CIR SEIU NEWS
COMMITTEE OF INTERNS AND RESIDENTS March 2006

INSIDE

2006 CIR MAKING A DIFFERENCE FOR PATIENTS AND RESIDENT RIGHTS

From successfully mobilizing administration and legislators to save their Family Medicine Program at NJ's Robert Wood Johnson University Hospital, to bringing County Commissioners on a "walk through" of Jackson Memorial Hospital in Miami, CIR members have been sharing their experiences on health care's frontlines with those who make the decisions that impact patient care.

In Northern California, CIR members are taking on the issue of the explosion of uninsured. They testified at City Hall, sent postcards, and made phone calls to political representatives in support of a city law to ensure health coverage for workers in San Francisco. In New York City, CIR leaders are working to redefine the task of a state commission charged with cutting health care costs.

In 2006, CIR contracts are up for negotiation at public hospitals in New York, New Jersey, Florida and California. CIR members in these regions have been confronting the reality that it's not enough to just "do your job." Sometimes you have to take on issues like taxes, budgets and politics, and reach out to County Commissioners and other decision makers behind public sector funding, in order to continue providing the patient care that is "your job."

See Page 3 for more of what's going on in CIR chapters throughout the country.

CIR SEIU NEWS
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CIR SEIU NEWS

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President's Report

BARBIE GATTON, MD

Seniors, get ready!

Taking that Next Step from Residency

From the beginning of internship, residents look forward to the day that they finish residency, and take that first job after training. However, some of those last, logistical steps can turn into stumbling blocks. There are things that those of you in your final year of training should start to think about now, if you have not already. You send out your CV, you interview, and you accept a position. Most residents think that this is all you need and you can merrily show up and start practicing. I would like to warn you right now that it is not that simple.

There can be an unexpected gap between residency and your new position. Each hospital or clinic has its own credentialing procedure. None of them are quick. In some states, the hospital medical board meets only once a month. If that happens to be on the 27th and you were planning to start on the 1st, you may have some unanticipated (and unpaid) vacation. That happened to a colleague of mine, who moved across the country. He arrived in his new home broke, only to find out that he would not be able to work clinically until he met with the hospital board, which did not meet until the next month.

I did not have to be interviewed by the credentialing committee. However, I had to fill out applications in three different offices and have my pre-employment physical at a different hospital in the same chain.

Different states have different levels of efficiency when applying for licensure. The process can take anywhere from three weeks to six months. Many people wait until the end of their training to apply and so state licensing agencies become overwhelmed with applications in the spring. If you apply late, it will take longer to obtain your license.

Money can be a problem. There are a lot of extra expenses before you receive your first paycheck. Save now! There are licensing costs, board certification fees, DEA number fees, moving expenses, and more. Every specialty has its own timeline and process for Board Certification. Be sure to know all of the deadlines and fees that apply to your specialty.

Many doctors find themselves adding several thousands of dollars of debt at a time when they are least able to pay. People expect to have an increase in salary, so they spend more toward the end of residency (a new car, new clothes, see list below). Then they are delayed in starting their new job because of license or credentialing or both. Instead of celebrating, they find themselves sweating over their inability to make ends meet. Too many of my friends solved this problem by living on high-interest credit cards, loans from parents, or actually moving in with their parents.

A little planning now can help prevent this unnecessary stress. The key lessons that I learned from my own, and my colleagues' experiences, are condensed into these nuggets of wisdom:

1. Start saving money now. I can't say this enough. Literally.
2. Ask your new employer about the details of the credentialing process in your facility. How many applications (human resources, your department, Medicaid/ Medicare, credentialing)? Do you need a pre-employment physical? Can it be performed by your primary care doctor or does it need to be done by their employee health office? What part of your previous health records do they need? Who makes the final decision and do they require a personal interview?
3. Find out the requirements in your state for licensure, and the typical timeline.
4. Apply for a DEA number, if you need to.
5. Don't buy a BMW. Or a house. Or a boat…just yet.
6. What are your specialty requirements for Board Certification? What are the deadlines, and what are the fees?
7. If you are in the U.S. on a visa, you should have already initiated the process for the coming year. If not, DO IT NOW!!
8. Have a lawyer familiar with MD contracts look over your new contract before you sign it.
9. Everything will cost more than you think, so….
10. Don't forget to start saving now!

"Many doctors find themselves adding several thousands of dollars of debt at a time when they are least able to pay."

Notice of Election of CIR National Officers

POSITIONS TO BE FILLED:

President

Executive Vice President

Secretary-Treasurer

Vice Presidents:

Florida	1
Massachusetts	1
New Jersey	1
New York	5
Northern California	1
Southern California	2

TERM OF OFFICE

One year, commencing with the election at the 2006 National Convention and ending on the next election date.

