COMMITTEE OF INTERNS AND RESIDENTS JANUARY 2005

Inside:

Stories from Northern to Southern California, pps. 3, 12

New Massachusetts Resident Work Hours Bill, p. 5

Harvard Study Finds Preventable Medical Errors Increase When Residents Work 24+ Hours

- Recommends 16-Hour Maximum Schedules
- How will the ACGME respond?

See Centerspread Pages 6-8

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President's Report

Barbie Gatton, MD, CIR President

Challenges for CIR in 2005

In 2004, CIR members were more active in the political process than ever before. We were involved in get-out-the-vote drives, in political discussions with colleagues, and in the campaign in California to expand health coverage to more working people and their families. I'm proud of us all for spending so much time and energy standing up for what we believe in. But our work is not done now that the election is over.

There are three areas that need our immediate and ongoing attention: health care funding and access; CIR contract negotiations; and resident work hours reform.

Most critically, we need to continue to work at every level—city, state, and federal, to fight the budget cuts that threaten our hospitals. We must also work to ensure that every man, woman and child in this country has access to medical care, and not just at 3 A.M. in the Emergency Room, when it may be too late, but also has access to regular preventive care and ongoing care with their provider.

Next, over twenty of our CIR hospitals are currently in contract negotiations. We need the support of our communities to ensure decent contracts with strong housestaff rights and patient care provisions.

Lastly, two recent Harvard studies published in the *New England Journal of Medicine* demonstrate again what we at CIR have been saying for many years, and what the public thought was just plain common sense all along: Long hours are bad medicine! The studies show that medical errors increase dramatically after working for 24 consecutive hours. But the authors

of these studies also showed that there are creative solutions to the work hours dilemma. (See centerspread, this issue, for more on the Harvard studies and what they mean for residents.) Improvements in patient safety and resident rest and well-being are both achieveable. CIR will continue to pursue both goals.

CIR members need to advocate for the ACGME to do better. Under current ACGME standards, residents may be scheduled to work 30 hours at a stretch. Moreover there is no effective inspection process and no whistleblower protections to keep the system honest. We need regulations that are both stronger and more enforceable. Importantly, we also need increased funding and more creative practices so that residents' work is not just pushed onto medical students or already busy attendings.

My hopefulness and commitment on all these issues were reinforced at a dinner I attended in Washington, D.C. in November. This annual event was originally founded by Physicians Forum and is now co-sponsored by a coalition of many activist doctor organizations and unions. The audience was a diverse group ranging from doctors who had been practicing for 50 years, to medical students and residents. All of the residents and medical students were struck by the dedication of the older generation of doctors, who have been fighting against health care disparities and injustices—in the U.S. and internationally—for decades.

Their long-term involvement challenged me, and I challenge all of you, to become more politically engaged in our work. We need to stay in touch with the idealism that brought us to medicine. A quick, easy, and important way to do this is to write and call your local, state and federal legislators on patient access and health care funding issues. We need to get together within CIR and in alliance with other organizations to take part in lobby days and public hearings. By reaching out to community groups, local schools and churches, we can fight for increased funding for our hospitals and for truly effective resident work hours reform.

> "There are three areas that need our immediate and ongoing attention: health care funding and access; CIR contract negotiations; and resident work hours reform."

Let's rededicate ourselves in the New Year to doing all we can to increase access to health care for all, winning contracts with strong provisions for excellence in patient care in all our hospitals, and truly reforming resident work hours.

And let me offer my best wishes to all our CIR members, friends, and alumni for a happy, healthy, and peaceful 2005!

ACTIVIST PHYSICIANS LAUDED

Every year, just before the American Public Health Association's huge convention starts, activist physicians gather at a dinner originally founded by Physicians Forum and now co-sponsored by a coalition of doctor groups and unions, including CIR, to recognize activist doctors and others who have dedicated themselves to humanitarian and social justice work in the U.S. and around the world. Honored on November 7, 2004 were AMSA long-time Executive Director Paul Wright (photo at left), Dr. Paul Farmer of Harvard University Medical School who is nationally know for his medical work in Haiti (photo at immediate right, shown here with Len Rubenstein, Executive Director of the Physicians for Human Rights), and Dr. H. Jack Geiger.

TOP PHOTO: BILL BURKE/ PAGE ONE PHOTOGRAPHY

Covering CA's Working Uninsured: A Continuing Campaign

CIR members throughout the state of California lobbied, testified, leafleted and put their hearts into advocating for passage of Prop. 72, which would have required mid to large-size employers to provide health insurance for their employees, or contribute to a state pool for coverage. By a very slim margin—51-49%—(the difference of 180,000 votes out of a total of 12.6 million) their efforts failed on Election Day. But a defeat this close at the ballot box is often not the end of a fight, but just the beginning.

"With 49.1% voting yes on Prop. 72, clearly a large proportion of Californians think that this is a tenable and important goal," said CIR member Dr. Patricia Lohr, a PGY 4 in OB-GYN at Harbor-UCLA Medical Center in Torrance. "Hopefully, we can come together over a plan that will increase health care coverage for the uninsured here in California and that can be a model for other states across the country."

CIR Northern California Regional Vice President Anita Gaind, MD, a PGY 3 at Highland Hospital in Oakland, said that when she spoke to people about the issue, whether during Grand Rounds, CIR meetings, or at grocery stores where she handed out leaflets, "people were interested and most supported it. They are very aware of the issues, and understand that a hospital like ours, which is public, bears the burden of non-insured workers, who have no coverage. The financial capacity of big companies like Wal-Mart to finance a media campaign overpowered our ability to win. But the coalitions built around support for Prop. 72 will be maintained, and will provide a structure for future work," she said. "We will definitely build from this effort."

Advocates for health care reform in states ranging from New York to Washington, Illinois, Massachusetts and Maryland are picking up on the work done in California and applying it to reform legislation in their states.

Left to right, CIR leaders Anita Gaind, MD, N. Calif. vice president, and Rebecca Dwyer, MD, and Patricia Lohr, MD of CIR's southern Calif. region , worked together on the campaign to increase access to health care coverage for California's working uninsured. They are part of the continuing effort to bring health coverage to more people.

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>
> Patricia Lohr, MD
> PGY 4, OBGYN

Trauma Center Closure at King/Drew Medical Center

On November 24, 2004, the Los Angeles Board of Supervisors voted to close the King/Drew trauma center, despite the testimony they had heard in favor of the hospital and its mission during public hearings prior to the vote.

> "The services we provide are medically necessary to this community. Patients have poor access to health care, and many do not have transportation to seek care elsewhere…"
>
> Gwendolyn Harbert, MD
> PGY 3, Pediatrics

More than 1,000 people showed their strong support for the hospital at a rally organized by community groups, unions, and Congresswoman Maxine Waters prior to the Board's vote. "If the trauma center closes, it will cost many patients their lives," said CIR Southern California Vice Pres. Gwendolyn Harbert, MD, a PGY 3 in Pediatrics at King/Drew. "The services we provide are medically necessary to this community. Patients have poor access to health care, and many do not have transportation to seek care elsewhere…[If the trauma center closes] children who come in with gunshot wounds and other forms of trauma will have to take more time to travel to the next nearest trauma center. Those minutes will cost them their lives," she said in a statement entered into the public record.

The closure would also further exacerbate the strain on L.A. County's trauma centers, which are already stretched to the breaking point. The decision was made by the Board of Supervisors in an effort to improve the internal organization and health care delivery at King/Drew, which has been poorly managed, understaffed, and lacking in resources. In the meantime, trauma patients continue to stream into King/Drew, located in South L.A.

Attending physicians from King/Drew Medical Center, and community legal advocates have filed lawsuits to stop the closure. CIR is also working to protect resident training.

PHOTOS: AMY HALL/CIR

Residents at Children's Hospital Oakland Share Their Views with the Public

In the fall, residents at Children's Hospital in Oakland, California, held a press conference in front of their hospital to highlight the patient care issues they hope to resolve during contract negotiations. They were joined at this event by registered nurses, represented by the California Nurses Association, and other health care workers at the hospital, who are members of SEIU Local 250. "We want to make the hospital an even better place to treat children, and we have ideas that the hospital administration refuses to listen to," said Dr. Marlene Rodriguez, a PGY 3 in Pediatrics.

