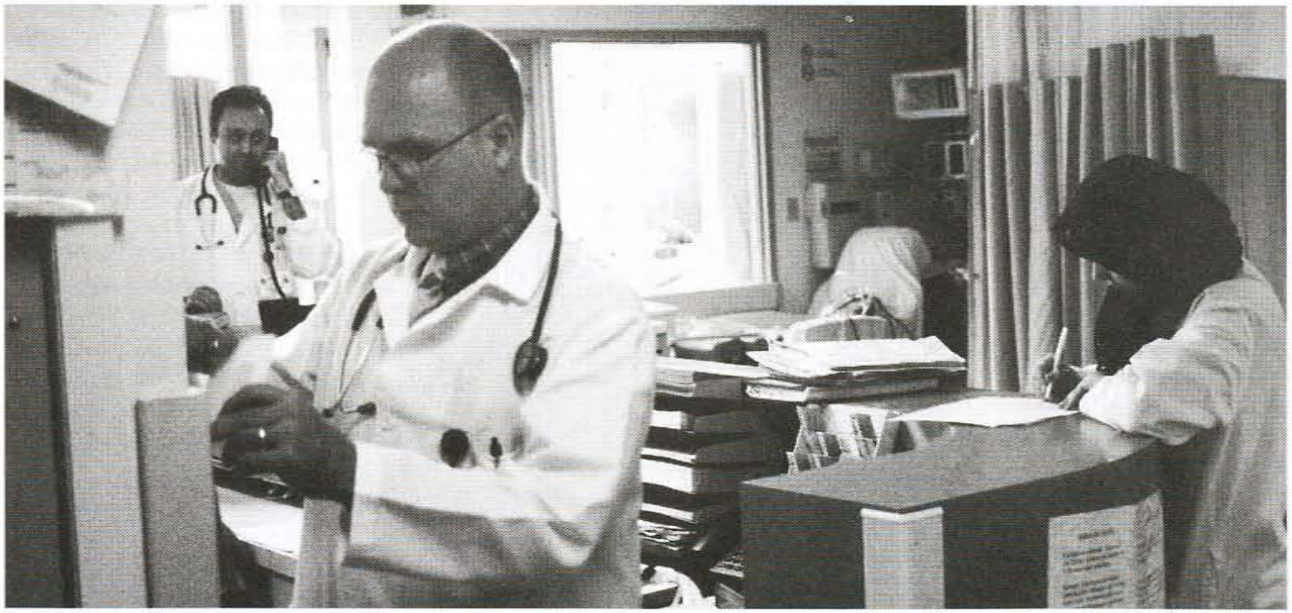
CIR SEIU NEWS

COMMITTEE OF INTERNS AND RESIDENTS September 2003



Hours Reform: Is It Working?

CIR wants to know your experiences with the new ACGME hours guidelines, which went into effect on July 1, 2003. Has your hospital made improvements? Is there still much to be fixed? Tell us, by logging on to our website, at http://www.cirseiu.org and clicking on the button, far right column, on homepage. You can also email directly to hours@cirseiu.org.

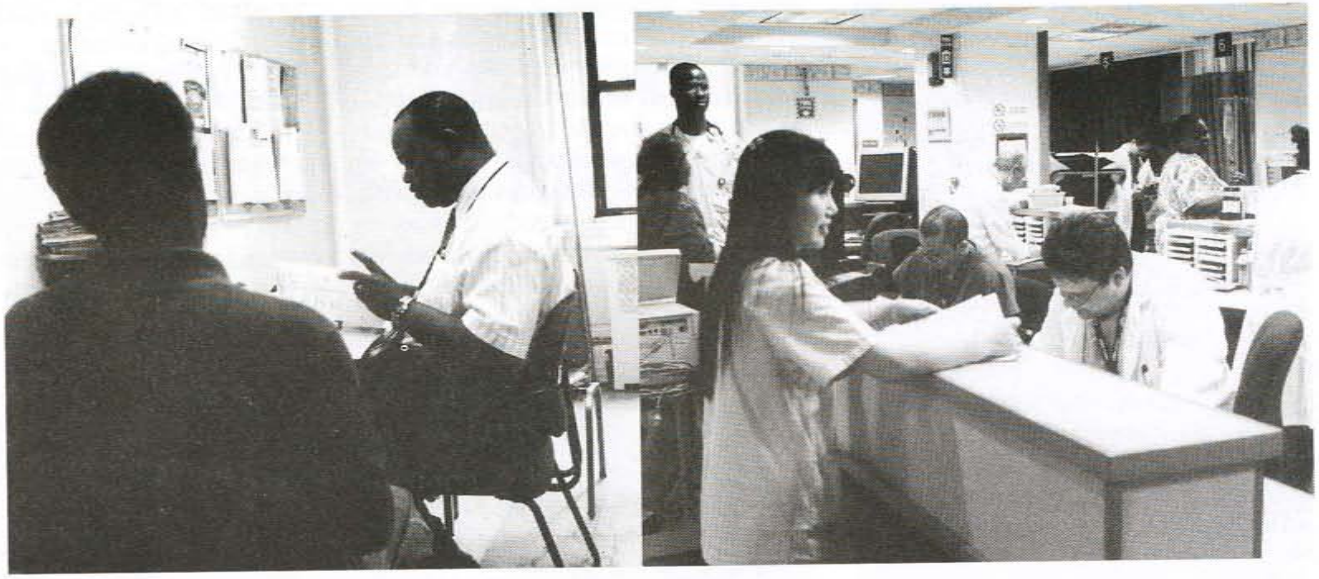
What Health Care Budget Cuts Really Mean

Telling Our Patients' Stories

CIR housestaff are in a unique position to see and hear what's happening to patients as budget cuts wend their way through state after state, and hospitals come under the budget axe. What happens to patient care when there are ancillary staff cuts, or whole departments are closed? With the unique and close-up view that housestaff have on the matter comes a responsibility to stand up for our patients, and for patient care.