ELIGIBILITY REQUIREMENTS

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

NOMINATION PROCEDURES

Nominations are to be made by petition signed by two delegates, which must be received in the CIR National Office at 520 Eighth Avenue, 12th floor, New York, N.Y. 10018 prior to May 10, 2006.

CAMPAIGN PROCEDURE

Officer elections will take place on Sunday, May 21, 2006, at the National Convention. Only delegates, and alternates who are replacing delegates who are in attendance at the National Convention, are eligible to vote.

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

PHOTO: BILL BURKE/PAGE ONE PHOTOGRAPHY

PATIENT AND RESIDENT RIGHTS

In New Jersey:
Family Medicine Program to Continue at Robert Wood Johnson University Hospital

For CIR residents at the Robert Wood Johnson University Hospital's Department of Family Medicine in New Brunswick, NJ, it took a lot of hard work to buck the trend towards specialization, and keep their program open. Their residency site was jeopardized after St. Peter's University Hospital withdrew its share of the funding in July of 2005. "The resident physicians and faculty in this program provide up to 50,000 outpatient visits a year," said CIR delegate Kennedy Ganti, MD, a PGY 3. Had the New Brunswick residency closed, he said, "our clinics would have had trouble staying open. NJ already has a serious shortage of primary care physicians."

"There are Family Medicine programs closing throughout the country. What do we have that they don't? We have CIR."

—Dr. Kennedy Ganti, PGY 3

Dr. Ganti and his colleagues discussed the situation with their program director and department chairman, and with other workers represented by unions at their hospital. "We felt that we had a duty to inform the public and elected officials that thousands of patients might lose their family physician," said Dr. Ganti. "We met with NJ legislators, the city council, and community groups, and presented our situation to Gov. Corzine. We had all our residents out and participating in a demonstration, with a full complement of CIR staffers, and attendings. We passed out cellphones so passersby could call legislators. It was a great experience! When you don't know what's going to happen, and have a public response like we had, it's a tremendous feeling, and more important, it led to something."

Chief Resident Rudy Patel, MD (left) and Dr. Kinshasa Morton leafletting at RWJ University Hospital.

At the end of all that work, there was a turnaround, and new interns are now being recruited for July, 2006. "We are thrilled that the hospital and medical school agreed to continue this program next year," said CIR Pres. Barbie Gatton, MD, "however, we need to ensure that this program continues to provide care to this urban, underserved community for years to come."

"Labor rights are not just about getting a paycheck. Participating in CIR is the best thing I ever did in my residency," said Dr. Ganti. "CIR makes us a force to be reckoned with, which helps in negotiations, and it helps residents that CIR is there for the health of residents and their programs. There are Family Medicine programs closing throughout the country. What do we have that they don't? We have CIR. When I joined this residency, it was as stable as anything. I didn't think I'd have to fight, but these fights are going to become more commonplace at clinics, hospitals and specialty programs," he said.

Fighting to Save St. Mary Hospital: A Hoboken Institution

Five hundred people, including many CIR members, rallied on January 25th, 2006 to save St. Mary Hospital, a 143-year-old Hoboken, New Jersey facility which is in jeopardy of closing unless it can find a new buyer. Residents at UMDNJ's Family Medicine program are based at St. Mary Hospital."This is the only hospital in Hoboken, and St. Mary takes the lead in treating the underserved of Hudson County. Where would they go if this hospital closes?" asked Dr. Jose Gonzalez, CIR department rep and a PGY 2 in Family Practice. "St. Mary is a gateway for future primary care physicians in the area, and we want that to continue. Residents are only here for a couple of years, but the needs of the community don't disappear when we go."

As part of the broad-based Coalition to Keep St. Mary Hospital Open and Caring, CIR members have taken part in City Council hearings, met with their local politicians, and started an online campaign (join in at www.cirseiu.org/action/) urging Gov. Jon Corzine—a Hoboken resident—to facilitate UMDNJ's acquisition of the facility. "During 9/11, St. Mary treated 8,000 people because of its strategic location near Manhattan and major transportation hubs," said one of St. Mary's medical directors, Angelo Caprio, MD, who is also a coalition member, and former CIR activist, in his testimony to the City Council.

"Residents are only here for a couple of years, but the needs of the community don't disappear when we go."

—Dr. Jose Gonzalez, PGY 2

"It was really emotional to see that our community is standing by us, and is part of the battle," Dr. Gonzalez said. City council members and politicians have been strong in their support of the hospital, including Hoboken's mayor, and State Senator Bernard Kenny. "We're still in negotiations with the governor to see if UMDNJ can take over St. Mary. At this point, it's all a matter of political power," Dr. Gonzalez said

Dr. Al Sumaquial, PGY 3 and Co-Chief Resident in Family Medicine, addressed the crowd at St. Mary Hospital.