Residents voted in January 2003 to be represented by CIR, and have been working to improve patient care at the hospital by making staffing and other resource proposals during their contract negotiations. Residents cite a lack of equipment, interpreters, and nursing staff as causing unnecessary delays in patient care. The hospital has refused to add contract language on these issues. Residents still do not have a first contract.

Oakland Children doctors at a press conference to alert the public to their concerns.

Physicians for Human Rights —

Inspiration for Those with Global Patient Advocacy On Their Mind

CIR members are an extraordinarily diverse group, hailing from dozens of countries worldwide. Add to that the large number of U.S. born housestaff who have volunteered their medical services in Latin America, Africa, Asia, and all points in-between, and you have a mighty interest in global health and humanitarian concerns.

At the very epicenter of that interest and good work is Physicians for Human Rights, a leading health and human rights advocacy organization in the world.

Physicians for Human Rights (PHR) has been working "for a healthier and more humane world," since 1987, whether it's exposing torture and the treatment of political prisoners, speaking out on chemical and biological weapons or documenting the sex trafficking of girls and women world wide.

This Boston-based organization has had many achievements over the years. In 1997, PHR shared the Nobel Prize for Peace as a founding member of the International Campaign to Ban Landmines. It has pioneered the use of forensic sciences to produce evidence of war crimes and sent medical teams to more than 100 sites from Bosnia to Venezuela to investigate humanitarian health concerns.

Much of PHR's efforts are focused on the medical community itself, whether exposing unethical practices (like the participation of physicians in torture) or developing health and human rights curricula for medical and public health schools. Its *Colleagues At Risk* project coordinates international letter writing campaigns on behalf of physicians who are imprisoned for their humanitarian activities.

As PHR has become an international force to contend with, some of the group's most active members in recent years have been medical students. The organization boasts more than 70 medical school chapters across the country and last winter drew 600 students on a cold February weekend in Chicago to its annual student conference in Chicago.

"Physicians are natural allies of the poor," notes Saranya Kurapati, PHR's National Student Program Coordinator. "Many of the students who get involved experienced social and health disparities in their own communities or saw them for the first time while traveling abroad. These same students go into the health professions and become active in PHR. They see advocacy on behalf of their patients, both here and throughout the world, as an extension of their professional obligation."

PHR's 2005 conference—"The Unsteady March: Achieving Equity in Global Health" will be held on Saturday, March 5 at the University of Alabama-Birmingham. The conference provides a dramatic endpoint to PHR's fourth annual "Global AIDS Week of Action," in partnership with the American Medical Student Association. Organizers expect well over 100 medical, nursing and public health schools to participate in the week-long education campaign February 28-March 5. PHR has been in the forefront of groups pushing the U.S. government to devote more resources to the global fight against AIDS.

Case Study in Activism: Jennifer Kasper, MD, MPH

Former CIR Boston Co-Pres. and PHR Fellow

The natural connection or affinity between CIR and Physicians for Human Rights is perfectly illustrated by the story of Jennifer Kasper, MD, MPH, who served as co-president of the House Officers' Association at Boston City Hospital in 1993-94, immediately after that local housestaff union affiliated with CIR. From activism within her housestaff organization, she continued her activism in the world beyond the hospital doors.

As Dr. Kasper tells it, her involvement with health and humanitarian efforts began in residency. "While serving as pediatric chief resident at BMC, my plans were to be a primary care doctor for the underserved. I thought it would be helpful to volunteer overseas, experience Latino culture and learn Spanish in order to better serve Latino families and their children. To be honest, when I got to El Salvador in 1996, I only intended to stay 2 months—but I stayed almost two years. My life has not been the same since, and I mean that in the best sense of the word."

Serendipity then led Dr. Kasper to PHR's door. After returning to Boston from El Salvador, she was a National Research Service Award Fellow in the department of pediatrics. The fellowship allowed her to receive her public health degree at Boston University. "One day, in my Health and Human Rights class, Susannah Sirkin, one of the founders of Physicians for Human Rights came to speak. We got to talking afterwards and I told her I was very interested in studying the impact of welfare reform on immigrants. She said that PHR had just gotten a Ford Foundation grant to look at that very issue—so I ended up doing my fellowship research through PHR."

That first study, "Hungry at Home," published in 1998, examined food insecurity, hunger, and related health issues of legal immigrants in California, Texas and Illinois. Dr. Kasper and PHR found alarmingly high rates of food insecurity and hunger. The study findings played a critical part in the successful effort to restore food stamp benefits for 250,000 immigrants across the country in 1998.

Dr. Kasper's second research project, this time as a Soros "Medicine as a Profession Advocacy Fellow," (report to be published in December 2004) was also done in conjunction with PHR. "In collaboration with seven community-based organizations in Greater Boston, we studied food insecurity, hunger and their impact on child health and well-being among Latino immigrant families with children in Massachusetts," explained Dr. Kasper.

Today, Dr. Kasper lives in Tucson, Arizona and works in the Tucson Medical Center Emergency Department—when she isn't carrying out her duties as president of Doctors for Global Health, the organization that first brought her to El Salvador almost ten years ago. [Note yet another CIR connection, Doctors for Global Health was founded by another former CIR member at Boston City Hospital, Dr. Lanny Smith, who is still an active DGH board member and assistant profession of medicine in the residency programs of primary care and social medicine at Montefiore Medical Center in the Bronx, NY.]

Dr. Kasper proudly points to the wide range of communities that DGH works with in El Salvador, Nicaragua, Chiapas (Mexico) and Uganda. "Our mission involves promoting health and other human rights. Taking a holistic, preventive approach to health, we've not only built clinics and trained health workers, but also constructed kindergartens, trained local women to be the teachers, and even helped build a bridge," says Dr. Kasper.

Thinking back, Dr. Kasper definitely credits her time spent in residency as key to her future vocation. "I was so fortunate to have amazing pediatric mentors who taught me that as physicians, we have to be advocates for kids; interested not just in their medical condition, but also in the broader social context of their lives."

THE OPPORTUNITIES TO GET INVOLVED ARE AS VAST AS THE WORLD WE LIVE IN.

To find out more about the *Physicians for Human Rights*, go to www.phrusa.org. For more information about *Doctors For Global Health*, including volunteer opportunities, go to www.dghonline.org.

Back to Beacon Hill

CIR Supports New Massachusetts Resident Work Hours Bill

A resident work hours bill will be back before Massachusetts state legislators in 2005. In early December, Richard Moore, Senate Chair of the Joint Health Care Committee, re-filed the Patient and Physician Safety and Protection Act.

The bill calls upon the state's Department of Public Health (DPH) to set up an advisory committee made up of representatives from the state's hospital association, medical society, and medical school, as well as from the Committee of Interns and Residents, the American Medical Student Association (AMSA), a patient advocate, and a sleep scientist. The group would be chaired by a representative from the state-funded Betsy Lehman Center for Patient Safety and Medical Error Reduction.

That committee is charged with recommending a set of mandatory guidelines on excessive resident work hours to DPH, which would then promulgate —and enforce—hours limits on the state's 18 teaching hospitals.

"In light of groundbreaking research published this fall in the *New England Journal of Medicine*, [see article on page 6] we think it is entirely appropriate that the legislation calls for a committee of experts in the field to make these recommendations," says CIR Massachusetts Vice-President Simon Ahtaridis, MD, PGY 2 in Internal Medicine at Cambridge Hospital.

"The ACGME hours limits are simply ineffective. Teaching hospitals can and do require residents to remain in the hospital for 24-30+ consecutive hours. But the Harvard research shows a significant increase in preventable medical errors when interns worked more than 24 consecutive hours," he said.

CIR and AMSA members have begun to visit Beacon Hill lawmakers to speak in favor of the bill. "The bottom line is that it's just not safe," says Dustin Petersen, an AMSA national leader and second year medical student at Boston University School of Medicine. "Voluntary efforts by hospitals and ACGME guidelines aimed at reducing excessive work hours aren't enough. We need legislation."

Lobbying for an hours bill for residents in Mass. are, left to right, CIR delegate Phil Cefalo, MD, from Boston Medical Center, CIR Regional Vice Pres. Simon Ahtaridis, MD, Cambridge Hospital and Dustin Petersen, from Boston University School of Medicine and the American Medical Students Association (AMSA),.

