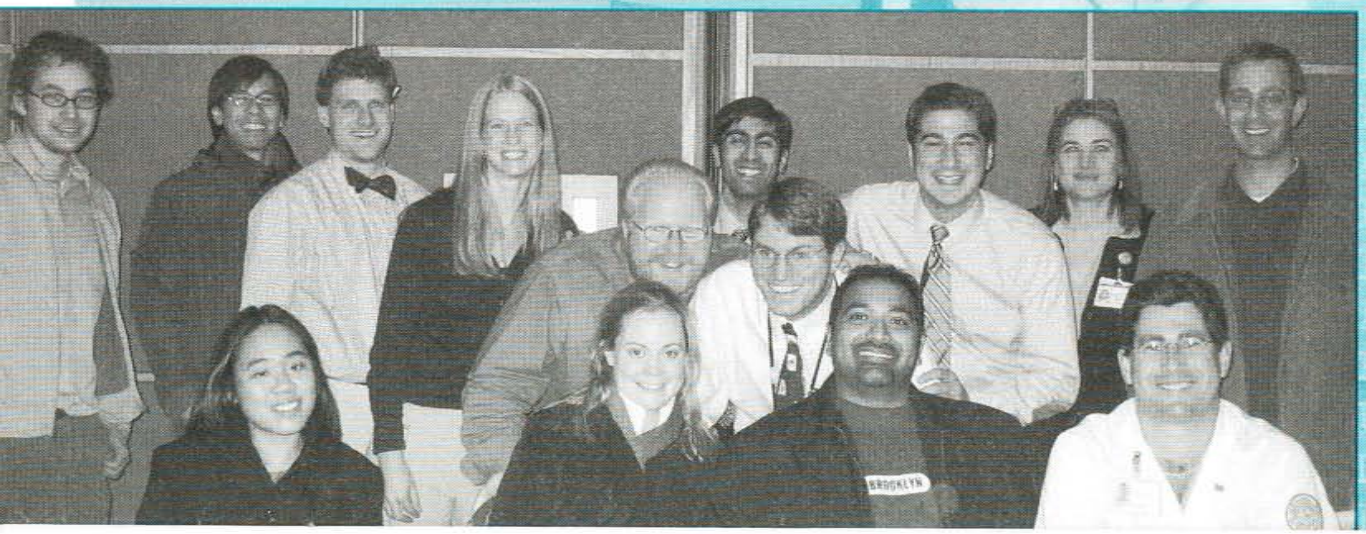
CIR SEIU NEWS

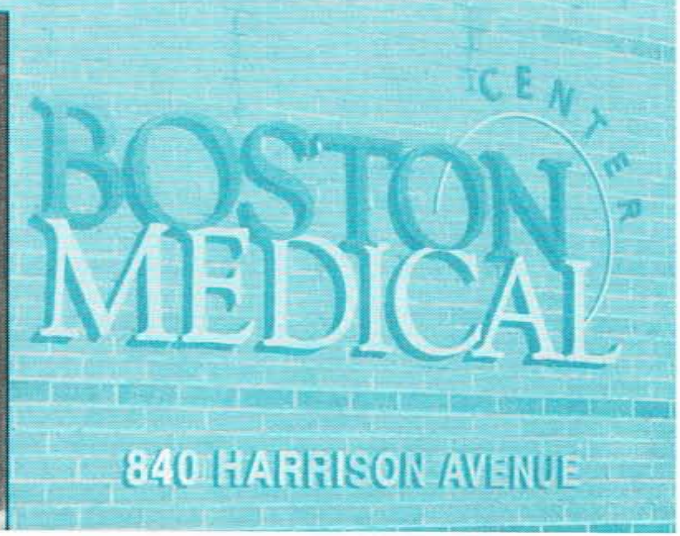
COMMITTEE OF INTERNS AND RESIDENTS December 2003

Inside

BMC Residents Celebrate New Contract

CIR Negotiating Team Delivers Groundbreaking Salary and Ancillary Service Gains





Negotiating team members, as they successfully settled their contract, nearing midnight on November 18, 2003.

Boston Medical Center housestaff overwhelmingly ratified a new contract on December 2, 2003, with an economic package that keeps the 600 CIR members in the enviable position of being the highest paid residents in Boston.

"Residents are thrilled," reports Dr. Rachel Mott, a PGY 3 Family Medicine resident and Co-President of the CIR chapter at BMC. "The salary increase, parking, our educational allowance and the gains in ancillary services are amazing, especially when you consider that these are tough economic times." The new three-year contract calls for salary increases of 4%, 3.75% and 4%, with an additional one-time boost of $500 to $1,500 in the second year of the contract for PGYs 6, 7 and 8, whose salary levels badly needed adjustment. The annual Professional Education Allowance jumped from $250 to $350 (for PGY 1 & 2) and $450 (for PGY 3-8). Extra on-call pay for house officers required to cover for an absent colleague jumped to $250/weeknight and $350/weekends & holidays in 2003 and to $350/$400 in 2005. The current subsidized parking rate was also locked in place for another three years.

While the economics of the new contract are undeniably something to write home about, many house officers point to the quality of life improvements as even more important. BMC Co-President Daniel Oates, MD, a first year Geriatrics fellow, explains that the excitement stems from the fact that "we've worked hard for the last three years to get these ancillary service and hours improvements. They are huge." As of April 2004, for example, BMC housestaff will no longer have to do blood cultures, with the hospital providing that service 24/7 (currently housestaff do about two-thirds of all blood cultures in the hospital). By December 2004, the hospital is committed to that same 24/7 service for IVs (current service is limited to 16/7). The Hospital also agreed to place the new ACGME hours limits into the contract and to work together to identify and improve rotations with excessive hours demands. Alphanumeric pagers—"something we have consistently pushed for in our labor-management meetings," says Dr. Oates—will be a reality within 60 days of the signing of the contract. And two personal days—also a first—will be added to the benefit package in the second year of the contract.

Members of the twenty-plus resident negotiating team are quick to point out that this contract was not handed out on a silver platter. There were four long months of meetings just about every Tuesday night. Houstaff posted leaflets, wore their 'We Are CIR' buttons and distributed 'I support the housestaff' stickers to attendings and hospital employees. CIR staff played a critical role, too.