PHOTOS: JUSTIN WOOD/CIR; (TOP RIGHT) SANDY SHEAD/CIR

More on CIR Chapters, page 6

CIR WORKS FOR US AND OUR PATIENTS

CIR Exec. Vice Pres. Simon Ahtaridis, MD, MPH

PGY 3, Internal Medicine
Cambridge Hospital,
Cambridge, Massachusetts

"Being a part of the nations' largest union of residents has given me a voice to advocate for my patients and their health care needs, whether it be at a hospital committee meeting, or at the State House. CIR's longstanding presence at my hospital has helped ensure that resident concerns are not only heard, but acted upon.

"In addition, CIR has given me first-hand experience with issues that will come up when I seek employment after residency. This includes understanding and writing an employment contract, negotiating a contract, and the business of medicine. These are skills that cannot be learned without actively participating, and using them."

CIR Vice Pres. Christine Dehlendorf, MD

PGY 4, Family and Community Medicine
San Francisco General Hospital,
San Francisco, California

"Having a union gives you the legal right to affect conditions at your workplace. At our hospital, CIR has enabled us to get a huge increase in compensation, which is appropriate to match the high cost of living in San Francisco. Equally important is having the administration at the table with us, and being able to explain what a day in the life of a resident is like. We sit across from the head of the Department of Public Health and are able to explain the on-the-ground realities of patient care in our institution.

"We've also won increases in our patient care fund. Working with CIR has definitely given me more leadership skills, and a sense that things can change, I can influence the world around me, and effectively advocate for my patients."

INTERNATIONAL RESIDENT WORK HOURS

Alert & Awake for

Sleep researchers, resident and attending physicians, hospital administrators, and union staff from New Zealand, Australia, Canada, the U.K., and the U.S. gathered in Auckland, New Zealand in late 2005 to tackle the internationally recognized problem of long work hours. "Alert and Awake for Everyone's Sake," was hosted by the New Zealand Resident Doctors Association, a national union that represents all of the country's 2,500 physicians in training.

New Zealand Resident Medical Officers, as they are called, have had strong contract language limiting their work hours since the mid-1980s. Consecutive on-call shifts greater than 16 hours are prohibited, cumulative week totals are capped at 72 hours and residents are guaranteed two full weekends off a month. And yet, the union reports that some 15% of New Zealand residents – surgeons in particular – still work 24+ hour shifts on occasion.

"We learned that we all have a problem with residents working excessive hours whether it's New Zealand, Australia, Canada, the United Kingdom or here in the States," said CIR President Barbie Gatton who represented CIR at the conference. "But it was also clear to us that we definitely have it the worst. People couldn't believe that we are routinely scheduled to be in the hospital for 24-30 hours."

The international sleep researchers presenting at the November 9-11 2005 conference were all in agreement that those long hours take a serious toll on patients and those who care for them.

Dr. Philippa Gander, Director of the Sleep/Wake Research Centre at Massey University in New Zealand, and former NASA physiologist, reported on the results of a just released national survey (*"Work Patterns of New Zealand Resident Medical Officers: Implications for Doctors and Patients and Strategies for Improvement," Nov. 5, 2005*). The four-page survey was completed by 64% of the country's full time residents in training. The results caused Dr. Gander to conclude "this is the sleepiest group of people I've ever come across."

According to Dr. Gander, the survey revealed that 15% of Resident Medical Officers were required to be available for work for at least 24 hours continuously on at least one occasion; 42% had fallen asleep at the wheel while driving home from work; and fully two-thirds could recall making a fatigue-related clinical error at some time in their careers.

There will be resistance to change, summed up Dr. Gander, but the evidence speaks for itself. "When people come up to me to say, 'I worked this and that number of hours and I was just fine,' I respond to them, 'you are an 'n' of 1. I have an 'n' of 1366 and 64% is a pretty good response rate.'"

Charles Czeisler, MD, PhD, Chair of the Division of Sleep Medicine at

Dr. Philippa Gander

Director, Sleep/Wake Research Centre, Massey University, New Zealand

"There will be resistance to change. When people come up to me to say, 'I worked this and that number of hours and I was just fine,' I respond to them, 'you are an 'n' of 1. I have an n of 1366 and 64% is a pretty good response rate.' Residents are the sleepiest group I've ever come across! You can't just cut back on hours. This will only transfer more work to others. It's important to take a much more integrated look, a much more systems-based approach to redesign how the work gets done and by whom. In future research, we want to focus on the team – RNs and MDs."

