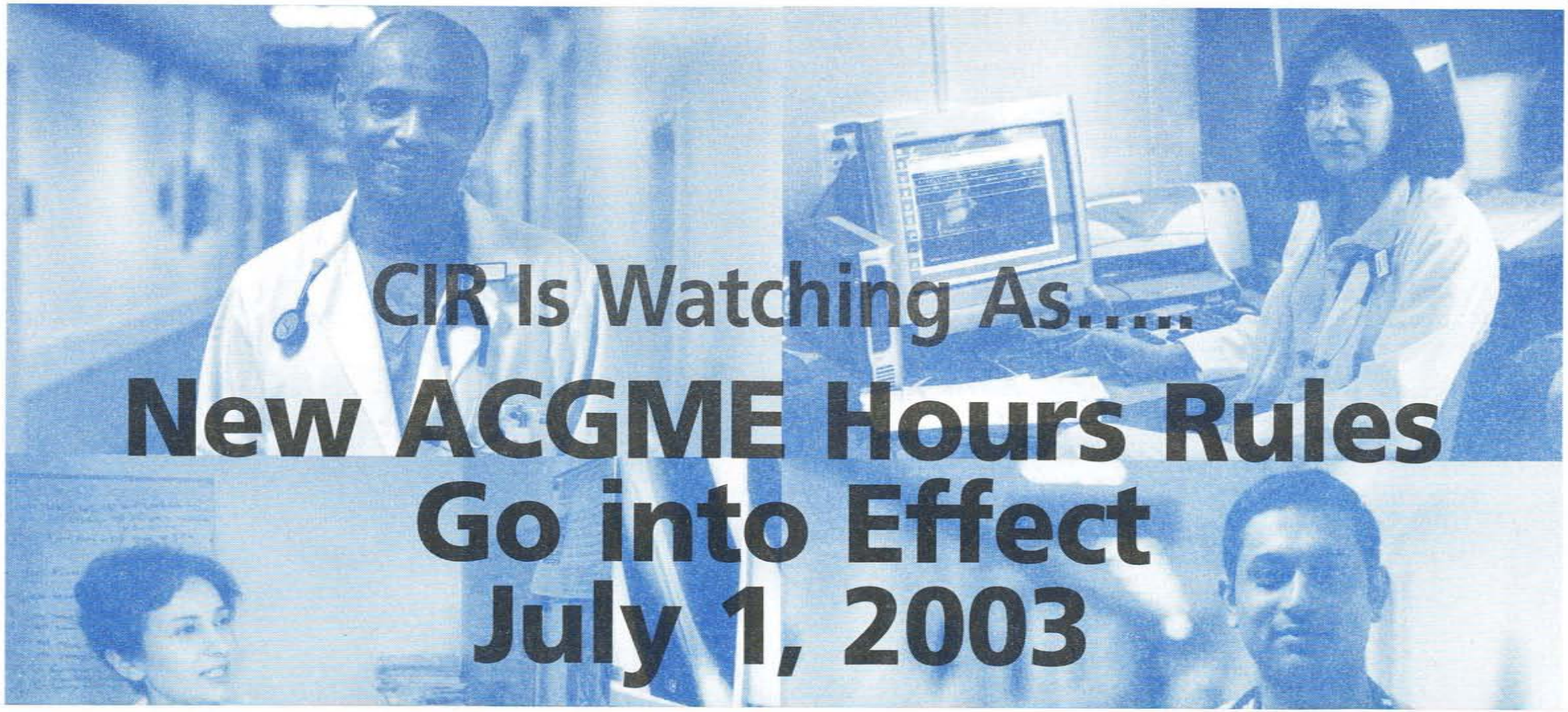
CIR SEIU NEWS

COMMITTEE OF INTERNS AND RESIDENTS June 2003

**WELCOME NEW MEMBERS!**

*Special Orientation Section*
*Pages 5-10*

*CIR Benefit Plan Information*
*Special Section, Center*



## CIR Is Watching As....

# New ACGME Hours Rules Go into Effect July 1, 2003

Is your program making scheduling, staffing, or ancillary service changes this spring in preparation for July 1, 2003 and the new ACGME hours limits? Do you expect real change based on what you're seeing, or just more of the same? CIR wants to know!

"We don't expect perfection on July 1st, but we do expect hospitals to take action towards making this work. CIR is looking for—and expecting—that hospitals begin to make real change in their programs," said CIR President Ruth Potee, MD.

Reports to CIR from across the country indicate that there are real variations among hospitals and programs in their willingness and readiness to comply with the new rules.

Enforcement remains a major concern to CIR, as the ACGME is still dependent upon residents reporting violations. The ACGME website (www.acgme.org) lists the new rules under its Resident Duty Hours section, but there is currently no email address, no telephone number, no specific mechanism for residents to report non-compliance, other than the standard institutional review, which usually occurs every three years.

CIR members are urged to bring any hours problems to the attention of their local CIR organizer or to call the CIR National Office at 1 800 CIR-8877. "We know that for many programs, it will be a big stretch to reach the 80 hour work week: to get residents safely home after 24-30 hours of work, and to ensure that residents' medical education is improved, not diminished," said Dr. Potee.

New York State housestaff know all too well that timely enforcement is key. New York residents saw many improvements when the state established a stringent monitoring process, including unannounced site inspections, a hotline for resident reporting, the required filing of annual schedules for all programs, and sunshine provisions that make violations public information.

The ACGME announced its new rules one year ago. Many were surprised by the accrediting body's about-face, since up until then it had steadfastly insisted that across-the-board limits were unnecessary. But the growing chorus for reform had its effect: the filing of the OSHA petition, federal and state hours legislation, the growing influence of the medical errors movement, the pressure from housestaff and medical student organizations, both in and outside of organized medicine—all contributed to convincing the ACGME that if it did not institute change, then change would be imposed upon it.

Dr. Potee stressed that CIR will be watching the ACGME closely to see how rigorously it takes its enforcement role.

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Ruth Potee, M.D.
*President*

## President's Report

Ruth Potee, MD, CIR President

# Welcome to CIR

Welcome to CIR. Today, we are nearly 12,000 members strong—interns, residents and fellows in more than sixty hospitals in New York, New Jersey, Massachusetts, Florida, California and the District of Columbia. The issue which has held most of our attention since the majority of us became residents has been resident work hours, and how it impacts the safety of housestaff and the patients we care for.

This past year, CIR has been on the cover of *The New York Times*, *Boston Globe*, *L.A. Times*, *Washington Post*, and *Chicago Tribune*. Our resident leaders have been interviewed on TV, radio and in print making a powerful argument that "Long Hours = Bad Medicine." We made some friends, but we also made people very nervous that change could be coming their way.

After the ACGME announced their new resident work hour standards a year ago, CIR members began to work at their chapter level to help design a system that would work for residents and ensure good

hours regulations into effect for Puerto Rico that are similar to New York's Bell regulations.

our history. We predict, though, that much of our work has just begun. In addition to staying on top of the ACGME (see front page), and continuing to push for resident work hour reform, settling contracts and organizing new members, we also have to fight to ensure that our patients get the care that they need.

All of us have trained for a long time to be able to provide the world's most advanced medical care. But fewer and fewer people have access to this care. Our teaching hospitals, which provide a disproportionate share of medical care to the poor and uninsured, are increasingly underfunded and under assault.

In a country where 65 million people are either uninsured or underinsured in any given year, where state budgets are slashing very basic health services to our patients, we all know that our healthcare system is broken. When hospitals begin to

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FRONT PAGE PHOTOS:
CARA METZ/CIR AND JIM TYNAN

training and education. We also worked at the national level to demand that programs do more than just make a few adjustments in the call schedule. We continued to put more pressure on hospitals, and on the ACGME, and pushed for state and national legislation.

In covering the legislation, the *New Jersey Star-Ledger* editorialized, "Much of what is wrong with medicine may well be bred into our physicians during the mean-spirited residency years." In the meantime, in January, 2003, our CIR members in Puerto Rico worked hard and had the privilege of seeing that work come to fruition. The governor signed

While those of us on the East Coast were lobbying to change resident working conditions, on the West Coast, our colleagues were battling to save their hospitals. Most states have overwhelming budget deficits, but few appear as desperate as California. They marched, rallied, phone-banked and testified their way through the fall, winter and spring, and racked up impressive victories along the way. Measure B, a referendum to increase taxes in order to fund trauma care in public hospitals in L.A. County, passed by an overwhelming margin.