"In the end, even though we didn't get all we wanted, our team did a great job of representing all the different priorities of our members, from economics to education and patient care," summed up Dr. Mott.

"We've worked hard for the last three years to get these ancillary service and hours improvements. They are huge."

—BMC Co-Pres. Daniel Oates, MD

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Ruth Potee, M.D.

President's Report

Ruth Potee, MD, CIR President

Tackling the Larger Issues

You know the drill. Patient presents in clinic for the first time. Within minutes you see that her simple medical diagnosis is hopelessly complicated by the larger social issues at play: no insurance, no home, no family; issues you feel helpless to fix.

On a much larger scale, CIR has simple goals, too: to care for our patients, regardless of their ability to pay for that care; to speak with one strong voice in our conversation with the hospital over the terms of our employment; and to help more house officers across the country organize to win that voice in their hospitals. But everywhere we turn, those simple goals are complicated by some very big problems: the growing number of uninsured, state budget crises, federal Medicare cuts to teaching hospitals, the abandoning of public hospitals, and talk of reclassifying residents as 'students,' in an effort to deny us the right to organize.

off the ground, and most of the money we raise in the future will go directly to SEIU's COPE fund, pooled with the contributions of thousands of the union's 1.6 million tributes to political candidates, and coming into a presidential election year, its recent decision to endorse Dr. Howard Dean's candidacy received a lot of national media attention. Over many months leading up to the endorsement, individual SEIU members and leaders met with the candidates in many local, state and national venues. Thousands more were individually polled, based on three criteria most important for the union: was the candidate supported by the members, publicly committed to supporting people's freedom to join a union; and did he/she have a written, comprehensive health care plan, including a way to pay for it?

In the final analysis, after careful scrutiny and wide member participation, SEIU leaders decided that Dr. Dean fit the bill. Is Dr. Dean every individual SEIU member's candidate of choice? Unlikely. But he does most closely match up with SEIU's collective goals as a union. Some individual SEIU locals, like CIR, do not choose to endorse candidates for national elec-

"Let's not forget to advocate forcefully for our patients and the rights of house officers in the workplace."

FRONT PAGE PHOTOS:
SANDY SHEA/CIR

When faced with an emergency, physicians don't wring their hands or fret, or walk away. We are trained to spring into action and, to the best of our ability, to do what needs to be done. CIR sees that same need now, to spring into action to tackle the larger political issues that threaten our patients, our hospitals and our union. We are too often short on time, but one good way to pitch in is to contribute however much you can to the CIR CARE Fund, through voluntary payroll deduction or a one-time contribution (see article on page 3).

CIR CARE has only recently gotten lion members (700,000 of whom work in the health care industry). What will SEIU use the money for? Over the past few years, for example, the union led the successful campaign for federal legislation requiring hospitals to purchase safe needles, a law that will save the lives of countless nurses, doctors and other health care workers. More recently, SEIU launched the drive to pass Measure B in Los Angeles, a move that has produced critical funding to help save the health care safety net in southern California.

The SEIU COPE Fund also contions, and all SEIU members, including housestaff, will have the opportunity to vote their conscience in the voting booth next November. That's our individual right and responsibility.

In the meantime, let's not forget our collective need, as physicians and as CIR members, to advocate forcefully for our patients and the rights of house officers in the workplace. Those are the common threads that bind us all together. The political problems facing us will not go away by themselves. Consider contributing whatever you can afford to the CIR CARE Fund. Every little bit helps.

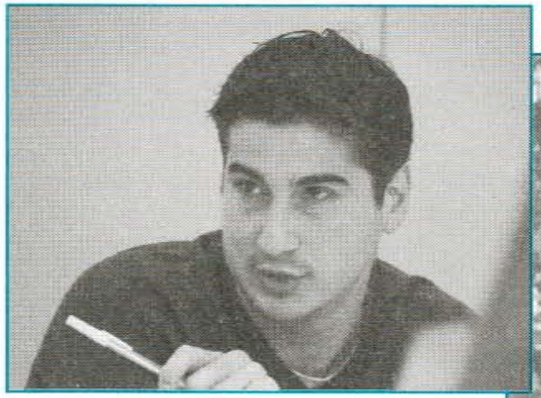
HoursWatch, a new website launched by CIR and AMSA, the American Medical Student Association, is the place for residents and medical students to share experiences and read up on the latest on work hours in the news, and behind the scenes. It goes live December 9th, 2003, at **www.hourswatch.org**. Check it out!

Think Politics Doesn't Affect Your Work? Think Again!

It does, and CIR's CARE Fund is here to bring residents' perspective to health care policy decisions

"When I decided to enter the medical field, I didn't see how big a role politics would play in my life," said CIR Los Angeles Vice President Christine Dauphine, MD. "I didn't think for a million years that I would have to fight to take care of patients, to get reimbursed fairly, to provide access to all Americans to health care, or to avoid huge malpractice costs. But we do have to…every day!"

Dauphine, now a veteran activist, has testified at public hearings, addressed rallies, met with politicians, and achieved her goals. Her hospital will remain open, thanks to the public pressure and funding from a tax measure she worked hard to get passed, which supports the strapped-for-cash trauma centers in L.A. County. "The measure passed with the highest amount of support for any measure on the ballot," Dauphine said. "Here we stand today, our hospital open, and secure that we will not be sacrificed….This would not have been possible without funds for political action."



Mark Amorosino, MD

Christine Dauphine, MD

Mohamed Ismail, MD

in Brooklyn, N.Y. The action got local elected officials to pay attention, and an unstoppable coalition is at work to fix the funding and other problems.

In Boston, Mass., a statewide budget crisis led to serious cuts in health care funding this past year, funding that both Boston Medical Center and Cambridge Hospital depend heavily upon. CIR housestaff at both hospitals joined a State House lobbying effort that included health care advocacy groups, unions and hospital administration. Though some cuts still went

President Mark Amorosino, MD, who was part of the lobbying effort.

