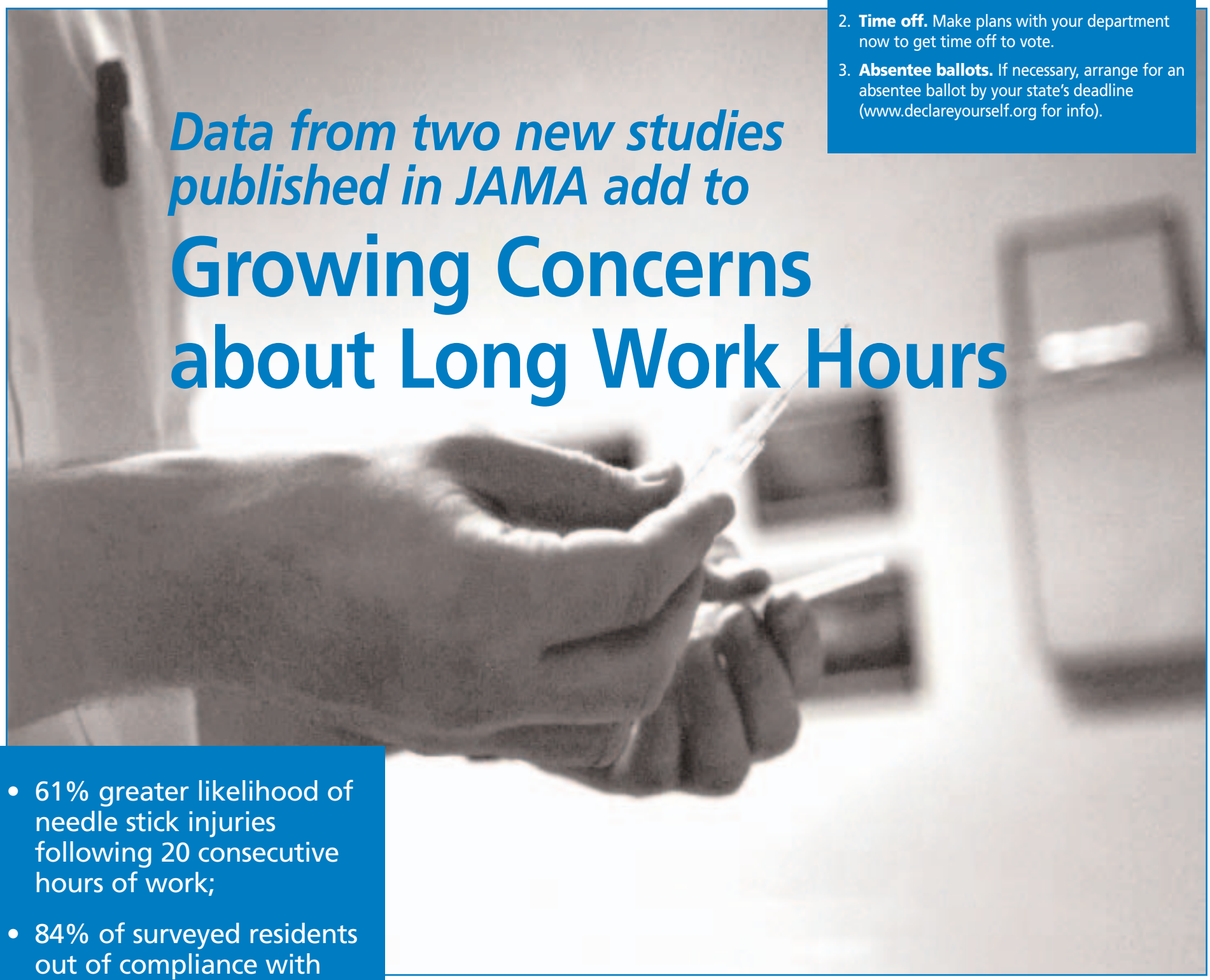
CIR SEIU NEWS
COMMITTEE OF INTERNS AND RESIDENTS September 2006

BE A HEALTH CARE VOTER!

Upcoming November elections will have an enormous impact on hospital funding, health care access and other important issues affecting CIR members and our patients.

1. **Register.** You can register to vote online at www.seiu.org under the "Political Action" section.
2. **Time off.** Make plans with your department now to get time off to vote.
3. **Absentee ballots.** If necessary, arrange for an absentee ballot by your state's deadline (www.declareyourself.org for info).



Data from two new studies published in JAMA add to

Growing Concerns about Long Work Hours

- 61% greater likelihood of needle stick injuries following 20 consecutive hours of work;
- 84% of surveyed residents out of compliance with ACGME guidelines.