We have been busier in the last two years than we have ever been in crack, it is residents who reside within those cracks. The work ahead of us involves thinking both very locally about the budget cuts and their impact on our patients, and also thinking broadly about how we can work together with SEIU to impact the national conversation on access to medical care for all who live within our borders. Welcome to CIR, which can provide you with a platform for understanding, and taking a role in improving, the future of healthcare in our country.

# Smallpox Vaccination Program Stalls

The federal government's smallpox vaccination program all but ground to a halt this spring, in the wake of published reports of cardiac problems among healthcare workers and military vaccinees, including three fatal heart attacks. In March, the Centers for Disease Control issued new guidelines recommending that people with a history of heart disease or those with three or more heart disease risk factors, such as high blood pressure, high cholesterol and diabetes, not be vaccinated.

To date, only about 35,000 of the targeted 500,000 healthcare workers have volunteered to be immunized.

In mid-April, by unanimous vote of both the House and Senate, the Smallpox Emergency Personnel Act was passed to compensate those caregivers, their families and patients who become disabled or die as a result of the vaccine.

"Healthcare workers sounded the alarm about the shortcomings in the smallpox vaccination program—and their elected leaders heard them," said Andrew L. Stern, president of the Service Employees International Union (SEIU). With 700,000 members working in healthcare, including CIR's 12,000 resident physicians, SEIU was instrumental in lobbying Congress for this important protection.

PHOTO: CARA METZ/CIR

CONVENTION 2003

# Access to Care and the Budget Crisis


Regional reports from Southern California (above) and New York (below) highlighted issues in their regions; At right, speaker Quentin Young, MD, of Physicians for a National Health Program, said, "Healthcare, at this moment, can be characterized as a perfect storm—everything is in play. We have all the resources to give us the very best system. We have everything we need to be great."

**"I come from a third-world country, Egypt, and I practiced there. We did not have to ask**

"Residents are some of the busiest working people on the planet," said CIR President Ruth Potee, in welcoming elected delegates and alternates to CIR's seventh annual convention, held in Washington, D.C., from May 16-18, 2003. She applauded the audience for finding the time to focus on the serious issues they face as doctors and frontline healthcare providers in this time of scarce resources.

The theme of access to healthcare wound its way throughout the convention this year, starting with keynote speaker Dr. Quentin Young of Physicians for a National Health Program.

CIR delegates addressed the theme of access in the workshop, "Our Experiences in the Healthcare Crisis," in which they shared personal stories of how budget cuts have impacted patient care, and what they are doing about it. A "Speak Out on Healthcare" came on the second day of the convention, and a panel discussion, "Do Politics Matter?" rounded out the third day.

In addition, the business of the convention—new delegates taking the oath of office, electing a national Executive Committee (see page four), and approving an annual budget for the year to come—were handled in stride.

"Your role as a delegate is extremely

appeal to the L.A. Board of Supervisors: "If these clinics close, where do I tell my patients to go? I want you to tell them, 'Sorry, you'll have to wait six months for an appointment; sorry, there is no vaccination for your child; sorry, you'll have to take your medicine only every other day instead of every day'....We do not need to be here year after year, begging for the funding we need."

New York presented a lighter report, with a "Jeopardy" spoof packed with information on contract gains and new organizing. The Florida region's witty presentation utilized slides from other region's power-point presentations that were surreptitiously borrowed and "enhanced." Puerto Rico had tropical music, lots of spirit, and good news to report, including pay raises, the right to organize, and legislation which will regulate resident work hours throughout the island.

Northern California's high-tech presentation reported on the budget shortfall in San Francisco, which has resulted in wage cuts at S.F. General for the next two years, as well as gains made in contract language at other hospitals in their region. Massachusetts pointed to changes made in anticipation of the ACGME's new resident hours guidelines and innovative new patient care fund provisions. New Jersey reported that they represent

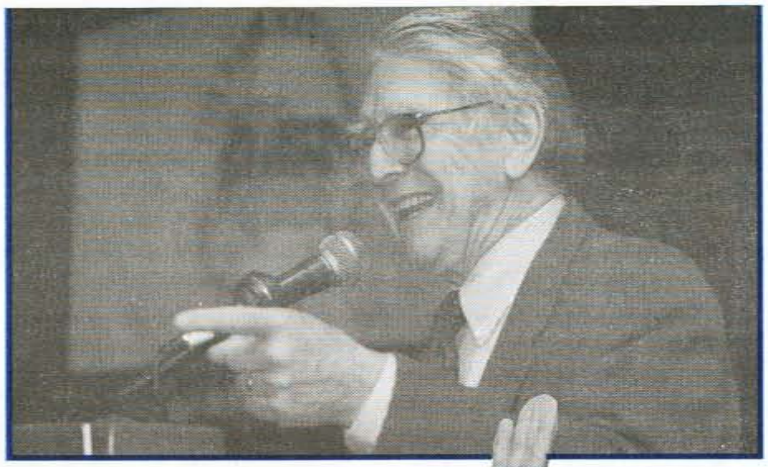
Continued from page 4

**patients for insurance cards. We treated everyone. If a poor, third world country can do that, why can't we do that here?"**

Dr. Emad Tewfik-Bishai,
Brookdale Hospital, Brooklyn,
New York

important," CIR outgoing Southern California Vice President Scott Selco told the audience. "You are the link between CIR and your chapter, you are the face of CIR to your members, and the outside world."

As always, regional reports were a highlight of the convention, and were scattered throughout the course of the proceedings. Southern California residents came down the aisles with the banners they have become accustomed to wielding at press conferences and rallies. Part of their report was a video of CIR leader Dr. Andrea Anderson's emotional






PHOTOS: BILL BURKE/PAGE ONE PHOTOGRAPHY

# CONVENTION 2003

Continued from page 3

60% of all interns and residents in their state, the highest union density of any CIR region, and featured an extremely cute baby and some Springsteen music.

Anna Burger, secretary-treasurer of the Service Employees International Union (SEIU), said, "We have to be laying the groundwork now so that the 2004 presidential election is all about healthcare. Public opinion is on our side—50% of all Americans believe they may lose their healthcare; 25% stay in jobs they hate but can't leave because of healthcare...We need your involvement—your faces and voices, because the reality is, people trust their physicians...When we stand together, we can do amazing things."

Quentin Young, MD, Physicians for a National Health Program, said, "I'm an activist. Living as long as I have, I've seen unpopular causes become the law of the land. I'm old enough to remember legal segregation, the House Un-American Activities Committee — it was all reversed. Healthcare, at this moment, can be characterized as a perfect storm—everything is in play. We have all the resources, all the assets in place to give us the very best healthcare system. We have everything we need to be great. But the market solution does not work for healthcare. We need universal, national health insurance, with everybody in, and nobody out....Destiny is yours—you are in a historic moment....We're living in a very bad patch, but it's there, and winnable."

## What Budget Cuts Mean for Patient Care

Every day, residents are delivering care to patients in increasingly underfunded hospitals. In workshops, delegates shared their stories of what happens to patient care during these times of budget crisis, as well as strategies for doing their best for patients and residency quality of life.

"I had a patient who could not speak English. He was a 58-year-old man, and was agitated and yelling. I was the psychiatrist on call, and had to deal with the situation. We had no interpreter, and he was increasingly agitated. I went there with the mindset to put him in restraints, or tranquilize him. I was able to find another resident who spoke Polish and could talk to him. It turned out he had lost his belongings in the hospital, and was concerned with where they were, so he was yelling. Who knows what kind of side effects may have resulted from a tranquilizer? It's a big mess, because budget cuts are really affecting a lot of healthcare," said Titus Okunlola, MD, of North General-Harlem Hospital, in New York.