Dr. Charles Czeisler

Chair, Division of Sleep Medicine at Brigham and Women's Hospital Boston, MA

"Let me give a case presentation: 39-year-old PGY 5 in anesthesia, driving home at 3 PM after a seven-hour shift fell asleep and caused an accident. As a PGY I, he had worked more than 30 consecutive hours and was also in an accident. How would this case be handled if it was in court? He would be evaluated as having had a history of falling sleep at the wheel and working long hours. In the preceeding 2-3 weeks he had taken home call in the ICU, and worked 2 weeks in a row, six hours of sleep each night with 3-4 pages a night. We got his cell and page records from the hospital. His sleep was clearly disrupted.

"Once we get this MD degree, we forget the commonsense things. Physicians need education in sleep medicine. This is a shared responsibility – it is institutional and it is personal. Why would we consider it reprehensible for someone to get behind the wheel of a car drunk, but not sleep deprived?"

"Sharing Across Borders"

"We would like to welcome all delegates, who represent a broad, international spectrum from the United Kingdom, United States, Canada, Australia and New Zealand. This is an exciting opportunity to explore critical issues facing the medical profession on a global scale. The health sector faces the challenge of handling the results of fatigue which compromise the health and safety of both doctors and their patients."

Dr. Deborah Powell
General Secretary
New Zealand Resident Doctors Association

"Our Issues are Universal"

"It's refreshing to hear consultants [attendings] saying the same things that we say. We assume that they don't want change, but they do. Our issues – in all countries – are universal. House Officers in the U.S. have it worse than us, but it's not perfect here either. It's taken us 20 years to be mostly in compliance [with call shift maximums of 16 consecutive hours]. But 15% of us are still doing 24-hour call, and that's a problem. But we will change."

Dr. Deralie Flower
4th year,Ob-GYN Registrar
President
NZ Resident Doctors Association

CONFERENCE, AUCKLAND, NEW ZEALAND

...o Everyone's Sake

Brigham and Women's Hospital in Boston and Director of the Harvard Work Hours Health & Safety Group, reviewed his recently published research in the *New England Journal of Medicine*. Dr. Czeisler stressed researchers' conclusion – that while resident work hour shifts in the U.S. of 24 to 30 consecutive hours may be approved by the Accreditation Council on Graduate Medical Education (ACGME), they are not safe.

Other conference speakers included Dr. Elisabeth Paice, who oversees graduate medical education for over 8,000 residents in London. She described the challenge of working to come into compliance with the European Union Working Time Directive, which currently limits residents to no more than 56 hours per week (by 2009 the figure must go down to 48 hours). The directive has caused hospital administrators and medical educators to re-think how patients are taken care of, how the work gets done and how best to teach doctors in training so that the length of their training is not increased.

The three-day conference gave participants ample time to share experiences and to learn that there were as many different approaches to limiting resident work hours as there were countries represented. In Canada, for example, all residents are organized, with one union for each province. Hours are then set through the provincial collective bargaining agreements. In New Zealand, hours are governed by the residents' national contract and by national occupational health and safety language. In Australia, the Australian Medical Association has also developed a comprehensive 'code of practice' for hours of work, but it does not specify an hours limit nor is it enforceable. In the United Kingdom, where residents are also all unionized, the EU's Working Time Directive does have the force of law. In the U.S. the accrediting body overseeing graduate medical education has set hours limits but they are very long (on-call shifts of 24 plus 6 are permissible and commonplace) and not effectively enforced.

Asked what most impressed him about the international hours conference, CIR Executive Vice President Simon Ahtaridis, MD, who attended along with Dr. Gatton and CIR national staff Mark Levy and Sandy Shea, said he was "struck by the degree of organization house officers in other countries have compared to here in the U.S.

"We are far behind them in being able to develop evidence-based guidelines for resident work hours that are safe for patients and ourselves," said Dr. Ahtaridis. "Having all housestaff unionized really allows for a much greater impact on policy. They are able to engage in serious dialogue with high level government officials, hospital administrators and senior physicians, who are all working on identifying problems and solutions."

Dr. John P. Collins

Dean of Education, Royal Australasian College of Surgeons

"I have a passion to do something about hours and training. I can assure you not everyone wants the system [of training physicians] to stay the same. It nearly destroyed me, my wife, and my marriage. According to the Australian Medical Association (AMA)'s "Risk Form" – a survey geared to identifying residents who are working unsafe hours, 45% of the 178 surgical trainees fell into the high risk category, that is, who were working more than 100 hours per week. Our goals – and why we care about resident work hours – are high quality patient care, improved training and improved house officer well-being."