The Patient and Physician Safety and Protection Act was originally filed in December 2002 and in the following two-year legislative cycle successfully passed the full Senate. This time around, says Dr. Ahtaridis, "we'll be working hard for passage in both Houses."

Cross Border Communication

Canadian and U.S. Residents Meet to Discuss Health Care, Hours

On an icy cold December Saturday, eleven CIR residents and staff received a warm welcome from their colleagues to the north—Canadian representatives from the housestaff unions of Ontario, Quebec, and British Columbia.

Hosted by the Professional Association of Internes and Residents of Ontario (PAIRO), the group of twenty something residents and staff gathered in Toronto on December 4th for a first ever day of 'cross border talking.'

"This meeting was an incredible opportunity to dispel myths about the Canadian and American health care systems and talk about the common issues facing residents within our organizations," said Dr. Danielle Martin, PAIRO president. "I think the connections we made are the beginning of a very important collaboration."

Much of the day's discussion revolved around the common characteristics of Canadian and U.S. residency training, from problems with parking, food and on-call rooms to work hours limits. "I was struck by how similar our lives as residents are," said CIR President Barbie Gatton, MD.

As the discussion turned to health care systems, however, there were many differences to digest. Housestaff to the north described a health care delivery system funded by the federal and provincial governments that provides health care to all Canadians—no denying care for lack of health insurance, as is so common in the United States.

"Our Canadian colleagues don't have to spend so much of their time fighting to keep a vital clinic or hospital open, or fighting for patients' right to health care. I was jealous," confessed Dr. Gatton, a PGY 3 in Emergency Medicine.

The daylong discussion revealed some misconceptions on the part of the two groups. Dr. Gatton found it striking, for example, that the Canadian residents thought health care was instantly available in the U.S. to anyone who could pay. "We explained that in certain specialties, we too have long waits for an appointment, even when a person can pay—and then there are at least 47 million uninsured who have no coverage at all!"

CIR residents, for their part, were surprised to learn that most post residency Canadian physicians work in a fee for service setting, with fees negotiated between the provincial medical associations and governments. They also learned that while Canadians are enormously proud of their health care system, significant reductions in funding throughout the 1990s have weakened the system. What was clear, however, was that the Canadian residents were as intent on preserving and improving their system as the U.S. residents were on creating a health care system that would care for all, regardless of ability to pay.

"I think we were all surprised by how similar our ideals are," commented Dr. Danielle Martin, a family medicine resident training in Toronto. "Despite working in completely different health care systems, residents across North America clearly want to be able to offer patients the best possible care based on need and not on the ability to pay."

"We're both realizing that by the nature of who we are and what we do, resident unions have to get more involved in the bigger picture of health care in our respective countries," summed up Arun Chopra, MD, CIR Vice-President from New Jersey/Washington DC.

By the end of the day, all participants agreed that there was much to be gained from continuing the north-south dialogue, because good ideas don't stop at the border, and we have much to learn from one another.

Top: Dr. Danielle Martin, president of PAIRO, the Ontario residents' union.
Above: House officers and staff from Canada and the U.S. shared information about their common experiences and different medical systems.

Interview With Sleep Researcher Dr. Charles C

Harvard Study Documents Pre and Challenges Safety of 24 H

The NEJM Articles in Brief: Work Hours, Sleep & Medical Errors

Both articles in the October 28, 2004 issue of the *New England Journal of Medicine* are based on the results of the same study in 2003-04 in the Brigham & Women's Hospital MICU and CCU during a total of 2,203 patient-days involving 634 admissions. Each intern was studied during their two 3-week rotations and each did both a—

- Traditional schedule with 3 interns (Q3, with 30 consecutive hour shifts and total work weeks greater than 80 hours per week)
- Interventional schedule with 4 interns (no consecutive shifts greater than 16 hours, total work weeks less than 80 hours per week)

On average, subject interns worked 19.5 hours less per week, slept 5.8 hours more per week, slept more in the 24 hours preceding each working hour and had less than half the rate of attentional failures while working during on-call nights on the interventional schedule.

Conclusions:

"Eliminating interns' extended work shifts in an intensive care unit setting significantly increased sleep and decreased attentional failures during night work hours." (NEJM p. 1829)

Conversely, the authors report that interns on the traditional Q3 schedule (with shifts of 30 consecutive hours) made:

- 35.9% more serious medical errors, including
- 56.6% more non-intercepted errors
- 20.8% more medication errors
- 5.6 times as many diagnostic errors

"Interns made substantially more serious medical errors when they worked frequent shifts of 24 hours or more than when they worked shorter shifts. Eliminating extended work shifts and reducing number of hours interns work per week can reduce serious medical errors in the intensive care unit." (NEJM p. 1838)

October 28, 2004—mark the date. The prestigious *New England Journal of Medicine* publishes two articles about resident work hours, sleep deprivation, and medical errors that should give the world of medicine something to consider.

Conducted by the Harvard Work Hours Health & Safety Group, the study observed interns at Boston's Brigham & Women's Hospital as they worked in the intensive care units on both a traditional every third night, 30+ consecutive hour schedule and on an "interventional schedule" of no more than 16 consecutive hours.

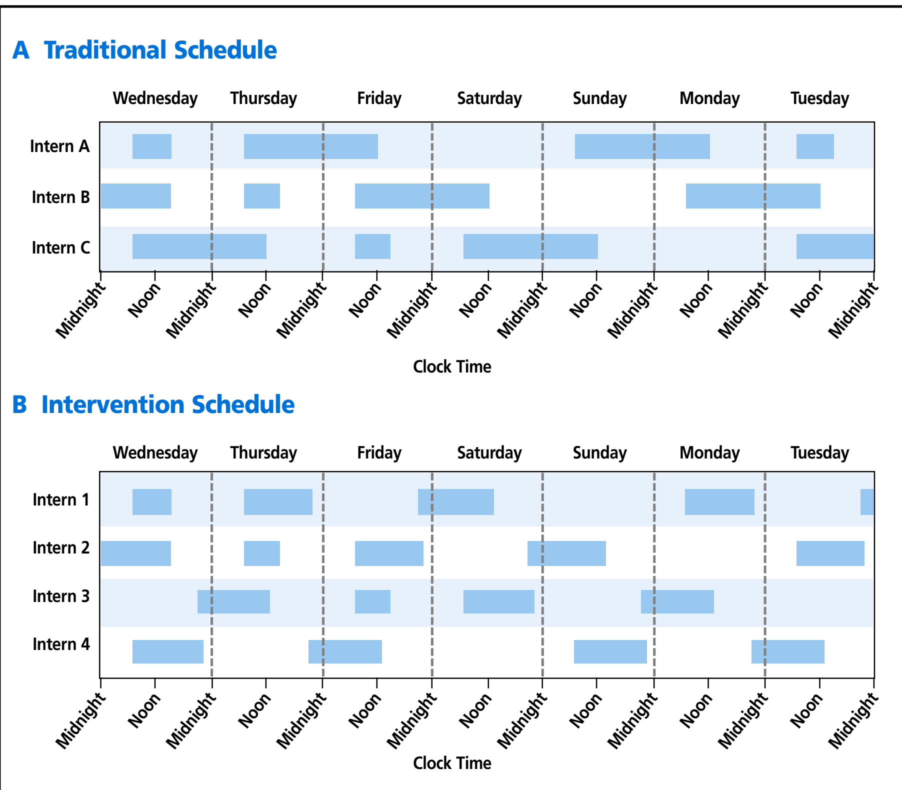
The data confirms what many in the medical community have long maintained: rather than improving patient care and reducing errors, scheduling residents to extended shifts of 24 or more consecutive hours does quite the opposite.