"If we are to begin addressing the epidemic of medical errors in this country…we must begin by establishing and enforcing safe work hour limits for our doctors."

—Christopher Landrigan, MD, MPH
Lead Author

See story, page 3

CIR SEIU NEWS
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President's Report

SIMON AHTARIDIS, MD, MPH

When Physicians Ignore the Evidence

Change can be hard. The culture of medicine, despite its emphasis on evidence and scientific studies, can nonetheless be a change-resistant entity. Just how far have we come since the early days of medicine?

Think of poor Ignaz Semmelweis, the Hungarian doctor credited with pioneering routine hand washing. Until the 1900s, most doctors did not wash their hands between patients. It is no surprise that infection was a major cause of mortality. Students dissected cadavers in their morning classes, and then performed vaginal exams on pregnant patients in the afternoon. When Dr. Semmelweis introduced routine hand washing to combat an outbreak of peurperal fever in young mothers in his obstetric clinic, the maternal mortality rates instantly dropped from 13% to 1% overnight.

Semmelweis released his findings, but rather than receiving praise for his work, he was ridiculed. Undaunted, he continued to advocate for hand washing for the next two decades until he suffered a nervous breakdown, which was thought to be related to the stress of his failed advocacy. Unfortunately for the patients of his day, the medical culture was not ready to accept something as simple as hand washing despite growing evidence.

We've come a long way since those days. Yet when it comes to something as straightforward as resident work hours, medicine remains similarly impervious to evidence, research, and studies. Our culture supports the view that we are indestructible individuals, immune to the effects of illness and fatigue. Our profession asserts that good doctors put their own needs aside to be there for patients. Those who claim that long shifts are bad for patient care are thought to be weak, undedicated, or selfish. Concepts of team are still not entirely accepted, and we often ignore the fact that a well-rested, competent colleague is just down the hall.

For decades, resident unions have questioned the extraordinarily long shifts that we perform. One of the first studies on resident work hours showed that sleep-deprived residents were more likely to miss critical EKG abnormalities. The author of this study concluded that, "there never was a good reason to indulge in the false heroism of 36-hour duty stints by the interns. We now appreciate excellent reasons for abandoning this practice."

Since then, dozens of studies have shown that fatigued subjects performed more poorly in tests of memory, concentration and math. One eye-opening study showed that 24 hours of sleep deprivation caused psychomotor function to deteriorate to the equivalent of a 0.1% blood alcohol level.

"Our culture supports the view that we are indestructible individuals, immune to the effects of illness and fatigue."

Yet despite this compelling evidence, there was no reform. Finally in response to pressure from CIR, Public Citizen, and AMSA, the ACGME adopted universal work-hour guidelines limiting work hours to 80 hours per week, and 30-hour shifts. Unfortunately these guidelines are not consistent with the evidence.

Sleep researchers argue that the shift length may be a more important contributor to errors than the total number of hours worked. The Harvard Sleep Research Group recently published a study showing that residents on a traditional Q3 ICU rotation made 36% more errors as compared to residents in the same ICU that limited shifts to 16 hours.

The medical profession has been slow to adopt evidence-based work hour regulations. Some cite cost as a major impediment; others feel that education will be compromised, or that we will produce doctors who are not committed to patient care.

Procedure oriented specialties often face the dilemma of losing procedures with reduced work time. The challenge for residents and educators will be to devise means of increasing efficiency and the educational quality of time spent at work. There are many tasks that residents perform that can be picked up by other staff that are of minimal educational value.

If we cannot educate residents to be practicing doctors after years of 80-hour work-weeks and 16-hour shift limits, then we probably need to rethink the way we organize the work day, improve efficiency, and maximize educational time. I have yet to meet a resident who feels that every moment they spend at work is educational. Finally, if we want to produce energetic, idealistic doctors who are eager to serve their patients, then we should abandon practices that seem to conform more with hazing rituals rather than a sound educational program.

For more resources on evidence-based standards for resident work hour reform, visit us on the web at: www.cirseiu.org.

HEALTH CARE FACTS

The U.S. spent $1.9 trillion on health care, or $6,102 per person in 2004 — more than any other nation in the world. The top five global per capita health spenders are listed below.

United States	$6,102
Luxembourg	$5,089
Switzerland	$4,077
Norway	$3,966
Iceland	$3,331

Despite high spending, the U.S. fairs poorly on leading health indicators.

Neonatal and Infant Mortality	24th
Life Expectancy for Males	22nd
Life Expectancy for Females	23rd
Diabetes Related Mortality	24th

Clearly we are not getting our money's worth. Keep your eyes open for future *Health Care Facts* in this new series.