If you have compelling stories to tell about how budget cuts, or lack of health insurance have impacted your patients, please contact CIR. Marshalling this information is one important way to fight the cuts. By providing the real life stories that illustrate what these cuts mean to real people, in the real world, housestaff can help shape the national debate that is underway.

Contact CIR with your first-hand accounts by phone at 1-800-CIR-8877 (and ask for extension 157); email to: info@cirseiu.org; or fax: (212) 356-8111, attn: *CIR News*. Remember to include your hospital, and department.



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Ruth Potee, M.D.
President

Angela Nossett, M.D.

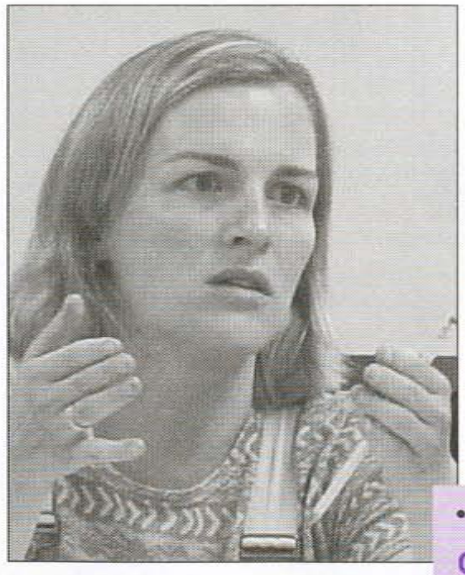
President's Report

Ruth Potee, MD, CIR President

"Student?" No Way!

When I was an intern, the National Labor Relations Board (NLRB) reversed a long held position that residents were "students." The "Boston Medical Center Decision" was a case initiated by CIR and closely watched by everyone in the medical establishment, from hospital CEOs to medical school deans and residency program directors. Winning it meant that residents in private hospitals across the country finally had the right to sit down across the bargaining table with hospital management and negotiate the terms of their employment.

I was surprised by the case at the time—astonished, in fact, that anyone still viewed residents as "students." I had graduated from college and from medical school, and had the diplomas and the enormous debt to prove it. I was the sole wage-earner in the family, supporting my son and medical-student husband. My resident colleagues at Boston Medical Center all received a salary from the hospital as well as benefits such as health and dental insurance, disability, and full malpractice coverage. We worked all day, every day providing medical care to our patients. Our patients saw us as "their doctor" not as "their student-doctor." "Student-doctors" were medical students—paying tuition, attending classes, receiving grades, and not yet having received the title of Doctor.



Our patients see us as "their doctor" not as "their student-doctor."

Our first priority in the hospital was the care of the patient. Pre-potential for free food) but was riddled with residents darting in and out, answering pages, and running to codes. The care of the patient and the learning that is associated with the direct care of that patient is the highest priority for a resident. Medical students—who pay a heavy premium for the luxury—could stay in lectures or conduct a two hour-long history and physical exam. Residents were doctors with on-the-job training.

The BMC decision made it clear: residents are employees who also happen to be learning. We are both students and workers. The dual role of doctor and student does not end with the completion of residency. We are both students and practitioners of medicine until the day we retire. We rely on the presence of senior residents and attendings in the hospital the way anyone who is new to a profession relies on their more experienced colleagues: they are there to provide wisdom and guidance, training us in our selected career.

Four years later, the BMC decision still stands. There are many, however, who would relish its fall. The ACGME and the AAMC have gone out of their way to demonstrate their contempt

paid full federal and state taxes, including contributing to our Social Security. The two CIR hospitals in the city set the salary and benefit standard for every other teaching hospital in the area, thanks to collective bargaining and resident activism.

My resident colleagues and I were doctors. We had our medical or osteopathic degrees and initial licenses. We

rounding in the dark winter months involved collecting vital signs and determining whether your patients were "stable enough" for you to attend Morning Report. If a patient was "unstable," you would call your senior resident and stay at their bedside providing medical care. Noon Conference had a slightly higher attendance (partly because of the

for the notion of residents as anything other than students. They would rather turn back the clock to a time when hospitals and residency programs had complete control over the decisions that govern our working life without knowing or caring how those decisions impact residents. But we must, and we will, continue to make our voices heard.

CIR's Executive Vice Pres., Dr. Angela Nossett Appointed to Council on Graduate Medical Education

Dr. Angela Nossett, CIR/SEIU executive vice president and family practice physician in Los Angeles, was appointed by Tommy Thompson, U.S. Secretary of Health and Human Services, to a four-year term as a member of the Council on Graduate Medical Education (COGME) effective September 17, 2003. COGME advises and makes recommendations to the U.S. Department of Health and Human Services and to Congressional committees regarding the state of graduate medical education, the physician workforce, and ways in which the federal and private sectors can address identified needs.

Nossett, who was appointed to the 17-member Council as a representative of labor, will be joining government administrators and representatives of medical and specialty teaching institutions, health insurers, business and labor groups. Dr. Nossett says her goals are to "analyze how GME policy impacts residents and other health care providers as workers, and to meet the challenge of improving access to health care for the underserved, and increasing the diversity of resident physicians."

Dr. Nossett brings years of experience, from a variety of perspectives, to her new position as a COGME member. Prior to becoming a physician, Dr. Nossett was a home health care worker. Born and raised in Southern California, Dr. Nossett did her undergraduate work at UCLA, and received her medical degree from the University of Illinois at Chicago. She rapidly took on a position of leadership in CIR among her fellow resident physicians. In her capacity as a family physician in a public hospital, Dr. Nossett, who is Latina and Spanish-speaking, combines professional commitment with leadership in the fight for access to health care for all.