"Our results may have important implications for health policy, since more than 100,000 physicians are currently in training in the United States," the study's authors conclude. "Most of these residents are regularly scheduled to work 30-hour shifts, since extended work shifts and long workweeks continue to be permitted, even under the scheduling reforms instituted last year by the Accreditation Council for Graduate Medical Education. Further modifications of these standards, particularly with respect to the duration of work shifts, may be needed to improve patients' safety in teaching hospitals nationwide." (NEJM p. 1847)

In a recent interview, *CIR News* asked Charles Czeisler, M.D., PhD, head of the Division of Sleep Medicine at Brigham and Women's Hospital, what made the "interventional" schedule so successful. First, he stressed, reducing the consecutive number of

> "We were stunned to find that there were five times as many diagnostic errors in the traditional schedule as there were in the interventional schedule."
> Charles Czeisler, MD, PhD

hours worked was key. "I must have been asked hundreds of times—why didn't we just add a 4th intern, a Q 4 schedule? I explained that it's not the total number of hours worked per



THINKING OUT

Intervention Call Schedule: 16-Hou

This "outside the box" intervention call schedule is unique because it splits the intern's on-call into two distinct parts—"Day Call" and "Night Call." As described by the Harvard Work Hours Health & Safety Group (NEJM p. 1830): Four interns provided continuous coverage on a four day schedule consisting of:

Day #1: Standard Day—approximately 7 am to 3 pm (8 hours).

Day #2: Day Call—7 am-10 pm (15 hours)
Intern can stay 1-2 hours more if necessary for patient care and/or medical education.

Day #3: Night Call—Intern sleeps in on the morning of Day #3.
Then takes a nap before returning to work at 9 pm to complete the second half of the call shift.

Day #4: Night Call continues until 1 pm the next day (16 hours)
Again, if patient care and/or medical education requires, intern can stay longer.

zeisler, MD, PhD

ventable Errors ours On-Call

week that is the problem—it's the *consecutive* hours worked."

Dr. Czeisler went on to explain that the most important feature of the new schedule "was that it eliminated the practice of scheduling residents to work 24 or more consecutive hours. That practice is not safe.

"We've heard it repeated so often, that in order to really know your patient, you have to stay with that patient to observe," he continued. "We were stunned to find that there were five times as many diagnostic errors in the traditional schedule as there were in the interventional schedule. It was just remarkable to be able to compare the conventional wisdom with the actual data."

Resident input in devising the interventional schedule was also essential to its success. Dr. Czeisler pointed out that the new schedule was actually adopted after two previous schedules were thrown out.

"Originally, we thought we would use a night float to guarantee ICU interns 10 hours of protected sleep. But as we began to work with that model, we realized that because we had to hire more staff, it was enormously expensive. Also, in talking with the interns, we found that they wanted to be able to work at night. They argued that if they never worked at night, how could they then come back as senior residents to work and supervise others at night?"

Then the research team went to "Plan B"—deciding to test out the Association of American Medical College's 2001 recommendation that house staff work no more than 12 consecutive hours in an ICU setting. "We had four interns and they weren't supposed to work more than 12 hours at a time," said Dr. Czeisler. "But they were so conscientious—they would come in early before their shift and stay late after their shift. The shifts started blending into each other and soon the interventional schedule hours were as long, or longer, than the traditional schedule.

> "It's not the total number of hours worked per week that is the problem, it's the *consecutive* hours worked."
>
> Charles Czeisler, MD, PhD

"We had to stop," said Czeisler. "We didn't want to enforce the schedule; to tell people 'you must leave.' We felt that was just the wrong message to give them."

Then it was back to the drawing board and interventional schedule #3 was devised, a decidedly 'outside the box' schedule that breaks the call into two parts, separated by 24 hours (see chart and box for more details).

Inevitably, the Harvard research team had to confront concerns about continuity of care, universally recognized as a crucial ingredient in the provision of quality patient care, not to mention avoiding serious medical errors. The interventional schedule meant that not every intern was able to attend morning rounds and some attendings were displeased. Asked how that problem was addressed, Dr. Czeisler replied that, "we learned it was critical to develop team building skills. It's not 'my patient,' but 'the team's patient.'" He also stressed that there was much to be done to improve the transfer of information. Wrote the NEJM authors:

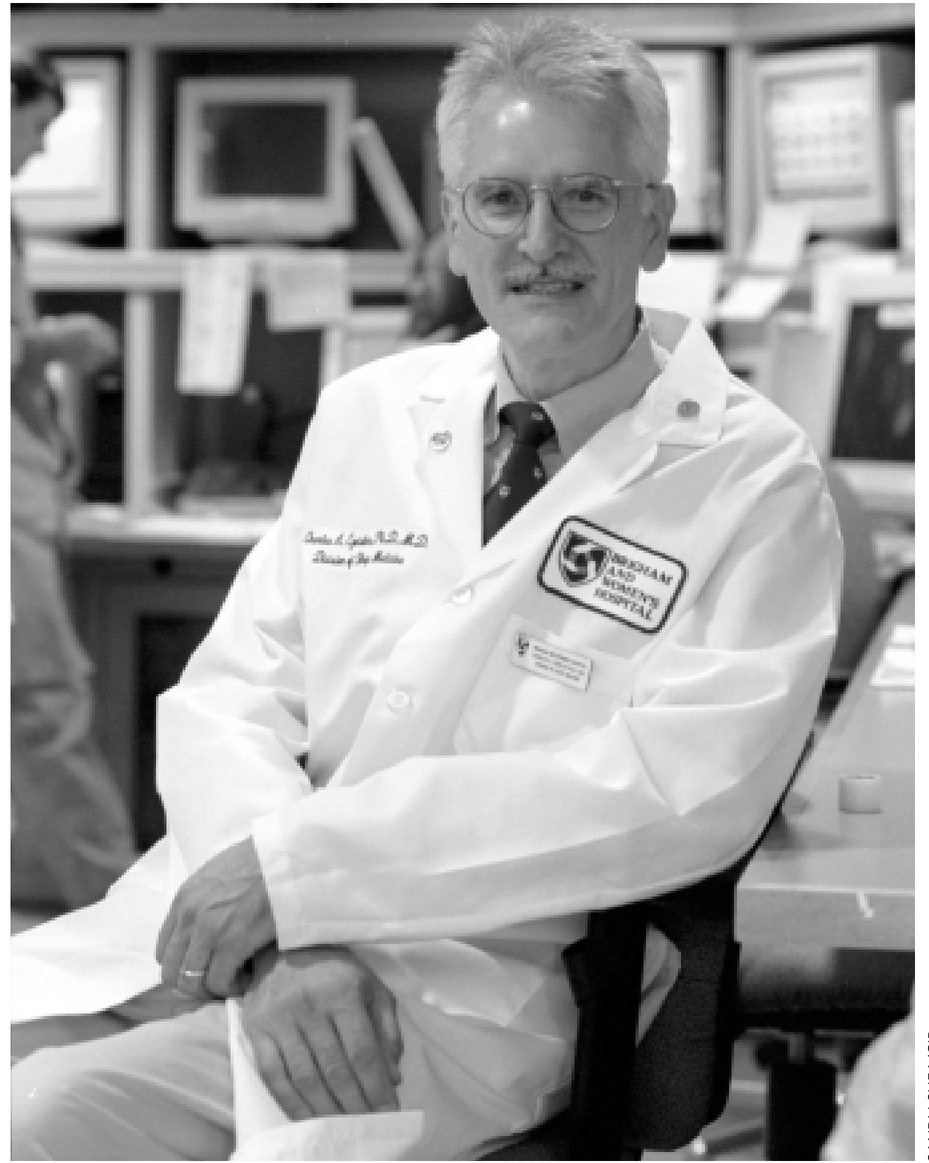
> "We learned it was critical to develop team building skills. It's not 'my patient,' but 'the team's patient.'"
>
> Charles Czeisler, MD, PhD

"Although our intervention decreased the rate of serious errors overall, our efforts to optimize the sign-out process were only partially successful. The computerized template was never fully adopted, and the effectiveness of the planned evening sign-out was frequently suboptimal. Although some groups of interns worked successfully as teams and effectively signed out every evening, even in the absence of formal training in team management, others did not.

"We suggest that future scheduling interventions address this issue by adding formal evening rounds for the entire team. Such improvements, coupled with the elimination of extended work shifts, could further improve patients' safety." (NEJM p. 1846)

Finally, *CIR News* asked Dr. Czeisler about the C word—cost. What were the implications of this study for the hospital's bottom line? He stressed, "how proud I am of our hospital, that they opened themselves up to this kind of scrutiny," and noted that the hospital did incur additional costs because of it. Still, Dr. Czeisler reported that Brigham and Women's was seriously considering limiting schedules to a maximum of 16 hours next year. So what about the cost? Dr. Czeisler noted that the annual cost of an additional intern in the ICU was about $50,000 and the daily cost of billing in the ICU was probably greater than $50,000.

