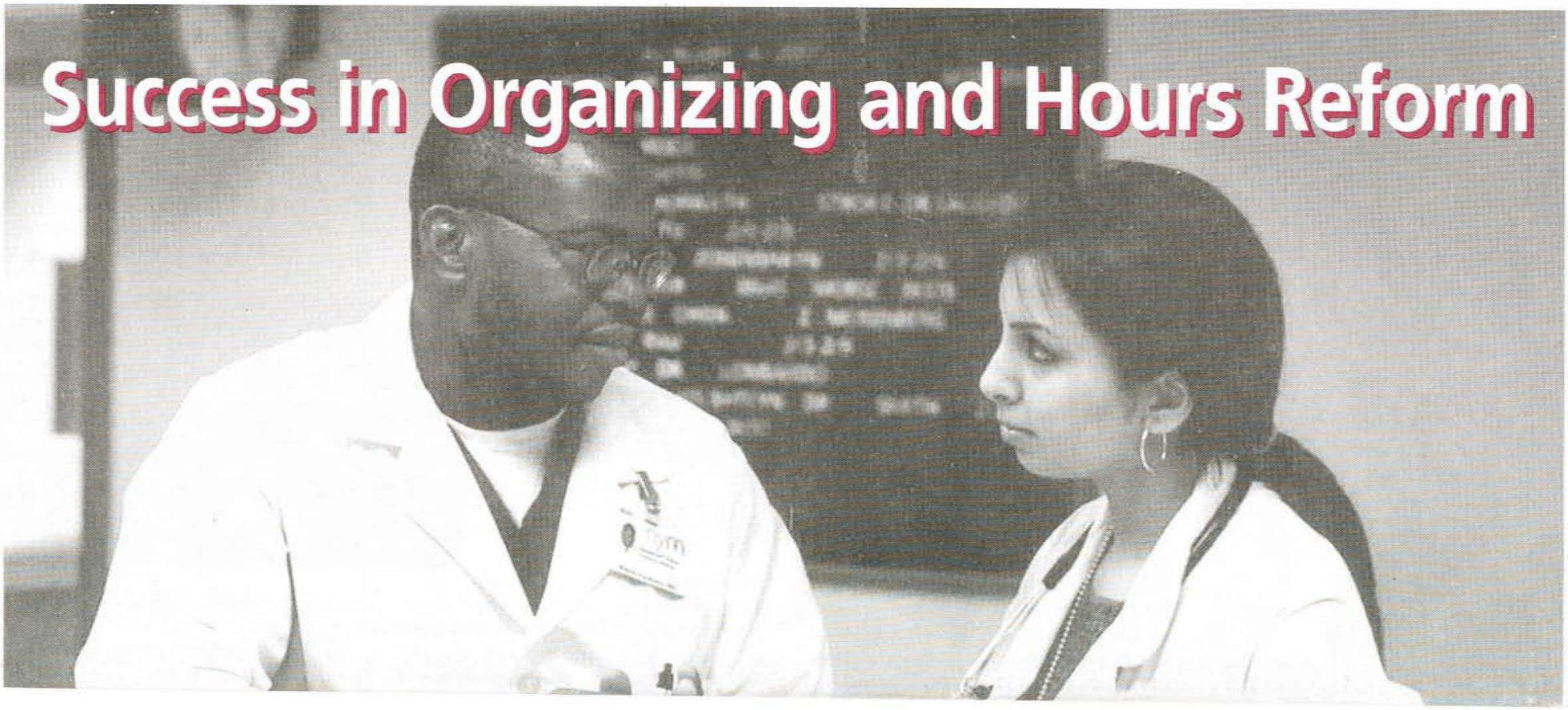
CIR SEIU NEWS

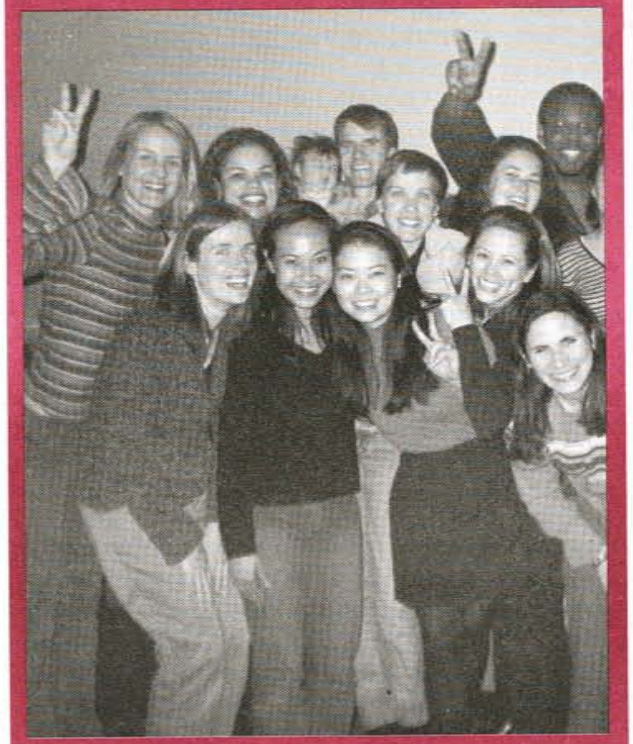
COMMITTEE OF INTERNS AND RESIDENTS

March 2003

Inside:

Success in Organizing and Hours Reform





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CIR SEIU NEWS

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Ruth Potee, M.D.

President's Report

Ruth Potee, M.D., CIR President

Beyond Band Aids

Each of you reading this column likely cared for a patient today who doesn't have enough money for their prescriptions. On your service right now is a patient awaiting placement in a rehab facility or nursing home but because they have no insurance, no one will accept them. Last night in the ER, some of you took care of individuals who really should have seen a primary care doctor first. They didn't because they couldn't afford it.

Taking care of patients who have no insurance and little disposable income is something to which all residents become accustomed. We learn how to make a broken system work for our patients. We rummage through the drug closet for antibiotics, keep a mental list of the free clinics which will extract a rotted tooth or provide eyeglasses and make sure that the WIC forms are filled out and the Head Start paperwork is in order.

The current health care system, where our patients' needs now go unmet, is about to get a lot worse.

1995 and nearly twice as many Emergency Rooms have shut their doors. A half a million patients in California will lose their insurance this year. Illnesses, mild and severe, ices, and a focus on profit over patients. Don't let yourself become **accustomed** to the gaps in care for the uninsured. Don't let it go **unnoticed** that you can't meet the medical needs of your patients. Fundamental change can and must happen.

At CIR, we have an understanding of what can be achieved by working together and in alliance with other groups. We have the experience of making change happen. Our collaborative work on reforming resident work hours was one of the key factors that led the ACGME to act on resident work hours now, after decades of inaction. CIR activism, again, in collaboration with other groups and unions, was instrumental in winning the stunning new legislation in Puerto Rico that will reform residents' excessive work hours there (see story, page 5).

As times get tougher, we will need to work harder at getting our message

Don't let yourself become accustomed to the gaps in care for the uninsured. Don't let it go unnoticed that you can't meet the medical needs of your patients. Fundamental change can and must happen.

FRONT PAGE TOP PHOTO:
CARA METZ/CIR
EM Doctor Wayne Abrahms conferring with medical student Amardeep Singh at N.Y.'s Methodist Hospital
PHOTO THIS PAGE: JIM TYNAN

Thirty-six states are projecting enormous budget gaps for the current fiscal year. Projections for the next fiscal year demonstrate the worst fiscal crisis in half a century. Some of the hardest hit are those where many of us are training: California, New York, New Jersey, Massachusetts, and Florida. Every day, the newspaper delivers fresh news of more budget cuts. As many as 1 million people will be dropped from the Medicaid pool this year, joining the ranks of more than 40 million people in this country who have no health insurance.

In California, two-thirds of the 470 hospitals are operating with a deficit. Thirty hospitals have closed since will be taken care of in the state's emergency rooms. Waiting rooms will be packed, ERs will be on diversion, and patients will board in the crowded halls for days waiting for a bed to become available on the floor. Routine health care, prenatal care, blood pressure monitoring, and diabetes education will slip through the ever-widening fissures in our nation's health care system.

A broken system may soon be shattered. Nearly one-third of Americans are either uninsured or underinsured and that number will only grow this year. The delivery of health care in the United States is burdened with high overhead, duplication of serv- across to the decision makers at our hospitals, policymakers in Washington, and, most importantly, the voters, who will all be patients at one time or another. Fixing our nation's patchwork quilt of health care services to better provide for all patients is a tall order. But it's the task in front of us now, and will only become more and more urgent. In the coming years, we will all be stretched to our limits providing care – and we have to stretch even more, to find a solution that amounts to more than a stopgap to our nation's health care crisis. We at CIR have changed many things that seemed insurmountable before. It's time for us to take up the challenge.

Notice of Election of CIR National Officers and Convention Resolutions

POSITIONS TO BE FILLED

President
Executive Vice President
Secretary-Treasurer
Vice Presidents:

Florida	1
Massachusetts	1
NJ/Washington, D.C.	2
New York	5
Northern California	1
Southern California	2

TERM OF OFFICE

One year, commencing with the election at the 2003 National Convention and ending on the next election date.

ELIGIBILITY REQUIREMENTS

Members in good standing, who will be serving as housestaff officers at a member institution for the next residency year, shall be eligible to stand for election as officer. In addition to such persons, housestaff officers in good standing at a member institution for the current residency year, or a housestaff officer in good standing who is serving as a full-time officer of CIR during the year preceding the election, shall be eligible to stand for election as officer, but in no event shall service as officer commence or extend more than two years after separation from a housestaff program. No person may run for more than one Executive Committee office.

NOMINATION PROCEDURES

Nominations are to be made by petition signed by two delegates, which must be received in the CIR National Office at 520 Eighth Avenue, 12th floor, New York, N.Y. 10018 no later than May 6, 2003.

CAMPAIGN PROCEDURE

Officer elections will take place on Sunday, May 18, 2003, at the National Convention. Only delegates, and alternates who are replacing delegates who are in attendance at the National Convention, are eligible to vote.

CONVENTION RESOLUTIONS

Resolutions must be submitted in writing by a delegate to the President at least 30 days prior to the Convention in order to be considered at the Convention.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE CIR NATIONAL OFFICE AT 1 (800) CIR-8877.

Residents Vote for CIR at Children's Hospital Oakland

"It's for the Kids"

They voted for CIR for many reasons: In the broadest possible sense, "It's for the kids," said Elizabeth Shashaty, M.D., a PL 1.

On January 24, 2003, pediatric resident physicians at Children's Hospital Oakland, in Oakland, California, voted 61-12 for representation by CIR. Seventy-three out of a possible 81 residents voted, a level of participation we can only dream about for U.S. political elections. "This is enough to tell everyone that we have a lot of people supporting this, enough to make it work," according to Dr. Susan Wu, a PL 2 who put together the "Here's Why We're Voting Yes" literature at right.

"The nature of residents in our program is to be involved, invested in the hospital and in our patients," said Dr. Wu. So when budget cuts pushed the hospital to close down an off-site unit without consulting with attendings or residents on the matter, residents felt the need for a voice in the important decisions that get made at the hospital.

"It's a tough time everywhere for health care now, but many changes in our hospital, made in the name of saving money, are detrimental to the care of our patients. We wanted the power to talk about things with the admin-

istration and negotiate for improved care for our patients," said Dr. Sarah Coats, a PL 3.

"Budget cuts are really hard for our patients. We have more cuts still pending. Nationwide, California has been hit the hardest. The cuts magnified the problem. It emphasized that we didn't have an effective mechanism for dealing with problems at our hospital," Dr. Wu said.