Bellevue Residents Band Together for Safe Angiocatheters

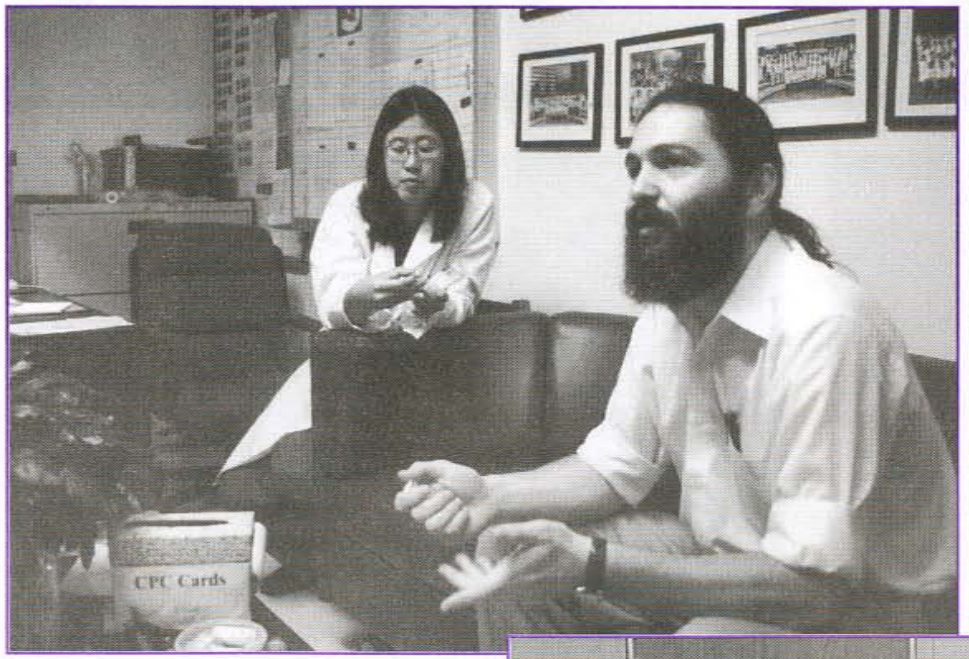
Perseverance Brings Results

Residents at the largest and oldest public hospital in New York City had a rude awakening when they walked in to work one day to discover that the angiocatheters they were accustomed to using were no longer there. In their place was a new product that was both more difficult and dangerous to work with.

According to Shelly Mazin, Director of Safety for Bellevue Hospital, "We put a product into play housewide, and not long afterwards, we were getting a lot of complaints, including a CIR petition." After hearing the residents' complaints, hospital administration agreed that changes were needed. Working together, administrators and residents began a process, now near completion, of evaluating what products are available, and seeing which best meet their needs.

Dangerous to Residents, Painful for Patients

"We tried to give it a chance. Usually when there's a change, people don't like change, but this is a bad product. The new catheter doesn't have a safety button like the previous



Captions: At left, Dr. Jennifer Lin, of Internal Medicine, and Dr. Greg Mintz, chief resident in Internal Medicine, discuss the hazards of the current angiocatheters. "Accidents happen when you're rushing all the time," Dr. Lin said.

Below, Drs. Adam Trosterman, Medicine, Moira Davenport, Emergency Medicine, and Rahul Sharma, Emergency Medicine, holding a larger-than-life version of the petition that brought the problems with the new angiocatheters to Bellevue's attention, and led to a successful group process to find a better product.

"If residents get together, we can

the administration, and in one week's time, got more than 135 signatures on a CIR petition asking for a different product. "We also decided to file incident reports every time it took more than two sticks to use these angiocatheters," Dr. Sharma said.

Dr. Michael Liang, a PGY 3 in Anesthesia, who was stuck by the blunt end of the new angiocatheters, says the retractable model is better.

make change. That's what we've done here."

—Dr. Rahul Sharma, Emergency Medicine

one. They said it had a blunt end, but it isn't. It could penetrate the skin," said Rahul Sharma, M.D., a CIR delegate, and PGY 3 in the Emergency Department at Bellevue.

"The manufacturer says there's an eight-month training period. I don't think a patient needs to be a pin cushion for that. It can take five or six tries to get it in," said Adam Trosterman, M.D., also a delegate, and PGY 3 in the Internal Medicine Department.

Faced with a product that was difficult to use, potentially dangerous to residents, and more painful for patients, residents banded together to address the problem. They met with

"It would minimize the possibility of needlesticks," he said. Dr. Jennifer Lin, a PGY 4 in Medicine, has complaints about the difficulty of using the new product both as a doctor, and as a patient. When she was sick and had to have an IV line put in, "it hurt. It's such a basic thing: the more you have to fiddle and the more time it takes to insert, the more anxiety and pain for the patient."

"This new angiocatheter is more difficult to use for arterial lines (A-lines)," said Dr. Diana S. Jose, a PGY 3 in Anesthesia. "It's harder to thread the catheter off, because it's softer, and it kinks. If you have to stick the patient again, you can get stuck yourself. The problem is, we need different catheters for different things. The bottom line is, we need more choices."

Involving Residents in Decisions that Affect Them

"We were trying to use a device for more tasks than it was really effective

for," Safety Director Mazin said. "It may turn out to be the case that we need a separate device for the A lines, to improve patient care. We have had more communication and more active presence from CIR in this product evaluation than before. It was cooperative, we all approached it from a patient care angle. This was not an adversarial process. We don't want injuries to providers, we're all here to do the best we can. We'll have a greater presence from residents now, and I think they've gained more understanding of the hospital's process. It's a positive thing to involve residents in the decisions that affect them."

Making Change

"This should be a stepping stone for getting the necessary equipment for thoracentesis, paracentesis, spinal taps and A-line placements," said Dr. Trosterman. "We have no spinal tap kit—you have to grab pieces from four different places. You may grab a needle from one floor, a tube from another, sterilization from a third place, and Lidocaine from a fourth. It

"This was a cooperative process. We'll have a greater presence from residents now."