"Because of attending cuts at an affiliated hospital, we have patients shipped to our hospital for treatment. Now they pay for our hospital to treat their patients, but we can't admit them. We don't always get their entire chart. We had a patient with a pseudoaneurysm due to a gunshot wound who was transferred to our hospital. The patient was not insured, and various surgeons got into an argu-

Continued on page 11

Residents shared their stories about how budget cuts impact patient care during workshops (top, far right), and climbed aboard a trolley ride to view the DC monuments (below, right). Surgery resident Neelu Pal, of UMDNJ said, "CIR can be a training ground for those who want to create changes in healthcare." Below, Firas Rabi, a pediatric resident at Jersey City Medical Center, spoke about the stresses budget cuts have put on his hospital.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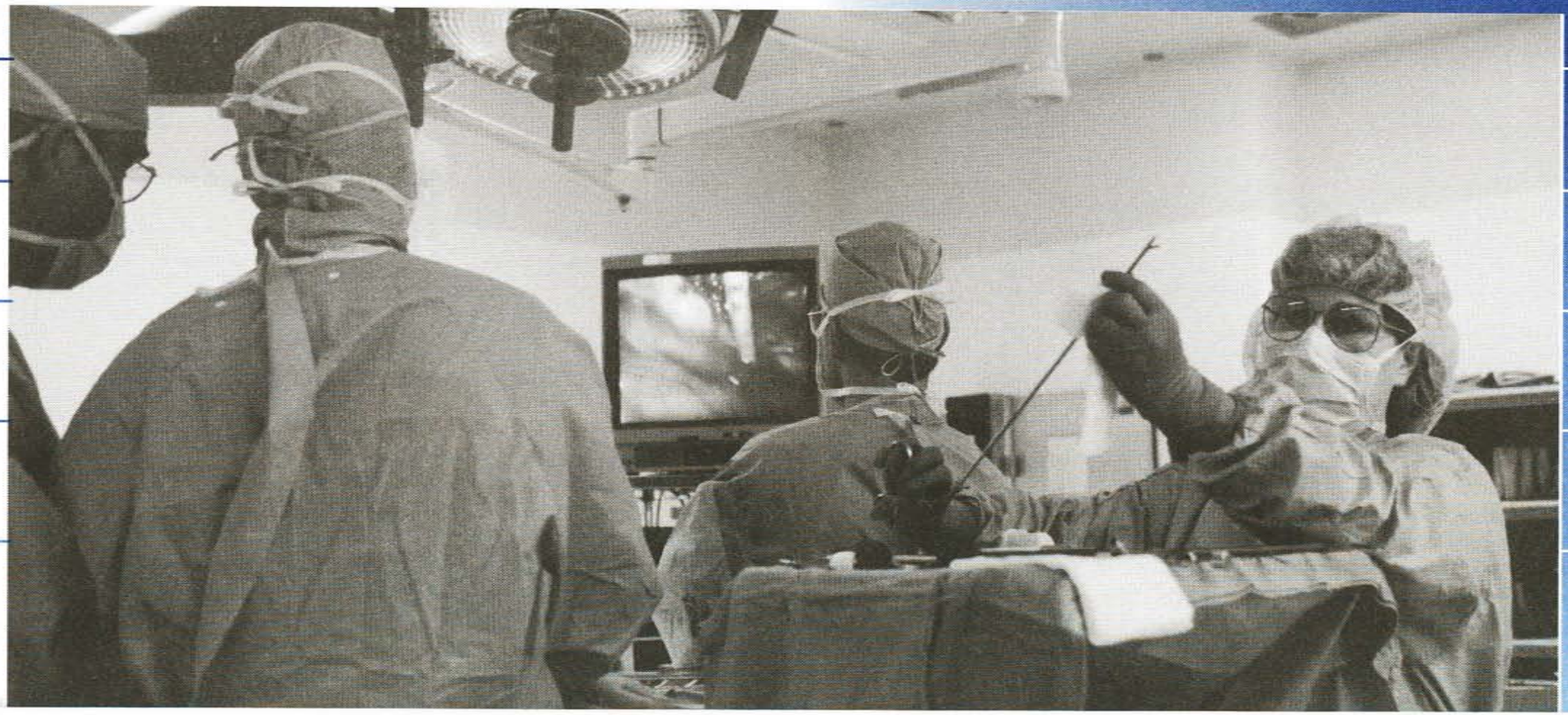
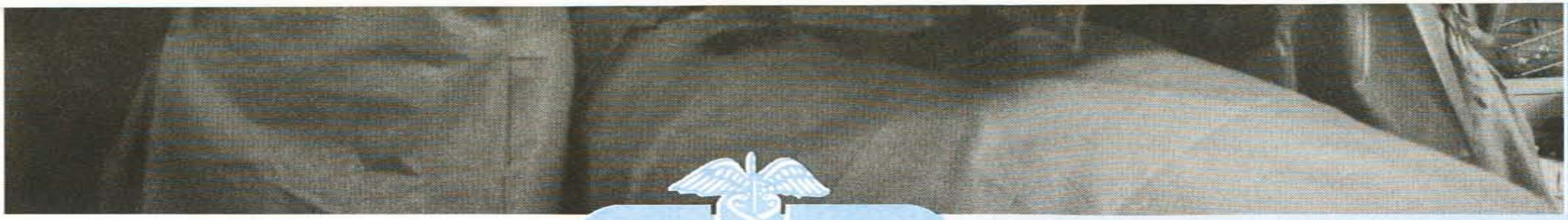
# SPECIAL ORIENTATION SECTION





# Welcome to The National Voice of Housestaff

*Congratulations!* You are about to begin what will be the most exciting, harrowing, excruciating and thrilling experience of your life. *You are now a resident physician!*

Congratulations, too, to those of you who arrive as fellows, beginning another arduous but rewarding year of training.

Fortunately, the Committee of Interns and Residents, the largest and fastest-growing organization of housestaff in the U.S., will be behind you as you face each new challenge. For 46 years, CIR has been the national voice of residents and fellows, protecting and advancing housestaff rights, education and working conditions, and defending quality patient care.

This Special Orientation Section of CIR News will help acquaint you with CIR. We urge you to take time to read these pages. Here you will learn about:

- Your rights and benefits as an employee of your hospital, as spelled out in a collective bargaining agreement negotiated by your CIR colleagues.
- The history of CIR and some of the current issues confronting housestaff.
- Some of the many other benefits which you will receive by being a part of CIR.
- How you, as a member, can participate in CIR within your department, your hospital, and as a representative on CIR elected bodies.

*An affiliate of*

SEIU

# *The Patients' Voice, The*

# CIR 1957-2003: 46

**Today, through CIR collective bargaining agreements, more than 12,000 interns, residents and fellows in New York, New Jersey, Massachusetts, Washington, D.C., Florida and California enjoy salary, benefits and working conditions that are the envy of their colleagues in non-unionized hospitals. They also have a strong, unified voice to advocate for their patients in their local hospitals, and in the state and federal arenas, where healthcare policy is forged.**

**But it wasn't always that way. Getting to this point has taken 46 years of commitment and collective activity by housestaff in public and private hospitals across the country. Here is our story.**


### 1934

*First housestaff organizing efforts begin in New York City and the Interne [sic] Council of Greater New York is formed. For the first time, interns receive salaries—$5 per month.*

### 1957

*The Committee of Interns and Residents (CIR) is founded, representing housestaff in*

### 1970

*CIR begins organizing in New York City's private—"voluntary"—hospitals. Under the State Labor Relations Act, residents at many of the major voluntary hospitals vote*

### 1975

*With negotiations over the work and training issues stalled, CIR leads the first multi-hospital strike of doctors and dentists in New York history. The strike, which uses the slogan "Our hours make you sick," receives AMA and media support. The settlement is a landmark victory; it eliminates every-other-night on-call, improves working conditions, and places housestaff on hospital*

### 1980

*CIR institutes CIRLS, offering pre-paid legal services to members. Contract negotiations with New York City establish the $200,000 HHC Patient Care Trust Fund to purchase needed equipment and supplies*

*New York's municipal hospitals.*

## 1930-1960

### 1958
*The first CIR contract with New York City increases annual salaries from $852 to $1212 a year for interns and from $1260 to $1500 a year for residents. It also defines enforceable grievance procedures and provides benefits while establishing living-out allowances, PGY levels, and guaranteed on-call rooms.*

### 1965
*CIR negotiates The House Staff Benefits Plan, a union-administered benefit fund for New York City-paid housestaff that provides supplementary health benefits in addition to the already existing basic city-wide hospitalization and major medical insurance.*

*to approve representation by CIR.*

## 1970

### 1974
*The National Labor Relations Act is amended to include employees of voluntary hospitals. CIR begins negotiating with the League of Voluntary Hospitals on working hours, out-of-title work, and the quality of training programs. The negotiations prove difficult and continue to stall through year's end.*

