, cost-effective effective health care."

A Lewin Group Inc., did a study of open-heart surgery at eight heart hospitals as compared to 1,056 peer hospitals across the country. They found better service, less mortality, shorter average length of stay, and lower medical complications.

Finally, the California HealthCare Foundation's California Hospital Experience Survey consistently rank specialty hospitals highest in quality and patient satisfaction.

Recent State Actions:

In the last legislative session, two bills (AB1261 and SB 828) were introduced and successfully opposed by the CMA.

Assembly Bill (AB) 1261 would have required that any new hospital provide a broad range of adult acute inpatient medical and surgical services and at least basic emergency services as a condition of licensing. Furthermore, this bill would have prevented physicians from having an ownership interest in ANY general acute care, psychiatric or specialty hospital.

Senate Bill (SB) 828 would have required "boutique" hospitals to maintain and operate an emergency department, participate in the Medi-Cal program, and provide emergency services to non-paying and low-reimbursed patients. This bill would have also prevented physicians from having an ownership interest in any specialty "boutique" hospital.

Hospital Actions:

Without waiting for the results on any of the ongoing studies, the national and state hospital associations are already intensely lobbying Congress to make this 18-moratorium a permanent ban. In fact, AHA and the Federation of American Hospitals both want to close the loophole in Stark that allows for physician self-referrals to "whole" hospitals.

The California Healthcare Association (CHA) is no exception as well, having introduced or supported SB 828 and AB 1261 last legislative session, and plan to do so again this year.

Hospitals have also retaliated by refusing staff privileges to physicians with ownership stakes in competing facilities, or refusing those physicians medical staff governance positions or voting rights (ie Ventura Community Hospital).

AMA Policy:

The AMA believes that competition between and among physicians and other health care providers is not only ethical, but encouraged. The AMA reaffirms it belief that physician ownership interest in commercial ventures can provide important benefits in patient care. However, the AMA stresses

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California Technology Assessment Forum Report

By Dean Hadley, MD

The California Technology Assessment Forum (CTAF) invited the California Urological Association (CUA) to comment on issues pertaining to urologic practice at their meeting in San Francisco on October 20, 2004. CTAF is sponsored by Blue Shield of California Foundation and is a panel of physicians from various specialties, a nurse and a Ph.D. The CTAF maintains its own independent staff reviewers and that our (CUA) invited comments were in addition to their own in-house recommendations. The CTAF uses a system of formal established set of criteria to decide on supporting and evaluating the safety and efficacy of new technologies.

Seven issues were considered at the meeting, ranging from Extracorporeal Shock Wave Therapy for Treatment of Lateral Epicondylitis to Recombinant Human Bone Morphogenetic Protein as an alternative to spinal fusion and for tibial non-union fractures. The two issues CUA was asked to comment on were magnetic stimulation and electrical stimulation for the treatment of urinary incontinence in women.

Magnetic Stimulatio: we (CUA) testified that the Neotonus Chair was an innovative technology and we applauded any attempt to help incontinence in women not helped by traditional treatments, but that to date clinical experience does not support the chair as meeting the forum's criteria for efficacy. We felt the response has not been demonstrated to last long enough to be included as standard therapy. We are also concerned that treatment strategies are not adequately developed.

Also testifying were representatives from the California Chapter American College of Obstetrics and Gynecology, and the president of Neotonus, the maker of the chair. Neotonus feels the chair is a reasonable attempt to help women who are unable to learn to do Kegal's maneuvers and that the data does show enough improvement and safety to help some people. He felt this justified including magnetic stimulation as appropriate therapy. **The Forum voted with the recommendation of their assigned reviewer: Criteria for approval were not met.**

Electrical Stimulation for Urinary Incontinence: a more complex issue, but was discussed less at the forum. Our position was of interest, and recognition of conflicting scientific data that holds hope of benefit, although we did not feel this treatment met the criteria for safety and efficacy. **The Forum again voted with their specialist, and our position, that criteria for approval were not met.**

Included in our testimony was the source of information. The CUA was represented by a urologist in private practice. Our positions were formed in consultation with the advice of the CUA Officers and with specialists in female urology.