Dr. Elisabeth Paice

Dean Director, London Deanery United Kingdom

"Teams are the answer to so much of what's wrong. It's the idea that you sit down with a multidisciplinary group to discuss what is to happen with each patient. That is more valuable than one person's non-reflective just 'being around.' The old style team — residents in the hospital for hours on end — is gone. In the airline industry, for example, the team forms as they walk into the cockpit. We are professionals because of our training, our skills and we can move into a situation and work as a team. In other industries, people learn how to do this. We have to let go of some things in the past that were great. We do have to do things differently. What are physicians doing after hours? For example, on Saturday and Sunday there may be no phlebotomist in the hospital, so the second resident on call gets called in to do phlebotomy. We need to get real — there's no advantage to a house officer's training here!"

"We are a High-Risk Group"

"There is comfort in knowing everyone else has the same problems and everyone – all countries – are trying to find solutions, for example, Dr. Czeisler's car crash study. We all know the anecdotes, but I've never actually seen the data before. Now I understand the science of why it happens. In Australia, we have a campaign about drunk driving and driving when you're too tired, but it doesn't target doctors. We are a high-risk group because of the long hours we work and the fact that we have to drive from site to site and rotation to rotation. There is a role for the employer to take the initiative with taxi vouchers or staff buses. The Hospital should provide these things because we are too tired to assess our own fatigue."

Dr. Nada Hamad
2nd year, Internal Medicine
President, Resident Medical Officers Assoc.
New South Wales, Australia

"Now We Have Some Ideas"

"I'm going back home to Canada with a few ideas for pilot projects. The speakers made me think again about the problem of long hours and addressing it in new ways. For us the traditional schedule is 1 in 3 or 1 in 4. Shift work is nowhere in our collective agreement. There are no consecutive hours limitations – no way to intervene. Now we have some ideas for how to address this. We could, for example, go to the hospital administration and propose Dr. Czeisler's 16-hour, 4 day shifts [interventional schedule identified in NEJM article as reducing intern errors in a medical ICU setting]. If you go to the Administration, identify a problem and then identify a solution it's much better. Now we have something to propose and the evidence to back it up."

Dr. Martin Bernier
3rd year, Internal Medicine
President
Federation of Medical Residents in Quebec

"Unionization = Greater Impact on Policy"

"I was struck by the degree of organization house officers in other countries have compared to here in the U.S. We are far behind them in being able to develop evidence-based guidelines for resident work hours that are safe for patients and ourselves. Having all housestaff unionized really allows for much greater impact on policy. They are able to engage in serious dialogue with high level government officials, hospital administrators and senior physicians who are all working on identifying problems and solutions."

Dr. Simon Ahtaridis
3rd year, Internal Medicine
Executive Vice President
Committee of Interns and Residents/
SEIU, USA

PATIENT AND RESIDENT RIGHTS

In Florida:
Residents Speak Up at Miami's Jackson Memorial Hospital

"Imagine, if you can, sitting down with a colleague discussing an evaluation of a patient. Now imagine ten seconds later you have been violently and unexpectedly knocked from your chair…" Dr. Janetta Cureton, a CIR member in the Psychiatry Department at Jackson Memorial Hospital, who has been assaulted twice in the past few months by psychiatric patients, shared her experience at a Public Health Trust Board Meeting on January 23rd, 2006.

> **"To have a resident tell them about her own experiences was eye-opening."**
>
> **— Dr. Seema Chandra, PGY 3**

One month earlier, Miami-Dade County Commissioners Rebecca Sosa and Natacha Seijas joined CIR members Seema Chandra, MD, a PGY 3 in Med-Peds and CIR Vice Pres. Zachary Pearson-Martinez, MD, for a walk through the hospital. Alongside Local 1991/SEIU members and officers, which includes nurses, social workers, and attending physicians, the residents discussed patient care and safety issues with the Commissioners. The Jackson Memorial CIR contract, which covers 1,000 residents, is currently up for negotiation.

Reflecting on her role as a CIR delegate, Dr. Chandra said, "I became a leader in CIR because I wanted to improve the lot of residents and patients at my hospital. Through CIR, I've had many unique experiences, such as the opportunity to meet with some of our County Commissioners and members of the Public Health Trust. I have tried my best to open their eyes to the realities of patient care and resident work hours at our institution. Most of these people are not involved in patient care on a daily basis, and are not familiar with the process of medical education and training. To have a resident tell them about her own experiences—both as a patient and a health care provider—was informative and eye-opening.

"While my primary responsibility as a CIR leader is to negotiate the best possible working conditions for my fellow residents, I also feel we have a responsibility to our patients."

On a "walk through" tour with Commissioner Natacha Seijas (center), are SEIU L.1991 members and officers and (far right) CIR Drs. Seema Chandra and Zachary Pearson-Martinez.

In New York:
Talking Back to the Commission

NY Governor George Pataki and the NY State Legislature established the *Commission on Health Care Facilities in the 21st Century* in April 2005 to rein in health care spending throughout the state. The commission's mandate is to reduce spending and hospital capacity by up to one-third, mainly by closing hospitals and nursing homes. Its appointed members primarily come from the world of finance and not health care. The commission has begun its work with the erroneous premise that there is "excess capacity," in the form of unused beds, throughout the state.