—Bellevue Safety Director Shelly Mazin

can take an hour to assemble the parts. We should be just opening up a kit," Dr. Trosterman said. Ultimately, in his opinion, "we learned how residents can get things done."

"I feel so strongly that this is a safety issue," said Dr. Sharma. "If residents get together, we can make change. That's what we've done here," he said. "The issue could have completely died out if we didn't stay with it."

Safe Needles

The movement for safe needles came to a successful resolution in the year 2000 with passage of legislation mandating the use of needles that automatically retract, are blunt, or covered. The need for this legislation was apparent, with OSHA estimating 600,000 to 800,000 needlestick injuries to health care workers a year. More than 1,000 health care workers a year contract potentially fatal diseases such as Hepatitis C or HIV, according to OSHA.

SEIU was in the forefront of the national campaign to protect health care workers with safe needle legislation. CIR has also been long involved with the issue, and in 1994 produced a video called, "Defending Your Life: Technologies to Make Doctors' Work Safer," which was written and directed by Dr. Richard Levitan, who was a resident at Bellevue at that time.

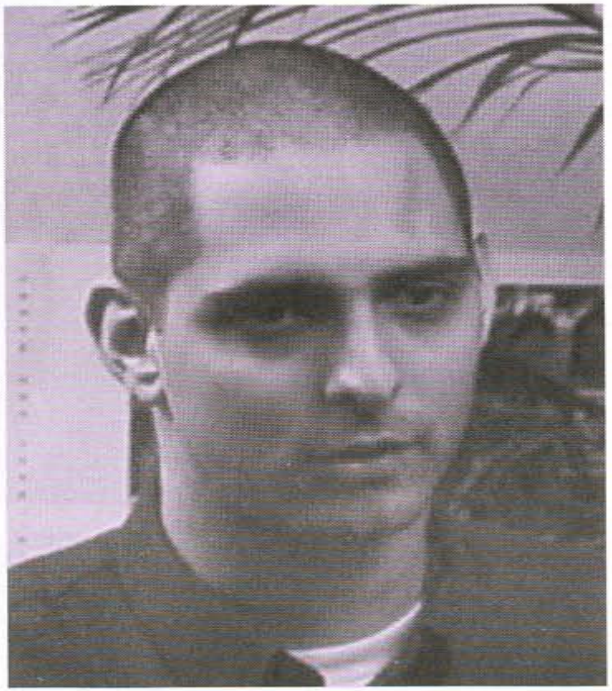
PHOTOS: CARA METZ/CIR AND PAT FRY/CIR

PHYSICIANS SHARE

DOCTORING DURING A TIM

Just as any generation entering the same profession at the same time will share certain experiences, for CIR members today, that means struggling to provide care to our patients in a time of severe budget crisis. Budget shortfalls have hit all states and all hospitals, some harder

Dr. Harmit Kalia
PGY 2, Internal Medicine
New Jersey



Dr. Arun Chopra
PGY 3, Pediatrics
Washington, D.C.

than others. What that means for residents as doctors, what it means for their patients, and for the country, was explored recently in a series of videotaped interviews with CIR delegates and representatives of Doctors Council/SEIU, the attending physicians union. Here are some excerpts:

"I certainly wasn't taught about the health care crisis in medical school. We were just taught about the diseases—this is how patients present, and that's how you treat them. And then, when you finally end up in the hospital, you have to deal with the bureaucracy of the administration, and of the HMOs. I am just learning how that affects my job on a day-to-day basis. It becomes very difficult with the cutbacks. We rotate through the Veteran's Administration (VA) hospital, and interns and residents are basically responsible for drawing the blood, and doing all the work that someone else should be doing, on top of providing care for our patients. It's very, very stressful.

"I feel I am doing more of a social work job—all the things that a patient needs in an inpatient setting, phlebotomy, social work, dietary counseling; because of the cutbacks, a resident or intern has to provide those services, although we're not trained for it, but who else is going to do it? There are people on the ancillary staff, but they are limited in terms of resources.

"Let me give you an example. I was on-call yesterday, and in the emergency room, we had a patient who came in and had to be put on dialysis. We took care of him, and when it was time for him to go home, he couldn't, because the social worker could not be found. All the patient required was a ride home. Two of the residents chipped in, put up $12 each for a cab ride home. Think of the cost that would have entailed if the patient had to stay overnight in the hospital because the social worker wasn't there [to do the discharge]...nursing care costs, phlebotomy, doctor costs, cleaning costs, if you add it up, it's thousands of dollars. But the hospital doesn't look at it like that, they look at it, 'we can't afford another social worker.'

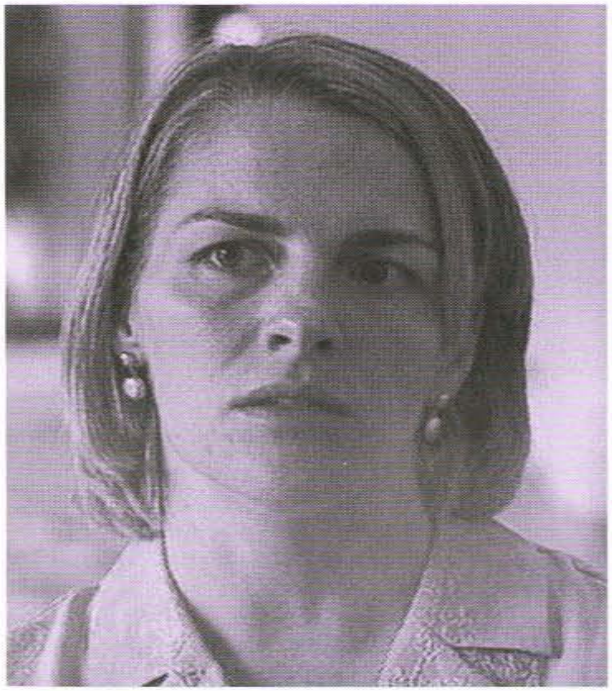
"In talking to my colleagues from other hospitals, the general consensus is that we're not getting our job done the way we would like. And that's things like services being cut, hospital patients not being able to afford medications...How can I do the right thing for a patient if she cannot afford medication?"