The AUA has a position on magnetic stimulation formed by a working group comprised of members from a coding committee, a quality assurance and safety committee and urologists experienced in incontinence. They conclude that “there is lack of durability of the therapy after conclusion of the proposed therapeutic course…it would appear that most patients revert to baseline symptoms over a period of time ranging from a few weeks to few months post therapy.”

Welcome New Members

Richard Bevan-Thomas, Fremont
Vodur C. Reddy, Apple Valley
Herbert C. Ruckle, Loma Linda
Gary W. Smith, Van Nuys

In Memoriam

We are saddened to announce the passing of Dr. Henry Ritter of Atherton on December 20, 2004. Dr. Ritter was a long time member of the CUA and actively represented the CUA as the Northern California Representative to the Medicare Carrier Advisory Committee. Dr. Ritter was 84 years of age and was just as active as his prior 50+ years in medicine. He will be missed.

that a physician should have personal involvement with the provision of care at the referral site.

Current CMA Policy:

The CMA does not currently have specific policy, but has opposed CHA introduced bills in the post legislative sessions. The CMA does oppose physician economic incentives that conflict with the patients' welfare, and the physician should not share with the hospital the profit the hospital makes from the physician's patient care decisions.

Discussion:

The CHA presented to the entire COL general session. They primarily discussed poor financial conditions of hospitals due to mandatory earthquake retrofit and poor contract reimbursement. They discussed the problems of emergency and trauma center closures. They ignored all the issues that demonstrated that competition from specialty hospitals is not responsible for the current state of affairs. They also avoided the obvious, that hospitals do not want any competition and ignored the fact that physicians are forming such hospitals due to total lack of cooperation from hospital administrators.

At the breakout session, all members except the Emergency Medicine representative opposed any and all efforts to limit responsible and ethical physician ownership of specialty hospitals or surgery centers. The group also felt that there was no room for compromise with the hospitals, including first right of refusal to join in a partnership. The emergency medicine representative tried to blame the problems of reimbursement and the emergency room crisis on the development of specialty hospitals.

I specifically pointed out that there is no record of any hospital failing due to competition from any surgery center or specialty hospital in California, and pointed out that the following hospitals closed their doors this year without any such competition: Santa Teresita Hospital in Duarte, Long Beach Community Hospital and Daniel Freeman in Marina Del Rey. There also is no verifiable, concrete evidence that illegal or unethical business practices have occurred between physicians and physician-owned specialty hospitals or surgery centers.

More recently, several hospital closings including Martin Luther King Trauma Center, including the recently proposed sale of four Tenet hospitals have been in the news, and never has there been any blame for their demise placed upon competition from specialty hospitals or surgery centers.

Conclusion:

Medical staff independence has finally become legislative law in California. The opponent, CHF, the successful proponent, CMA. There is no evidence that physician owned specialty hospitals or surgery centers have compromised patient care, or contributed to the current, past, or pending demise of several hospitals in California. The CHA and AHA are actively attempting to prevent a free market economy and continuing to try to control physicians. There are currently no other groups supporting the positions of CHA and AHA, nor are there any valid arguments for extending the Federal moratorium or for creating new prohibitive measures except that hospitals do not want physician competition nor loss of control. The committee forwarded these decisions to the head of our group committee. They will develop a position that will be evaluated and further amended by the Board of Trustees of the CMA. I will keep the CUA posted as the CMA position is determined.

Other News:

Department of Justice (DOJ) Asks Physicians to Return Unused Triplicates After Jan. 1: Do Not Throw Expired Triplicates in the Trash. Physicians are reminded that triplicate prescription forms are only valid until December 31. As reported previously in CMA Alert, triplicates are currently being phased out in California. Beginning January 1, all prescriptions for controlled substances (Schedules II-V) must be written on new tamper-resistant prescription forms.