Intern Marlene Rodriguez, a PL 1, "knew nothing about a union or what was going on here. But I came to have respect for the senior residents and wondered, 'Why are they so strong for the union?'" At first, she found the idea of a union, "new and frightening." But as her respect for the senior residents and her appreciation of their concern for their patients grew, Rodriguez found herself in support, too.

A Unified Voice

"We wanted the power of a unified voice," said Dr. Coats. And support for the union was growing. By June 6, 2002, more than 90% of the residents signed a petition and delivered it to the hospital's CEO asking for representation. Fifty residents delivered it, and they were joined by nurses and office workers at the hospital who cheered them on, and wore buttons showing their support and solidarity.

Housestaff celebrating an overwhelming vote to join CIR.

PHOTO: (TOP) RESIDENTS AT CHILDREN'S HOSPITAL OAKLAND; (BOTTOM) JEANHEE KIM

"Most of us go into medicine for altruistic reasons," Dr. Rodriguez said. "I didn't expect a big paycheck...I'm Mexican-American, only the second member of my family to graduate from college. I was inspired to become a doctor after college, when I worked as a volunteer translator at a Latino outreach clinic. I saw sub-optimal care for Spanish-speaking patients because of language difficulties. Patients might be given the medication but not educated about the disease, and I felt like I could make such a big difference in my community, and become a role model as a Spanish-speaking doctor. I quit my job, took pre-med courses and went to medical school. My former co-workers are in awe!"

That level of commitment is evident as residents from Children's Hospital Oakland talk about their work. "You're serving children, and helping families as a whole," said Dr. Wu. "We see the entire family — siblings, parents, grandparents. Taking care of a child means taking care of the whole family, making sure Mom is not depressed, that the caregiver can read the labels on the bottles....I have friends who are doctors, but not pediatric doctors, and it's different. They can be frustrated with their patients for not taking care of themselves, but with children, it's not like that. They can't do things for themselves," so we all have to care for them, she said.

It's that kind of concern that makes the doctors at Children's Hospital Oakland stand out, and it's what motivated them to seek union representation.

On their first contract wish list is a reduction of the non-physician work they do; help with discharge planning; an overnight IV team, a patient-care trust fund, and an end to post-call clinic. "It's hard to be an advocate for your patient when you're post-call," Dr. Rodriguez said. "I've gone in and examined a patient not realizing it wasn't my own patient because I was so tired!"

The new CIR negotiating committee will be meeting in early March to hash out their concerns and top priorities for negotiations. They are looking forward to starting the process, and to "having a say in changes that affect our educational experience," said Dr. Coats.

NEW CIR N.Y. V.P.

Stepping Up: Steven Celestin, M.D.

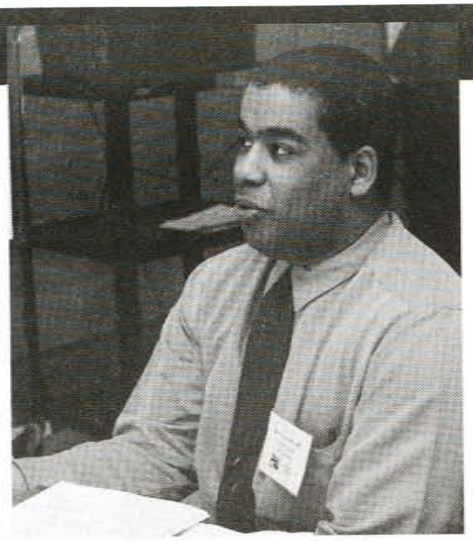
At the winter CIR Executive Committee meeting on March 1, 2003, CIR Pres. Ruth Potee appointed Steven Celestin, M.D. to fill an unexpected opening on the Executive Committee mid-year. The Executive Committee approved the appointment of Dr. Celestin, who is a PGY 2 in Family Practice at Jamaica Hospital in Queens, New York.

For Steven Celestin, M.D. good things sometimes happen "randomly." That was how he heard about Sophie Davis, an accelerated medical school program at City College in N.Y.C. that recruits minority students who might not otherwise overcome financial and social obstacles to attend medical school, and significantly subsidizes their education in exchange for a commitment to become Primary Care physicians and to serve underserved communities for at least two years.

"I was sitting in my college advisor's office in my junior year of "high school, and a graduate came by to say 'hi.' He was a Sophie Davis student, and that's how I found out about it."

It was also how he came to his involvement with CIR. Dr. Jade James, CIR N.Y. V.P. in 2001 got to talking to him and interested him in CIR. "She riled my interest and brought me to a regional meeting. I was impressed. It made me think about going outside the box at Jamaica Hospital, and thinking of things in terms of all residents. We hear from older attendings how bad things used to be. And progress comes from people working towards goals. I wanted to be a leader to change things, even if it's for those who come after me," Dr. Celestin said.

Leadership seems to come naturally to Dr. Celestin. He was the Class Representative for the Sophie Davis class of 1999 for four straight years, facilitating dialogue between students and faculty. "I'm relying on that experience now to approach people from different disciplines and backgrounds. We brainstorm solutions to our everyday problems. I'm not as shy as I used to be because of this," he said. "I overcame my own fears of public speaking,



which made being a CIR delegate, and now, officer, possible.

"I could easily stay in my own program with residents I know...It's so easy to sit back and let things happen to you, especially during your first year of residency. It seems like the whole world is crashing in on you and you have no control. But the whole point of CIR is to take charge of your training and make a difference for future residents. By accomplishing things, such as working on the hours reform campaign, we can make this a national achievement."

Dr. Celestin's main goals in CIR are:

1) Making sure there are no more unfortunate patients such as Libby Zion;

2) Improving standards of residency training so more undergraduate and medical students are encouraged to continue on in their training;

3) Generating more awareness on the part of the general public about what it's like to be a doctor-in-training, and opening up new lines of communication between doctors and their patients.

To Dr. Celestin, everything that is discussed at CIR Regional Meetings has an impact on the general public. "Why doctors organize, and how to improve patient care – these all come up every meeting."

Time is a big factor that stops many residents from involvement in CIR. But for Dr. Celestin, "We don't always realize how much time we do have. We have a lot of exposure to our colleagues. If we're preoccupied with our goal of making working lives of residents better, we can accomplish a lot. We went through a lot to become doctors, so we need to use our hard-earned exposure to our colleagues to make the working lives of residents and the standards of the patient care we provide better."

OPEN TO ALL E ECTED DELEGATES AND ALTERNATES

2003 CIR National Convention

Washington, D.C. • May 16-18, 2003

All 2003-2004 Delegates and Alternate Delegates are invited to attend the CIR Annual Convention. Delegates are chosen by colleagues in elections that are held each year in CIR hospitals in the month of March.

Join us for an exciting weekend in Washington, D.C., as more than 100 CIR delegates from Massachusetts, New York, New Jersey, the District of Columbia, Florida, Puerto Rico, and California come together to learn more about CIR and about issues facing all housestaff. You'll have the opportunity to trade ideas on important matters such as how to reduce resident work hours, and get fired up to go back home and make your hospital a better place – for you and your patients. There will also be time for socializing with your colleagues from around the country.

Travel and hotel accommodation in Washington, D.C. (double-room occupancy) will be paid for by CIR.

For more information regarding convention travel or registration, please call CIR toll-free at 1-800-CIR-8877, or contact your local CIR organizer. More information will be mailed directly to all newly-elected delegates.

PHOTOS: (TOP) JIM TYNAN; (BOTTOM) BILL BURKE/PAGE ONE PHOTOGRAPHY

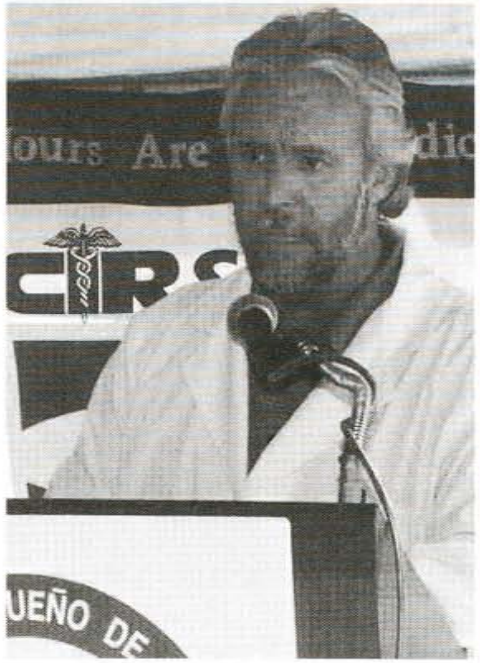
Puerto Rico Hours Legislation:

New Law to Reform Resident Work Hours

Residents in Puerto Rico gained important new work hour protection with a law that was signed by the governor in early January, 2003. CIR members on the island worked hard lobbying for the bill and turning back attempts to weaken it; they were "very proud" of its passage, said Dr. Margarita Medina, a CIR delegate who is a PGY 3 in Internal Medicine at Hospital San Jaun Bautista Caguas. "You know the crazy hours we doctors work...You can't provide optimum medical care when you're so tired."

Law #47 will limit their work hours to 80 per week, averaged over four weeks; limit shifts to 24 hours, with no exceptions; mandate a minimum of 8 hours off between shifts, and on-call duty no more than every third night, with a guarantee of at least one day off per week.

"My worst experience was working 41 straight hours, without a wink of sleep," Dr. Medina said. "I couldn't even think about lying down. You feel like a walking zombie. This hasn't been spoken about, but residents have had car accidents and even been



killed after working these hours. I have two friends who were in accidents after working too many hours." For Medina, "this terrible tradition of treating us like slaves has got to end." She sees the new law as protection for both patients and residents. It's also a way to help residents who come after her, such as her daughter, who is currently a medical student.

"My future goal is to work on enforcement of the law. That's where CIR and all of the residents in Puerto Rico have to work very hard, to make sure this is a functioning law."

Dr. Alex Agostini, PGY 2, Family Medicine

Although residents are very pleased with its passage, they are not resting on their laurels just yet. "Laws are obeyed more than academic requirements are," said CIR Delegate Alex Agostini, a PGY 2 in Family Medicine at UPR/RCM. "My future goal is to work on enforcement of the law. That's where CIR and all of the residents in Puerto Rico have to work very hard, to make sure this is a functioning law. We have to make people aware of the law, and its full impact. At least we have the written law now." Dr. Agostini hopes to work with the Department of Health, and his hospital on a committee charged with enforcement of the new law.

"Puerto Rico has taken a strong step in protecting their resident physicians from fatigue, which will improve the care they provide to their patients. We are encouraged by this legislation and hope it leads to more hours reform legislation in the U.S., following the example set here," said CIR President Ruth Potee, M.D.

The success in passage of this law would not have occurred without the dedication and work of residents as well as the assistance of other unions and leaders, such as Roberto Pagán, president of the Sindicato Puertorriqueño de Trabajadores (SPT/SEIU).

PHOTOS: MERALYS ROSARIO/CIR

Photos above show a press conference held January 30, 2003 at the University Hospital Medical Center of San Juan, Puerto Rico. Clockwise from top left: CIR Delegate Dr. Alex Agostini; Dr. Johnny Rullán, Secretary of Health for Puerto Rico; Julio Rodriguez, President of the Senate's Commission on Health; Roberto Pagàn, President of the SPT/SEIU; Dr. Oscar Rodriguez, President of the College of Doctors and Surgeons of Puerto Rico; residents in audience; Dr. Rafael García Colón, author of the bill, and President of the House of Representatives Commission on Health; and Dr. Eric Carro, CIR delegate and Internal Medicine resident, who said, "Justice was done."