"We see a lot of tragic cases, where someone isn't insured or doesn't know that they are insured. All pediatric patients should have government coverage, but people don't know that, or don't know how to get it. There are a lot of barriers between the theoretical, 'you are covered,' and getting the paperwork through so that you really are covered. If you don't know how to navigate that system, or don't speak English, you may never learn that. I had a patient who was 13, and he had groin pain for about a week. His family delayed coming to the doctor because they didn't have the money. He had a condition that if you catch in the first 48 hours, is treatable; if you don't, you can't treat it, and in essence he lost a testicle and may be permanently sterile. That was an entirely preventable situation.

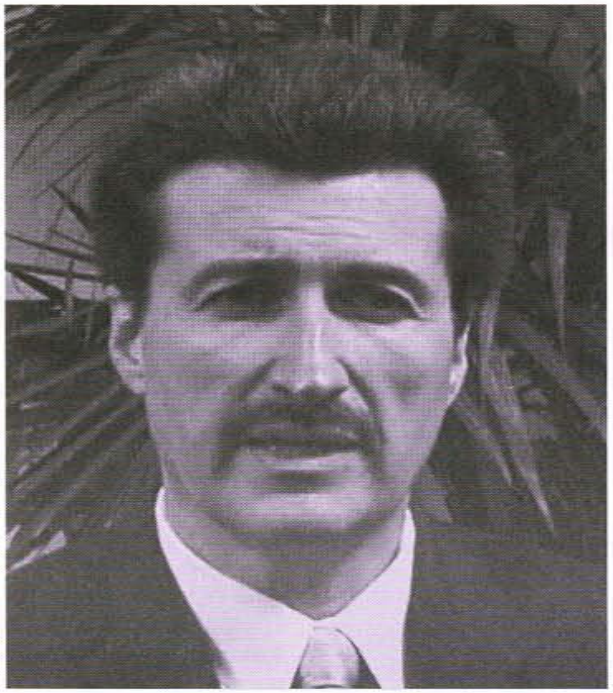
"People are starting to listen, and starting to realize that this is a system in crisis. It's not just that it's the right thing to do, that we should pay for everyone to have health care. It's not just that in a rich, industrial nation, it doesn't make sense that we have people who can't get basic healthcare. People are realizing that the whole system of medicine needs help, or it's going to collapse. The way medicine used to be practiced is not happening anymore. The doctor doesn't have time to spend with the patient, or they have to see so many patients to maintain their practice. We see more and more practices going under, we see crises in malpractice insurance....The doctor's job is to advocate for their patient. I wouldn't classify myself as an activist, I never pictured myself being that, but I think that all doctors are beginning to realize that we need to advocate on a national level. It's a question of doing what we signed up to do, which is advocating for our patients."

THEIR EXPERIENCES:

ME OF HEALTH CARE CRISIS



Dr. Ruth Potee
President, CIR/SEIU
Family Medicine, Boston



Dr. Frank Proscia
Executive Director,
Doctors Council/SEIU, New York

Dr. Claudia Zaragoza
PGY 3, Family Medicine,
Los Angeles

"In training to be a doctor, I anticipated the terrible long hours. I anticipated dying and death and illness and sadness. I didn't anticipate feeling like I couldn't come close to meeting the needs of my patients every single day. There is nothing that feels worse to doctors than feeling like you can't actually provide the care your patients need. I don't think anybody likes to care for a patient, hand them a prescription, and think to yourself, 'I know there is no way they can afford to fill that prescription.' The intention of your entire occupation loses its purpose and utility in that situation.

"In Massachusetts, 50,000 people were taken off the Mass Health rolls, the Medicaid coverage for the uninsured. Benefits that previously had been covered under Medicaid no longer are. A patient had all her teeth removed because they were in bad shape, and she knew that she would be losing her dental benefits as of April 2003. But what she hadn't understood was that there was no longer a denture benefit. So here is this woman who has no teeth in her mouth, and no ability to get dentures. She developed abcesses in her mouth that affected her bloodstream. She became very, very ill, and suffered a complete body collapse. She has now been cared for in the intensive care unit for several weeks, at a huge expense, all because the system wouldn't pay for dentures."

"With the problems in healthcare today, the economy and the budget, I truly cannot function the way I would like as a professional in psychiatry. We are mandated to discharge people faster, treat people with stock medications versus the more cutting edge drugs that are more expensive. A lot of times, I do discharge patients faster. Would I like to keep them longer? Yes. It's one thing to stabilize a person for one day versus seeing a person for a week to be sure they really are stabilized.

"If you look at health insurance, most of mental illness is not carved out with parity compared to other illnesses. If I break my leg a hundred times a year, they will treat me a hundred times a year, and pay for it. With mental illness, there are only 25 visits a year, or it's $50 a visit. They cut it out because they don't want to spend the money on it. That is the shame of it all.

"As health care changed, I saw the almost criminal intent of robbing people of the right to health care. I just couldn't stand aside and get by treating people the best I could with the limited resources I had. I now predominantly spend my time with union affairs, trying to promote fair and equitable health care for everybody."

"I think every doctor wants to treat every patient appropriately, and some doctors have more advantages than others. Unfortunately, I am in a system where the advantages aren't there. In L.A. county, 11 clinics were closed this year already. A clinic patient was in generally good health, but he started having blood in his urine. As part of that workup, he was referred to a urology clinic to rule out prostate or bladder cancer. With the (health care) crisis, the specialty clinic referrals take much longer than they used to. It used to be a month, now the intervals are longer. Eventually, the patient ended up coming into the hospital with renal failure that was the result of bladder cancer. Had it been treated earlier, it may have been prevented, but now we are looking at cancer spread to the kidneys, that has metastasized.