"It is an extremely powerful, and unaccountable commission — their recommendations automatically become law within 30 days, unless rejected *in their entirety* by the state Legislature," said CIR Pres. Barbie Gatton, MD. "CIR swung into action immediately, consulting with health care experts to learn the history of such commissions and joining together with patient, health care, religious, labor and community groups to form a coalition. The coalition established criteria for hospital closings to ensure that they are not aimed at the most vulnerable populations, and we are working to ensure that there is public discourse on health care needs and the role of this commission," she said.

> **"Many of my patients will fall through the cracks if there are more closings."**
>
> **—Dr. Marino Tavarez, CIR VP**

In January, four CIR Executive Committee Members traveled to Albany, NY with the *Save Our Safety Net Campaign* coalition to hold a press conference and attend one of the commission's meetings. The coalition has been attending every meeting, sending letters to the commissioners, and publicizing the work of the commission. CIR NY Vice Pres. Marino Tavarez, MD, told the Albany press, "As a family doctor, I spend most of my time in clinic. I suspect many of my patients will just fall through the cracks if there are additional hospital closings. They are too sick to take three buses to get to another hospital. They will simply stop seeking care, and lose that last option, the local emergency room. This needs to be part of the consideration of this commission – where will these patients go?"

"The health of the community is at stake," said Dr. Gene Lui, CIR NY Vice Pres., explaining why he came to Albany, and why the coalition's work is ongoing and important. Dr. Ayodele Greene, also a NY CIR Vice Pres., added that she was disheartened to see the commission operating without input from doctors, hospital administrators or patients, and in such a rushed timeframe – with their entire study lasting only 18 months and their final recommendations set to be issued in December of 2006.

CIR Pres. Barbie Gatton, MD, at an Albany press conference.

In California:
An Idea Whose Time Has Come — Health Care for Working Families

CIR members in Northern California have been advocating for the Worker's Health Care Security Act, which would provide health insurance for working people in San Francisco County. "As frontline providers of health care for the uninsured and underinsured, every day we see families who delay treatment due to lack of insurance, and then flood the county's emergency rooms as their source of primary care," said CIR Vice Pres. Christine Dehlendorf, a Family Medicine physician at San Francisco General Hospital, in her testimony on behalf of the legislation at a public hearing at City Hall.

She was joined in her efforts by other residents from her hospital, who have been sending post cards, phoning legislators, and using e-activism to get out the word about this innovative way to address the health care crisis in our country. The Worker's Health Care Security Act would require San Francisco businesses that employ 20 or more workers to provide health insurance for their employees. It was introduced by Tom Ammiano, of the S.F. Board of Supervisors, as a way to ensure that both full-time and part-time workers have health coverage, and that the enormous cost of emergency medicine for the uninsured be more equitably paid for. While the cost is currently paid for by taxpayers, this act would ensure that businesses also pay their fair share.

> **"Every day we see families who delay treatment due to lack of insurance, and then flood the county's ERs as their source of primary care."**
>
> **—Dr. Christine Dehlendorf, CIR VP**

At presstime, S.F. Mayor Gavin Newsom had come up with his own version of a health access plan, which would be less costly to business. Community and health care activists, including CIR members, hope that the Mayor and Board of Supervisors will together come up with a plan that provides greater health care access for the working people of San Francisco. Stay tuned for an update in our next issue.

New Contract at Oakland, Ca.'s Highland Hospital

The 110 CIR members at Highland Hospital in Northern California ratified a new contract on January 20, 2005, after long and hard negotiations. Dr. Nailah Thompson, a PGY 2 in Internal Medicine declared herself "ecstatic" with the new contract. "Two things that were most important to residents were maintaining the Patient Care Fund, which gives residents the ability to purchase things we need in our everyday patient care, and salaries that will keep our program competitive with other programs, ensuring that we can continue to attract quality physicians who choose Highland as their first choice, and not their last resort," said Dr. Thompson.

Highlights of the new contract include salary increases of 3% in March 2006; 4% in March 2007; 4% in March 2008; and 3.75% in 2009 for all residents, with an additional $1,000 for graduating PGY4s, $700 for PGY 3s, and .5% for interns. Although administration had hoped to save money by discontinuing the Patient Care Fund, residents would not give up on it. It will receive an infusion of $100,000 over the life of the contract. "We have purchased things such as ultrasound machines, electronic electrocardiogram and echocardiogram software so that patient tests are available online 24 hours a day to aid in making critical treatment decisions," Dr. Thompson said.