*committees.*

## 1975

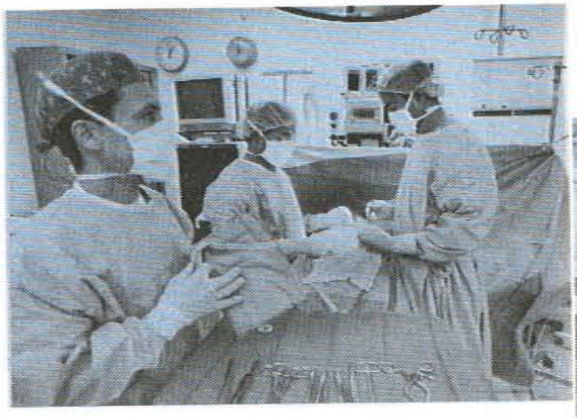
### 1976
*The National Labor Relations Board, in the* Cedars-Sinai *decision, rules that housestaff are "primarily students." Housestaff in the private sector have to now rely on their own collective strength to secure union recognition. Housestaff pressure wins back CIR contracts in some hospitals but others are lost.*

### 1978
*Over 900 housestaff employed at the College of Medicine and Dentistry of New Jersey (now UMDNJ) vote to join CIR.*

### 1979
*CIR leads a one-day protest against funding cutbacks in New York City health programs. The action receives broad community and labor support. CIR successfully rebuilds in the private sector, gaining 1,000 new members and contracts with six voluntary hospitals. The Voluntary Hospital Benefits Plan is formed for housestaff from private sector hospitals.*

*for city hospitals.*

## 1980



### 1981
*Protesting severe understaffing and equipment shortages, CIR undertakes a strike to establish staff and equipment standards involving more than 2,000 doctors at ten hospitals. Although the action does not lead to the hoped-for contract language, it dramatically increases public awareness of the issues.*

### 1984
*CIR housestaff at University of Medicine and Dentistry of New Jersey hospitals conduct a series of protests that lead to a vastly improved contract. In April, CIR initiates a loose federation of local housestaff unions from around the country.*

# *Doctors' Choice*
# YEARS OF COMMITMENT & LEADERSHIP

## 1985
*Doctors at Interfaith Hospital in Brooklyn successfully strike to retain CIR as their chosen representative.*

## 1986
*CIR negotiates precedent-setting protections on maternity leave and an additional $850,000 for the NYC HHC Patient Care*

## 1990
*CIR undertakes a number of organizing campaigns. Doctors at Bronx Lebanon Hospital strike to win recognition and a CIR contract. Housestaff at the District of Columbia General Hospital and Prince George's Hospital in Maryland vote to affiliate with CIR.*

## 1996
*Newly merged Boston Medical Center recognizes HOA/CIR as collective bargaining agent for combined housestaff at formerly public and private entities. CIR wins legal decision establishing "employee" rights for Florida housestaff at Jackson Memorial Hospital in Miami. Jackson housestaff vote for CIR by 4-to-1 margin in largest election ever held by doctors in U.S.*

## 1997
*CIR and Boston Medical Center housestaff launch legal challenge to overturn National Labor Relations Board 1976* Cedars-Sinai *decision. CIR-initiated campaign gets New York Supreme Court to block Mayor Rudolph Giuliani's plan to privatize NYC public hospitals. The 1,600-member Joint Council of Interns and Residents of Los Angeles votes to affiliate. On its 40th anniversary, CIR holds National Convention, where delegates vote to join the Service Employees*

## 2000
*Organizing accelerates in response to NLRB and PERB decisions. 300 residents at Brookdale Medical Center in Brooklyn, N.Y. win voluntary recognition. CIR establishes a new region for housestaff in Puerto Rico. CAIR/CIR at San Francisco General wins breakthrough contract, including new $120,000 Patient Care Fund. SEIU wins state/federal funds to save Los Angeles County health system, sponsors Universal Health Security for All Americans Act in Congress and successfully lobbies for federal Safe Needle Act.*

## 2001
*CIR organizing rolls on, with the addition of almost 1,000 new members from the New York region. Housestaff in Puerto Rico vote to affiliate with CIR. Together with the American Medical Student Association and Public Citizen, CIR petitions the Occupational Safety and Health Administration (OSHA) for emergency regulations to reduce resident work hours and wins congressional sponsorship for the Patient and Physician Safety and Protection Act (H.R. 3236), also*

*Trust Fund.*

*International Union, AFL-CIO.*

*to address excessive resident work hours.*

## 1985

### 1987
*The New York State Department of Health announces plans to reduce residents' hours and CIR wins inclusion of weekly and daily hours caps and ancillary staffing levels as essential parts of the proposal. CIR grows into Washington, D.C., as Children's Hospital Housestaff Association votes to join.*

### 1988
*CIR's "Long Hours Are Bad Medicine" campaign sets the tone for a national discussion on changes in residents' work lives. Thanks to CIR's efforts, New York State residents assigned to Emergency Room duty become the first in the country to benefit from regulations limiting hours. The new State regulations limit residents' work hours and set standards for ancillary staff and supervision. The transition goes smoothly.*

### 1989
*Despite significant resistance on the part of many program directors and hospital administrators, New York remains firm in its intention to implement an 80-hour weekly hours cap and a 24-hour consecutive hours cap. CIR signs a new three-year contract with HHC that raises PGY-1 pay rates above $30,000.*

## 1990

### 1991
*Organizing success continues in the District of Columbia as residents at St. Elizabeths Hospital vote to join CIR. The New York State Supreme Court upholds hours regulations. Studies on the effect of reduced hours on residents and their patients show hours reform is working. CIR/HHC Patient Care Trust Fund contributions top $1,000,000.*

### 1992
*CIR brings legal suits blocking New York City from closing HHC dental clinics, outpatient pharmacies, and employee cafeterias. This challenge protects jobs, patient care, and hospital workers' rights from the budget axe.*

### 1993
*House Officers Associations at Boston City Hospital and Cambridge City Hospital vote to affiliate with CIR.*

### 1994
*CIR's TV, radio, and bus and subway ads help to build the community-based New York City "Save our Public Hospitals" campaign against budget cuts and privatization.*

## 1995-1999

### 1998
*L.A. housestaff represented by Joint Council of Interns and Residents/CIR win their first salary increase in 7 years with 1st-year interns getting 15.85% raise. In Miami, Jackson Memorial residents win first contract in Florida history; PGY1 rates increase 25 percent by end of contract.*

### 1999
*The NLRB upholds the CIR challenge at Boston Medical Center and rules that private-sector housestaff are again guaranteed collective bargaining rights. The California Association of Interns and Residents (CAIR) at four northern California hospitals affiliates with CIR. CIR participates in legislative efforts by SEIU for safe needles and adequate staffing levels. Massive lobbying and media campaigns by SEIU and Local 1199 win legislation to strengthen enforcement of New York State's hours regulations, safeguard funding for graduate medical education, and extend healthcare coverage to one million uninsured. The Doctors Council union joins SEIU.*

## 2000-2003

### 2002
*Federal hours legislation gains momentum with 60 House and 2 Senate sponsors; state bills are filed in New Jersey, Massachusetts and Puerto Rico. Housestaff at Maimonides Medical Center and Brooklyn Hospital, N.Y. vote to join CIR.*

### 2003
*Under pressure from CIR, AMSA and Public Citizen, the ACGME establishes new hours guidelines for July 1, 2003. Puerto Rico passes hours limits; CIR members in Los Angeles join with community groups and other SEIU members to win continued funding for hospitals and clinics throughout the county. Housestaff at Children's Hospital in Oakland, California vote to join CIR.*

PHOTOS: BILL BURKE/PAGE ONE PHOTOGRAPHY; JIM TYNAN; CARA METZ/CIR

# Who We Are & What We Do

**An informed and involved membership is our greatest strength. Below is some information to better acquaint you with CIR.**

## Who We Are

CIR—the Committee of Interns and Residents—is the largest and fastest growing housestaff union in the United States. CIR represents 12,000 interns, residents and fellows in New York, New Jersey, Massachusetts, Florida, California, the District of Columbia and Puerto Rico. Since 1957, CIR has negotiated collective bargaining agreements with over 60 public and private hospitals. These agreements improve housestaff salaries and benefits, hours of work and working conditions and the quality of care we deliver to our patients.