"If I want an MRI or CT scan, a lot of times, I'll feel compelled to send these people to the ER, because you know it will actually be done. Whereas 3-4 months later, it may be too late. You know you are adding to the bottlenecked ERs, and they won't appreciate all that work. But we're trying to treat people here, and what else can we do? We're kind of stuck."

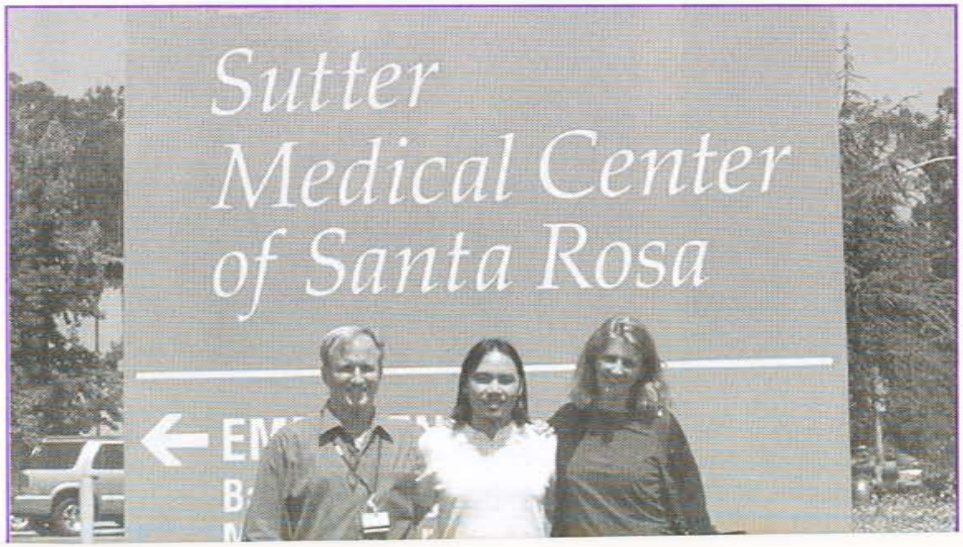
CIR Website's New Look

By the end of September, CIR will have launched a newly-designed website. Log on to www.cirseiu.org and you'll find a whole new look, with a broad array of news and information of interest to residents, including CIR benefits, and other resources.

Contracts 2003

Innovative Contract at Ca.'s Sutter Santa Rosa:

Inspiration!



- Book and education fund of $1,200 a year in non-taxable income;
- All meals paid;
- Orientation at fully paid salary of $770/week;
- Pay hikes of 5.5% in first year, and 14.5% over five years of contract, with first year residents receiving an impressive 11.5% increase;
- Increased elective away time—four weeks of working in another country, or another part of the U.S.; previously offered to PGY 3s, now offered to PGY 2s as well;
- Bilingual pay differential of $1,500 per year to Spanish speaking residents.

"A lot of people were anticipating cuts when we started negotiating," Blackledge said. "But we got a salary increase. People were very surprised with what we got...But if our salary was cut even 5%, that would have created an unbelievable amount of hostility. I was able to show administrators that it would be a disaster to save $25,000 overall, but lose residents.

es are filled out and paid for is huge. These forms are a pain to do. It's wonderful for us, and it makes sense for the hospital, because there are some residents who don't do it on time, or mess it up and don't get their licenses on time. This way, it's streamlined, one person who knows how, does it for all residents. These kind of little things can have a huge impact on resident lifestyle," Blackledge said.

For Dr. Vin Ngo, a PGY 3 in Family Practice, who was also on the negotiating committee, the sick call benefit was very important. "Sick call pay makes you not angry at your coworkers if they need to take the day off," he said.

For negotiating team member Dr. Win Bertrand, a PGY 2 in Family Practice, the contract overall is, "pretty awesome. For us, it's not just the salary, but the ability to get paid for moonlighting and sick call that makes a difference. The flexibility of our program is astounding. There's a lot of room to live and breathe and work."

Elective away is another very pop-

Sutter Santa Rosa's negotiating team and CIR delegates, from left to right, Drs. Aaron Blackledge, Vin Ngo, and Jessica Stanton.

In difficult economic times, how can residents negotiate a contract with new and innovative clauses, and better pay and benefits than ever before? How can they do so in a state like California, which has been experiencing the worst budget crisis of any state in the nation?

"Many of the benefits are things that may not wind up costing that much in dollars, but are a huge morale booster for residents."

—Dr. Aaron Blackledge

It sounds counterintuitive at best, but that's just what the 36 residents accomplished at Sutter Santa Rosa, a small community hospital in Northern California with a Family Practice program, when they approved their new contract on June 29, 2003.

"My job was to look at [negotiations] creatively, to make our hospital more attractive to residents, so that we would be able to compete in this residency marketplace. Family Practice has experienced a large decline in the last three years....If we were to slip and not be competitive, it could hurt us and the hospital a great deal," said CIR delegate Dr. Aaron Blackledge, a PGY 3 in Family Practice, who led the CIR negotiation team.

"I have a practical interest in policies and systems....Some people like gossip. I like to know how things work. I'll sit at lunch and ask administrators how things are working," Blackledge said.

His ability to see the big picture and find common ground between the interests of residents and administrators, led to some remarkable achievements in the newly-negotiated contract. "I saw the large amount of work my predecessors had done to make ours a progressive contract," he said. "I felt that the building blocks were there to make a benchmark contract that can serve as an inspiration to residents across the country as they go to the negotiating table fighting for benefits."

Here are some highlights of the new contract:

- Sick-call system in which residents who are called to fill in are paid $40 an hour;
- California Physician's License filled out and paid for by the residency ($1,000);
- Moving expense allowance for new residents of $1,000;

Our interests and the hospital's interests were really aligned."