If you do not use up your triplicate supply, the state DOJ asks that all unused forms be returned to DOJ for destruction. Send unused triplicate prescription forms by certified or registered mail to DOJ Triplicate Prescription Program, 4949 Broadway, Sacramento, CA 95820.

Although physicians are not required by law to return extra triplicates, CMA and DOJ encourage physicians to do so. There is a black market in prescription forms. Blank triplicate forms have a significant “street value” and physicians who do not properly dispose of unused triplicates expose themselves to potential liability, should those forms fall into the wrong hands, according to DOJ. All unused triplicate prescriptions returned to DOJ will be voided out of the department's tracking system, eliminating any potential for physician liability. Under no circumstance is it acceptable for triplicate prescription forms to be thrown in the trash. If you choose not to return your unused forms to DOJ, they must be destroyed by shredding or incineration.

2004 LEGISLATION IN REVIEW

SB 1325: Medical Staff Self-Governance recognizes the independence of medical staffs. This bill was a tremendous victory for the CMA and medical staffs of California. This bill recognizes the rights and responsibilities of the medical staff and clarifies their ability to seek an injunction against the hospital if their independence is threatened.

After passage in the Senate, CMA was able to negotiate an agreement with the California Healthcare Association, which represents California hospitals. Despite this agreement a number of hospitals led by the United Hospital Association continued to oppose SB1325, nearly jeopardizing the outcome of this historic measure. In the face of continued opposition from the hospitals, Governor Schwarzenegger ultimately signed the measure, delivering a huge victory for medical staffs. SB 1325 would prevent future intrusions against medical staff independence by hospital administrators $24.8 million in Maddy Emergency Funds Protected. *Continued on page 6*

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The Maddy Fund is used by counties to reimburse emergency and on-call physicians who provide uncompensated emergency care. This state appropriation helps supplement local revenue generated from fines and forfeitures. Implementing language necessary to disperse these funds was inadvertently left out of the budget by the administration and Legislature but will be replaced when the Legislature reconvenes.

Worker's Compensation Reform

In mid-April, the Governor signed SB 899, that contains the compromise workers' compensation reform proposal.

The law significantly redirects the focus of the California workers' compensation system from a program that emphasizes the legal process to one that is designed to be more objective and based on physician assessment of injury. The law is flawed, but the CMA did successfully head off strong efforts by labor, business, and insurance interests to cut physician reimbursement and mandate a Medicare-based fee schedule. CMA also defeated unmanageable billing requirements and an "economic credentialing" program that would have excluded physicians based on the cost of care that they authorize. The CMA also won legislative support for the independent medical review process, which places treatment decisions in the hands of qualified physicians with appropriate clinical knowledge, and the ability to integrate treatment of injured workers with other healthcare services.

CMA will participate fully as new workers' compensation regulations are written to ensure that the changes are evenhanded and do not hurt physicians or their patients. A key battleground will concern the criteria for creating provider networks and whether the networks will seed out the lowest-cost providers, as well as how the regulations will implement the legislative mandate to use scientific-based treatment guidelines instead of existing standards of practice.

SB 1336: Oral and Maxillofacial Surgeon Scope of Practice: Although this bill has no direct effect on urologists, its outcome is significant. SB 1336 proposed to expand the ability of Oral and Maxillofacial surgeons to perform facial cosmetic surgery. Despite heavy opposition from the CMA and California Society of Plastic Surgeons, it moved fairly easily through legislature because the bill was co-authored by Senate President Pro-Tempore John Burton and former Senate Republican leader Jim Brulte. This bill was one of the highest priorities of the California Dental Association. This bill sailed through both the Senate and Assembly. However, Governor Schwarzenegger vetoed the bill. This hopefully will reflect on how the Governor will act on future scope of practice expansion issues.

SB 1782: Physician Practice Investigations and Prescribing Guidelines: This bill marked a major step forward in protecting physicians from inappropriate law enforcement intrusion into the practice of medicine. This bill provides greater peace of mind to physicians practicing in pain management that they will not be unfairly targeted by law enforcement. This bill's relevance to urologist concerns treating terminally ill cancer patients. This bill requires the California District Attorneys Association, in conjunction with CMA, the Attorney General, local law enforcement and various specialty societies to develop and implement protocols and investigation guideline to balance between inappropriate prescribing behavior of physicians and protections for physicians when allegations occur.