In 1997, CIR affiliated with the 1.3 million member Service Employees International Union (SEIU), with 650,000 healthcare workers across the country. As the national affiliate of physicians within SEIU, CIR housestaff continue to set our own policies, decide our own priorities, elect our own officers and negotiate our own contracts—all with considerable economic and political backup from SEIU that adds to CIR's own resources.

## Why We're Needed

Housestaff across the country need an organized voice to stand up for our rights and the rights of our patients. CIR enables residents to voice their concerns as a group. CIR collective bargaining agreements carefully spell out housestaff rights and benefits. Experienced staff work with residents to improve and enforce the gains negotiated in each contract. Because residents are at an important

process provisions, including grievance procedures, arbitration, and representation rights, ensure that each housestaff officer gets a fair hearing when he or she needs that kind of support.

## Look What We Have Achieved

CIR has 46 years of experience with the problems and concerns of housestaff in public and private hospitals. This organizational experience is critical.

- CIR contracts set the standard in their geographic areas with higher than average salaries and
- CIR's groundbreaking work on resident hours reform eliminated, across the board, every other night call in 1975. We spearheaded New York State's landmark hours regulations in 1987. We've worked with SEIU to put added teeth into those regulations in 1999. CIR's current contracts provide additional limits on excessive work hours and an internal enforcement method.
- CIR's negotiated "extra on-call pay" is a first in the nation. It guarantees that hospitals pay housestaff additional salary when they are required to cover for an absent colleague

and busy stage in their careers, they find that being in CIR is an effective way to work together for improvements in working conditions, residency programs and patient care. In addition, established due

benefits, including, in many hospitals, CIR's own comprehensive health and welfare plan.

## What's in a CIR Contract

Negotiated contracts between the employer and the employees are called "collective bargaining agreements." CIR contracts not only document the terms and conditions of employment for housestaff at each hospital, but, very significantly, make enforceable those hard won gains. Because of different local needs and priorities, these collective bargaining agreements vary somewhat from one hospital to another. CIR negotiating committees—made up of housestaff from different departments and PGY levels, working with a CIR staff member—bargain diligently to win the best contracts possible. Among the elements we work to include are clauses covering:

- Salary increases for each PGY level
- Health and other insurance benefits
- Malpractice coverage
- Cap on the number and frequency of on-call periods
- Specific dates for renewal/non-renewal notice of individual contracts
- Vacation and other leave time
- Sick, maternity, and disability leaves
- Fair disciplinary procedures with due process
- Grievance procedures leading to outside, impartial arbitration
- The right to be represented by CIR at negotiations, grievance meetings and hearings
- Protections from excessive assignments of "out-of-title" (non-physician) work
- Prohibition against discrimination based on race, gender, national origin, place of medical education, sexual orientation and age
- Access to one's own personnel records
- Good conditions for on-call rooms and lounges
- Health, safety and security issues
- Program security, ensuring housestaff the right to complete their residency program

- CIR's contractually negotiated Patient Care Funds funnel millions of dollars of hospital funds to the patient care needs that housestaff are best able to identify.
- CIR is in the forefront of efforts to support hospital funding, access to care for the uninsured, and to oppose the ravages of managed care and hospital mergers. We work for quality patient care and superior residency education.

### How Are Contracts Negotiated?

All CIR members are covered by a collective bargaining agreement—a contract between CIR and your employer that spells out your salary, benefits and working conditions. CIR collective bargaining agreements usually cover a two to three year period. Toward the end of that period, housestaff at each hospital decide what to include in their proposals for a new collective bargaining agreement. They also select a representative group of their colleagues to work with experienced CIR staff on the negotiating committee, the group that sits down with the hospital's representatives to discuss the terms for the contract. The committee draws upon a full range of CIR research, legal, media and technical resources, as needed.

After the negotiating committee determines that it has reached the best possible agreement, the members covered by the agreement vote to ratify or reject it.

### CIR Is Run By Housestaff For Housestaff

Each CIR hospital elects its own local leadership. Elected delegates meet regionally to discuss ongoing issues at their hospitals and to focus on healthcare in their regions. At the annual national convention, CIR delegates come together to discuss issues of housestaff concern, set the direction for the coming year and elect a national Executive Committee. This Executive Committee —made up of a president, executive vice president, secretary-

PHOTO: JEANHEE KIM/CIR

treasurer, and regional vice presidents—serves as a steering committee between annual conventions.

## Who Are The CIR Representatives At My Hospital?

In addition to the CIR delegates from each hospital who attend the annual national convention, each CIR hospital, or chapter, has its own structure to determine policy on local matters. Some chapters elect colleagues to serve as co-presidents and department representatives and most choose members to serve on the Medical Board and other hospital committees. Local chapter representatives determine the collective bargaining proposals and negotiations process at their hospital.

CIR assigns a staff person to each of the hospitals it represents. The staff person, called an organizer, helps coordinate chapter activities and assists housestaff communications between departments. The organizer works with delegates and department representatives to insure that the collective bargaining is professionally negotiated and enforced. In addition, the CIR organizer handles grievances and other problems that residents may encounter.

## What Is A Grievance?

One of the ways to resolve disagreements about your rights or conditions of employment is the grievance procedure contained in your CIR contract. Each CIR contract contains a definition, but generally, a grievance is a complaint that your hospital or department has neglected or a right or benefit guaranteed by your CIR contract that is not provided.

Grievances can be filed by an individual or a group of residents, or by CIR, about almost any matter covered by your CIR contract, but they must be filed within a specified time. (Check your CIR contract.) Many grievances are resolved informally in forums such as "labor-management" committees. Once the grievance is in writing, the CIR contract requires that the hospital adhere to specific procedures and deadlines for responding.

All grievance procedures provide for appealing an unfavorable decision to higher hospital authorities. Most grievances not settled at the hospital can be submitted to a neutral arbiter who will render a final decision, which is binding to both sides.

The union contract is also an essential guarantee of your due process rights to review your personnel file, dispute a complaint about your performance, an evaluation, probation, non-renewal, termination or any other problem you may have with your department.

It is important to act quickly when you have a question, or a problem, even if you're unsure about whether it's a grievance or a due process disciplinary matter. Your CIR organizer will assist you in determining the appropriate steps. Also, if you misplace the CIR contract that is given to you during orientation, ask your CIR organizer for another copy. Read your contract and use it.

## What About Dues?

collective bargaining agreements and to run this national organization. CIR dues are set at 1.5 percent of a house officer's salary and are paid through payroll deduction from members' paychecks and sent to the national office of CIR in

## CIR Says, "Check Your Personnel File"

Sometimes adverse letters from patients, hospital staff, or supervisors that make misstatements or are very one-sided find their way into your file. Incident reports and departmental evaluations that you should have been shown (and weren't) often get put in your file.

While the specific language may vary among different CIR contracts, CIR members are guaranteed the right to see and respond to materials put in their files. Most often you are entitled to photocopies.

CIR staff can assist you in deciding what action would be most appropriate in responding to adverse documents. You might want to insert a written rebuttal, or file a grievance to have the document modified or even removed. CIR can represent you in these steps.

With increasingly stringent credentialling and more aggressive malpractice litigation, you don't want any surprises lurking in your file. You initiate the process of examining your record; we can help after that.

Your right to examine your file may be important to your reputation and your career. Use that right to check your file regularly.

filed within a specified time. (Check your CIR contract for the time limit applicable to your hospital.)

Written grievances are usually preceded by informal attempts to resolve the question or disagreement with your department or hospital in

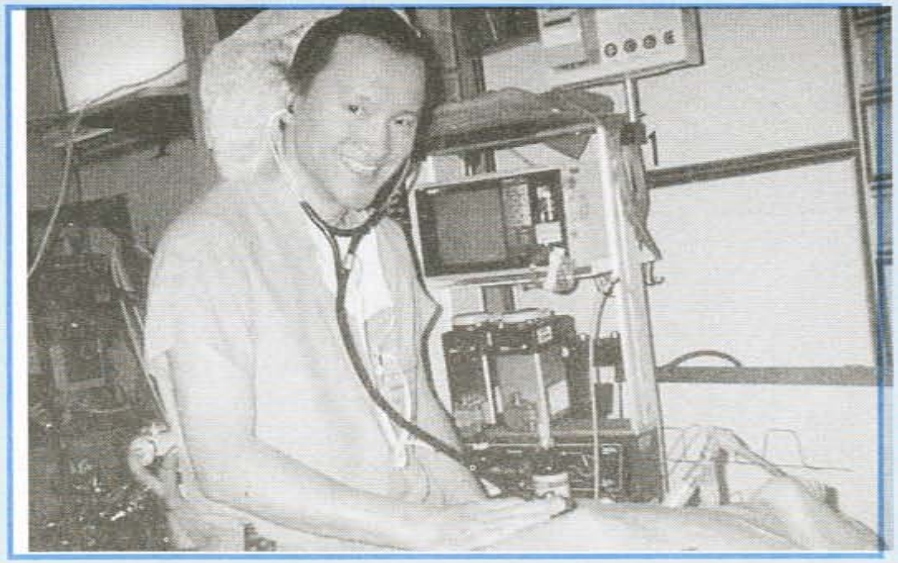
The elected House of Delegates decides membership dues, which provide the only source of income for CIR to pay for staff and all other expenses necessary to negotiate and enforce our

New York City. As with our medical training, so with CIR: the more we as residents stick together, pool our resources and work "as a team," the more we will accomplish and the stronger we will be.