"The cost of reducing preventable medical errors," he concluded, "Priceless."



Dr. Charles Czeisler discussed the findings of the Harvard Work Hours Health and Safety Group with *CIR News*.

PHOTO: SANDY SHEA/CIR

SIDE THE BOX:

ur Maximum for Safety

The intervention schedule includes a one-hour overlap between the out-going day-call intern, and incoming night-call intern—this overlap is often extended as clinically required. Interns only attended clinics when it coincides with standard day shift.

The big advantages of this schedule are:

- **Flexibility**—allows for interns to stay 1-3 hours longer than their scheduled 16-hour shift when patient care and/or medical education requires—without cutting into their sleep time.
- **Rested Interns** working nights were much more awake. Dr. Czeisler said one resident described them as "the energizer bunny—the only one really awake in the unit at night."
- **More Procedures** were done at night by interns on the intervention schedule than by those on the traditional schedule (contrary to the conventional wisdom that says housestaff see more/do more when they are in the hospital longer).
- **Fewer medical errors!**

What the Harvard Work Hours, Health and Safety Group Had to Say…

CIR News urges all housestaff to read both "Effect of Reducing Interns' Weekly Work Hours on Sleep and Attentional Failures" and "Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units," in their entirety (NEJM Vol 351, No. 18, p. 1829-1848, 10/28/04). Here are just a few highlights.

On The Need to Review ACGME Hours Limits

"…work hours during the pre-ICU clinic rotation averaged 40 hours per week, but increased to 85 hours per week during the three week traditional ICU schedule. The resulting four-week-average of 74 hours per week, calculated as specified by the ACGME, means that interns' schedules in high intensity settings can far exceed the weekly work-hour limits of "no more than 80 hours in any week" and "no more than 12 hours of continuous duty" specified by the Association of American Medical Colleges." (p. 1835)

"Our results may have important implications for health policy, since more than 100,000 physicians are currently in training in the United States. Most of these residents are regularly scheduled to work 30-hour shifts, since extended work shifts and long workweeks continue to be permitted, even under the scheduling reforms instituted last year by the Accreditation Council for Graduate Medical Education. Further modifications of these standards, particularly with respect to the duration of work shifts, may be needed to improve patients' safety in teaching hospitals nationwide." (p. 1847)

On Education and The Transfer of Patient Information

"Before we initiated the intervention schedule, concern was expressed that decreasing the number of hours interns worked might diminish their role in the units, thereby shifting the burden of order writing and procedures and, hence, the risk of errors to more senior staff. Our results did not bear out this concern: the number of medications ordered and tests interpreted by interns per patient-day did not differ significantly between the two schedules, and interns performed significantly more procedures per patient-day during the intervention schedule. Thus, the substantially lower rates of errors by interns during the intervention schedule cannot be due to shifting of errors to more senior staff." (p. 1845-1846)

On Schedules—All are Not Equal

"It is important to emphasize that not all interventions that reduce interns' work hours will increase interns' sleep or improve patients' safety. Schedule design is a critical factor in determining the extent to which around-the-clock work schedules disrupt wake-sleep cycles, even when the number of weekly work hours remains the same." (p. 1846)

On Errors—'Robust' Results

"The acute and chronic sleep deprivation inherent in the traditional schedule caused a significant increase in attentional failures in interns working at night. The robustness of this result, which was evident in 13 of 20 interns, is striking, considering the fact that caffeine use, compliance with the protocol and individual differences in the need for sleep among subjects could not be controlled in this field study." (p. 1835)

On Excessive Work Hours—Not Just a Problem for Interns

"Our findings may apply not only to residents working in critical care units but also to those on other rotations and specialties and to more senior residents, attending physicians, nurses and others. Future studies should further evaluate the effects of current working practices on physicians and objectively measure the effect of interventions designed to improve physicians' health and patients' safety." (p. 1836)

Visit www.HoursWatch.org, the website for anyone with an interest in resident work hours reform. You can read the NEJM articles at HoursWatch.

PHOTO: STEPHEN WELSTEAD/CORBIS

CIR's History with the 16-hour Schedule

For CIR history buffs, the maximum 16-hour on-call schedule that formed the basis of the Harvard "intervention schedule" was deja vue all over again. In 1975, CIR members in several New York City hospitals put jobs and careers on the line in an intense contract battle to shorten hours and move away from every other night call (then the norm for all residency programs, not just surgery). In city-wide negotiations, CIR proposed a maximum of 15 hours of continuous work and an 80 hour weekly limit.

When the dust settled, the NYC League of Voluntary Hospitals agreed to move to the first ever limits on hours—Q 3 call and no more than a total of 10 calls in 30 days. Soon, that standard spread across the country.

In 1988, after the death of Libby Zion and subsequent grand jury investigation, New York State appointed a commission, headed by Bertrand Bell M.D., to recommend changes in supervision and hours of work for residents. CIR advocated for a 16-hour maximum, based in large part on the experience of New Zealand housestaff, who were championing their recent conversion to a 72 hour per week, 16 consecutive hour schedule.

Once again, the hospital industry and medical educators objected vociferously to *any* hours limits whatsoever. CIR mobilized housestaff across the city, as well as other healthcare unions and patient advocacy groups to testify and lobby the governor and NYS commissioner of health to support regulations limiting resident hours. In the end, the compromise was 24/80. The Bell Regulations went into effect in 1990, the only such mandatory hours limits on the books anywhere in the fifty states.

In July 2003, under threat of national legislation, the ACGME moved toward establishing 24+6 hours for on-call nationally. Informed by the Harvard team's "robust" evidence that working 24 or more consecutive hours is not safe, it just may be time to start talking about 16 again.

Starting CIR

Founding Officers Reflect on History and Growth Since 1957

As we approach CIR's 50th anniversary (two years from now), we wanted to take this opportunity to reflect upon our past, which often has a way of shedding light upon the present. In 1957, municipal workers of all kinds in NY gained the right to form unions. A young lawyer named Murray Gordon teamed up with some activist residents. The result was CIR.

Dr. Herbert Vaughan, now retired, was CIR's first president. Back in 1957, the year CIR was formed, Dr. Vaughn was starting his medical career at Bronx Municipal Hospital Center (now Jacobi Medical Center). Dr. Saran Jonas was CIR's second president, and worked at Bellevue Hospital at that time. He is currently professor of Neurology at New York University Hospital.

Dr. Saran Jonas

What gave you and others the idea of forming CIR?

Dr. Vaughan: CIR was a movement that started in the municipal hospital system, which had a number of hospitals in really in bad shape, with no teaching programs to speak of, and terrible conditions physically, and in terms of personnel.

At the time we started CIR, interns were earning $715 a year, and second year residents $1,200 a year. We were all working more than 100-hour workweeks. All of a sudden, the hospital decided interns and residents should be having Social Security payments withheld from their paychecks, and that they would do this retroactively. It was more money than housestaff could part with. We decided to start an organization that we did not want to call a union. We thought it would give us an odd image to have a union. So that's how we came up with the name, Committee of Interns and Residents.

We called a meeting at Bellevue to discuss the situation, both the compensation and the poor standard of medical care being delivered in the city medical system. We plotted a strategy to convince City administration that paying interns and residents so poorly was outrageous, [and to promote] affiliating the hospitals with medical schools. We called a meeting, and 200 housestaff came, the room was packed. I decided we needed to present a plan to the city, and wrote a white paper that was a comprehensive critique of the hospital situation.

Dr. Jonas: When we went to the first budget hearings, I worked on the financial part that demonstrated that New York City hospitals were at the very bottom of the payroll situation for housestaff. Our argument was that this was a very negative factor in terms of recruiting housestaff. We were also able to show that mortality rates at some of the city hospitals were among the worst in the nation. At the end, the Mayor said, 'I instruct the budgetary people to go over this with you.' They asked me where I had gotten my financial calculations. I said, 'I did them myself.' There were no computers or pocket calculators at the time, so I did this all by hand, and brought in 20 sheets of paper with the calculations on them. He wanted to see the evidence, how the work was done. The financial person said, 'This is not about you people, it's about the budgetary pie, and if you can convince us that a slightly larger slice for you would make a difference for the people of the City of N.Y., we'll do our best.'

What was the result of your presentation to the Mayor?