SB 1569: Physician Reimbursement: This was one of the most bitterly contested bills this legislative session. Authored by Senator Joe Dunn, SB 1569 would have clarified the right of physicians to bring a court action against a health plan for failure to pay claims properly. It passed in the Senate by one vote, and the health plans put up a ferocious fight in the Assembly. Again, it eventually passed in the Assembly by a single vote. Its passage was due, in large part, to the incredible work of the physicians who called, faxed, and wrote their Legislator. Unfortunately, the Governor vetoed SB 1569 under heavy pressure from the opposition.

SB 262: Physician Prescribing Habits: This bill would have prevented pharmacists from selling, and pharmaceutical salesmen from using, the prescribing information of physicians who do not want that information sold and marketed. Opposition came from the pharmaceutical and biotech industry. Unfortunately, this bill failed to pass by a close margin in the Assembly.

SB 1853: Clinical Social Workers Scope of Practice: This bill would have allowed clinical social workers to engage in the "diagnosis and treatment of mental, emotional, and behavior disorders, conditions, and addictions." This bill was carried by the newly anointed Senate President Pro-Tempore Don Perata but was defeated by the CMA on the Assembly floor.

WRAP UP:

Arnold Schwarzenegger dominated this legislative year. From the state budget to worker compensation, the Governor cast an enormous shadow. The loss of Senator Burton will greatly exacerbate the inability of Democrats to push a comprehensive alternative to the Governor. Republican legislators, on the other hand, are thrilled to be in the Governor's office, but are at odds with Arnold's liberal social views. This past year, Arnold sided with the CMA on critical legislation such as SB 1325 and SB 1336, but he vetoed SB 1569. Most important, however, was the fact that he was open to physician input and given the scope of challenges facing California health care, that is crucial. Critical issues for 2005 will be MICRA, balance billing, and access to care. CMA will engage early and often to ensure that physicians are well represented and their interests and those of their patients are protected. I therefore strongly encourage each physician can help this important process by joining the CMA and contributing to CalPac, the lobbying organization.

CUAction Report *continued from page2*

residents (and had to prove our proficiency on our board examinations) and most of us rely on our own readings of ultrasounds, IVPs and CT scans more than the "official" interpretations of our radiology colleagues (after all, we know the clinical history of the patient and often have an advantage in interpreting complex studies). Unfortunately, the administrators who decide on who can charge for such studies may be persuaded more by the economic argument put forth by radiologists that physicians who profit from studies are motivated to order tests more for their own benefit than for the patient's. We would counter that we are in the best position to perform and monitor studies knowing the patient's clinical background and we are the best qualified to tailor the study to provide just the information needed for managing the patient. We will always do well emphasizing our concerns for patient care. Time will tell how this argument is resolved but it is unfortunate that physicians feel the need to criticize each other when all our interests are best served by uniting. Remember when circling the wagons, it's best to shoot outward.

One thought worth considering in view of the above onslaught on our freedom to practice as we think best and to make a living at the same time concerns other opportunities in the healthcare field. To the list of suggestions on how to enhance practice revenue, I would add purchasing or investing in a full service hospital. While there are indeed challenges to running a profitable health care center in the current economic atmosphere, a dedicated cadre of physicians might still be able to support a full service community hospital, maintain quality care and with a careful eye toward efficient management, remain profitable. Several years ago, this idea was appealing enough that quite a few physician-owned facilities sprang up. Most have gone away or been bought up by the large chains but some of those groups (like Tenet) have fallen on hard times and are divesting. Several of Tenet's sales have gone to physician groups who have had some success in managing other hospitals. In the entire health care field, no one has more control on overhead expenses than the physician. Even while maintaining the highest quality of care, we have a great deal of potential to keep costs down. We have the additional advantage of not having the huge legal bills attached to some of the large hospital chains. Nor would we be beholden to Wall Street in our management decisions; we would be free to plough more of the hospital income back into improving equipment and the physical plant. Issues of conflict of interest, turf battles over who performs imaging studies, and whether a surgery is approved for an ASC all become moot when treatment is done at a full service, physician-owned community hospital. Regulation is straightforward and quality standards are all out in the open. Physicians can take solace that they have control over the quality of care delivered and don't have to fight with the bean counters to do the right thing for their patients. Even in areas heavily impacted by managed care, the physician staff model (look to Kaiser) can work with sufficient support and commitment by doctors. Taking back control from the business managers, CPAs and lawyers may be one way for us to provide ongoing high quality care to our patients and thrive economically at the same time.