Source: http://www.oecd.org

PHOTO: SANDY SHEA/CIR

Harvard Work Hours Health and Safety Group's

New Studies Show Increased Risk of Needle Sticks and Unenforced Work Hours

The data keeps coming in. First the New England Journal of Medicine (NEJM) *published a study showing a strong link between the marathon shifts that residents work and an increased rate of medical errors (October 28, 2004); next that these shifts double the rate of car crashes among residents who leave the hospital and drive (*NEJM, *January 13, 2005). Two new studies, published September 6, 2006 in* The Journal of the American Medical Association (JAMA) *emphasize the link between long work hours and an increased risk of potentially fatal needle stick exposures, and show that the ACGME, charged with overseeing the training of the nation's 100,000 resident physicians, is not enforcing even these inadequate hour limits.*

Long Hours Increase Risk of Interns' Needle Stick Accidents

"Needle sticks are too common when you work long hours," said Najib T. Ayas, MD, MPH, lead author of the study conducted by the Harvard Work Hours Health and Safety Group, in an interview with CIR. "The major danger of these incidents is that you can be infected with hepatitis, or HIV. In addition, there's a lot of psychological stress involved, waiting to learn if you have contracted a disease from the injury. If you're tired, you're just more likely to make mistakes."

In a study of 2,737 interns over a period of 11 months (conducted by researchers at Brigham and Women's Hospital in Boston, where the Harvard Work Group does its research), there was a 61% greater incidence of percutaneous injuries — from needle sticks to lacerations by other sharp instruments, causing exposure to potentially contaminated blood or body fluid — when interns had been working 20 plus consecutive hours. Additional findings were that a lapse in concentration was the reported contributing factor in 63.8% of the needle sticks, and fatigue was the reported factor in 44% of the injuries.

"The data strongly suggest that performance of many procedures is compromised due to fatigue; if you're making more mistakes with a needle, you're probably making mistakes in the operating room, too," Dr. Ayas said. "Other studies with simulated surgeries have shown greater rates of mistakes among fatigued doctors. Although ours was an observational study, I would tell program directors that interns should not be performing invasive procedures following on-call shifts. It's foolhardy. And on a global scale, these long shifts should be eliminated. That would prevent a substantial number of these injuries."

Dr. Charles Czeisler, a co-author of the study, and Director of Sleep Medicine at Brigham and Women's Hospital, and Harvard Medical School concurred. He said, "academic medical centers should abandon the practice of scheduling physicians-in-training to work 24 consecutive hours, as it endangers both patients and the young doctors in training."

Drs. Czeisler (left) and Landrigan of the Harvard Work Hours Health and Safety Group.

Widespread Non-Compliance with ACGME Hours Limits

How many residents dutifully record their "duty hours" when it comes time for their hospital to report to the ACGME? 80 hours (averaged over 4 weeks) – sure! Worked no more than 24+ 6 consecutive hours – of course not or rather, who can remember! Had one day off in 7 – always! It's a cynical in-joke for most residents, the proverbial garbage in…and garbage out.

Not surprisingly, the ACGME reports near unanimous compliance with its hours limits, in place since July 2003. In the year after those limits were announced, the medical education accrediting body reported only 5% of residency programs violated these standards and only 3.3% of residents who were surveyed reported violating the 80-hour rule.

Now the Harvard Work Hours Health & Safety Group has punctured a big public hole in the confidence of those ACGME stats. Its September 6, 2006 article in the Journal of the American Medical Association ("Interns' Compliance with Accreditation Council for Graduate Medical Education Work Hour Limits,") reports that:

- 83.6% of interns reported work hours in violation of the standards during one or more months;
- Working shifts greater than 30 consecutive hours were reported by 67.4%;
- Averaged over four weeks, 43% reported working more than 80 hours weekly and 43.7% reported not having one day in seven off from work.

In the Harvard Group's national web-based study, 4,015 interns completed monthly surveys to assess their work and sleep hours pre-ACGME hours implementation (July 2002 to May 2003) and post implementation (July 2003 to May 2004). In total, interns completed 29,447 monthly surveys, representing residency programs from around the country and across specialties.

> **"Academic medical centers should abandon the practice of scheduling physicians-in-training to work 24 consecutive hours, as it endangers both patients and the young doctors in training."**
>
> **Dr. Charles Czeisler, Director, Sleep Medicine at Brigham and Women's Hospital, Harvard Medical School**

Interestingly, in the only state (New York) and territory (Puerto Rico) where regulation and/or law enforces hours limits, violations were reported from a smaller proportion of hospitals and "30-hour violations were reported in less than half as many New York and Puerto Rican hospitals."