Resident Work Hour Legislation Introduced in Massachusetts

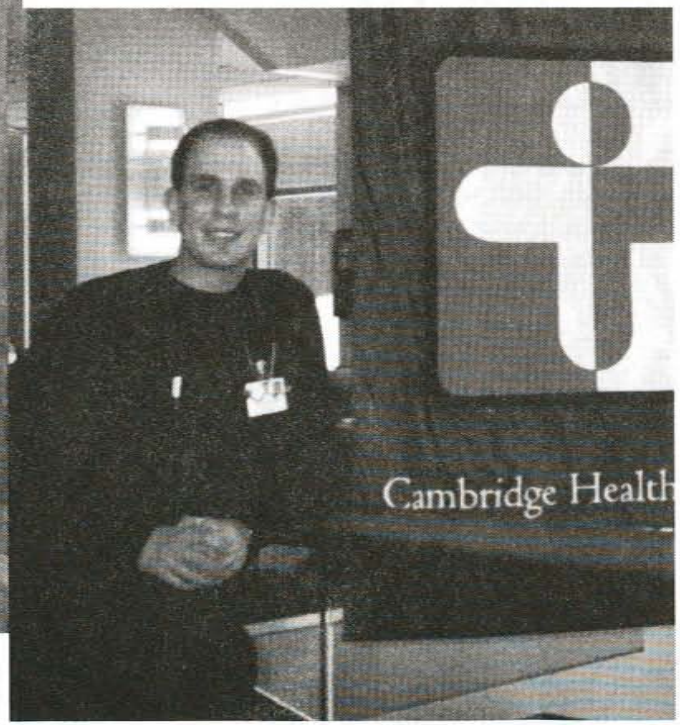
Massachusetts is now the second state in the nation to introduce resident physician work hour legislation, following on the heels of New Jersey. The Massachusetts Patient and Physician Safety and Protection Act was officially filed in early December, 2002 by the Senate and House chairs of the legislature's Health Care Committee.

"We have a reputation for top-quality health care here in Massachusetts, and it should be delivered by rested resident physicians," said Nick Siebers, M.D., CIR delegate and PGY 3 in Internal Medicine at Cambridge Hospital. "There's an increasing sentiment from all fronts that hours should be limited. It's only common sense. It's extremely important that CIR is doing this."

Michael Hochman, a second year Harvard Medical School student who is active in the American Medical Student Association (AMSA), agrees. "Why is AMSA involved? Because medical students see how hard residents work. We're concerned for their safety and the safety of their patients – and we know that soon, we'll be residents, too."

AMSA representatives from Harvard and Boston University School of Medicine began meeting with CIR delegates in the fall of 2001 to explore the idea of filing legislation. They formed the Resident Physician Work Hours Initiative and began reaching out for support to organizations like Health Care For All, the largest and most influential health

Top: CIR President Ruth Potee, M.D. with Michael Hochman, AMSA activist from Harvard Medical School at the statehouse after lobbying for the bill.
Bottom: Nick Siebers, M.D., CIR leader active in the campaign to reform work hours.



announced in June, 2001. CIR and AMSA reps wondered if legislators – and even some of their own members – would ask why legislation was needed when the ACGME had finally acted. "We answered our own question pretty quickly,"

"We couldn't have hoped for a better initial response to this issue from the joint Health Care

> "We are fortunate at both Cambridge and BMC to have CIR and a very good working relationship with our hospital administrators. We know our hospitals are committed to positive change – but the majority of residents in this state are unprotected and don't have a voice. That's yet another reason why legislation is needed."
>
> Dr. Ruth Potee, CIR President

care consumer advocacy group in the state. "We discovered that many people were quite familiar with the issue and that to the lay public, it was a no brainer," said Sonya Rasminsky, M.D., Massachusetts CIR Vice-President, "so this fall, we decided to approach the Health Care Committee."

Not without some serious discussion, however, about the new Accrediting Council on Graduate Medical Education (ACGME) hours rules, first explained Dr. Rasminsky. "You'll be hard pressed to find residents who believe that the current system is capable of enforcing these new rules. There is just too much pressure to do things the way they've always been done before."

AMSA's Michael Hochman agreed, citing a recent survey of 130 Harvard Medical School students who overwhelmingly responded that they didn't feel the medical community adequately regulated resident work hours.

Some of the ACGME's rules are already weakening, points out Dr. Siebers, in reference to ACGME now including post-call clinics as an acceptable reason for residents to work 30 consecutive hours. The ACGME's "exemptions are subject to abuse," says Siebers. "Legislation would tighten up those loopholes and will do a better job of protecting residents and our patients."

"We are fortunate at both Cambridge and BMC to have CIR and a very good working relationship with our hospital administrators. We know our hospitals are committed to positive change – but the majority of residents in this state are unprotected and don't have a voice. That's yet another reason why legislation is needed," said Dr. Ruth Potee, CIR president, who hails from the Bay State.

Medical Training in Massachusetts at a Glance

- 4 academic medical centers (Harvard, Tufts, Boston University, and the University of Massachusetts)
- 3,793 resident physicians
- Second highest ratio of resident physicians per 1,000 people in the U.S., behind New York State
- Highest percentage of admissions to teaching hospitals in the U.S.
- 45% of all inpatient admissions were to a teaching hospital
- 41% of all outpatient and emergency room visits were to a teaching hospital

Source: American Hospital Statistics (2002) based on FY 2000 statistics

Committee," said Michael Hochman. "Senator Moore, joint chair of the committee, has a keen interest in the medical errors movement and quality improvement. He is also a leading supporter of the efforts to improve hours and working conditions for nurses in the state."

The proposed legislation would establish a nine member advisory committee. That committee would

> "Legislation would tighten up those loopholes and will do a better job of protecting residents and our patients."
>
> Dr. Nick Siebers, PGY 3, Internal Medicine

have four months to make recommendations to the Department of Public Health, which must then promulgate rules and regulations limiting resident physician work hours. The bill lays out specific guidelines for those regulations which are similar to those contained in the federal hours legislation (HR 3236) introduced one year ago: a maximum 80 hour work week; no more than 24 consecutive work hours; a guaranteed one day off in seven with at least one full weekend a month; call no more often than every third night; and at least 10 hours off between shifts.

The advisory committee consists of one representative each from the hospital association, the medical society and the academic medical centers, two resident physicians appointed by CIR, one AMSA representative, a physician with expertise in sleep deprivation, a consumer, and the executive director of the Betsy Lehman Center for Patient Safety and Medical Error Reduction, who would serve as chair.

"Massachusetts is a leader in health care and the training of physicians," sums up Dr. Rasminsky. "It only makes sense that the state should also help lead the way in reducing excessive hours, improving patient care and our education."

PHOTOS: SANDY SHEA/CIR

First Los Angeles, Then the Nation?

Residents Continue the Fight to Save L.A. County's Health Care Safety Net

"In L.A. right now, we're fighting for people's right to health care," said CIR Executive Vice President Angela Nossett, M.D. The meltdown of L.A. County's system may be a harbinger for other states pressed for funds in these difficult economic times.

Los Angeles County is home to 2.5 million uninsured people, with 85% of the uninsured coming from working households. Other counties in California and other states in the nation are facing similar threats to their public health care systems, but none on so large a scale. Los Angeles County has more uninsured people than the entire populations of 17 states and the District of Columbia.

Clockwise from top left: Dr. Rich Moon rallied a crowd to "Keep Rancho Open;" Drs. Khalid Channel and Jason Harvey, CIR leaders, who do a rotation at Rancho, were active in opposing its closure. A massive phonebanking campaign yielded immediate results. Shown here engaged in cellphone activism are Drs. Danielle Robertshaw; Jennefer Russo with Andrea Anderson.

Putting Patients First

JCIR, Los Angeles's CIR Chapter, has been fighting and advocating for their patients every step of the way, with hundreds of members involved in a variety of actions. There are some important victories to show as a result, most notably, the resounding victory last November of Measure B, brain, spinal cord and other major injuries. They also decided to cut 100 hundred supporters in a chant of "Keep Rancho Open," that lasted 10 minutes anteed two more years, but LAC + USC will lose 100 inpatient beds, and

"We'll be fighting this battle again before I complete my training."

Dr. Roger Sohn, PGY 2, Harbor-UCLA

a property tax that will deliver some $168 million to the county for emergency and trauma care. But a $210 million health budget shortfall remains, and the county has made some tough decisions in response to that reality.

At a January 28th meeting, the County Board of Supervisors voted to close Rancho Los Amigos National Rehabilitation Center, the only publicly funded county hospital for treating low-income people with inpatient beds at L.A. County + USC Medical Center (LAC + USC).

At that heart-wrenching meeting, the Board heard from patients whose lives were quite literally saved by the treatment that received at Rancho. Surrounding hospitals lack the expertise to treat these severe injuries, and patients already suffer from "15-hour waits in packed hallways," said Marina Rodriguez, a nurse from nearby Harbor-UCLA who was interviewed by the *Daily Breeze*, a local newspaper.

JCIR residents rotate through Rancho, and many regularly refer patients there for subacute care. They are fighting the closing with rallies, public testimony, and outreach. Dr. Rich Moon, a PGY 2 in Internal Medicine at LAC + USC, rallied a crowd of several on January 28, 2003. With local news media looking on, Dr. Moon predicted that cuts here will be deadly.

The SEIU International put tremendous financial resources into the campaign, and members of SEIU Local 660 along with JCIR members, launched a media and community support campaign to fight the cuts.

CIR and other SEIU members hit the phones hard on January 16, 2003 to prevent the threatened closure of Harbor-UCLA. More than 400 phone calls flooded the offices of the Board of Supervisors. While morning callers were told their messages would be passed along to the officials, by day's end, callers were told that Harbor-UCLA would remain open.

Hard-won funding will keep Harbor-UCLA's doors open for a guarRancho Los Amigos will be added to the ranks of shuttered facilities as of June, 2003. In addition to the health care calamity this presents, it also creates a problem for residency programs. "This situation really hurts recruiting because all we can tell applicants is that we know we have two more years," said Dr. Roger Sohn, a PGY 2 in Orthopedics at Harbor-UCLA. "What is two years when you are committing to a five-year program? We'll be fighting this battle again before I complete my training."

CIR members have now shifted their advocacy to helping to find private funding for the world-renowned rehabilitation center, which would allow it to stay open.

Coming Soon: Tent City

On February 19, 2003, a crowd of more than 100 supporters gathered in front of Rancho. Drs. Jason Harvey and Khalid Channel, Orthopedic residents from Habor-UCLA and King/Drew who are both on rotation at Rancho, are among those who are keeping up the fight. Rancho has provided a key part of their training in orthopedic surgery, and treats patients who other hospitals would simply give up on, the doctors said.

The next step in the "Keep Rancho Open" campaign is a Tent City planned for March. Supporters, including JCIR members, plan to camp out on the front lawn of the hospital, in an attempt to draw more public support, and to pressure local and state officials to find a way to save the hospital, and not turn their backs on the severely injured and disabled patients who rely on its services.

The Human Cost of Hospital and Clinic Closures

JCIR Releases L.A. Study

In an ongoing campaign to keep the plight of their patients front and center, JCIR released its 10-page study, "Breaking the System: The Human Cost of Hospital and Clinic Closures in Los Angeles County" at a press conference on January 21, 2003. The survey of JCIR's 1,600 resident physicians found that six months after the closure of 11 community clinics, there may be a countywide health care catastrophe if further cuts are planned.