In the coming era of ever increasing regulation and limited resources, we must keep all our options open, consider all alternatives, be creative, cooperate with each other and speak with one loud voice to make our concerns known. We should continue to communicate with each other and make our elected representatives aware of our needs. Write them often, lobby at every opportunity and contribute generously to our organized associations. The practice of medicine remains the highest calling and urology is still the most exciting field I can imagine.

CALL FOR NOMINATIONS

Become an Officer

The CUA is inviting members in good standing who are interested in serving as President-Elect and Secretary for 2005 to submit their name or the name of another nominee for this position. Please submit your nomination by March 30 in order to be considered and put on the ballot for the 2005 election.

President-Elect:The president-elect works under direction of the President, adheres to the bylaws and established polices in the conduct of the following duties: Attends all meetings, takes certain actions as required in the bylaws, assists in program/educational planning with the officers, works towards the goals of the CUA, works with administrative office to accomplish goals and tasks, communicates frequently with staff, officers and committee members, and fills in for the president if absent.

Secretary: The Secretary works under the direction of the President, adheres to the bylaws and established policies in the conduct of the following duties: Reviews organizational records, reviews and approves minutes, provides brief reports on membership activities, attends all meetings, signs official documents, takes certain actions as required in the bylaws, works towards the goals of the CUA, works with the administrative office to accomplish tasks, and communicates frequently with staff, officers and committees.

Please email us your interest or nomination at info@CUAnet.org

The CUA needs the participation of members to be successful and represent every member's interests. For us to continue, we need more than your support; we need your involvement.

President's Report *continued from page 1*

wounded Iraqi detainees. Life was dangerous, and living conditions were Spartan. The nearest urologic care was a Combat Support Hospital, run by active duty Medical Corps folks from Fort Bliss, who evacuated their patients to the multi specialty hospital in Langstuhl, Germany. I have arranged my Iraqi photos complete with soundtrack, into a DVD movie format, and would be happy to speak on my wartime experience as a battalion surgeon to any interested gathering. For those interested, I memorialized my tour of duty in an online "blog" at www.yovito.com.

IMPORTANT MEETING DATES 2005 - 2006

- CUA & WSAUA Socioeconomics Forum
  Sun. July 31, 2005, 12:00 noon
  Vancouver, BC, Canada
  Westin Bayshore Resort & Marina
- CUA Annual Business Meeting & Luncheon, Vancouver, BC, Canada,
  Tues. Aug.2, 2005 - 12:00 pm,
  Westin Bayshore Resort,
- Western Section 81st AUA Annual Meeting, Vancouver, BC, Canada
  July 31 - August 4, 2005
  Westin Bayshore Resort & Marina
- American Urological Association Annual Meeting
  San Antonio, Texas
  May 21-26, 2005
- CUA Interim Board Meeting
  Sunday, May 22, 2005
  12:00 pm-2:00 pm
  San Antonio, Texas

Visit CUA on the WEB

www.cuanet.org

Let your views be known, call your US Senator & Reps. directly at the US Capitol switchboard at **(202) 224-3121**. To find out who your Representative is, call Lisa Marie Brody at **(443) 524-1169.**

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Have your CMA I.D. & Medical License at hand.

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