Residents used a variety of creative strategies to first, keep their hospital funded, helping to pass Measure A which provided taxpayer money for health care in Alameda County, and second, win this strong contract. There were informational pickets, coordinated meetings with all the other unions in the facility, buttons to keep the campaign visible to administration and patients, and a final touch was personalized Christmas cards to the hospital's Board of Trustees with the not-so-subtle message, "All I want for Christmas is my Union Contract." Perhaps the holiday cards were the final *coup de grace*, because it was just at that time that the hospital came through with what residents were looking for in their contract.

Dr. Brita Zaia, PGY 1, EM, (left) and CIR Delegate Steve Carney, MD (below) casting their ballots in contract vote.

Other features of the new contract include an increase in the relocation allowance, and maintaining the disability insurance and education bonus. "You have to be firm on the things that are important to you and your patients, and not settle too quickly," was Dr. Thompson's takeaway message from this arduous, but ultimately rewarding contact campaign. "And, you have to be patient," she added.

CIR Supports Evidence-Based Standard for Resident Work Hours

Since July of 2003 when the ACGME came out with guidelines on resident work hours, there has been a flurry of new research that spells out the dangers —to patients and residents—of what is currently allowable: working 24 hours at a stretch, with an additional 6 hours tacked on for didactics and continuity of care.

"The ACGME work hour limits were based on precedent and tradition rather than evidence from sleep research," said CIR Exec. Vice Pres. Simon Ahtaridis, a PGY 3 in Internal Medicine at Cambridge Hospital in Massachusetts. "Recently published evidence suggests that the limitations are woefully inadequate."

With new research published by the Harvard Work Hours Group in the *New England Journal of Medicine* in 2004 and 2005, and additional studies published in the journals such as *SLEEP* and *JAMA*, we have learned that:

- being awake for 24 hours produces deterioration equivalent to a 0.1% blood alcohol content; [1]
- residents working a traditional Q3 schedule suffered twice as many attentional failures, and made 36% more serious errors than residents on an alternate schedule limiting consecutive hours to 16; [2]
- residents driving home post-call had twice the risk of being involved in a serious car crash than control groups.[3] Residents may now face civil and criminal liabilities for "driving while drowsy," even though they are scheduled to work those hours by their hospitals; and
- in a poll, 86% of patients said they would be extremely anxious if they knew their surgeon had been awake for 24 hours; 70% would ask for a different doctor.[4]

From left, CIR Pres. Barbie Gatton, Dr. Landrigan, AMSA leaders Tom Ricart and Danielle Bertoni, and CIR NJ VP Cristin McKenna, at UMDNJ in Newark, N.J.

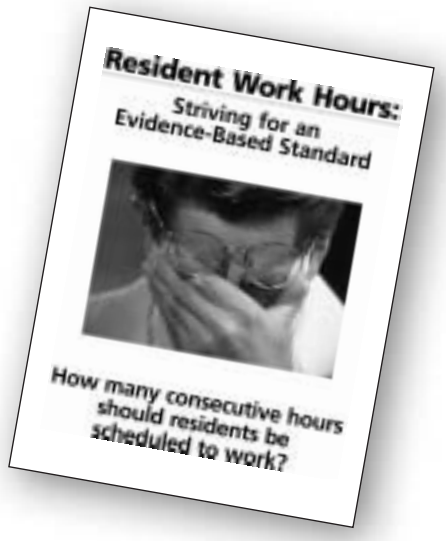
PHOTOS: (TOP) RITA SHARMA/CIR; (BOTTOM) MARIA SVART/CIR

Dr. Christopher Landrigan, Director of the Sleep and Patient Safety Program at Brigham and Women's Hospital, presented his findings to CIR's Executive Committee in December 2005, and to UMDNJ-NJ Medical School on January 25, 2006. In an editorial in *SLEEP* in November, 2005, he wrote that, "Residents working 30 hours in a row under the current guidelines of the ACGME perform as poorly as if intoxicated. The intelligent, motivated, highly-educated graduates that our medical schools produce are reduced by an overnight 24-hour shift to a fraction of their intellectual selves. Our patients are endangered by their work hours. And…our trainees' themselves and the general public are endangered by residents' driving home after shifts of more than 24 hours."

The Case for 16 Hours

Believing that medicine should be informed by evidence-based research, CIR's Executive Committee decided at its Fall 2005 meeting to begin to advocate for the 16-hour work guidelines that have been scientifically shown to provide the best in patient care. "We are asking for the necessary resources, and scheduling to ensure that work hour guidelines are consistent with the highest quality care, medical training and resident well-being," said CIR Pres. Barbie Gatton, MD.