# Patient Care Funds: An Achievement for Residents and Patients

Over decades of collective bargaining, CIR chapters throughout the country have won millions of dollars for Patient Care Funds as part of their contracts. These funds are used to buy essential supplies, equipment and patient amenities that are not included in hospitals' budgets.

"We're the people on the front lines of taking care of patients every day, but we felt that nobody listened to our suggestions and complaints. Now we have some power," said Lori Weir, MD, CIR delegate and chief resident in Radiology, at St. Luke's-Roosevelt Hospital, in New York City. "Now we can say what's lacking, and through our Patient Care Fund, we have



$50,000 in the first year of our agreement, $75,000 in the second and $100,000 in the third to purchase necessary equipment."

Patient Care Funds are an innovation that began in the 1970s with JCIR residents in Los Angeles. CIR chapters have achieved these funds in contracts at hospitals in Boston, New York City, Cambridge, Oakland, and San Francisco. Recent purchases by CIR Patient Care Funds have included bedside monitors, EKG machines, blankets, video fiber-optic endoscopes, pediatric ventilators, high-tech microscopes, computer-based image archiving systems, a cardiac chair (at left), and even a fish tank (above) for use in patient waiting rooms, and clothing for homeless patients.

"A committee of residents oversees how the money is spent," said Weir. "Residents bring proposals to the committee, and together, the committee gets to decide what is most important." It's a way for CIR residents to step in and fill in the gaps in patient care that they see on a daily basis.

PHOTOS: TOP: SANDY SHEA/CIR; BOTTOM: JANE JOSE/CIR

# What's in a CIR Contract?

Besides salaries and health benefits, CIR collective bargaining agreements include many provisions that improve working conditions for residents. Below are some samples of actual contract language in different CIR collective bargaining agreements.

## Limitations on Working Hours

"Housestaff working their 'scheduled 24-hour in hospital call' shall not be assigned normal clinical duties (i.e. clinic, operating room duties, and/or new patient assignments), except under unusual circumstances, following an on-call period.

"Scheduled on-call, in hospital duties should not be more frequent, on average, than every 3rd day.

"When averaged over any 4-week rotation or assignment, residents must have at least 1 day out of 7 free of patient duties."

**Los Angeles County Hospitals**

"Housestaff officers shall not be regularly required to work in-house more than 160 hours biweekly. Housestaff officers shall receive a minimum of 24 consecutive hours off per work week, i.e., duty free, except on those occasions when the medical needs of a patient require transition between the housestaff officer and an oncoming physician.

"Housestaff assigned to the Emergency Room shall not be required to work a total of more than a maximum of twelve (12) hours in any twenty-four (24) hour period and maximum of sixty (60) hours per week."

## Orientation Pay

"All incoming residents shall be paid for orientation and/or work performed prior to July 1st of their first year, or they shall receive equivalent paid time off no later than June 30th of the academic year."

**Boston Medical Center**

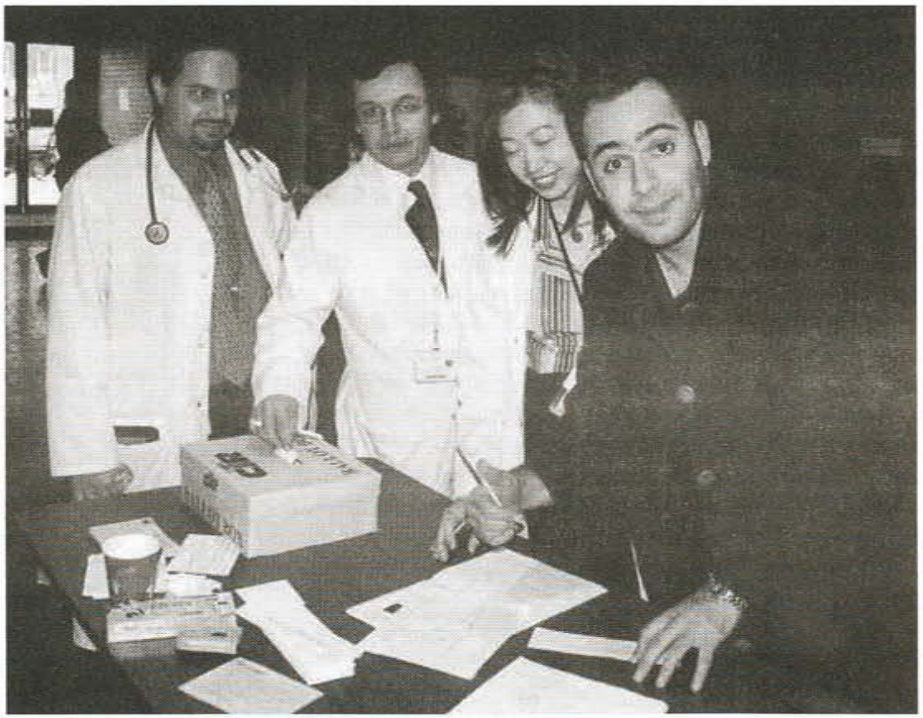
## On-Call Pool

"The [employer] shall fund an extra on-call pool in the amount of $85,000 per annum. If an officer is required to work an extra on-call in excess of the hour limitations set forth above, he/she shall be compensated at the rate of $300."

**Jackson Memorial Hospital**

"A house staff officer who performs on-call duty for an absent or disabled colleague in addition to his/her anticipated normal schedule shall be compensated according to the following: $550 weekday, $650 weekend and holiday."

**Westchester (N.Y.) Medical Center**



## Professional Education Allowance

"...the Trust shall provide each HSO $900 per residency academic year to be used as reimbursement for professional/educational expenses."

**Jackson Memorial Hospital, Miami**

"A $1500 non-taxable, reimbursable professional education stipend shall be paid annually to each House Officer...Any House Officer who has not

**Jackson Memorial Hospital, Miami**

## Ancillary Staffing

"Services will be provided for the movement of patients and materials...seven days a week, 24 hours a day for both routine/stat calls.

"Three daily phlebotomy rounds in all inpatient areas will be provided seven days a week, 365 days a year. Twenty-four phlebotomy was instituted on February 1, 2003.

"IV Therapy Services, to start and maintain routine IVs, will be provided to all general care inpatient areas 16 hours a day, seven days a week.

"Clerical services will be available [on all inpatient areas] 16 hours a day, seven days a week."