"Many of the benefits are things that may not wind up costing that much in dollars, but are a huge morale booster for residents. The fact that the forms for our medical licensular benefit, he said. While most programs have it only in the third year, at Sutter Santa Rosa, residents can take advantage of this program in both the second and third years, which has been a draw for prospective residents.

7-month Negotiation Yields Wages, Other Gains

Turning it around at N.Y.'s Jamaica and Flushing Hospitals

On April 17, 2003, residents at Jamaica and Flushing Hospital Medical Centers, located in Queens, New York, ratified new contracts that come with wage increases of 8.5% over the year-and-a-half life of the agreement. Both hospitals belong to the Medisys network. Previously, the two hospitals negotiated separately; by joining forces and negotiating together, they doubled their strength at the bargaining table.

The 8.5% increase insures that the hospital is squarely within New York salary ranges. The new contract is set to expire on October 31, 2004, which is the expiration date for a group of more than 10 voluntary hospitals in the area.

"Despite what seemed intolerable delays between negotiating sessions at times, we were able to maintain support and pressure and reach the end of this marathon," said CIR New York Vice President Steven Celestin, M.D., PGY 3, Family Medicine. "Thanks to the collective voices of residents, significant gains were made with additional on-call pay, computer/internet resources, increased conference reimbursements, and a cap on parking costs," Celestin said.

The lengthy seven-month negotiating process took its toll, as frustration mounted among residents about the delays. To show management their feelings, residents wore armbands and signed petitions to signify their solidarity. "Being part of the negotiating process was an invigorating and enlightening experience," Dr. Celestin said. It was gratifying, he said, "to sit across the table and engage in reasonable discussions meant to improve the working lives of our hospitals' hardest workers."

PHOTO: ELIZA BATES/CIR

At UMDNJ in N.J., After a Grueling 8 Months,

Exhilaration!

The negotiating process "was extremely educational for me," said Dr. Wah Lee, a PGY 4 in Physical Medicine and Rehabilitation at the University of Medicine and Dentistry of New Jersey (UMDNJ) campus in Newark. "I've never entered negotiations at this level before. Watching the people we're negotiating against say, 'No, no, no,' all through, and at the end hearing them say, 'yes' was an exhilarating experience!" Negotiations began in September of 2002 for the statewide agreement that covers 1,150 resi-

"Watching the people we're negotiating against say, 'No, no, no,' all through, and at the end hearing them say, 'yes' was an exhilarating experience!"

Dr. Wah Lee

it's very important to be able to go home and read textbooks. We would have lost that allowance without negotiating hard for it," she said. The book allowance is improved in this new contract because while you must hand in receipts, it is now non-taxable.

"We also won payment for orientation. Prior to this, the week-long orientation was not reimbursed, which is kind of absurd," said Dr. Lee. "In any other field, you would be paid."

Other gains included:

- Pay for working additional on-call shifts beyond what is published in the call schedule;
- conference reimbursements as mandated in the contract, not just at the discretion of each individual department;
- a new procedure where residents submit a written request for comp time if they work on holidays, and if there is no response, or it is not approved, they will automatically get paid for that holiday; and
- UMDNJ picking up the expense for New Jersey state licenses for resi-

The UMDNJ negotiating team, from left to right are: Drs. David Cennimo, CIR N.J. Vice Pres. Paulo Pinho, Harmit Kalia, Sonya Knight, Marcus Rivera, and Wah Lee.

their PGY 6 year, as mandated by N.J. state law. Licensure ranges from $700-$1,000.

"Negotiations were a bit intimidating at first," Dr. Knight said, "but got better in time. It was a wonderful learning experience. I wanted to know more about what goes on in a hospital. A lot of times, you complain without knowing what's involved, the reasoning behind things. I hear residents complaining and I like the idea that I can be helpful.

Lee. "I've been telling others to get involved. Too often, we hear things like, 'You will be competing with each other from this day forward, forever.' Administrators said that to my class on the first day of medical school. I can't understand why the medical field has to be so competitive against each other. There are jobs enough for everyone, do you know any doctor who can't find a job? I think CIR provides a platform that fosters the opposite thinking—teamwork and soli-

dents, and the contract was ratified in June, 2003.

"They originally offered us 0% wage increases over three years," said CIR N.J. Vice President Paulo Pinho, "but then moved quickly" on the last day, agreeing to a solid 8.2% over the three-year contract, which expires on October 31, 2005. "It all came together on the last day of negotiations," Dr. Lee said. "Our requests were not unreasonable, and we didn't lose our stamina while defending our positions."

A new addition to the contract was the regulation of work hours. "That was very important," said Dr. Sonya Knight, a PGY 3 in Neurology, who was also on the negotiating team.. "Not only is the ACGME saying we have to follow these hours guidelines, but our own contract says it. It makes people more secure because it's in the contract." Because hours legislation has not yet been passed in New Jersey, it's even more important that it is part of the contract. This means that complaints can be resolved internally, without having to call in the ACGME. These gains, "took a lot of pushing," Dr. Knight said. "We had to show how important it was to a lot of the residents. You have to go for what you want, because if you don't, you won't get anything."

In addition to the pay increase, another major gain was an improved book allowance, "which they were proposing to take away completely," said Dr. Pinho, a PGY 4 in Internal Medicine/Pediatrics. "Administration said 'since a lot of things are online now, you don't have to worry about reading a book,' said Dr. Knight. "But

dents if their training program requires a license prior to entering

tions was very empowering," said Dr.

clarity. We need more of this if we are to survive as a profession."

Cambridge & Boston CIR Contract Negotiations in Progress

As the *CIR News* goes to press in late August, CIR housestaff in Cambridge and Boston are knee-deep in contract negotiations at their respective hospitals. Both hospitals have long histories of collective bargaining—BMC since 1969 (when it was known as Boston City Hospital) and Cambridge since 1976.