The Harvard researchers devote much of their article to a discussion of why its statistics and the ACGME's are so divergent, e.g. survey methodology (Harvard's "open-ended questions directed towards accurately reporting work and sleep hours" vs ACGME's emphasis on noncompliance), focusing on interns (the ACGME surveys all residents), a lack of resident confidentiality in the ACGME's survey, resident fears that accurate reporting could result in a loss of program accreditation, etc.

But in the end, lead author Christopher Landrigan, MD, MPH and his colleagues take issue with the weakness of the ACGME duty hours themselves.

In a press release issued by the Division of Sleep Medicine at Brigham and Women's Hospital in Boston, Division head Charles Czeisler, MD, PhD remarked that "[Our] data demonstrate that academic medical centers have not complied with even the very modest restrictions that the medical profession attempted to self-impose on physician work hours."

Dr. Landrigan added, "If we are to begin addressing the epidemic of medical errors in this country… we must begin by establishing and enforcing safe work hour limits for our doctors."

THERE ARE OVER 600,000 SHARPS INJURIES TO HEALTH CARE WORKERS PER YEAR.

National Alliance for the Primary Prevention of Sharps Injuries (www.nappsi.org)

CIR PATIENT

CHAPTERS FIND NEW WAYS

What precisely *is* a Patient Care Fund? Some CIR-affiliated hospitals have them, some don't. They vary widely in what they fund, and how much money they have. They are always hard-won, created through contract bargaining between residents and their hospitals. In most cases, residents agreed to forgo some percentage of negotiated raises in order to create this fund which directs money to patient needs that residents determine are going unmet in their hospitals. So they are a way for residents, who often feel on the bottom of the medical hierarchy in their hospital, to have some say in improving the care that they deliver.

Patient Care Funds (PCFs) are wildly popular in the hospitals that have them, and residents refuse to give them up even through years of tough bargaining. Other hospitals hope to achieve them, but have not yet been able to. This past year's crop of PCF projects, as always, are a product of the creativity of the residents who came up with the ideas, and the dedication of those who served on the committee that determines which projects win the funding.

In Massachusetts:

Aiding Refugee and Asylum Seekers

"Our Patient Care Fund Committee really encourages innovative requests from the greater Cambridge Hospital community, says Cambridge CIR delegate Matt Ehrlich, a PGY 3 Psychiatry resident and CIR co-president. "We've funded everything from yoga classes for patient stress-reduction, to groceries for victims of domestic violence, and waiting room fish tanks."

"At Cambridge Hospital, we often take care of people who fall through the cracks," said Dr. Robert Marlin, a CIR leader and resident when he thought of the idea of opening a coordinated care program for immigrant patients who are refugees, asylum seekers, torture survivors and trafficking victims from other countries. These patients come from all over the world, he said, and because most of them don't have health insurance, they were afraid to seek medical care. "The PCF has always revolved around meeting the needs of the underserved," Dr. Marlin said, so he submitted a request to open the coordinated care program.

As of September 2006, the program is educating patients on disease prevention and management, and supplying food, meal vouchers, OTC drugs, emergency prescription medication and travel subsidies. Through a multidisciplinary and coordinated care program, a diverse variety of medical, mental health, social, dental and legal services have been arranged for the patients.

"Our Patient Care Fund Committee encourages innovative requests," says Cambridge CIR co-president Matt Ehrlich, a PGY 3 Psychiatry resident.

"I knew that the PCF would be able to fund innovative projects that no one had ever thought of before. Without it, we would not have been able to meet the needs of these patients." Dr. Marlin said. He also holds a PhD in Medical Anthropology.

At nearby Boston Medical Center, CIR residents also used their PCF dollars to give refugee and torture survivors phone cards to call home, and transportation money to get to their medical appointments. CIR received a recognition award from the Boston Center for Refugee Health and Human Rights at its' "Night of Remembrance and Rejoicing." The annual event recognizes support for survivors of torture in commemoration of the signing of the UN Convention against Torture. BMC patients, staff and guests participated in the event.

In NYC:

Helping Pediatric Patients & Getting Data When You Need It

There are few things scarier than a hospital stay for pediatric patients. To ease their anxiety and help them deal with time alone, Dr. Ravi Mangal Patel, a PGY 2 at New York City's Bellevue Hospital thought that the department could be more child-friendly. After consulting with the Child Life Staff at the hospital, Dr. Patel submitted a request for two fun centers. These mobile entertainment devices are equipped with movies and video games that can ease the burden of illness for children, many of whom are hospitalized for extended peri-

Dr. Ravi Patel and his patient Matthew Camacho in the Child Life room at NY's Bellevue Hospital Pediatrics Department. Matthew will be one of the patients to enjoy the new video game and movie "fun centers," which were purchased by the CIR Patient Care Trust Fund.