All these actions have paid off, with good results—but this kind of work takes time, and money. That's where the CARE Fund comes in. The CIR Executive Committee decided to add another component to our political involvement—the health care advocacy CARE Fund. It is our own political action committee, which accepts volun-

Service Employees International Union, the largest union of health care workers in the country. That way, we get more "bang for the buck" as we join with 1.6 million SEIU members to fight against staff reductions in hospitals, for safe needles legislation, and greater access to health care for our patients.

"As part of SEIU, we have more power and get more attention, whether for rallies in California, or public testimony in New York," said CIR President Ruth Potee. "It's the

"Politics are important for CIR," said New York Regional Vice President Mohamed Ismail, MD, who spoke with other health care unions at a Town Hall meeting last winter that highlighted inadequate staffing levels, poor security, and inadequate facilities at his hospital, Interfaith Medical Center through, many of the worst cuts were avoided, at least for now. "This funding protects the mission of hospitals like Cambridge and BMC—to provide exceptional care, without exception, to the residents of Greater Boston, not just those with adequate health insurance," said CIR Regional Vice tary contributions from staff and residents to fight for improved patient care. As more and more hospitals face budget cuts and financial crises, those who provide front line care need to speak up and be heard.

CIR sends most of the contributions to our national union, SEIU, the best way to advocate for our patients, and the right thing to do as doctors."

For more information on the CARE Fund, contact your CIR contract administrator. This is one way to engage in local and national political action and stand up for patients and health care access.

First "Best Practice" Awards Go To 3 HHC Emergency Departments

CIR Fund Rewards Innovation

We all know how hard it is to change. It's the same for hospitals. When work has been scheduled a certain way, that tradition becomes hard to change. CIR and New York City's public hospitals last year agreed to do something about that, and collaborate on a program to reward best practices that reduce resident work hours, and improve patient care. Called "CIR Recognition Awards," the first recipients of the $5,000 awards are the Emergency Medicine Departments at Bellevue, Kings County, and Lincoln Hospitals. Read on and learn how these hospitals solved their work-hour dilemmas.

PHOTOS: (TOP) CARA METZ/CIR; AMY HALL/CIR; (BOTTOM) LILIA RODRIGUEZ/CIR; AND NEIL GONZALVO/CIR

Left: Bellevue's Emergency Medicine residents gather around the new PowerPoint projector and laptop computer they bought with their award money, for use in their 100% attended morning conferences. Right: At Lincoln Hospital, from left to right, Drs. Joel Gernschiemer, program director, John Munyak, associate director of Emergency Medicine, and Lloyd Peña, CIR delegate. Award money funded travel expenses for guest speakers to a recent Emergency Medicine Wilderness Symposium, and hosting journal club meetings at a nearby restaurant.

Bellevue Adds Daily Morning Conferences

Bellevue, like most Emergency Medicine Departments, has a four-hour morning conference once a week. A group of senior residents and attending physicians met and came up with the idea of adding an additional one-hour morning meeting to the remaining four days of the week, and exempting residents from clinical duties for that hour to attend.

About 40 residents participate in the daily conference, including Emergency residents on rotation to other departments. "This is now known about nationwide," said Dr. Rahul Sharma, a PGY 3. "With this one change, four protected educational hours were added to the week, which adds up to hundreds of hours a year. Patient care and education are the two areas you don't want to be compromised," said Dr. Sharma.

Residents Decide the Schedule At Brooklyn's Kings County Hospital

Housestaff made their own sched-

continued on page 6

CIR, AMA-RFS, and CMA-RPS Sponsor Conference

Hours Workshop Draws Residents from Across California

"Thank you for a wonderful Sunday." With that last comment from a California intern, the November 2, 2003, workshop entitled "How Can Residents Make Hours Reform Work?" came to an end. The day-long, problem-solving session was held at Harbor-UCLA Medical Center in Los Angeles, jointly sponsored by the CIR, the AMA-Resident Fellow Section (AMA-RFS) and the California Medical Association-Resident Physician Section (CMA-RPS). The event attracted about 40 residents from 14 California hospitals, as well as housestaff and medical school leaders from Chicago, New Jersey, Boston, Washington, D.C., Arkansas, and Kansas.

After an early morning welcome by Dr. Tony Blaine, CMA-RPS president, CIR President Ruth Potee, MD, traced the resident activism that created enough pressure to finally convince the ACGME to institute new resident work hours limits, which went into effect July 1, 2003. Dr. Maurice Sholas, AMA-RFS President, prepared participants for the day's work, explaining that the morning session would focus on "What keeps us in the hospital so long?" and the afternoon on sharing 'best practices' for reducing resident hours (see box, facing page) and on how hospitals and programs are responding four months into the new ACGME rules.

Have the ACGME hours limits been a positive change? The answer from workshop attendees was

'We were a part of making that happen.'"

Charles Mashek, an AMA-RFS delegate, agreed. "It's exciting that residents are coming together from all across the country in a way we never did in the past. There are no quick fixes. We're going to have to find a way to make it work. But no more just talking about it—we're doing it!"

Residents' Views Must Be Included—but often are not. A show of hands revealed that only about 50% of the residents were involved in devising plans to meet ACGME compliance at their hospitals. About 30% said only chief residents were involved, and 20% reported zero resident involvement. As a result, some participants reported that the original scheduling changes made for July 1 in their programs had to be altered because residents were

a resounding "yes." Participants reported returning to the hospital refreshed after leaving post-call; getting regular days off; uncovering hospital inefficiencies; learning to do better sign-outs; seeing a nationwide increase in surgery applications; and recording patient satisfaction improvements when hospitals hired physician extenders.

Are there problems with the way the new rules have been implemented that need addressing? Again, the answer was an overwhelming "yes" from workshop participants.

"We all think that we are supposed to work all the time and never leave the hospital. We all feel guilty," said CIR Regional Vice President Arun Chopra, MD, a Pediatric Critical Care Fellow. "The truth is we need to change the way everyone practices medicine. These new pressures on attendings will force them to press for change. And those changes will require more money in the system. It's exciting to be in this room today. We're witnessing a real change in the culture. We'll look back 20 years from now and say,

Residents Talk About What Works (And What Doesn't) for Hours Reform

Whether hours reform is deemed a success or failure will depend on how hospitals choose to put the new guidelines into practice. Here are some of the most recent data, shared by residents from a variety of hospitals—on the roadblocks and winning strategies for hours reform.