In a system already overwhelmed with patients, "We will be flooded with desperately, dangerously ill patients," said Dr. Rich Moon. "The private sector cannot absorb all these patients, the capacity does not exist." In the report, Dr. Matthew Deustsch, a resident in Emergency Medicine at Harbor-UCLA described leaving his shift in the evening with "123 patients waiting to be seen. Many of them were still there waiting when I came back the next morning."

"The state has budget problems, but it cannot ignore L.A. County," said CIR leader Dr. Naeemah Ghafur, a PGY 3 in Family Practice at King/Drew Medical Center. "The entire system is about to melt down, and it will take the state down with it if nothing is done."

To read the press release and Breaking the System report in its entirety, log on to CIR's website at www.cirseiu.org.

PHOTOS: JOHNNY KNOX; AMY HALL/CIR

Congress Considers Legislating Safeguards for Volunteers

Bush's Smallpox Program Raises Questions

The first phase of the Bush Administration's smallpox vaccination plan, initially scheduled for completion by March 2003, is barely off the ground. The CDC reported in late February that less than one percent of the 500,000 health care workers targeted by the president's plan had been vaccinated at this time. Hundreds of hospitals nationwide have decided to opt out of the plan because of safety, compensation, and liability concerns and hundreds more are undecided.

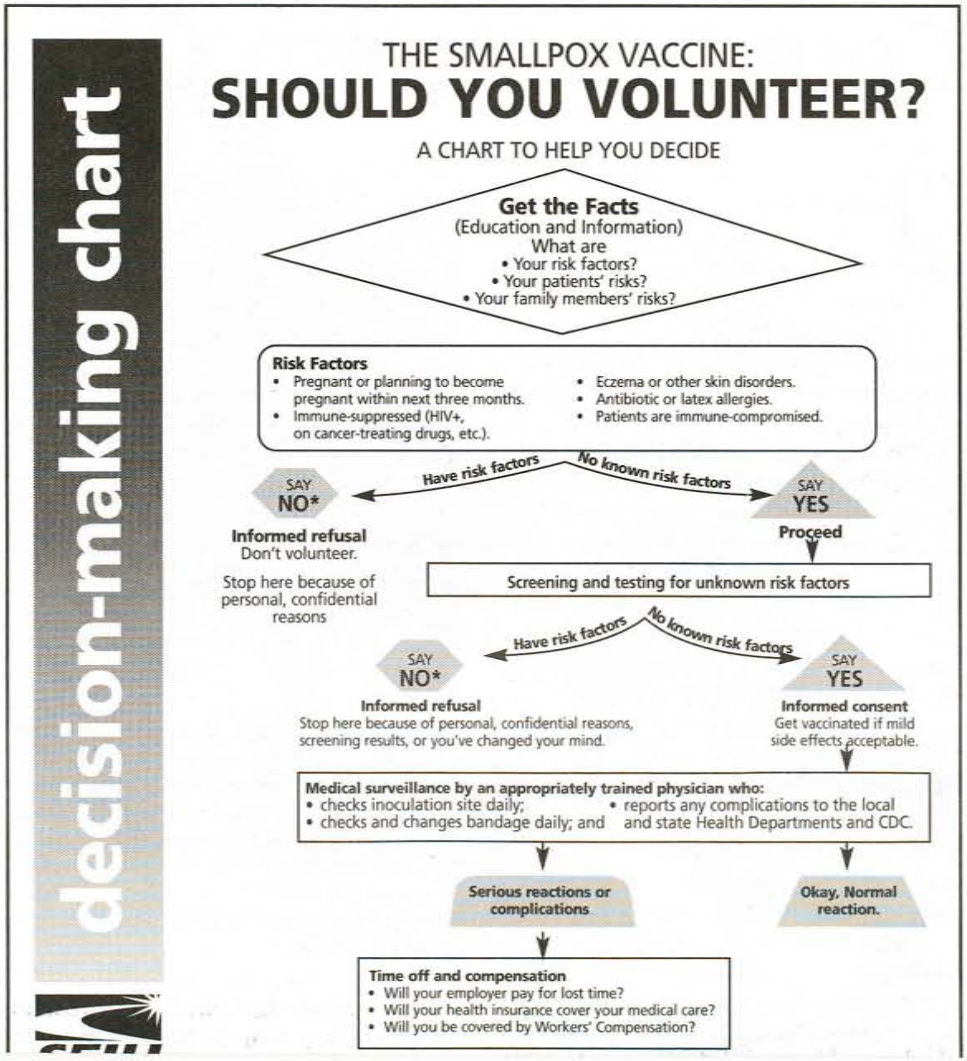
Addressing the serious concerns of many health care unions, led by SEIU, and public health organizations, Congressional Representative Henry Waxman (D-CA) filed legislation on February 14. Through state grants, the Smallpox Vaccine Compensation and Safety Act (HR865) would offer education, medical screening and surveillance, and provide medical care and a no-fault compensation fund for any vaccine victim.

For every million vaccinated, as many as 1,000 people could have a significant reaction, between 14 and 52 will suffer life-threatening illness and one or two could die. And as many as 1 in 3 healthy persons will have flu-like symptoms and feel too sick to come to work after being vaccinated. Those health care workers months), cancer patients, people who are HIV+ (or are otherwise immune-compromised), have eczema or other skin disorders, or are allergic to antibiotics or latex — should not volunteer for the vaccine.

Initial vaccination program plans filed at most, if not all, CIR hospitals appear to indicate that house officers will not be within the first 100 health care workers in each facility asked to volunteer for the vaccine. Assuming that Congress does eventually pass legislation providing medical and employment protections for volunteers, and that the Bush vaccination program picks up speed, all health care workers, including housestaff, will eventually be faced with the decision of whether or not to volunteer.

"It is absolutely critical that we take the time to educate ourselves about the risks and benefits before we decide," cautions CIR President Ruth Potee M.D. "Weigh the risk factors – to yourself, your family and your patients – and make the decision that's best for you."

For up to date news and information about the smallpox vaccine program, federal legislation and other related subjects, go to SEIU's website, which has been a national clearinghouse for information on the smallpox



with known risk factors — pregnant women (or those planning to become pregnant within the next three

vaccination program. Log onto www.seiusmallpox.org.

CIR Benefits Plans Release Annual Reports

Every year, CIR updates and publishes the following financial report on the five benefit funds provided to CIR members. Four of the funds have reported their results on the calendar year and included are the audited reports for the year ended December 31, 2001. The only exception is for the Professional Educational Plan for which the results of June 30, 2001 are reported.

Summary Annual Report of the Public Sector:

- **House Staff Benefits Plan**
- **Legal Services Plan of HSBP and**
- **The Professional Educational Plan of CIR**

This is a summary of the annual report of the **House Staff Benefits Plan** of the Committee of Interns and Residents No. 13-3029280 for the year ended December 31, 2001. The annual report has been filed with the Internal Revenue Service. The Plan is not required under the Employee Retirement Income Security Act of 1974 (ERISA) to release financial information, but elects to do so for the information of the participants.

The Board of Trustees has committed itself to pay optical, newborn benefit, out-patient psychiatric, short term disability, supplemental major medical, supplemental obstetrical, hearing aid, prescription drug, childbirth education, accidental dismemberment, smoking cessation and conference reimbursement as well as substance abuse counseling and treatment benefits.

The plan is also self-insured for short term disability and for the life insurance benefit of domestic partners.

Insurance Information

The Plan has contracts with Prudential Insurance Company of America to pay all dental and life insurance claims under the terms of the Plan. The total payments paid and accrued for the plan year ended December 31, 2001 were $1,280,248 (comprised of $1,023,892 in Dental Insurance and $256,356 in Life Insurance).

The Plan has a contract with The Guardian (since April 1, 2000) to process and pay long-term disability benefits and The Guardian was paid $280,442 for the year ended December 31, 2001.

House Staff Benefits Plan of CIR – Basic Financial Information

The value of the Plan assets after subtracting liabilities of the Plan was $4,422,100 as of December 31, 2001 compared to $3,913,817 as of December 31, 2000. During the year, the Plan experienced an increase in net assets of $508,283 and this increase includes unrealized gains or losses on securities.

During the year, the Plan had total income of $3,481,800, which included employers' contributions of $3,318,713, interest on investments of $174,498, COBRA receipts of $23,340, administrative income of $7,995 and $42,746 in investment losses (realized and unrealized).

Plan expenses were $2,973,523. These expenses included $2,523,904 in benefits paid (to participants and beneficiaries) and $449,619 in administrative expenses

Legal Services Plan of HSBP

This plan covers certain basic legal services for the members.

The House Staff Benefits Legal Services Plan ended December 31, 2001 at a deficit of $ 105,508 (liabilities exceeding assets by $105,508), which was $188 more than 2001. During 2001 total employer contributions were $234,108 and total costs were $234,296 ($169,600 in benefits and $64,696 in administration expenses).

Professional Educational Plan of CIR (PEP)

The PEP plan reimbursed up to $500 per year to members for the fiscal year ended June 30, 2001, which is presented here. Effective July 1, 2001 this benefit was raised to $600 per member per year. This plan reimburses for licensing exams, video and audiotapes and certain other job related expenses.

The Professional Educational Plan of CIR ended the June 30, 2001 fiscal year with a surplus of $789,030 (assets exceeding liabilities by $789,030). During the fiscal year ended June 30, 2001 total employer contributions, were $1,315,309, and total costs were $719,386 with $601,111 in benefits and $118,274 in administration expenses.

Summary Annual Report of the Private Sector:

- **Voluntary Hospitals House Staff Benefits Plan and**
- **Legal Services Plan of VHHSBP**

Voluntary Hospitals House Staff Benefit Plan

This is a summary of the annual report of the **Voluntary Hospitals House Staff Benefits Plan** of the Committee of Interns and Residents No. 13-3029280 for the year ended December 31, 2001. The annual report has been filed with the Internal Revenue Service as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has committed to pay on a self-insured basis for short term disability, optical claims and the life insurance benefit for domestic partners.

Insurance Information

The Plan has contracts with Prudential Insurance Company of America to pay all dental, life insurance and accidental dismemberment claims. In addition, coverage is secured with United Healthcare to pay medical, basic medical surgical and major medical claims incurred under the terms of the Plan. The total cost of the United Healthcare premiums for the Plan year ended December 31, 2001 was $7,173,824. Because of a negative claims experience there was no insurance dividend in 2001 and in addition United Healthcare absorbed $546,520, which had been set-aside in a SERA Fund. This SERA fund was required by United Healthcare and they used it to offset some of this negative claims cost in the year. The high cost of claims in 2001 was a historically unusual event, and it appears that for 2002 United Healthcare will pay a dividend to the Fund as they had in past years.

The plan paid $832,966 to Prudential Insurance ($655,283 for Dental Insurance and $177,683 for Life Insurance) for the year ended December 31, 2001.

The Plan paid The Guardian Insurance $186,848 to process and pay long term disability benefits in 2001.

Basic Financial Statement

The value of the Plan assets after subtracting liabilities of the Plan was $9,247,998 as of December 31, 2001, compared to $10,105,505 as of December 31, 2000. During the year the Plan experienced an operating loss of $857,508. This decrease included unrealized gains or losses on securities and depreciation of the value of the Plan's fixed assets.

During the year the Plan had a total income of $7,679,291, which included employers' contributions of $7,270,965; earnings from interest (on both investments and delinquent accounts) of $526,523, COBRA receipts of $276,406, and $394,603 as a net loss (realized and unrealized) on securities held. The impact of a negative claim history in 2001 in the Plan and the resultant impact on insurance costs and the use of the SERA fund are covered in detail in the insurance section of this document.