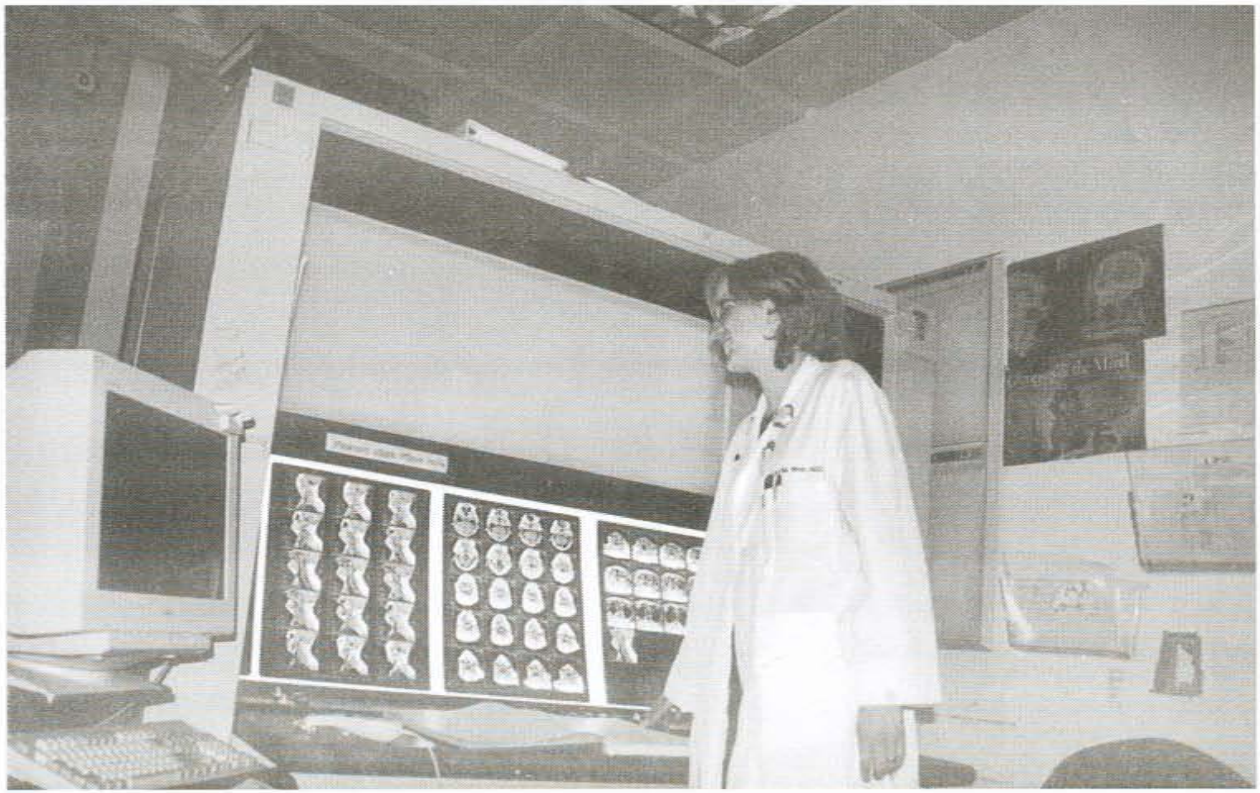
**Boston Medical Center**

## On-Call Rooms

"The County shall provide safe, secure on-call rooms, bathrooms and shower facilities which are readily accessible to patient care areas. On-call rooms shall be designated as smoke-free areas and properly maintained with adequate temperature control. The number of on-call rooms shall be sufficient for all housestaff officers on duty at night.

"On-call rooms shall have functional locks and the room key shall be available to each housestaff officer. On-call rooms shall be properly maintained seven (7) days a week. Where possible, on-call rooms shall be equipped with large-sized lockers for the secure storage of each housestaff officer's personal effects."

**Los Angeles County Hospitals**



BOTTOM PHOTO: CARA METZ/CIR

turned in receipts for the total amount of the annual stipend by May 1st of that year shall receive a payment (taxable) equal to the difference between the total annual stipend and the total reimbursable expenses claimed and documented by said House Officer."

**Cambridge Hospital**

## Patient Care Funds

"The amount of the JCIR Quality Patient Care Fund will be $2.2 million each year. Mutual agreement of the administrative 'team' of 5 and a resident 'team' of 5 shall be required to initiate the authority to expand."

**Los Angeles County Hospitals**

"SFGH agrees to contribute to the Patient Care Fund the following amounts during the Agreement: 2000-2001: $10,000; 2001-2002: $43,000; 2002-2003: $68,000."

**San Francisco General Hospital**

"Effective each April 1st and October 1st, the Corporation shall transfer a sum equivalent to 0.15 percent of the Gross Annual Payroll of housestaff officers to the Patient Care Trust Fund." [This fund, which receives approximately $130,000 twice a year, is controlled by the CIR Executive Committee members in New York City.]

**Health and Hospitals Corporation, New York City**

## Program Security

"In the event of termination of the residency program for any reason whatsoever, the Bergen administration will, to the best of its ability, place their housestaff officers in other accredited New Jersey residency programs. In such event, Bergen will continue to pay the salaries of displaced housestaff officers until they are re-employed in a residency program at another facility, or choose not to pursue further medical residency."

**Bergen Regional Medical Center, Paramus, N.J.**

# Access to Care: The Canadian Experience

*Dr. Joseph Mikhael, a PGY 6 in Hematology, and president of Ontario's* Professional Association of Internes and Residents (PAIRO), *attended this year's CIR Convention. During the open mike discussion on "Do Politics Matter," Dr. Mikhael stepped forward to answer a delegate's question about the biggest problem to be faced with a single-payer healthcare system. Later, CIR News interviewed Dr. Mikhael on the Canadian experience with universal access to healthcare.*

"I come from a system that is universal, single payer, and has no tiers. And despite problems, because there are always problems, the system works. It is tremendously gratifying to function in this kind of a system. I treat a homeless man and a corporate lawyer exactly the same. The Canada Health Act ensures universal healthcare—residents were critical in getting it passed. If you go through the same process as we did, residents in your country will be critical in getting it passed, as well.

"Last year, Roy Romanow, former premier of Saskatchewan, was made Health Commissioner and asked to review the whole Canadian system. We at the Canadian Association of Internes and Residents (CAIR) wrote to him and said, 'If you really want to understand the views of new doctors, come meet us in a hospital in inner city Toronto, at midnight and you can see what a resident's work looks like.' He met us at midnight, and we had the press with us. Each resident gave him one piece of equipment, a pager, a stethoscope, clipboard, coffee, and the rest of the night, we called him Dr. Romanow. We showed him a sample case in the ER, we were able to talk about things like the shortage of physicians and information technology in medicine, who residents are, how we contribute to the healthcare system, and our suggestions for change. Commissioner Romanow did a press interview after his hospital tour, stating that this had opened his eyes to understanding residents, and our view of the system.

"Afterwards, the Romanow Report, which came out last November, stated that, 'If we had any shred of evidence that the for-profit model would improve healthcare, we would recommend it. But we don't.' Our view of healthcare is that we support a publicly funded, one-tier public system. There are pressures in Canada to move towards a more American, for-profit model.

"We did radio interviews together the next day, as well. I did 15 interviews afterwards, and we were on TV, print, and in medical journals. This allowed us to communicate well with politicians and the public, and get our message across. The whole notion of having to tell people, 'I can't treat you because you don't have insurance,' is not something we would want. Philosophically, the Canadian system is one in which people are treated equally. However, even this philosophy can fail if it's underfunded.

Dr. Joseph Mikhael

"We do, of course, have problems with our system. There is a human resource shortage—of doctors and nurses—and that translates into access problems. It's not a problem of a single-payer model, but due to the shortage, there are longer waiting lists in Canada than the U.S. for treatment, but people always have immediate access to acute care. I work in a cancer hospital, and people get immediate access. If you have a heart attack, of course it's immediate. But if you have an elective procedure, that can take a 4-6 month wait.

"The U.S. spends more than we do on healthcare, without covering everyone. There is no question that your system is in a crisis. What I find is that a

## Residency in Canada

In Canada, almost all residents are members of their housestaff organizations as employees of their respective provinces. There are 7 different housestaff organizations federated into the Canadian

Association of Internes and Residents (CAIR), and Quebec has their own organization. While they have collective bargaining, and a grievance structure, they are called professional associations, not unions. There are approximately 7,500 residents in Canada (in the U.S., that number would be about 100,000).

The average resident workweek is approximately 80 hours; the maximum on call schedule in most provinces is 1:4. Many of their contracts state that residents are not to do non-resident work, i.e., patient transport, phlebotomy, etc. Resident "well being" is a major issue addressed by the Canadian resident organizations.

lot of people in Canada are happier to be taxed and to have healthcare, than to have to worry about not being able to provide healthcare for themselves and their families.

"I think physicians do bring credibility—people do trust their doctors—and if we're seen as advocates for our own patients and for a public healthcare system, we'll be heard."

# CONVENTION 2003

Continued from page 4

ment about who would do the surgery. My attending intervened and did the procedure, but he caught flack for it, because there was no insurance. Every moment counts, and we have people sitting around arguing about who's going to pay for it, while this man's belly could explode at any moment," said Lori Weir, MD, a radiologist from St. Luke's/Roosevelt Hospital in New York.