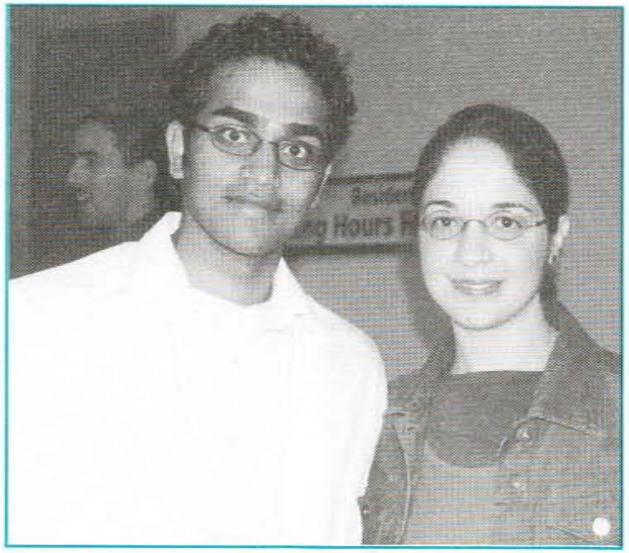
Hospitals Need to Allocate New Resources—Almost all of the residents reported that their hospitals had not provided additional funds to bring their training programs into compliance with the new hours rules. One resident from Olive View Medical Center echoed the remarks of many during the day when she pointed out that, "Resident resentment comes when a program thinks that just by shifting work to other house officers or devising a 'creative schedule,' the hours problem will just go away. No, the problem doesn't go away. Either the work load has to be reduced or more people have to be hired to do the work."

unhappy and/or the changes caused more problems.

Success Depends on Strong Leadership from Chief Medical Officers and Program Directors. "When the program director says, 'You must do this—it's not a choice,' then things change," noted one Loma Linda Medical Center resident. Or as another participant put it, "If the Chief Medical Officer isn't on board—you are screwed."

Focusing on Hospital Efficiency Wins Support and new resources for hours reform when residents can show improvements in patient care, and overall efficiency. One resident described how Anesthesia residents in his hospital were routinely starting cases at 8 a.m. instead of the scheduled 7 a.m. Investigation revealed that the residents had to wait until the cafeteria opened at 7 a.m. to get breakfast (knowing that they would probably be stuck in the OR and miss lunch). The cafeteria began opening at 6:30 a.m. and then cases began on time.

Ancillary Services, Ancillary Services, Ancillary Services—They shorten a resident's



Photos above, facing page; residents came from hospitals throughout California to discuss strategies for successful hours reform, and how to avoid obstacles that can sabotage the process. Right, co-sponsors of the event, left to right, Maurice Sholas, MD, PhD, AMA-RFS Chairperson; Ruth Potee, MD, CIR Pres.; and Tony Blain, MD, MBA, CMA-RPS Pres.

PHOTOS: (TOP) PATTY FRIST/CMA; (BOTTOM, LEFT TO RIGHT) SANDY SHEA/CIR, AMY HALL/CIR

Best Practices—Thinking Outside the Box

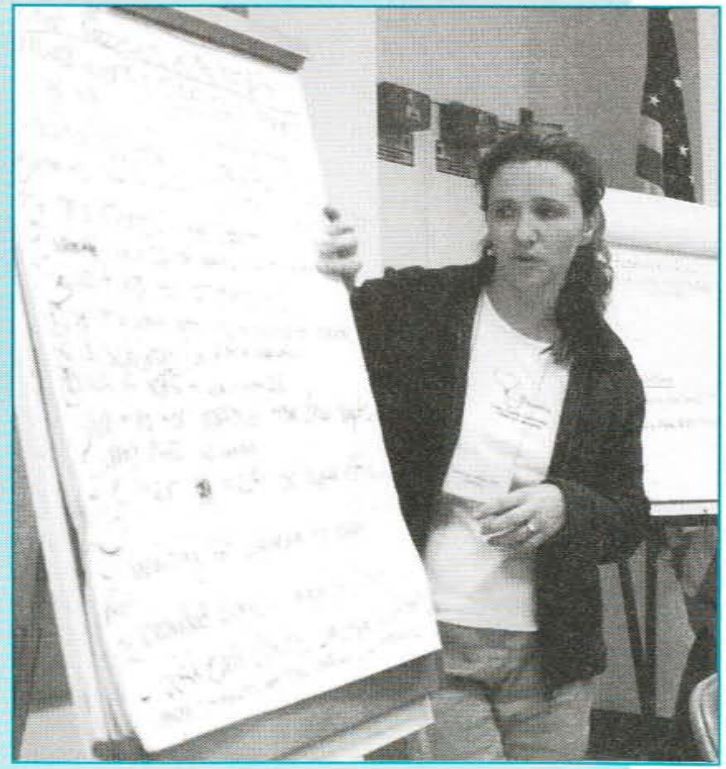
Here are some of the best practices participants of the November workshop described to their colleagues. CIR members have a big advantage, with greater ability to be part of the decision making at their hospitals when it comes to implementing best practices.

Procedure Team—A designated surgical team which responds quickly to the need for patient procedures. Team members rapidly improve their skills and their log book numbers, while remaining residents save valuable time in their day; patient care needs are often attended to more quickly.

Elective Surgery Cases Assigned by Resident Schedule—Elective cases are booked based on the surgical residents' on-call schedule, so that residents will be able to maximize their time in the OR doing the cases they need for their training; by concentrating hours, residents are more rested and better able to learn at other times.

Day Float System—Tuesdays through Fridays, the Day Float Team takes the first admits of the morning, so that the other residents don't have to come in to work until 10:30 am.

Night Float Expanded to 7 Days—Night float gets one guaranteed day off a week, when the resident on Rheumatology elective is pulled on Thursday nights. Saturday and Sunday nights, the night float only has to come in if and



"After rounds, all the housestaff used to dive for the phones to call Radiology and order the necessary tests," explained Arun Chopra, M.D.,

day, improve a resident's education (when residents are allowed to focus on physician tasks) and improve the efficiency and quality of care delivered to patients.