Plan expenses and benefits were $8,331,098 before the United Health Care dividend. These expenses included $298,800 in administrative expenses and $8,032,298 in benefits paid to participants and beneficiaries.

Legal Services Plan of VHHSBP

The plan covers certain basic legal services for the members.

The Legal Services Plan of VHHSBP ended the year with a deficit of $11,780, a decrease of $13,874 from the prior year's deficit of $25,654. During 2001 employer contributions were $152,892 and costs were $139,018, (benefits of $129,831 and administration expenses of $9,187).

Participant's Rights to Additional Information

Any participant in any of the above-mentioned plans has the right to receive a copy of the full annual report or any part thereof on request. The items listed below are included in that report:

- an accountant's report;
- assets held for investment;
- fiduciary information, including transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);
- transactions in excess of 3 percent of plan assets; and
- insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report of any plan or any part thereof, write or call the Benefits' Plan Office, 520 Eighth Avenue, Suite 1200, NY, NY 10018, (212) 356-8100, attention: Plan Administrator. There will be a nominal charge to cover copying costs for the full annual report or for any part thereof.

Any participant has the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs does not include a charge for copying these portions of the report because these portions are furnished without charge.

Any participant also has the legally protected right to examine the annual report of any plan at Benefits Plans Office (520 Eighth Avenue, Suite 1200, NY, NY 10018, (212) 356-8100) and the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to Public Disclosure Room, N 4667, Pension and Welfare Benefit Programs, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20216.

"CIR Housestaff Appreciation Day" Declared in Miami-Dade County

Soaking Up The Sun, and the Appreciation

The pungent smell of barbeque and sounds of laughter marked the Second Annual Housestaff Appreciation Day held at Jackson Memorial Hospital in Miami, Florida on January 8th, 2003. More than 300 house officers and supporters attended the Appreciation Day, which was declared last year by Miami-Dade County Mayor Alex Penelas and the County Board of Commissioners. Commissioner Jimmy Morales joined CIR delegates and other housestaff leaders in the celebration (see photo of housestaff delegates and leaders with Morales, in front row, at right).

Commissioner Jimmy Morales, front row at right, joined CIR Delegates and other housestaff leaders on their "Appreciation Day."

Many Miami unions joined in by presenting a plaque in recognition of the valuable service that housestaff perform. Housestaff took the time to relax and enjoy their latest accomplishment – a new tentative agreement that was overwhelmingly ratified on February 10, 2003. One item eagerly awaited in the contract is Jackson Memorial Hospital's first Patient Care Fund, which will have $25,000 each year to purchase items beneficial to patient care.

"We were very pleased at the turnout for our second annual Housestaff Appreciation Day," said Brad Deal, M.D., co-chair of the seems the hospital community as well as political leaders are starting to expect and look forward to the event. Fortunately, we had reached a tentative agreement on the new contract specifics with the residents. All in all it was a huge success."

His co-chair Alicia Coker, M.D., concurred, and added, "I appreciated the support of housestaff for CIR, and the progress we had made in negotiating the most recent contract."

The contract next goes to the Board of Trustees for the Public Health Trust and then to the County

Jackson Memorial CIR chapter. "It tract and could share some of the this was a great opportunity to share Commissioner for final approval.

PHOTOS: MARY JANE BARRY/CIR

H-1B Visas Require Immediate Action

CIR Legal Services has prepared the following advisory for residents renewing their H-1B status

International Medical Graduates who are in H-1B status must act immediately to renew their H-1B status for the upcoming residency year. The Immigration & Naturalization Service (INS) must receive a completed H-1B renewal petition before the expiration of your present H-1B status, which is usually June 30th. The process of preparing the H-1B package, including securing all the necessary signatures, can take many weeks. At the very least, your hospital employer may require a copy of the INS receipt verifying that your H-1B renewal petition was filed in a timely manner, in order for you to continue in the residency program. If you cannot provide at least this receipt, you may have to stop working.

CIR Legal Services (CIRLS) entitle housestaff in the New York and New Jersey regions who are in either the House Staff Benefits Plan (HSBP) or Voluntary Hospital House Staff Benefits Plan (VHHSBP) to certain legal services, including H-1B visa renewals, without charge for attorney's fees. If you are a covered CIRLS member and need an H-1B visa renewal, you can call CIRLS at (212) 356-8100.

FICA Resident Refunds Dead in the Water

April 15 and the IRS tax deadline will soon be upon us. Many housestaff are wondering how to increase their tax refund, and getting advice about it. In recent years, many residents have called CIR, requesting information about how to file a FICA tax exemption. After initially granting a few such refunds to teaching hospitals and individual residents, the IRS instructed its regional offices to put all further claims on hold until it reviewed the statute and regulations, and issued standards by which all refund claims would be judged.

The IRS concluded this review in 2002. The CIR Legal Department reports that as a result of the IRS's interpretation, it will be virtually impossible for any hospital that employs residents (or for any individual house officer) to qualify for FICA tax refund claims and for FICA tax exemption. For more information on the FICA issue, log on to the CIR website at www.cirseiu.org.

Residents in Brooklyn Speak from the Heart

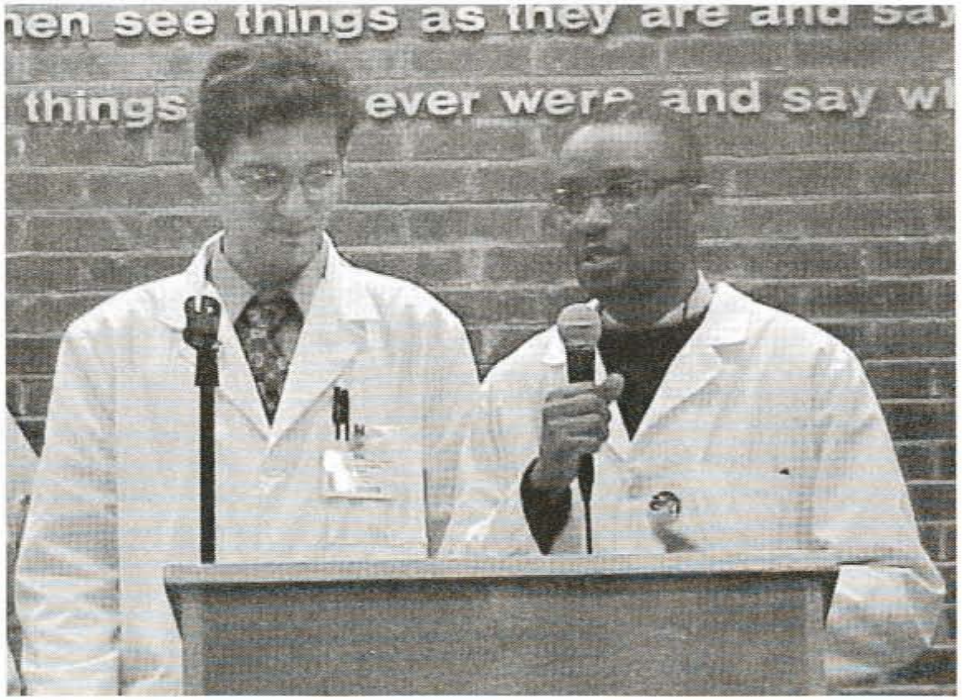
Interfaith Medical Center The Focus of Labor and Community Concern

It was a cold winter evening, but a hot crowd of some one hundred and fifty Interfaith Medical Center employees and community residents came together in Brooklyn, NY on February 27, 2003. 1199/SEIU hosted the Town Hall Meeting to highlight serious problems at the hospital and the event attracted local city and state politicians, who heard an earful.

Two Interfaith CIR members began the meeting by offering the residents' perspective on inadequate staffing levels, poor security, and inadequate facilities and equipment. Dr. Mohamed Ismail, an Internal Medicine resident, and a leader at CIR, spoke eloquently about the stress and adverse effects on patient care that low staffing levels produce. His comments were interrupted several times by enthusiastic applause.

Medicine resident Dr. Makanjuo Oladigbo passionately addressed the crowd on several concerns, including the poor security that imperils workers at Interfaith. Both doctors acknowledged that the hospital's 100 CIR members felt that much of their time was taken up doing the work that others should be hired to do. The two doctors' support for all hospital workers made a strong impression with the crowd.

Speaker after speaker from 1199 thanked the speakers for bringing the issues to their attention and pledged to demand answers from the hospital. They also stressed the need for everyone at the Town Hall to work in the



Speaking to a packed house (left to right), Drs. Mohamed Ismail and Makanjuo Oladigbo were received warmly by the audience.

and NYSNA lamented the administration's lack of concern for patient care and respect for the people who provide that care. State Senator Velmanette Montgomery, State Assemblyman Roger Green and Assemblywoman Annette Robinson political arena to solve the state's budget crisis. Veteran and new members from all three unions pledged to work together to solve the issues at Interfaith that stand in the way of patient care and employee rights.

HHC's Woodhull Hospital:

Celebrating 25 Years of CIR Patient Care Trust Funds

What better way to celebrate a 25th Anniversary than with a purchase? If it were a wedding, it would have to be silver, but when it's HHC's Woodhull Hospital, and it's the 25th anniversary of its CIR Patient Care Trust Fund, the purchase will have to be something that provides for better patient care and enhanced medical training for residents. Their choice of equipment was the Site Rite 3 Ultrasound System, which is state-of-the-art. This $25,000 ultrasound system will be used in the ICU unit. This ultrasound helps in inserting IVs accurately, quickly, and painlessly, which should be very beneficial to patients. Pictured here at the February 25th, 2003 anniversary celebration are, left to right, Dr. Wyssem Ramdani, CIR Delegate and Internal Medicine resident; Dr. Edward Fishkin, Medical Director of Woodhull Hospital (and a former CIR delegate); Dr. Andres Hernandez, Chair of the Medicine Department; Dr. Van Dunn, Vice President, Medical Affairs for all HHC Hospitals; Dr. Mitchell Cappell, Program Director for Internal Medicine Department; Dr. Llanko Updendran, CIR Delegate and resident in the Internal Medicine Department; and Miguel Restrepo, CIR Delegate and resident in the Pediatric Department.

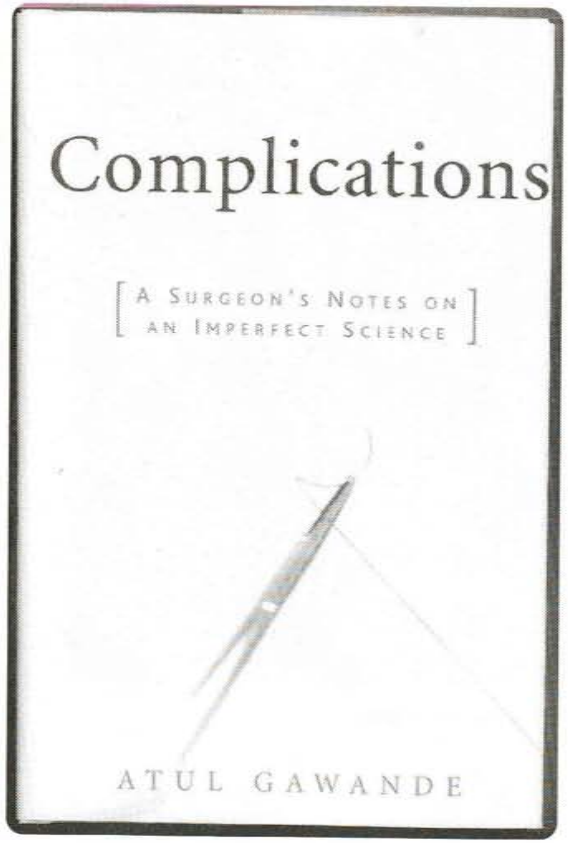
PHOTOS: (BOTTOM) PATRICK ASHLEY; (TOP) PAT FRY/CIR

CIR NEWS Book Review

One Surgical Resident's Wise Ruminations on the State of Medicine

These things we know to be true: In unprecedented numbers, physicians in Florida, New Jersey, Mississippi, West Virginia, Nevada, and many other states are fiercely protesting the sharp increase in malpractice premiums. They call for torte reform and rue the day that they began to see their patients as just another potential lawsuit walking in the door. At the same time, a Harvard School of Public Health study, published in the *New England Journal of Medicine* in December 2002, finds that four of every 10 Americans (and one of every three doctors) said that they or their family members had been the victims of a preventable medical error, with nearly 10% dying as a result.