Dr. Vaughan: The City decided to have a contractual relationship with CIR, and they increased our salaries to $10,000…We worked with the people who had the power, and worked with them directly. Since then, there has been steady improvement in salary and benefits.

Dr. Jonas: What convinced them that we were a bargaining unit was that they asked us, 'How many residents do you represent?' We said, '2,000.' So they asked, 'How many are paying dues?' We had 600 people paying dues right at the beginning, even without the right to bargain.

What do you think accounted for your swift success?

Dr. Vaughan: The Journal of the American Medical Association's Intern and Residency issue listed every program along with its statistics—admissions, procedures, death rates and autopsy procedures. One of the municipal hospitals at that time had death rates that were three times higher than in hospitals with teaching affiliations. I really think it was that statistic that pushed the affiliation with medical schools through in 1957-58.

How do you feel about CIR's evolution over time, and your role in founding CIR?

Dr. Jonas: I had a senior attending warn me, 'Be careful, you're going to be labeled a Communist.' But we won by demonstrating that the city was suffering by underpaying us. CIR was really a workers' committee, we didn't envision it as an operating union. It only became formalized later on. I was not opposed to the idea of forming a union, I was just surprised to see how far it evolved. It's great. I'm delighted at CIR's growth (to a national union). It's Herb (Dr. Vaughan) who deserves the real credit—he conceived it, and assembled the people to carry it out. He was a creative thinker and leader. Without him, none of this would have occurred. I recruited many people, but didn't think of the idea. I would never have thought of the idea!

Dr. Vaughan: It was our hope that CIR would grow beyond the New York area. We had no idea it would have as much momentum as it did. Really good people affiliated themselves with CIR over the years. I put my heart and soul into CIR. Our tactics were different from the usual ones. We never had to have a strike (to form CIR). I view the founding of CIR as one of my life's greatest achievements. The improvement of medical education and the quality of hospital care of patients has been the motivation for CIR since its founding.

Dr. Herbert Vaughan

"I view the founding of CIR as one of my life's greatest achievements. The improvement of medical education and the quality of hospital care of patients has been the motivation for CIR since its founding."
Herbert Vaughan, MD

The CIR Executive Committee voted in November, 2004 to plan a celebration for CIR's 50th Anniversary at the CIR May 2007 Annual Convention.

Delegates meet and caucus prior to negotiations in CIR's early days.

Residents Strategize for a First Contract in Puerto Rico

"It has become a cycle," says CIR delegate Fernando Soto, MD, explaining why he and a group of residents (see photo, below) brought a letter signed by more than 200 of their colleagues to the Chancellor of the University of Puerto Rico, Dr. Jose R. Carlo, on November 23, 2004. "Residents are unhappy with salaries, nothing happens for years, and then after a strike, demands are met. People are tired of that cycle. We want an increase without having to struggle and strike."

The letter they delivered requested a meeting with Dr. Carlo and the university's president, to begin negotiations. CIR in Puerto Rico has been recognized by the Department of Labor as a union, but doesn't have collective bargaining rights yet. For many years other unionized workers at the university have won collective bargaining agreements, and interns and residents are demanding that same right.

Some of the residents who delivered a letter signed by more than 200 of their colleagues to the University of Puerto Rico's Chancellor.

"We're all working towards the same goal, it would benefit the school as well as us residents."
Marta Suarez, MD, PGY 3, Pediatrics

"Our key issues are being able to gain an increase in salary without resorting to strikes, and improving patient care," said Dr. Soto, a PGY 3 in Emergency Medicine at the University of Puerto Rico's Medical Sciences campus. Patient care suffers, he says, because of the understaffing of nurses and transport workers. "Residents work 24 hours, so we end up doing the patient transport. We also have too many patients in ICU, and not enough room for new patients."

CIR delegate Marta Suarez, MD, with Chancellor Jose R. Carlo, MD, discusses residents' goals, outlined in their letter.

Other issues that residents are concerned with include, "call rooms with computers, health insurance that includes a prescription benefit, and reimbursement for meetings and books," said CIR delegate Marta Suarez, MD, a PGY 3 in Pediatrics.

"I asked Dr. Carlo [the Chancellor] about meeting with us, and he said he was willing to talk. I told him we are available at any time to talk," said Dr. Suarez, shown in photo, above, discussing the letter with Dr. Carlo. "I wanted to be a delegate and be involved," Dr. Suarez said. "I have union members in my family, and I think it's a good thing to get involved. One of my passions is better working conditions. We're all working towards the same goal, it would benefit the school as well as us residents," she said.

CIR Benefits Plans Release Annual Reports

Every year, CIR updates and publishes the financial reports on the five benefit Plans provided to participants. Four of the Plans have reported audit results for December 31, 2003. The Professional Educational Plan, which has a June fiscal year end, has presented the audit results for June 30, 2003.

Summary Annual Report of the Public Sector (Supplemental Plans):

- **House Staff Benefits Plan (HSBP)**
- **Legal Services Plan of HSBP**
- **Professional Educational Plan (PEP)**

This is a summary of the annual report of the **House Staff Benefits Plan** of the Committee of Interns and Residents (HSBP), Federal Identification Number 13-3029280, for the year ended December 31, 2003. The annual report has been filed with the Internal Revenue Service. The Plan is not required under the Employee Retirement Income Security Act of 1974 (ERISA) to release financial information, but elects to do so for the information of the participants.

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

Insurance Information

The HSBP Plan has contracts with Aetna to pay all dental claims and with Prudential Insurance Company of America for life insurance claims under the terms of the Plan. The total payments paid and accrued for the plan year ended December 31, 2003 were $1,170,346 in Dental Insurance to Aetna and $270,340 to Prudential for Life Insurance.

The Plan has a contract with The Guardian (since April 1, 2000) to process and pay long-term disability benefits and The Guardian was paid $249,091 for the year ended December 31, 2003.

Housestaff Benefits Plan – Basic Financial Information

The value of the Plan assets after subtracting liabilities of the Plan was $5,157,874 as of December 31, 2003 compared to $5,155,614 as of December 31, 2002. During the year, the Plan experienced an increase in net assets of $2,157. This increase included both realized and unrealized gains and losses on securities.

During the year, the Plan had total income of $3,097,508, which included employers' contributions of $2,638,935, interest on investments of $143,247, COBRA receipts of $18,224, investment losses of ($24,573) (realized and unrealized), and $321,675 in insurance dividends (including a de-mutualization stock dividend from Prudential Insurance).

Plan expenses were $3,095,351. These expenses included $2,574,021 in benefits paid (to participants and beneficiaries or on their behalf) and $521,330 in administrative expenses.

Legal Services Plan of HSBP

This plan covers certain basic legal services for the members. The Federal Identification Number is 13-3011915.

The House Staff Benefits Legal Services Plan ended December 31, 2003 at a deficit of $ 141,405 (liabilities exceeding assets). This was a deficit increase of $33,682 over the prior year. During 2003 total employer contributions were $235,800 and total costs were $269,482 ($201,355 in benefits and $68,128 in administration expenses.)

Professional Educational Plan (PEP)

This plan reimburses up to $600 per year to members for licensing exams, video and audiotapes and certain other job related expenses.

The Professional Educational Plan of CIR (Federal Identification Number 13-4071468) ended the June 30, 2003 fiscal year with a surplus of $1,826,556 (assets exceeding liabilities). During the fiscal year ended June 30, 2003 the plan reported an operating surplus for the year of $226,401. Total employer contributions, were $1,222,158, investment income totaled $119,360, and total costs were $1,115,117 ($1,003,398 in benefits and $111,719 in administration expenses.)

Summary Annual Report of the Private Sector:

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

Voluntary Hospitals House Staff Benefit Plan

This is a summary of the annual report of the **Voluntary Hospitals House Staff Benefits Plan** of the Committee of Interns and Residents, Federal Identification Number 13-3029280, for the year ended December 31, 2003. The annual report has been filed with the Internal Revenue Service as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has committed to pay for insurance costs (listed in the next section) and for optical claims incurred under the terms of this plan.

Insurance Information

The Plan has contracts with Aetna to pay all dental claims and with Prudential Insurance to pay all life insurance and accidental dismemberment claims. In addition, coverage is secured with United Healthcare to pay medical, basic medical surgical and major medical claims incurred under the terms of the Plan. The total premiums paid to United Healthcare for the Plan year ended December 31, 2003 were $11,607,582. The plan will receive a United Healthcare dividend in the amount of $873,000 and $99,312 from Prudential Insurance Company both because of favorable claims experience during 2003.