Education Must Be Protected—The general consensus was that the move to limit hours had accentuated, and perhaps even accelerated, the already alarming problem of reduced resident education. Participants reported feeling pressured post-call to miss conference, feeling that attendings now rush through rounds and morning report and that residents don't get to 'do as much' and have less 'ownership' of their patients in the rush to get things done and get out of the hospital.

Many spoke of the need for medical educators to start 'thinking outside the box' more effectively to organize medical education. Said one Santa Clara Valley Medical Center resident, "We need to wean attendings away from thinking the 30 minute lecture is the only way to teach."

Attendings, Med Students Working Harder—When hospitals do not identify additional resources to relieve the work burden on housestaff, that burden gets shifted to others. Both the American Medical Student Association and AMA-Medical Student Section participants reported that medical students are now expected to work harder and longer. Virtually all participants reported the frustration of junior attendings, worried that their own workload and hours had increased, while their time to teach had decreased.

"This system takes idealistic people, stomps on them and spits them out," said one resident leader who has recently become an attending. "In clinic, I see a patient every five minutes, with 10 minutes

when the ward team 'caps' (this could be at 4 am).

Rounding With Post-Call Resident First—Hospitalist rounds first individually with the post-call resident/s; then with the rest of the team. This helps to get the post-call resident out as early as possible and give some extra time for the other residents to do work before rounds.

Rounding with Attendings between 9-11 PM—Granted, by moving away from the traditional morning rounds, this constitutes a major change in attending physician culture. But residents who have tried it say there are several advantages: increased hospital efficiency (by allowing the team to get a big jump on the next day's discharges); and evening out resident workloads and teaching time so that more is accomplished during non-prime-time hours.

Rounding with a Laptop Computer—Providing each team with a laptop computer that can be wheeled from one patient to another in order to write discharge notes and orders at the bedside greatly speeds up the paperwork that residents are deluged with.

Schedule < 80 Hours—Base schedules on 60 hours per week, not 80. By not cutting the schedule so tight, residents then have the flexibility to attend conferences, stay for a case or to follow an interesting patient.

Hire a 'Resident Assistant'—Residents at D.C. Children's Medical Center took a cue from Johns Hopkins and convinced their hospital to hire two resident assistants to help housestaff with discharge paperwork, ordering tests, etc. CIR Regional Vice President, who was part of the CIR bargaining team that negotiated the new jobs. "All of us were on hold, waiting in line for the radiology tech to answer our call and take our orders. Then we had a realization: one person could do the job of 12 residents better than 12 residents could do this one job."

Hiring Ancillary Staff—Hospitals are urged to hire more ancillary staff to take the work burden off residents—for example, more transport workers, phlebotomists, a person to do visual acuity exams in the Ophthalmology clinic.

Hiring Physician-Extenders—The Cardio-Thoracic program at one hospital hired physician extenders, and now service runs more smoothly, patient outcomes are improved and residents have more time for the OR, studying and rest.

Website Improves Education/Patient Care—One Family Medicine program put every grand rounds PowerPoint presentation for the last three years on the department's website. They also included the top 20 diagnoses at the hospital; click on each one and the residents get the top 10 best articles on the subject. Patient handouts, in twelve languages, are also easily printable from the website, which saves resident time and improves patient care.

Monitoring Hours? Set Up a Hotline—Some GME offices have set up a hotline for residents to call if they have concerns about working too many hours on a particular rotation, but feel they are getting no support from their program.

"Do-It-Yourself" Hours Reform Kit

Wish you could have been at the workshop but were unable to attend?
You can recreate the experience and begin making changes at your hospital.
Here's how: CIR has an abbreviated "Do-It-Yourself Kit" on our website. Go to:

http://www.cirseiu.org/docUploads/Do-It-Yourself.pdf

PHOTO: AMY HALL/CIR

for paperwork. By the end of the week, I am no damn good."

No Confidence in ACGME's Ability to Monitor Compliance. At least one resident attending the workshop reported that at his hospital, resident *threats* to call the ACGME had indeed produced results! But actually making the call with the accrediting body was another matter. Participants universally pointed to an inherent contradiction—residents are afraid to report violations for fear of bringing down their own program, or the wrath of their housestaff colleagues, attendings and program directors, none of whom want to lose accreditation. Although the ACGME has reported receiving only seven complaints in the first three months of the new rules, AMSA's website has logged three dozen complaints, e.g. reports of forged hours records and the 'scam' of home call, that on paper takes a house officer out from under the 80 hour requirement, but in reality can keep them up all night answering calls.

"Working more than 80 hours a week is just wrong; wrong for our patients and wrong for us. Let's not forget that."

Evaluating the Impact on Patient Care—Some residents worried that patient care has been negatively affected by the hours changes, but no one seemed to think that this should be blamed solely on the hours limits, nor were the problems unsolvable. "Sign-out has always been a problem," said one resident. "The hours limits force us to do a better job, and that's good." Several participants called implementation of the hours limits a "work in progress" and one resident from LA County + USC Medical Center urged the group to keep problems with implementation in context. "Working more than 80 hours a week is just wrong; wrong for our patients and wrong for us. Let's not forget that."