How to begin to cut through the thicket of facts and emotions surrounding the current debate over medical errors and the malpractice system? A good starting place is *Complications: A Surgeon's Notes on an Imperfect Science*,



of essays is no dry dissection of medical mistakes or know-it-all finger pointing from the quality improvement folks. Dr. Gawande divides the book into three sections: *fallibility* ("asking...how mistakes happen, how a novice learns to wield a knife, what a good doctor is, how it is that one could go bad"); *mystery* ("the unknowns of medicine and the struggle of what to do about them"); and finally *uncertainty* ("for what seems most vital and interesting is not how much we in medicine know but how much we don't – and how we might grapple with that ignorance more wisely."

For physicians (in training and out), *Complications* is sure to elicit many knowing nods (been there, done that, doing it tomorrow). The observations may be familiar, but they come loaded with background, wit, compassion, and insight that makes for transcendent reading. For patients and their families, the book is a rare, sometimes disturbing, but utterly

Who is Atul Gawande, M.D.?

"I am a surgical resident, very nearly at the end of my eight years of training in general surgery, and this book arises from the intensity of that experience. At other times I have been a laboratory scientist, a public health researcher, a student of philosophy and ethics, and a health policy adviser in government. I am also the son of two doctors, a husband and a parent. I have attempted to bring all of these perspectives to bear on what I have written here. But more than anything, this book comes from what I have encountered and witnessed in the day-to-day caring for people. A resident has a distinctive vantage point on medicine. You are an insider, seeing everything and a part of everything; yet at the same time you see it anew."

written by a surgical resident in a hospital in Boston," named Atul Gawande, M.D. The name may ring a bell. Dr. Gawande's essays on medicine have been a regular feature in the *New Yorker*, and his study of foreign objects (sponges, clamps, etc.) left inside patients after surgery, was just published in the *New England Journal* in January. Why, asked Dr. Gawande and his colleagues, were objects left behind, even with safeguards in place to prevent the error?

In *Complications*, Dr. Gawande examines the conundrum that we, physicians and patients, find ourselves in. "Western medicine is dominated by a single imperative – the quest for machinelike perfection in the delivery of care," says Gawande. "From the first day of medical training, it is clear that errors are unacceptable." And yet, the very act of training physicians (not to mention the medical advances our society has come to expect, even demand), brings with it an understanding that errors will be made. To err is human, and, says Dr. Gawande, "Not only do all human beings err, but they err frequently and in predictable, patterned ways."

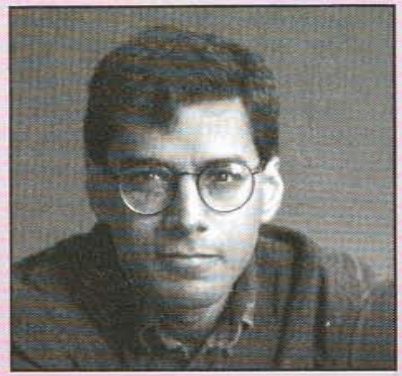
Not to worry – this vivid collection captivating glimpse into a world that few are privy to.

As we all struggle with the pressing issues of life and death, medical errors and malpractice suits, look to Dr. Gawande and *Complications* for the badly needed help that physicians and patients will need to find common ground.

Complications: A Surgeon's Notes on an Imperfect Science was written by Atul Gawande, M.D., and published in 2002 by Metropolitan Books, Henry Holt and Co. LLC.

This review by Sandy Shea, CIR Senior Area Director in Massachusetts.

Excerpted from Complications.



Excerpts from *Complications: A Surgeon's Notes on an Imperfect Science*

On The Malpractice System

"If error were due to a subset of dangerous doctors, you might expect malpractice cases to be concentrated among a small group, but in fact, they follow a uniform, bell-shaped distribution. Most surgeons are sued at least once in the course of their careers. Studies of specific types of error, too, have found that repeat offenders are not the problem. The fact is that virtually everyone who cares for hospital patients will make serious mistakes and even commit acts of negligence, every year. For this reason, doctors are seldom outraged when the press reports yet another medical horror story. They usually have a different reaction: That could be me. The important question isn't how to keep bad physicians from harming patients; it's how to keep good physicians from harming patients.

"Medical malpractice suits are a remarkably ineffective remedy. Troyen Brennan, a Harvard professor of law and public health, points out that research has consistently failed to find evidence that litigation reduces medical error rates. In part, this may be because the weapon is so imprecise. Brennan led several studies following up on the patients in the Harvard Medical Practice Study. He found that fewer than 2% of the patients who had received substandard care ever filed suit. Conversely, only a small minority among the patients who did sue had in fact been the victims of negligent care. And a patient's likelihood of winning a suit depended primarily on how poor his or her outcome was, regardless of whether that outcome was caused by disease or unavoidable risks of care.

"The deeper problem with medical malpractice suits is that by demonizing errors they prevent doctors from acknowledging and discussing them publicly. The tort system makes adversaries of patient and physician, and pushes each to offer a heavily slanted version of events. When things go wrong, it's almost impossible for a physician to talk to a patient honestly about mistakes. Hospital lawyers warn doctors that, although they must, of course, tell patients about injuries that occur, they are never to intimate that they were at fault, lest the "confession" wind up in court as damning evidence in a black and white morality tale. At most, a doctor might say, 'I'm sorry that things didn't go as well as we had hoped.'"

On Perfection

"Whatever the limits of the M & M, its fierce ethic of personal responsibility for errors is a formidable virtue. No matter what measures are taken, doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it."

On Uncertainty

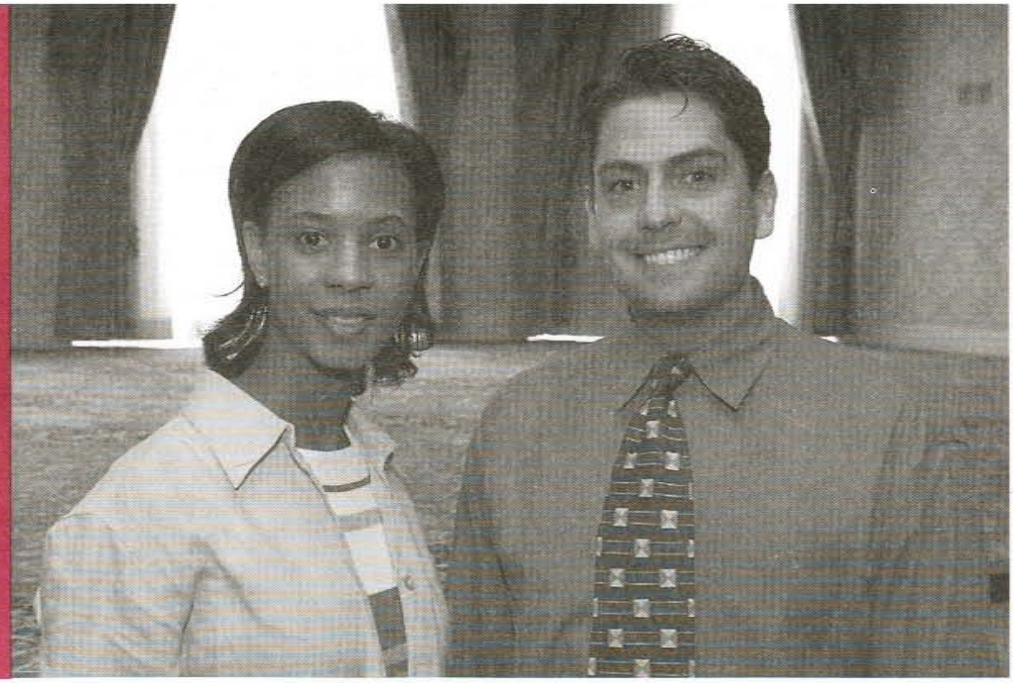
"The core predicament of medicine – the thing that makes being a patient so wrenching, being a doctor so difficult, and being a part of a society that pays the bills they run up so vexing – is uncertainty. With all that we know nowadays about people and diseases and how to diagnose and treat them, it can be hard to see this, hard to grasp how deeply uncertainty runs. As a doctor, you come to find, however, that the struggle in caring for people is more often with what you do not know than what you do. Medicine's ground state is uncertainty. And wisdom – for both patients and doctors – is defined by how one copes with it."

AMSA and CIR:

Working Together for a Better Health Care System

"[AMSA is] able to mobilize large numbers of medical students quickly – through local chapter activity, monthly newsletters, and a list serve of 40,000. We lead by doing, not by talking."

Eric Hodgson, M.D., AMSA President



Makeba Williams, AMSA's Legislative Affairs Director, and Dr. Eric Hodgson, AMSA's President, at CIR's Convention last May.

"In America's medical system, few battles are won single-handedly," notes Eric Hodgson, M.D., president of the American attention to the issue of resident work hour reform. In the wake of New York State's commitment to stronger enforcement of the Bell Regulations, the legislation, reached out to members of the press, and identified and contacted potential allies in the healthcare policy arena.

Residents! Interested in Advanced Training in Public Health?

Check out AMSA's innovative new Leadership Seminar Series (LSS) – a program designed to train resident-faculty pairs in the areas of leadership skills, health policy, public health, communication and advocacy skills. In three weekend seminars scheduled throughout the year, LLS participants will work with experts from government agencies, national foundations and activist groups, and local community agencies and clinics. Areas of focus include: ethnic minority health, rural health and the health of people living in poverty. Deadline for applications: April 14, 2003. For more information, contact Shadia Garrison at (703) 620-6600 x214 or by email at lss@www.amsa.org.

Medical Student Association (AMSA). For the past five years, the country's most active organization of medical students and the largest union of resident physicians have been building ties and accomplishing, "significant changes that have made real improvements in the lives of resident physicians," says Dr. Hodgson.

Since its founding in 1950, AMSA has been committed to improving health care, promoting quality medical education, involving members in the social, moral, and ethical obligations of the profession of medicine, and contributing to the welfare of all physicians-in-training. With 40,000 members across the country, AMSA has built an extensive network of activist-minded doctors-in-training.

Dr. Hodgson attributes much of AMSA's clout to the fact that "we are able to mobilize large numbers of medical students quickly – through local chapter activity, monthly newsletters, and a list serve of 35,000. We lead by doing, not by talking. And we offer extensive training and leadership development for our members, which adds to our effectiveness."

AMSA's national office, located right outside Washington, D.C., in Reston, Virginia, has a staff of 25+, including four medical students who've taken a year off to work full-time on issues like universal health care, global AIDS disparity, medical school debt, reforming the pharmaceutical industry and resident work hours.