The VHHSBP plan paid $927,684 to Aetna for Dental Insurance and $311,691 to Prudential for Life Insurance for the year ended December 31, 2003.

The plan paid Guardian Insurance to process and pay long-term disability benefits. In 2003, $237,972 was paid to Guardian for long-term disability as compared to $276,582 for the prior year. The long- term disability plan became effective on April 1, 2000.

Basic Financial Statement

The value of the Plan (assets less liabilities) was $9,903,043 as of December 31, 2003, compared to $9,695,512 for the prior year. During the year the Plan experienced an operating gain of $207,532 (after deducting an allowance for uncollected receivables). The fund records all securities at market value and records any unrealized gains or losses on securities.

During the year the Plan had a total income of $13,966,778, which included employers' contributions of $12,005,047; COBRA receipts of $334,753, and $264,423 as interest income (from Investments and from delinquent employer contributions). In addition the fund made $132,392 on Investments (realized and unrealized) on securities held, and $189,008 from Prudential Insurance as a result of Prudential declaring a de-mutualization dividend and from subsequent appreciation. The Insurance Section, just above, details the dividends paid as a result of favorable claims experiences in both medical and life insurance claims.

Plan expenses and benefits were $13,759,247. These expenses included $437,488 in administrative expenses and $13,321,759 in benefits paid to participants and beneficiaries or on their behalf.

Legal Services Plan of VHHSBP

The plan covers certain basic legal services for the participants. The Federal Identification Number is 13-3029279.

The Legal Services Plan of VHHSBP ended the year with a surplus of $23,663, an increase of $4,453 from the prior year's surplus of $19,209. During 2003 employer contributions were $239,517 and costs were $235,064 (benefits of $227,343 and administration expenses of $7,721).

Participant's Rights to Additional Information

Any participant in any of the above-mentioned plans has the right to receive a copy of the full annual report or any part thereof on request. The items listed below are included in that report: an accountant's report assets held for investment; fiduciary information, including transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan); transactions in excess of 3 percent of plan assets; and insurance information including sales commissions paid by insurance carriers.

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

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

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

PHOTOS: JORGE ARZOLA, MD/CIR

Health Insurance Squeeze: Higher Costs, Less Care

Why Ranks of Uninsured Likely to Rise

Resident physicians are well aware of the impact of high health care costs on patients—what happens, for example, when they put off going to a doctor or can't pay for medications and then end up in your ER bay.

But chances are you don't know just *how* high those health care costs have risen—or how they may be affecting *you*. According to a report released in the fall of 2004 by *Families USA*, "Family health premiums, paid by employers and workers, rose to $9,320 in 2004."

The report, entitled, "Health Care: Are You Better Off Today Than You Were Four Years Ago?" answers that question by analyzing reams of data. "Our analysis leaves no room for debate. The answer is a clear *no*." The nonpartisan, non-profit organization based in Washington, D.C., and dedicated to high-quality, affordable health care found, for example:

"The number of Americans who had total health care costs that consumed more than one-quarter of their earnings rose from 11.6 million in 2000 to 14.3 million in 2004—an increase of almost 23%."

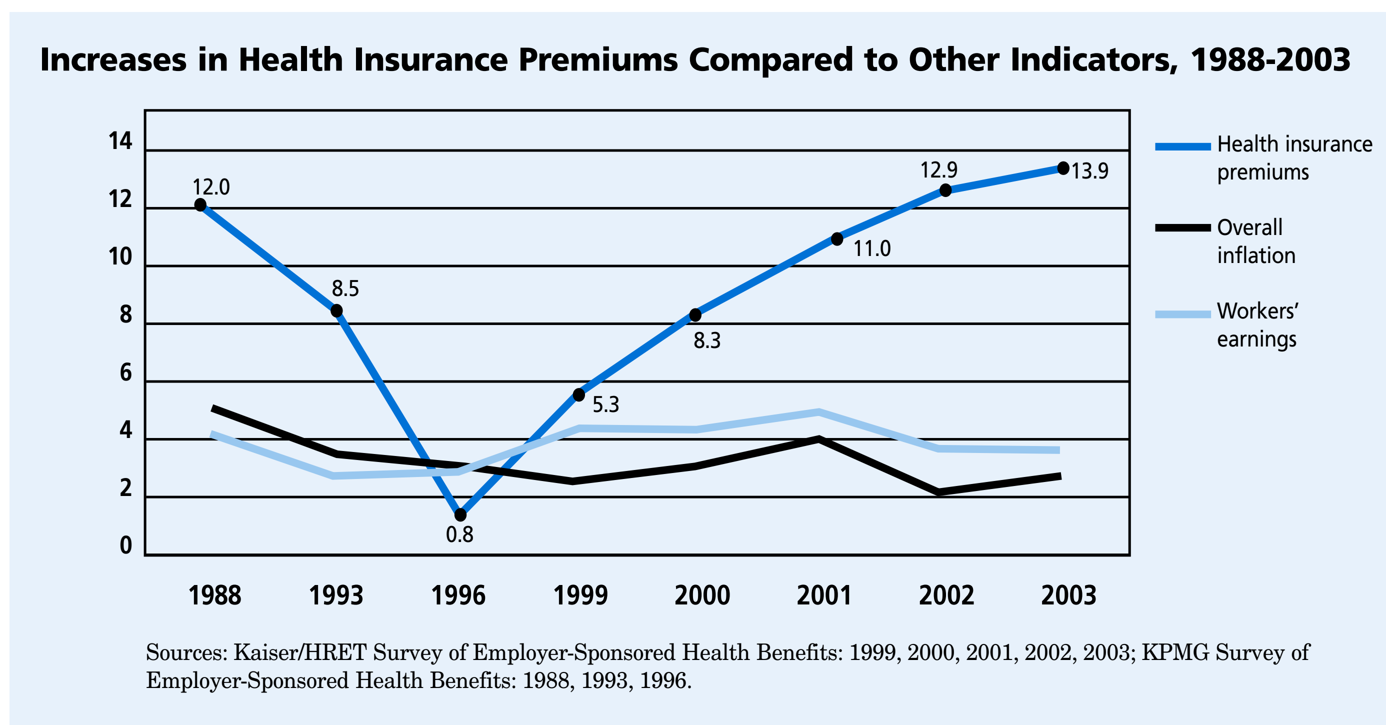
Job-based health insurance premiums surged an average of 11.2% from the spring of 2003 to spring 2004; marking the fourth straight year of double-digit premium growth. *(Source: Kaiser Family Foundation.)*

The Census Bureau reported 45 million Americans uninsured in 2003, up by roughly 5 million people since 2000. The Bureau defines the number of uninsured as those without health insurance during an entire calendar year (leaving out the approximately 40 million *more* who go uninsured for part of the year—a staggering 85 million people).

Employers have responded to the double-digit increases in health coverage by "thinning" the coverage they offer, shifting costs onto workers, (who may opt out due to lack of funds) or, in dire cases, ending coverage altogether. These events occur most frequently when the workforce is non-union, and unprotected by a collective bargaining agreement. These are some of the reasons the ranks of uninsured have swelled in the past four years.

Unionized employees have tried, and in many cases, succeeded in resisting employers' attempts to either provide diminished coverage or to shift the premium cost increases onto workers. This past fall, for example, 10,000 casino workers in Atlantic City, N.J., went on strike over maintaining their health benefits at no cost to workers. They won fully-paid employer health care coverage, as did building and elevator operator workers in New York City, who voted to strike over the issue in September, 2004.

CIR's benefit funds provide health insurance to more than 5,000 members in the metro New York area. Negotiations presently underway with private sector hospitals need to address overall increases in health care costs, and to maintain the current benefit plan, which provides a high level of benefits with no resident co-payment required for premiums.