More Nurses, Ancillary Staff Needed

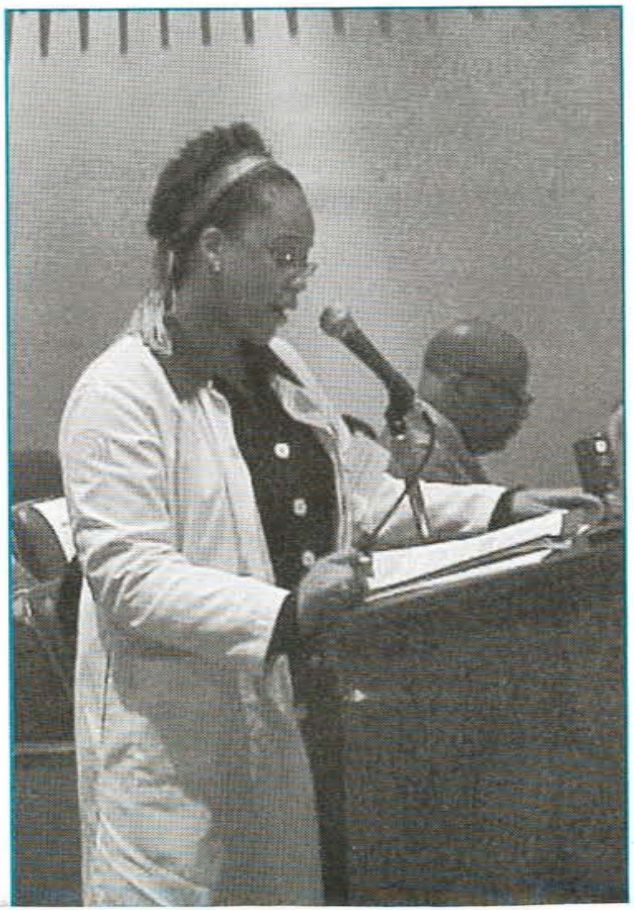
CIR Delegates Speak Out for More Staff at New York's Public Hospitals

"Staffing is the issue," said Dr. Laiandrea Stewart, CIR delegate at Harlem Hospital Center in New York City, speaking at a public hearing on September 22, 2003. The annual meeting, called by the Board of Directors of the Health and Hospitals Corporation (HHC), is one of a series held borough-wide to hear community concerns about the city's public hospital system. "A major issue at Harlem and other HHC hospitals," said Dr. Stewart, "is the shortage of nurses and ancillary staffing. We need more people to draw blood, insert IVs, transport patients, retrieve charts, and deliver lab work."

CIR representatives who spoke at the three separate hearings urged the Board to make staffing levels a priority issue in the coming year. Representatives of Doctors Council/SEIU, the union of attending physicians based in New York, and the New York State Nurses Association also addressed the public meetings. Staff shortages were the top concern for all groups.

Shortages "mean that residents must perform ancillary services, which takes time away from our physician care responsibilities," said Dr. Miguel Restrepo, CIR regional vice president and a resident at Woodhull Medical and Mental Health Center. Speaking at the October 1, 2003 hearing held in Brooklyn, New York, Dr. Restrepo said that there are only one or two assistants for every ten dentists at Woodhull's dental clinic. "This kind of staff shortage hampers our ability to deliver quality patient care."

At a hearing in the Bronx on October 21, 2003, CIR delegate Dr. Shiven Chabria spoke about the dedicated interns and residents at Lincoln Hospital, "who play an indispensable role in the health care delivery system for the people of the Bronx community." The staff shortages, however, translate into unacceptable waiting times. "Many patients have to wait up to an hour for a transporter to take them for an x-ray or other diagnostic exam. Quite often, the interns and residents feel so frustrated and upset that they take the patients themselves for the exam. It is inexcusable that a hospital with so many valuable services to offer the community can't provide an adequate number of staff," Dr. Chabria said.



Former CIR Vice Pres., Dedicated Doctor Honored

Lounge Dedicated to

Alyse O'Connell, MD

The memory of Dr. Alyse O'Connell will live on at Kings County Hospital's Department of Psychiatry in Brooklyn, New York—thanks to the efforts of fellow residents and the CIR Patient Care Trust Fund (PCTF).

Dr. O'Connell was diagnosed with brain cancer while she was a third year resident in Psychiatry, and serving as a CIR regional vice president. She died February 17, 2001. After two years of determined efforts, residents honored Dr. O'Connell's memory with a lunchtime dedication on October 16, 2003 of the newly furnished and decorated housestaff lounge.

At the dedication, Dr. Ellen Berkowitz, assistant program director for the Department of Psychiatry, spoke movingly of Dr. O'Connell as an "outspoken, challenging, and dedicated doctor." Whether taking up a collection among colleagues to help a fellow resident whose home had been robbed, or bringing the art of knitting to women in a homeless shelter, "Dr. O'Connell was always very involved with people," said Dr. Berkowitz.

CIR Executive Director Mark Levy spoke of Dr. O'Connell's role as a CIR leader. "She was a trailblazer in her understanding of the importance of CIR's involvement in political action as a way to improve patient care," he said. A memorial plaque with a photo of Dr. O'Connell was placed ceremonially on the wall of the lounge. The PCTF also provided a new couch, chairs, microwave oven, refrigerator, and coffee maker. Residents donated their labor, resurfacing a conference table and brightening the room with paint and floor plants. It's now a comfortable place to be thanks to the collective efforts of Dr. Alyse O'Connell's CIR colleagues, who were determined to honor her legacy.

From left to right are residents of the Department of Psychiatry at Kings County Hospital who were instrumental in establishing the Alyse O'Connell Memorial Resident Lounge: Dr. Katarzyna Derlukiewicz, Dr. Adam Jarczewski, Dr. Raslaan Nizar, Dr. Igor Kirzhner, Dr. Taninder Chadha, Dr. Pongsak Huangthaisong, Chief Resident (front). In the background is the memorial plaque with a photo of Dr. O'Connell.

Dr. Laiandrea Stewart addressing a public hearing Sept. 22, 2003.

Best Practices

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ules at Kings County, and chose to reduce hours for PGY 3s and 4s from 12 to eight-hour shifts during the weekdays. Weekend shifts remain 12 hours long, but are reduced in frequency. The result? Over a four-week period, PGY 3s and 4s have reduced their hours by 20 and 24 respectively.

Change, even positive change, can take some adjustment. "Initially it was odd. We were ending and beginning shifts at times we weren't used to," said Alexis Johnson, a PGY 4. "However, most people would say that we no longer end or begin a shift feeling as drained and fatigued as before. Residents with families are especially pleased, because now they have time to see them each day."

One of the most remarkable results has been a huge decrease (50%) in waiting time and walkout rates for patients since this practice has been in effect. "This is probably due to placing more staff, including residents, in the ER at the busier times, and may also reflect increased efficiency of a staff that now works less hours each day," said Dr. Johnson.