At Cambridge Hospital, bargaining began in mid-May with hopes of a quick settlement, but the state budget fight on Beacon Hill slowed the process down to a crawl. The CIR negotiating team, representing some 80 residents at the public hospital, will resume in mid-September. Hours language and economic concerns are paramount, as the greater Boston area rivals New York and San Francisco for the highest cost of living in the nation.

BMC negotiations for a new contract began in mid-July for the 600 residents at this private hospital. Ancillary service and hours language improvements are at the top of the list, as well as improved economics. Both the BMC and Cambridge negotiating teams are painfully aware of the Association of American Medical Colleges (AAMC) data that the average indebted 2002 medical school graduate (83.5% of all graduates) was burdened with med school debt of $97,000 and 18% of all 2002 med students owed $150,000 or more. Both CIR teams surveyed their members prior to the start of negotiations and found similar rates of indebtedness.

Cambridge Hospital and Boston Medical Center are premier safety net hospitals, providing the majority of Medicaid and free care to diverse patient populations in the greater Boston area. As such, they are particularly vulnerable to the state's budget crisis, which threatened to decimate the reimbursement rates at the two hospitals this past spring. Thanks to intensive lobbying by the hospitals—with help from CIR housestaff who organized a 'Lobby Lunch' and several rounds of calls to state senators and reps—the worst of the cuts have been avoided, at least for now.

Members of the BMC Negotiating Team (from left): Drs. Lamont Clay, Matt Turner, Erica Bernstein, Liz Frutiger, Steve Martin, Sannee DelRosario, Rafael Sanz and Mike Levitt.

PHOTOS: (TOP) SHARON MCALEAVEY/CIR; (BOTTOM) SANDY SHEA/CIR

In California, Threats Move North

Residents Fight Cuts in Oakland

CIR members at Highland Hospital in Oakland, California, have been fighting hard against proposed cuts which would leave a gaping hole in the Bay Area's safety net. With signs, rallies, press interviews and participation in hospital finance meetings, the residents are determined to alert the public to the dangers they will be facing if proposed cuts are not averted. The publicly funded Alameda County Medical Center (ACMC), which Highland Hospital is part of, has a $45.7 million budget deficit.

"Our ability to provide comprehensive care is eroding. People, including those with chronic conditions, are losing primary care doctors that they had had, in some cases, for over a decade. We will see increased Emergency Room visits and hospital admissions that could have been prevented," said Dr. Gènéve Allison, CIR delegate, and chief resident in the Internal Medicine Department at Highland Hospital. "This will further strain a system that is in crisis."

The Alameda County Medical Center, like other public facilities throughout the country, is suffering from rising health care costs, combined with less funding from federal and state governments. It is a lethal mix. "People will fall through the

From left to right, Drs. Corinne Widico and Jeremy Graff, of Highland's Emergency Medicine Department; Drs. Gènéve Allison and Amy Matecki, chief residents, Internal Medicine; are joined by Drs. Susan Wu and Elizabeth Shashaty, of Children's Hospital Oakland, in fighting proposed cuts to the Bay Area's public safety net.

announced that it is auditing the finances and management of ACMC. Meanwhile, CIR members are continuing to search for ways to ensure access to health care for the under-

HHC Patient Care Trust Fund

Improving the

cracks. They will get sick, and they will die," delegate Allison told *The Oakland Tribune*.

In late summer, the County's Board of Supervisors agreed to provide short-term funding to keep all services open. The Board also served, in coalition with other unions and community organizations. They are considering the strategy of a ballot amendment, such as Measure B, the bond measure that was successfully passed in the L.A. area to fund much needed emergency care.

CIR Members in L.A. Take Part in Presidential Roundtable on Health

CIR housestaff leaders Drs. Matthew Deutsch and Shahla Modir attended the first in a series of SEIU-sponsored roundtable discussions on health care in Los Angeles this summer. The series, which California union leaders hope will include all presidential candidates, began with Congressman and presidential nominee Dick Gephardt (D-MO), who discussed his proposal for extending health care coverage to the uninsured. Rep. Gephardt listened to the 30 health care workers in attendance describe overcrowded hospitals, a nursing shortage, skyrocketing health care premiums, and the legal pressures that physicians and nurses face.

"We have to push all of our elected leaders—and those running for public office—to finally and decisively find a way to provide health care for all."

—Dr. Matthew Deutsch

Dr. Deutsch, a PGY 3 in Emergency Medicine, said he is not yet sure which candidate has the right prescription for American health care but he is sure that the health care system needs some strong medicine. "We have spent the last year fighting to keep the County health care system intact and to preserve access to health care for our patients, but we are not making gains. We fight to keep what we have, when what we have now is nowhere near enough to serve this community. We have to push all of our elected leaders—and those running for public office—to finally and decisively find a way to provide health care for all."

Improving the Hospital Experience

The HHC-CIR Patient Care Trust Fund at Metropolitan Hospital, a public hospital in New York City, recently purchased an ultrasound vein finder to improve patients' hospital stay. "We use this to put in artery lines for those where access is not easily found," said Dr. Deepak Asudani, CIR delegate, in Internal Medicine. "It makes it easier to get in the right place for infusions or transfusions, and leads to fewer sticks. You don't have to go blindly poking patients," Dr. Asudani said, which clearly improves their hospital experience. This new ultrasound-based scanner will decrease the number of complications that can arise from vascular access procedures, and is available for use by residents, fellows and attendings throughout the hospital, especially in the ICU setting. Shown here, with the vein finder, from left to right, are Ms. Ainette, RN, Dr. Hector Lozano, CIR delegate Dr. Deepak Asudani, and residents Dr. Iwona Tatur-Krol, Dr. Stuart Resnick, and Dr. Samrina Hanif.

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