Three years ago, CIR and AMSA teamed up with Public Citizen (a national consumer advocacy group) to think about how to bring national the coalition recognized that the time for change had come; the next step was to set a national standard for resident work hours. In April 2001, the coalition petitioned the Occupational Safety and Health Administration to establish work hour limits. And seven months later, the first federal legislation to reduce resident hours – the Patient and Physician Safety Act - was introduced by Representative John Conyers (D-MI). Together, CIR and AMSA lobbied dozens of members of Congress to gain support for

Local AMSA – CIR collaboration is also expanding. In Boston and New Jersey, for example, medical students and housestaff are supporting state resident work hours initiatives. "Working with CIR has helped us learn more about the challenges we will face as residents in the years ahead," says Shipra Bansal, an AMSA leader from New Jersey Medical School. "We are excited to help impact change that will improve our training as residents." From testifying at legislative hearings to holding letter-writing campaigns, AMSA's involvement in these efforts has been critical in moving the resident work hours issue forward. "All residents remember what it was like being a medical student," says CIR Massachusetts Vice-President Sonya Rasminsky. "And all students can easily look ahead to see what their lives will be like when they become residents. AMSA and CIR working together – it's a natural fit."

WWW.AMSA.ORG

AMSA's website is a great place to go for up-to-date resident work hour information and other topics of interest to residents.

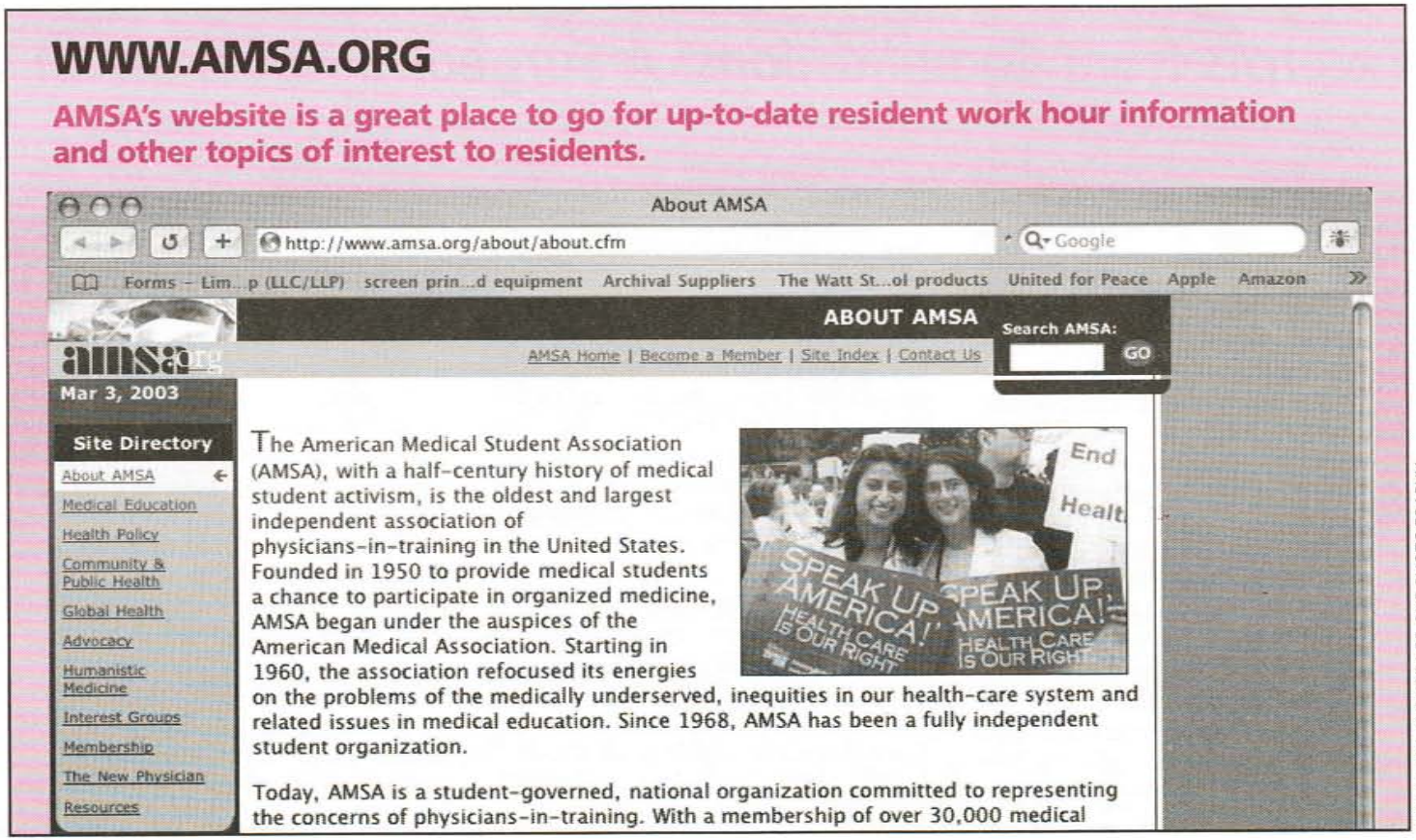
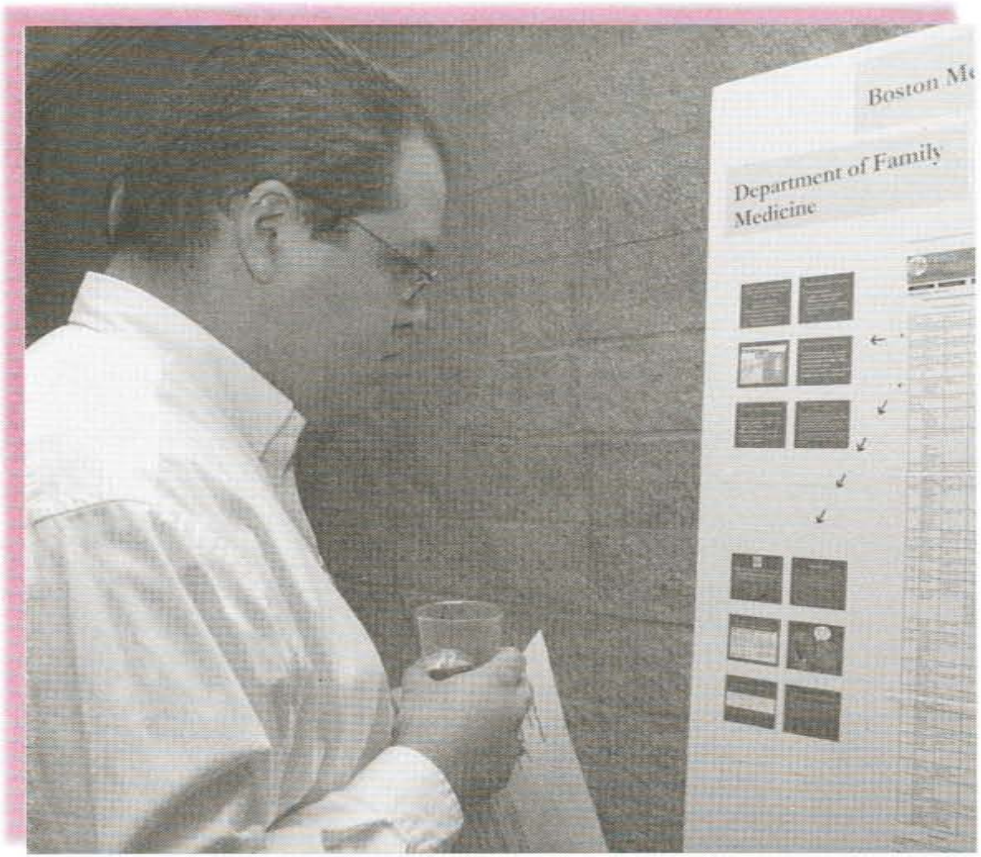


PHOTO: BILL BURKE/PAGE ONE PHOTOGRAPHY

Hours Reform: It's Not *Whether* But *How!*

But How?

JANUARY 18TH RESIDENT WORK HOURS CONFERENCE



CIR & AMA/RFS HOST NATIONAL

Sharing S for Ch

On January 18th, 2003, some 90 residents from across the country took part in the first-ever conference on resident hours reform – organized *by* residents, *for* residents. Jointly sponsored by CIR and the American Medical Association's Resident Fellows Section, the day-long event attracted residents from 23 states and 79 hospitals.

In workshop format, residents met colleagues from their hospital administrators are searching for those answers, too.

"Residents know ways to fix resident work hours," said CIR President Ruth Potee, M.D., in addressing the conference. "CIR has been working on this issue for many years, and our advocacy has gotten us to this point. We wouldn't be here today without all the pressure from advocates of resident hour reform. Currently, the ACGME doesn't consider resident input on this issue a priority. But we do, and that's why we're here."

"We don't want change to happen *to* us, but because of us," said Andy Blalock, M.D., the chair of the AMA's Resident Fellow Section (RFS). "Today is your opportunity to add your voice to the national debate on how resident work hours can be reformed," he said.

Participants from the conference can continue the dialogue by bring- participants went into their workshop groups to come up with a better way to work. They targeted the things that extend their day and prevent them from leaving. They thought about the obstacles to leaving by category: are they part of the tradition of medicine – the "we've always done it this way" thinking, or a resource problem – staff, technology, things that cost money. They estimated how much time could be saved by various strategies. The next session was about solutions: the sources of ideas, proposals for changes – and who do you present them to, how do you build support to actually get them done?

Voices for Change

Here is a small sample of what was said that day:

"A lot of the culture of resi

own and other specialties and shared what they saw as the major obstacles that prevent them from leaving the hospital, as well as new strategies that can reduce unnecessary work hours and improve both medical education and the delivery of patient care. With sweeping changes in resident work hours finally mandated by the ACGME and due to be implemented in July, 2003, conference participants at UMDNJ-New Jersey Medical School recognized that it was no longer a question of *if* excessive work hours should be reformed, but *how*.

The answers to the question of how to achieve resident work hour reform will be many, and varied, by hospital, and by medical specialty. Suddenly, many housestaff are reporting that program directors and ing the workshop questions and information back to their hospitals, and by staying in contact with their colleagues from other hospitals after the event through shared email or phone contact. But anyone reading this article can take the initiative to bring this dialogue into his/her hospital, with the Do-It-Yourself Kit on Supplement Page 4. For a full list of questions as well as some of the answers that were shared at the conference, contact hours@cirseiu.org.

Imagine...Whatever your program is like now, can you imagine it being better?

John Lennon may have said it best, but it applies to any problem – before you can fix it, you have to imagine a better way. With the *Imagine* question on their handouts,

dency dates back to a time when residents couldn't be married, couldn't have kids....that's all changed, the culture must change, too." Mark Levy, executive director, CIR.

"Every attending has the story of, 'When I was a resident it was so much worse.' It's encouraging to know you're not the only program going through this, it's universal." Devang Desai, M.D., Internal Medicine, Detroit Medical Center.

"As chief resident, I've met with housekeeping staff and asked, 'Why does it take 4 hours to have a bed cleaned?' We've brought it down to 1-2 hours. I can tell our Chief Financial Officer, 'I can't

A Model For Organizational Change

D x V x F > R

D = Dissatisfaction **V = Vision** **F = First Steps** **R = Resistance**

Conference participants considered the equation above: **Dissatisfaction** must be public and shared; **Vision** of what is possible must be public, shared, ennobling, and possible, but a stretch from where we are now; **First Steps** to reach this vision must be concrete, doable, and able to begin now. The product of these must be greater than **Resistance** to change in the organization.