Lincoln Residents Too Tired for Weekly Conferences

At Lincoln Hospital in the Bronx, "residents were leaving early from the conferences because we were just exhausted, and we were losing out on teaching points," said Dr. Tiffany McCalla, a PGY 3 in the Emergency Department. To solve the problem, clinical hours were decreased by four hours on the night shifts before and after the conference, and five hours on the day shift following the conference. Other weekday shifts have been cut down by one hour in order to allow for a daily lecture. "Residents can now focus and really learn," said Dr. McCalla.

PHOTOS: PAT FRY/CIR

CALIFORNIA UPDATE

From the north to the south, CIR members in California have been busy on campaigns that cover a range of issues from keeping the public hospitals they work in funded and open, to fighting for a fair union contract that "Draws the Line" against cuts, to mobilizing and lobbying for increased access to health care through local and state initiatives.

In Oakland, March Ballot Vote Will Decide Fate of Highland Hospital

Probably few people go into medicine thinking they will have to engage the political process in order to do their job. But sometimes that's what happens. Taking a page from the playbook of their Southern California colleagues, CIR members in the northern part of the state, who work at Highland, a public hospital in Oakland, have been working tirelessly to come up with creative solutions for the budget mess at their hospital — an $86 million deficit — that threatens to close it down. As part of a Blue Ribbon Task Force, CIR members met regularly with other stakeholders, such as the Board of Supervisors and Board of Trustees, to come up with solutions to save the hospitals and health clinics that together make up the Alameda County Medical Center (ACMC).

Dr. Amy Matecki, chief resident, Internal Medicine, Highland Hospital participating in rally to keep ACMC open. Days of lobbying and testifying at public hearings were part of a strategy that won a ballot initiative, to be voted on in March, to restore funding to ACMC.

At a public meeting, six CIR members spoke forcefully about the importance of ACMC just prior to a decision on its fate by the Board of Supervisors. Dr. Jeremy Graff, a PGY 2 in Emergency Medicine, detailed the health care disaster that would ensue if Highland was closed. Referring to a poll that showed that 72% of the voters would support a sales tax to protect ACMC, Dr. Anita Gaind, a PGY 2 in Internal Medicine said, "your constituents have made it clear that they want to see public health and ACMC stay open." Their testimony carried the day, and the Board of Supervisors, by a unanimous vote, approved an initiative which will go on the ballot on March 2, 2004, to raise taxes and bring increased revenue to ACMC. The vote came the day before Thanksgiving, and gave CIR members something extra to be thankful for this year.

L.A. Contract Campaign:

Drawing the Line Against Givebacks

In Southern California, a contract campaign for a new agreement to cover 1,600 residents has the full attention of CIR members at Harbor-UCLA, King/Drew Medical Center, and LAC+USC. The old agreement expired September 30, 2003. On October 28, 2003, 2,000 workers, including members of SEIU Local 660, the Coalition

Residencies Revoked at King/Drew: CIR Works to Ensure New Slots

Two residency programs at King/Drew Medical Center,

Dr. Almaas Shaikh, a

of County unions, and CIR, joined forces at the Los Angeles County Board of Supervisors in a spirited demonstration with whistles, music, picket signs, and a solidarity message against wage freezes and give-backs. Leading up to that rally, CIR, along with SEIU Local 660, held rolling rallies at each hospital. On October 16, 2003 LAC+USC and King/Drew Medical Center rallied, and on October 23, 2003 Harbor-UCLA union members rallied to send the Board of Supervisors the message that all County workers deserve a fair union contract. CIR members were featured speakers at all locations. In November, Local 660 members settled their contracts with the county, winning raises in 2005 and 2006, and holding the line against any additional co-pays for health care.

Dr. Joshua Perlroth, PGY 2, Internal Medicine, speaking against the County's stated goal of seeking wage freezes and higher contributions to health benefits from employees, at a rally at Harbor-UCLA.

CIR members have presented similar proposals, with additional improvements in work hours, maternity and paternity leave, the Patient Care Fund, program security and professional training. Tentative agreement has been reached on improved language regarding bereavement leave, interpreters, patient lift teams and increasing safety in the Psych ERs.

Surgery, and Radiology, lost their accreditation effective June 30, 2004. In response, CIR members continue to meet with elected officials and testify before the Board of Supervisors, to ensure that all 45 affected residents will have new placements as of July 1st, 2004.

King/Drew, which serves the neighborhoods of Watts, Willowbrook, Compton and South Central L.A., was created in response to the Watts riots of 1965. Named after Dr. Martin Luther King, Jr., it opened in 1972, providing the only access to health care in the underserved and underinsured surrounding communities.

Its history and continued mission in providing life-saving health care that would not otherwise be locally available is one of the reasons that it has drawn the interests of dedicated residents such as Dr. Almaas Shaikh, a PGY 3 in Surgery. In her testimony to the California State Assembly Select Committee on the King/Drew Medical Center, September 16, 2003, she said, "The community we serve very often cannot afford to take a cab or spend hours on the bus to travel to another county to seek needed medical care...Without trauma and emergency services offered by King/Drew, patients like mine who are critically injured will die....There is nothing more noble than saving a life, and perhaps nothing less noble than not saving a life when it could easily have been spared."

PGY 3 in Surgery, testified that without the emergency and trauma services offered by her hospital, critically injured patients, whose lives depend on immediate intervention, will die.

CIR News will continue to cover new developments at King/Drew, and the resolution of residencies for all involved. CIR proposals include strengthening contract language on program security at the bargaining table, so that if this happens in the future for any program, there will be more protection for residency positions in cases of loss of accreditation.

PHOTOS: (TOP) RANDY LYMAN/SEIU L. 616; AMY HALL/CIR

Groundbreaking Health Care Victory

California Legislation a Model for Other States

S.B. 2, Health Care for Working Families, a bill that extends health care coverage to millions of working Californians who are currently uninsured, was signed into law by then-Governor Gray Davis on October 12, 2003. It would bring health insurance to an estimated 1 - 1.5 million working Californians and their families, by requiring employers with more than 200 workers to pay for health insurance by 2005 or contribute to a state fund to do so. In 2006, companies with more than 20 employees would be required to provide coverage for their workers.