"The biggest impediment to getting resident involvement is that they're really afraid. If they learn that it is okay to rock the boat sometimes, especially when they see all the things it's won them, they become less afraid," said Christine Dauphine, CIR vice president from Southern California.

"Access to healthcare is not merely a matter of government doling out billions of dollars. Everyone should have access to healthcare. But there's a whole political realm to this, problems with malpractice costs rising, and many issues to be worked out," said Joshua D. Lenchus, D.O., CIR vice president, Florida.

## When We Fight, We Win

Despite tough economic times, residents at many CIR-affiliated hospitals have fought for, and won, improvements in their working conditions. At Sutter Hospital, in Santa Rosa, California, a new contract now includes sick call coverage, so that if a resident has to fill in for a doctor who is out sick, he or she will be paid for their work. "It makes you not angry at your co-workers if they need to take the day off," said Vinh Ngo, MD, a family practice doctor.

Reflecting on gains made in Puerto Rico, Alex Agostini, MD, family medicine, said, "As doctors, we are taught to observe, think and act...To get up and face a government is not easy. There are many competing interests, and in politics, the first thing that matters is money, not lives. This is very interesting, because lives are voters, or possible voters. In Puerto Rico, we made the impossible possible. In 1999, we started a movement for resident hours reform, and this year, we won that legislation."

In a workshop on negotiations and contract campaigns, Susan Woo, MD, a pediatric physician from the newly-organized Children's Hospital in Oakland, California, shared their winning strategy: "We involved all different class years of residents, so it wasn't coming from one particular department, or class. It was all the residents, from all backgrounds."

What works when you're trying to make changes? "We need to get together to respond first, and then meet with the administration, or even call the newspapers," said Stephen Martin, MD, family practice, at Boston Medical Center.

"CIR can be a training ground for political activism for those who want organization that is willing to put itself behind all member resident causes," said Neelu Pal, a surgery resident at the University of Medicine in New Jersey at Newark.

"It seems to me that speaking up on the issues has not cost us anything, but has gained a lot...Every time we fight, we win," said Dan Schaefer, outgoing CIR vice president from Southern California.

involvement in creating fundamental changes in healthcare...The spectrum of issues that one can chose to be involved in is wide. The bottom line is that CIR is a very strong and active

**"Think of yourselves as platinum card residents. As CIR delegates, you know everything residents know, plus so much more. Your understanding of the healthcare system will help you every day of your professional life, and will empower you to get things done, in your hospital, and in fixing the healthcare system."**

**Dr. Ladi Haroona, former CIR President**

PHOTO: BILL BURKE/PAGEONE PHOTOGRAPHY

*Fighting (and Winning) An Uphill Battle in California:*

# Funding for Healthcare

Throughout California, hospitals are facing the possibility of closures, service reductions, and layoffs. In Los Angeles County, interns and residents continue to fight an uphill battle to protect public health services. Thoughout the health crisis of the past year, CIR has pushed for stable, long-term funding solutions, opposed any cuts to health, and challenged L.A. County wherever it sought to slash services. More recently, CIR and its coalition partners won legal injunctions that blocked the closure of Rancho Los Amigos Rehabilitation Center, as well as the reduction of beds at LAC+USC Medical Center. Now the fight comes to King/Drew Medical Center, where resident physicians are facing the planned elimination of 79 physician positions and 300 hospital staff positions.

Hospitals across California are struggling with local budget cuts and anticipate steep cutbacks in Medicaid reimbursement rates, which are already the lowest in the country. In this environment, it is no wonder that many Californians, CIR members included, are looking to escape cyclical financial woes by finding comprehensive, longer-term funding solutions. "We must constantly fight for hospitals afloat to care for our uninsured patients," explains Christine Dauphine, CIR regional vice president for Southern California.

## The Bigger Picture

Californians are uninsured at a rate significantly higher than the rest of the nation, according to a number of statewide studies conducted by the Kaiser Family Foundation, the Medi-Cal Policy Institute, and UCLA. Although nearly 20 million Californians have health insurance, employers here provide healthcare at a rate lower than most states. "California has one of the world's largest economies and yet more than seven million Californians lack health coverage. It's simply not sustainable to have so many working people without adequate access to healthcare," said Claudia Zaragoza, a PGY 1 in Family Medicine at Harbor-UCLA. "We have too many patients to treat in the public sector and not enough resources to care for them humanely."

Heeding the call of patient advocates and healthcare workers across the state, two state senators have introduced groundbreaking legislation that would fundamentally change the way in which Californians pay for healthcare. The Senate will


CIR members and elected officers have been actively and successfully fighting healthcare cuts. The latest cuts target Martin Luther King/Drew Medical Center. In photo at left, residents from MLK/Drew rally against cuts.

bill, introduced by Senator John Burton, is a "pay or play" measure that would require employers in the state to provide health coverage to their employees or pay into a state purchasing pool that would purchase healthcare for the employees. The bill, known as SB 2, would hold California basic benefit to their workforce as well as take away the competitive advantage from employers who do not provide health insurance. It passed the State Senate on June 4, 2003, and now moves into the Assembly. "We are not looking to drive people out of business, but we are looking to drive peo-

funding to keep our clinics and public vote on these bills in June. The first employers accountable for providing a ple into the healthcare system," Senator Burton stated last February, just before he introduced the bill.

State Senator Sheila Keuhl is pushing a second bill, SB 921, which would make California the first state in the nation to implement a comprehensive, universal healthcare system. It would redirect state funds that are currently invested in programs like Healthy Families, S-CHIP, and Medi-Cal (California's Medicaid program) into a newly established California Health Care System.

## FROM SKEPTIC TO ACTIVIST

# Christine Dauphine, MD

*Dr. Christine Dauphine, a PGY 3 in Surgery at Harbor-UCLA Medical Center in Los Angeles, California, was elected Southern California Regional Vice President at CIR's May, 2003, Convention.*


"My first encounter with CIR was at our Intern Orientation Week. CIR representatives set up a table with information and gave a brief presentation. When I heard the word "union" I was sure I wanted no part of it! I was *really* upset that I would be in a union and pay money for what I thought was going to be nothing to my benefit!"

What changed Dr. Dauphine's mind was actually getting involved in the organization. Several people recommended that she run for delegate. "I reminded them that I'm a general surgery intern, and time was not something I had a lot of." But she agreed to run, and somehow found the time to make a huge difference, both in gains to her individual hospital, and in standing up against cuts to L.A.'s underfunded public healthcare system.

"I was elected, and started to wonder if I had just made a huge mistake. I had no idea of what I had gotten myself into. But when I went to last year's CIR Convention in Washington, D.C., I first experienced the strength and power of CIR. Most impressive was the regional reports, where each region presented their accomplishments in the previous year. To my surprise, I learned that my region had fought for, and won wage increases, food at night, and call-room improvements! That was when I saw how much power we hold as residents if we organize together.

"I think that as residents, we sometimes feel the system is too big, the administration is made up of people we never come into contact with, and that change is impossible. Who wants to come across as a complainer, anyway? But I realized we do have the strength to change things if we stand together, think of reasonable solutions to the problems we face, and work toward implementing these solutions. One person cannot come forward and say, 'I'm working too many hours' to their program director. But an organization of residents can come up with solutions to the problem and demand changes to the system.

"We've accomplished many things in our hospital, but what we have to be most proud of is fighting the threatened closure of our hospital due to budget cuts. After two months of phone banking, precinct walking, rallies and public testimony, we had an unprecedented 72% of the voters approving Measure B, which ultimately helped to keep my hospital open.

"I would urge every resident to get involved because with every person, we are stronger, and everyone benefits from that. Without CIR we have a very tiny voice, but with CIR, our voice is loud and strong."

*CIR testimony, study cited by judge in opposing healthcare cuts*

## Becoming Part of the Story

It's not every day that an organization can take direct credit for making a change in public policy, but that's the case in Los Angeles, where U.S. District Judge Florence-Marie Cooper cited the testimony of CIR residents, and our study, *Breaking the System*, in her May 8th tentative ruling to prevent cuts at LAC+USC and the closure of Rancho Los Amigos rehabilitation center. "We will continue this fight," said CIR Southern California Regional Vice President Gary Payinda. "We are patient care advocates, and we will not be silenced."

TOP PHOTO: JOHNNY KNOX; BOTTOM: BILL BURKE/PAGE ONE PHOTOGRAPHY