PHOTOS: JIM TYNAN

CONFERENCE ON HOURS REFORM

Strategies hange

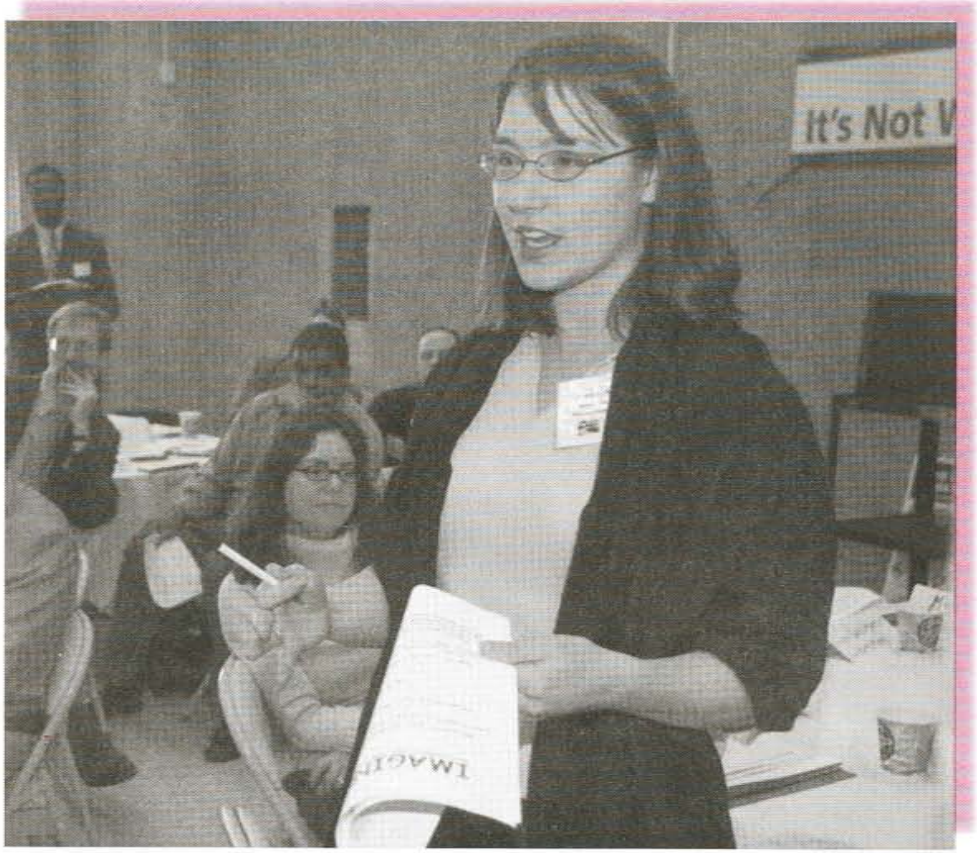
work more than 80 hours a week,' and it will have no impact. If I say instead, 'All these needless admissions are costing us money,' that has a big impact. People in housekeeping and in admitting make decisions that impact residents every day. You have to meet with and talk to these people." Peter Watson, M.D., Internal Medicine, Henry Ford Hospital, Detroit, Michigan.

"In a study in a surgery program, during years that resident work hours went down, board scores went up. We can improve our education simply by having time to sleep, and read. Residents were much happier, better residents, performed better on the boards, and improved both their education and their lives." Ali Mendelson, M.D., Pediatrics,

gram. The only thing I had to look at was the board pass-rate for each program. This should be published in a book for residents to look at before choosing programs." Firas Rabi, M.D., Pediatrics, Jersey City Medical Center.

"If there's a noon conference, it could be recorded and left available for other residents to review at any time. That doesn't cost any money, you don't even have to teach a second session." Srinivas Bonthu, M.D., Radiology, Harlem Hospital.

"We borrowed this idea from John Hopkins and created two Pediatric Resident Assistant positions. This is someone who can help do discharges, make appointments. These positions earn a reasonable amount of



only report 80 hours, regardless of how many they work. There are so many people who are glad to get into a program, they will not do anything to rock the boat."

"Residents who are the department 'pets' did the ACGME interviews at my hospital and lied and said there were no violations," said another resident in discussing the ACGME's role in hours enforcement.

"The ACGME is a stick used

Georgetown Hospital.

"For a General Surgery team, procedures can be done over the course of hours instead of days if it's organized in that way. It's a very reasonable solution to the problem of logging a number of procedures." Maurice Sholas, M.D., Ph.D., Pediatrics (PD/PM), Rehabilitation Institute of Chicago.

"A lot of commonsense things can be accomplished without much money. We can increase efficiency by looking at things like when and how we do rounds and sign-outs. Just because the nursing shift starts at a particular time, is that written in stone? Does it have to be that way, or can it be changed, for better communication between residents and nurses?" Steven Celestin, M.D., Family Practice, Jamaica Hospital, New York.

"Don't be constrained by the idea of a night float. Just think float. It can be a day float, too." Scott Selco, M.D., Ph.D., Neurology, Los Angeles County/USC Medical Center.

"I would have loved to have known about these ideas and about resident work hours at different residency programs when I was choosing a residency program, require a high school degree, and must enjoy interacting with people. They save a lot of time – about three hours of intern's time a day is now free. When I get called to cover an intern, I'm floored by how much work is now done for them. These positions are funded by our hospital and guaranteed in our CIR contract." Arun Chopra, M.D., Pediatrics, Children's National Medical Center, Washington, D.C.

"At Boston Medical Center, Surgery interns sign-out to a Nurse Practitioner, which has reduced resident hours in the hospital, led to more timely discharges, and improved patient satisfaction and patient care." Mark Amorosino, M.D., Internal Medicine, Boston Medical Center.

ACGME – Friend and Foe

The ACGME's new guidelines are the force currently driving the July 1, 2003, reform of resident work hours. But according to residents, it's a double-edged sword. While the new focus on hours reform is welcomed, the ACGME's only method of enforcement is to close down programs that are out of compliance.

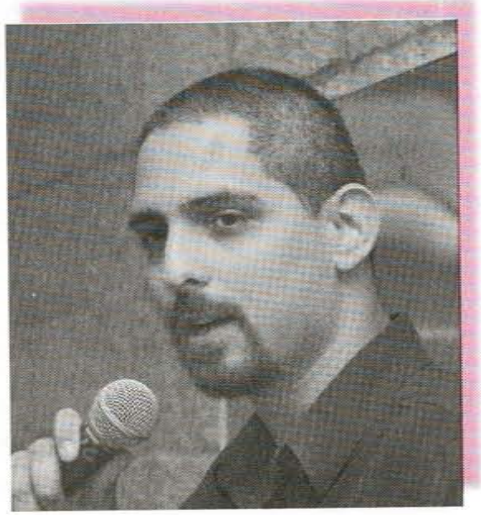
"Somehow, me telling the truth that I worked 120 hours a week shouldn't come back to haunt me," one resident said. "But it does. I was told that everyone knew they should against residents, because the ACGME can close your program, whereas IPRO (the agency that monitors New York's hours regulations) is a stick used against the hospitals. [They are fined if out of compliance.] A stick is good, but it must be aimed at the right person," said Amit Tailor, M.D., Internal Medicine, St. Vincent's Catholic Medical Center, New York.

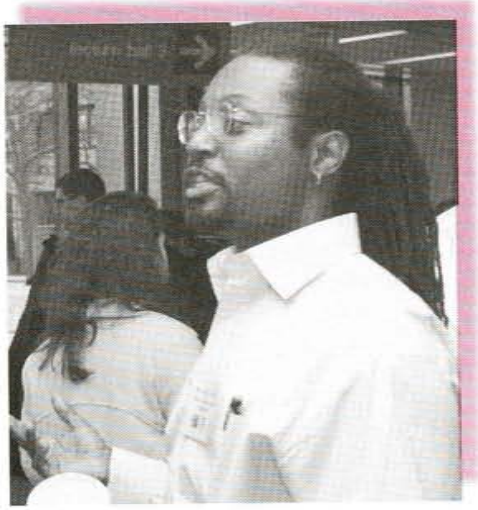
Bringing It All Back Home

The next step is making these changes, hospital by hospital. "We were having a hard time thinking outside the box. I'm going to take these ideas back with me," said Dr. Ali Mendelson of Georgetown.

"This opened up a lot of ideas about how to change problems in our program," said Paul Sunkavalli, M.D., Pediatrics, Jersey City Medical Center. "I'm going back to my department with ideas that can improve our program – improve the quality of our medical education and of patient care. We have to approach the administration with ways to change the flaws that we see. We all share the common goal of treating patients well, but we look at it differently."

"It's full of hope to see all of you here today. There's a humanity principle – we should treat others with humanity, and should be treated with humanity ourselves," said Canadian participant James Clarke, M.D., President of the Canadian Association of Interns and Residents.





Do-It-Yourself Kit

Pass It On – Take these questions to your department and your hospital, to begin the process of making changes in resident work hours.

These are some of the questions that many residents have found useful to analyze how to reduce work hours, and to improve the quality of medical education and patient care. Try asking these questions with a group of residents in your department, and in your hospital.

Operationalizing and Implementing Hours Changes

Operationalizing and Implementing Hours Changes

Session 1 (b) – Thinking About Possible Solutions

Proposing and Implementing Solutions:

Your Chair (and/or Program Director) asks you to help find and suggest some solutions to the problems you identified.

Getting ready – before suggesting changes:

1. **Sources for Ideas:** First, where might you get ideas for such changes?

   a) _____

   b) _____

   c) _____

   d) _____

2. **Categories Useful for Problem Solving:** Reviewing the list of hours extenders, and recognizing that the categories below are not perfect, make quick initial judgments to be noted on the flip chart about:

   a) TIME: Which changes might be accomplished relatively quickly [**Q**]? Which would take longer [**L**]?

   b) COST: Which changes would require little or no financial cost [**Lo-$**] for the institution to make? Which changes would require additional financial resources [**Hi-$**] to do (e.g., more staff, new technologies)?

Session 1 (a) – Brainstorming on Resident Hours-Extenders

A. Identifying Problems:

Your Chair (and/or Program Director) comes to you and asks you to list three things that keep you in the hospital longer than you need to be.

List three things below that extend your day and prevent you from leaving earlier than you could otherwise. Make your list on a flip chart.

1. _____

2. _____

3. _____

B. Categorizing Problems:

Reviewing the master list developed by the small group, which problems are predominantly the result of a program's traditions **[T]**? Which mainly result from of a lack of institutional resources (e.g. staff, technology, etc.) **[R]**?

Indicate on the flip chart which problems are driven more by "tradition" and which stem mainly from "resource" issues?

C. Saved-Time Estimates: Based on the discussion and the group's ideas on the flip charts, and before talking about how to fix any of these problems, make a rough estimate of how many hours might somewhat easily be shaved off an average resident day?

On average, without even modifying schedules, a typical day could be reduced from between _____to_____fewer hours per day.

3. **Proposals:** A) Next, think about and make a list for yourself of three (3) problems from the flip chart you would like to discuss. Then we'll share individual choices to find the group's top three issues.

a) _____

b) _____

c) _____

d) Next, out of the top choices the group should pick two (2) problems to discuss as case studies: one that can be fixed in the short term **[Q]**... and one that would take longer **[L]**.

Discuss (or role play) how you could go about getting each changed.

(Case Study Discussions)

4. **Hospital Constituencies:** Who in the institution needs to be involved (and needs to give support) for such changes to be successful? How is each to be approached? List and discuss.

a) _____

b) _____

c) _____

d) _____

Where might you find support?

Where might you find resistance? How could you deal with resistance?

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