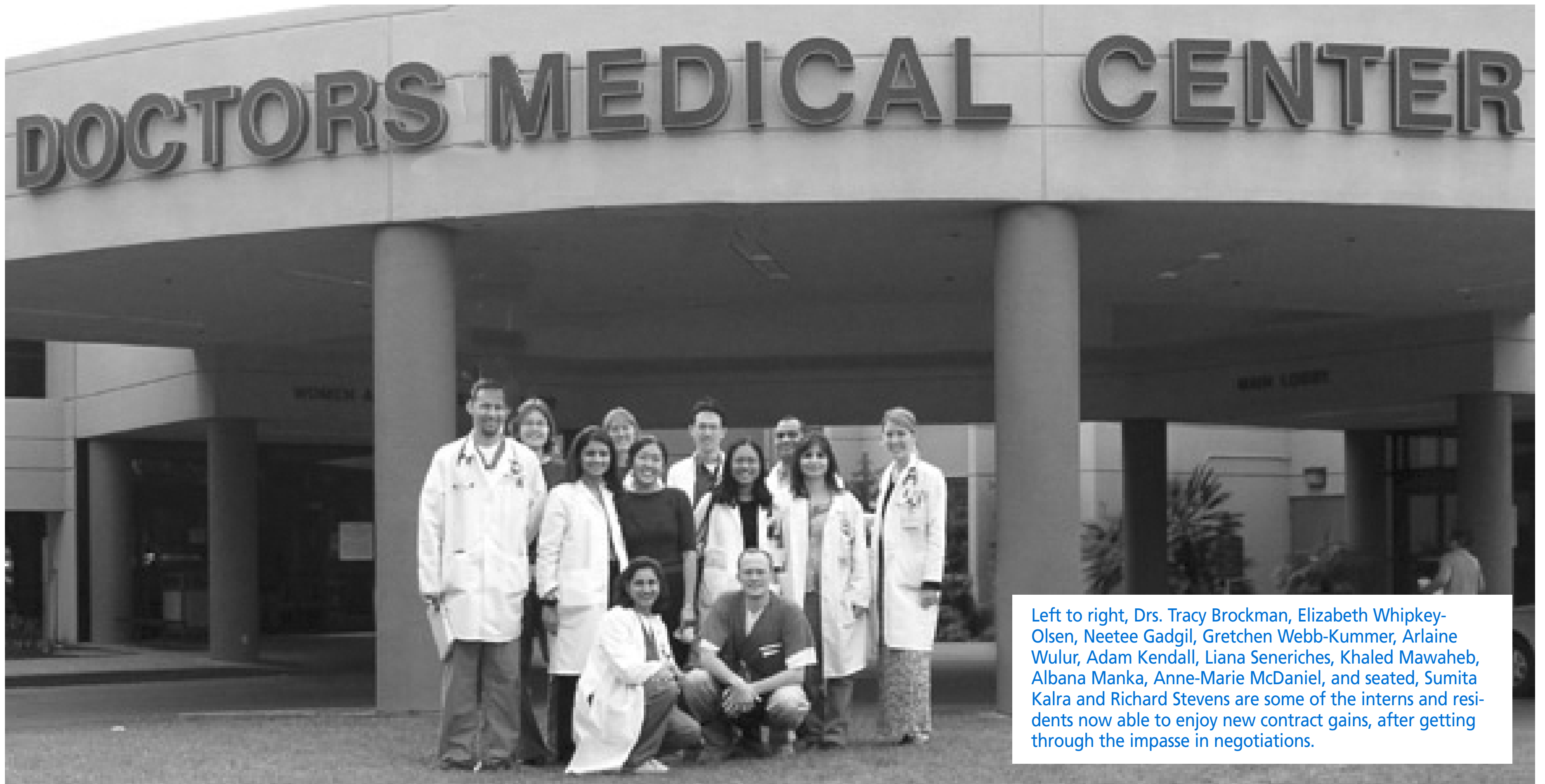
Double-digit increases to health plan premiums have dwarfed workers' earnings, and overall inflation, clearly shown in graph above.

CIR delegates, including NY V.P. Andrea Maritato, below, attending New York Regional meetings have been learning about the effect of increased health plan costs on current contract negotiations with New York's private hospitals. CIR is committed to maintaining our high-quality health benefits, with no increase in member costs.

PHOTOS: CARA METZ/CIR

Modesto, Ca. Family Practice Program:

Breaking Through Stalled Negotiations



Left to right, Drs. Tracy Brockman, Elizabeth Whipkey-Olsen, Neetee Gadgil, Gretchen Webb-Kummer, Arlaine Wulur, Adam Kendall, Liana Seneriches, Khaled Mawaheb, Albana Manka, Anne-Marie McDaniel, and seated, Sumita Kalra and Richard Stevens are some of the interns and residents now able to enjoy new contract gains, after getting through the impasse in negotiations.

PHOTO: LINDCY STEVENS

CIR members at the Stanislaus County Family Practice Program were tired of living with a wage freeze for the past two years. But when the CIR negotiating committee began meeting, they were told that because California's public sector is so short of funding, the big chill would continue.

While the key issue for most CIR members was a pay raise, "Making sure we kept our health insurance" was also high on the agenda, said Tracy Brockman, MD, a PGY 3 and co-chief resident. "A rumor had spread that they would try to take it away from us."

Altruism Meets Residents' $150,000 education debt

"In Family Medicine, we wanted to show (hospital administration) that we need to maintain our program's ability to attract good applicants in a field that is losing residents because other specialties are more highly paid," Dr. Brockman said. "A lot of us go into medicine for altruistic reasons, but by the time we finish our residencies, we're concerned with how to pay off $150,000 in debt. Residents look for programs that can help them pay off that debt."

STAYING MOTIVATED FOR SUCCESS

"I absolutely would do this again," said CIR leader Dr. Daren Garb, PGY 1, Family Practice. "I'd recommend that residents facing negotiations stand up for themselves. They (the hospital administration) won't give you anything unless you do. In hindsight, I'd say take their words with a grain of salt. We kept hearing, 'No way, there's no money,' but then we got 5%.

"There is political power in a public appeal by a physician. We do work in this community, and we do fairly noble work. Residents here have kids, and when they spoke about taking away health benefits in closed door meetings, people were shaken.

"Voters would not be pleased if doctors were saying, 'you pay us $15 an hour and take away our health benefits.' The administration really doesn't want these negotiations to go public.

"The thing is, you feel powerless when you're arguing with [administration]. They have all the money, you're a busy resident, but you have to stay motivated and realize the options you do have," and then you can be successful.

Negotiations were stalled from the end of May through early September 2004. Stanislaus County's residents negotiate with hospital administration, but a final contract must be approved by the County's Board of Supervisors. CIR's negotiating committee tried to meet with Board member, but all five Board members refused.

Not willing to take 'No' for an answer, residents attended the Board of Supervisors' meeting on September 7, 2004 and testified during the public comments period, which is required by law to be open to all.

"We forced the Board's hands," said Dr. Daren Garb, a PGY 1 in Family Practice. "They didn't want doctors showing up at public hearings. It was on public access TV, and several people I know saw it, including a surgeon I work with." He credits CIR staffer Jeanhee Kim with giving residents the resolve to go forward with their demands. "She kept reassuring us, 'They say there's no money every time, but don't get too freaked out by that.'"

"Workhorses of the County" Speak Up Publicly

"It felt good to stand up for ourselves and for the residency, especially when you feel you're not getting a fair deal," said Dr. Daren Garb, who testified at the Supervisors' meeting. "They had been stalling in negotiations, saying they didn't have the money, the County is broke, but others in the County had received raises, so we stood our ground."

In his testimony, Dr. Garb said, "I tried to appeal to their conservative sentiment, to the idea of efficiency, hard work, and strong work ethic. We're a very good deal for the County. We're highly skilled, work long hours, are very efficient, and are paid *less* than most skilled labor." He testified that,

> **"We're a very good deal for the County. We're highly skilled, work long hours, are very efficient, and are paid less than most skilled labor."**
>
> **Daren Garb, MD**
> **PGY 1, Family Practice**

"Many months we work 80+ hours a week. Our current wages, if calculated per hour, come close to $15 an hour; the same as I made in high school, working at a clothing retailer. However, then I got breaks every day and was paid overtime. I told them that from an efficiency standpoint, we are the best value there is…We residents are the workhorses of the County."

A Speedy Resolution

The Board responded that same evening, by authorizing an economic package for the first time in months that included a total 5% wage increase. Residents also scored other gains, such as higher conference allowances, chief residents pay, and removal of time limits on reimbursement of licensure fees. Residents ratified the package on September 16, 2004.