"Expanded health insurance means more preventive care, and, in the long run, healthier communities across the state," said Dr. Christine Dauphine, CIR Regional Vice President, at a press conference held by CIR in Los Angeles on September 8, 2003. "Patients who lack health insurance end up in the hospital with more serious conditions than they would have if they had received regular preventive care," said Dr. Claudia Zaragoza, a CIR delegate at Harbor-UCLA during the press conference in support of the legislation. In Northern California, CIR members participated in a phone blitz, calling legislators during their lunch break on September 4, 2003, to ensure that the bill passed. They also held a press conference, at San Francisco General Hospital, on September 24th, to draw attention to the need for greater access to health care.

California has an estimated 7 million uninsured. California is now among the very few states leading the way towards greater access to health care for its residents.

NEW CIR EXECUTIVE VICE PRESIDENT

Barbie Gatton, MD, Appointed National Officer

At the fall Executive Committee meeting on November 15, 2003, CIR Pres. Ruth Potee appointed New York Regional Vice Pres. Barbie Gatton, MD, to the position of Executive Vice President vacated by Dr. Angela Nossett, who resigned mid-year. The Executive Committee unanimously approved the appointment of Dr. Gatton, who is a PGY 2 in Emergency Medicine at Methodist Hospital in Brooklyn, New York. "Dr. Gatton's policy background and leadership experience are a great asset to CIR," said Dr. Potee.

"I took a circuitous route to medicine," says Dr. Barbie Gatton. After seeing family members and friends deal with illness, "it made me realize that improving health makes a big impact on people's lives." But this Louisville, Kentucky native did a lot of other jobs first, beginning with camp counselor, soda jerk at a movie theatre, fundraising for public TV, being a nanny, tutoring, proof reading, and working in real estate.

"I was 27 when I decided to become a doctor, and for my 28th birthday, I got Gray's Anatomy, and MCAT prep books from my family," Dr. Gatton said. She did two pre-med years, and at 30 began medical school at SUNY job in real estate, with my own office, health insurance, security, that was hard."

But in a sense, Dr. Gatton has been engaged with health care for much of her adult life. As an undergrad political science major, she wrote a 100-page thesis on problems in our health care system. She found her calling in emergency medicine during her second year

> "My goals are to work on greater access to health care...I will always try to be an advocate for my patients, individually, and as a group."
> —Barbie Gatton, MD

of medical school. "We shadowed doctors periodically, and Emergency Medicine was the most exciting. Everyone there is in crisis, and you have a unique opportunity to address not just the physical, but also the emotional side during a stressful time."

Dr. Gatton got involved in "union stuff" in her first year as a resident,

by her colleagues. "As a delegate, you become aware of regional issues, and think not just about your own hospital, but all New York hospitals." But her first labor experience came much, much earlier, when she was a counselor, at age 16, and took part in a walkout at her camp to protest understaffing and overwork of counselors.

"My goals are to work on greater access to health care," Dr. Gatton said. "In the U.S., the number of emergency number of people without insurance. People wait longer to go to a doctor...More and more, health care is seen as a strain on government budgets, and a place to make cuts. We need to push back and make sure it's a priority. I will always try to be an advocate for my patients, individually, and as a group, and I think the most effective way is within a union. If we unite with attendings, we can make such a difference. It's always

Stonybrook. "Coming from Kentucky to New York wasn't hard at all," she says, "but leaving the security of my when her department rep suggested she attend meetings with management. She was soon elected delegate gency rooms has gone down as emergency visits have gone up. ERs are more overcrowded, with a greater easier to make a change with a large group working together. That's the beauty of a union," she said.

At Florida's Jackson Memorial Hospital:

Arbitrator Restores Board and Licensure Fee Reimbursements

Housestaff—what do you do when hospital management denies you a benefit you *thought* the CIR collective bargaining provided? Do what residents at Jackson Memorial Hospital in Miami did—call your union when you have questions about the contract or about your rights and benefits. Don't just take no for an answer without checking with CIR.

Through the grievance and arbitration procedure set out in the CIR-Jackson Public Health Trust contract, CIR successfully prevented the hospital from unilaterally deciding not to reimburse housestaff for boards and state licensure fees in and outside Florida as Professional Education Allowance expenses.

"A Florida license is $1,200," said CIR Delegate Obinna Egbo, MD, a PGY 3 Med-Peds resident, "and my wife is planning to use her allowance for that. I'll probably use mine for the Peds boards—$2,000!"

In fact, boards and licensure fees were two of the reimbursable items housestaff negotiators had in mind when they first negotiated a $500 Professional Education Allowance in 2001. Thanks to successful contract negotiations that concluded in the summer of 2003, the professional/educational allowance is now $700 and will go up to $900 as of January 1, 2004. Monies not used in any one year of residency can be rolled over to the next year. Many residents very intentionally decided to save up their benefit to the final year of their residency, specifically to pay for one of these big ticket items.

So when hospital management abruptly stopped reimbursing these professional expenses residents called the union to find out why. Union staff investigated the problem. Once it was clear that this was not a simple misunderstanding, but rather a disagreement in the interpretation of contract language, CIR filed a formal grievance. After several meetings spent trying to resolve the issue with management, the union went on to the final step—filing for arbitration. Arbitration means that the case is heard before an independent arbitrator, whose decision will be final and binding.

In the case of the disputed Professional Education Allowance, CIR housestaff and staff met with hospital representatives on September 5, 2003, in the presence of the arbitrator. Within a couple of hours, an agreement was reached with the hospital that board and licensure fees (both in and outside Florida) were, once again, reimbursable items.

"This is a very popular item in our contract," sums up Dr. Egbo. "I'd say at least 80% of Jackson housestaff have PDAs—and most of those were bought with our Professional Education allowance. It's good news that we have it back again to use for the big professional expenses we face."

PHOTOS: (TOP) CARA METZ/CIR; (BOTTOM) SANDY SHEA/CIR

From left to right, CIR Delegates Drs. Okeke Adeaze, Obinna Egbo, CIR Fla. Vice President Joshua Lenchus, and Delegate Zach Pearson are pleased with the results of the grievance and arbitration procedure, which brought back reimbursement for Boards and Licensure fees to residents at Jackson Memorial Hospital.