CIR News, and the website www.hourswatch.org, (a joint project of CIR and AMSA), have been profiling the innovative programs that are helping to bring about resident work hour changes in line with today's research. For CIR Sec'y-Treas. Rajani Bhat, her experience as an Internal Medicine resident at Lincoln Hospital in the Bronx has been enough to turn her into a forceful advocate for this change. "We work no more than 16-hours at a time, and that goes for all departments at my hospital, with the exclusion of Surgery. When I have to rotate to another hospital and work 24 hours straight, I realize just how impaired I am." The downside of her program's scheduling is that there are fewer full weekends off, but in her estimation, it is more than worth the trade-off to know she is not harming any patients due to sheer exhaustion.



1 *Nature*, 1997; 88:235.
2 *NEJM*, 2004; 351:1838-1848.
3 *NEJM*, 2005; 352:125-134.
4 National Sleep Fdn., 2002; www.sleepfoundation.org/press/ index.php?secid=&id=223.

AMSA & CIR

Working with Today's Medical Students, to Reach Tomorrow's Residents

The American Medical Student Association (AMSA) and CIR have worked together at the national level for years, tackling resident work hour reform, lobbying legislators, and launching www.hourswatch.org, a website dedicated to the issue.

"We're both progressive groups of physicians-in-training," said Dr. Steve (Stevo) Gamboa, a PGY 2 in Family Practice at Sutter Medical Center in Santa Rosa, Ca., who is currently a CIR delegate, and was previously a national officer at AMSA for two years. He continues his AMSA involvement as a Resident Trustee. "I think the pressure that we (AMSA and CIR together) put on the issue of resident work hour reform drew national attention to the issue, and that we have the ACGME work hour guidelines as a result," he said. "Both organizations provide a source of inspiration and community. It's been a heartening experience to work with people who share my values and ideals."

In the past year, CIR has not only coordinated with AMSA President Leana Wen and Legislative Affairs Director Chris McCoy, but also begun to work more closely at the local medical school level to raise CIR's visibility among today's medical students, who will be tomorrow's residents.

In a whirlwind of dates and campuses, the two organizations have teamed up at conferences, workshops and mixers at campuses ranging from Brown University, the University of Miami, New York Medical College, UC San Diego, the Medical College of Wisconsin, and Boston University, to name a few. Topics covered have included Racial Disparities in Health Care, Surviving Medical School and Internship, and Reviving the Health in Health Care.

Connecting AMSA chapters with CIR residents has provided medical students with the opportunity to voice their questions and concerns about residency, and get some answers from CIR members.

AMSA leadership came together during a CIR/AMSA mixer at their regional conference in Milwaukee, Wisconsin to talk about "Reviving the Health in Health Care."

After an event at her UC San Diego campus, medical student and AMSA Chapter President Siobhan Wilson said, "It was very interesting and informative to hear Dr. Gwendolyn Harbert speak about CIR and residency life. I know many students at UCSD are apprehensive about residency. I think that it was reassuring to many students to learn that there is a group such as CIR that advocates for the life of a resident."

Reflecting on the combined activism of both organizations, CIR Pres. Barbie Gatton, MD, said, "CIR provides a forum for residents to carry forward the idealism and activism from their medical school days into their residency experience," adding that she's always glad to see AMSA alumni make their mark in their hospitals and within CIR.

Next up are events planned at the University of Washington, Columbia University, UCLA, and Temple University.

If you want to help with CIR's outreach to medical students, contact Maria Svart at msvart@cirseiu.org.

2006 CIR National Convention

Washington, D.C. • May 19-21, 2006

Keynote speakers: **Carolyn Clancy, MD**, *Director of the Agency for Healthcare Research and Quality for the U.S. Dept. of Health and Human Services; and* **Christopher Landrigan, MD, MPH**, *Director of the Sleep and Patient Safety Program at Brigham and Women's Hospital, Harvard Medical School*

All 2006-2007 Delegates and Alternate Delegates are invited to attend the CIR Annual Convention. Delegates are chosen by colleagues in elections that are held each year in CIR hospitals in the month of March. Join us for an exciting weekend in Washington, D.C., as more than 140 CIR delegates from Massachusetts, New York, New Jersey, the District of Columbia, Florida, Puerto Rico, and California come together to learn more about CIR and about issues facing all housestaff. You'll have the opportunity to trade ideas on important matters such as how to reduce resident work hours, and get fired up to go back home and make your hospital a better place – for both residents and patients. There will also be time for socializing with your colleagues from around the country.

Delegates' travel and hotel accommodations in Washington, D.C. (double-room occupancy) will be paid for by CIR. For more information regarding convention travel or registration, please call CIR toll-free at 1-800-CIR-8877, contact your local CIR organizer, or log on to **www.cirseiu.org**. More information will be mailed directly to all newly-elected representatives.

PHOTOS: (TOP) MARIA SVART/CIR; (BOTTOM) PAGE ONE PHOTOGRAPHY