PHOTOS FROM LEFT: BILL BURKE/PAGE ONE PHOTOGRAPHY; ANEEQ AHMAD; RITA SHARMA/CIR; L.1991SEIU

CARE FUNDS

S TO MEET PATIENT NEEDS

CIR members of the LAC+USC Patient Care Fund Committee grappled with their enormous fund, and streamlined the process; shown here, from left to right: Drs. Chi Lee, CIR Chapter Pres., LAC + USC; Paola Sequeira, CIR VP, Southern California; and Leilani Valdes, CIR Delegate, and 2006-2007 PCF Chair.

ods of time. He also requested PediaPals and ZooPals exam tables with themed wall decal kits, which the Patient Care Trust Fund approved and purchased. Next up: a digital camera and color laser printer which were just ordered for patient use in Bellevue's Computer Art Program. "It's great that CIR, via the Patient Care Fund, is giving residents ways to directly improve patient care," Dr. Patel said.

At St. Luke's-Roosevelt Hospital, also in NYC, residents used the PCF for a subscription to UpToDate.com, an online service that collects information from medical journals and research, and delivers it via internet, CD-ROM, and PocketPC, so that doctors can access the most current information within their specialty at the point of service where they most need it, even during a patient visit.

"Having the Patient Care Fund allowed us to get access to UpToDate.com, which is a very valuable service for residents. We use it for education, research, and as a clinical resource. Without our CIR PCF, it would not have been possible," said Dr. Neha Bhanusali, a PGY 3 in Internal Medicine.

"It took a lot of work, and a lot of meetings by residents on the PCF committee, but now every resident can access UpToDate.com through any computer in the hospital that has the intranet," said Dr. Kabir Mody, a CIR delegate, and PGY 3 in Internal Medicine at St. Luke's-Roosevelt.

In Florida:

Patients Work Out for Health, Physical Therapy

Thanks to CIR residents at Jackson Memorial Hospital, patients at Miami's Jefferson Reaves Wellness Center have a host of new work out equipment, and the individual attention they need to make the most of it. Dr. Joseph Etienne, a CIR leader and Family Medicine resident, determined that many of his patients were lacking the physical therapy and exercise that they needed to improve their health, so he applied for PCF funding.

The $15,000 in exercise equipment came through that fund, and the clinic opened on June 28, 2006. "The importance of the clinic is to improve and overcome patients' limitations. Our patients need to be able to exercise, under the careful supervision of physical therapists. This is vitally important for their recovery and day-to-day functioning. We were overjoyed when the funding came through, and look forward to working with our patients here, and seeing their progress over time," Dr. Etienne said.

Above: Dr. Neha Bhanusali keeps on top of new info while taking a break in the MICU work room at NY's St. Luke's-Roosevelt Hospital with the UpToDate online system.

Left: Dr. Joseph Etienne assists a patient in the newly founded Functional Assessment Clinic at Miami's Jefferson Reaves Wellness Center, with workout equipment thanks to CIR's PCF.

In LA:

CIR Members Streamline Process to Advocate for their Patients

As the oldest, and largest CIR PCF in the country, with $2.2 million countywide, and $1.21 million available annually, the Los Angeles County + University of Southern California (LAC+USC) fund just streamlined their process to make it more accessible to all departments, however large or small. With 50 departments and programs, submitting and justifying requests to the committee and the hospital administration had become a daunting task.

Over time, certain departments have requested large ticket items due their high-tech, high-cost needs. "So this year, we instituted a list of new guidelines for PCF requests – our basic message was, 'Let's be fair, let's be civil, let's share.'" said Dr. Chi Lee, CIR Pres. at LAC + USC, and a PGY 4 in Emergency Medicine. "We asked that:

- If a department had received a large ticket item (over $100,000) in the past three years, they were asked to order a smaller ticket item (maximum dollar amount of $50,000) this year. (A list of previous years' awards were presented in charts for all departments to see.)
- If the items requested were to be shared with other departments, they were more likely to be approved, and the large sum limit did not apply.
- Voting was done on paper, by secret ballot, to prevent animosity and alliances between departments."

Dr. Lee reports that this year's PCF requsts came in under budget, and that there were, "high-fives and pats of support instead of bickering, and every department that submitted requests got all that they wanted." It was, she said, "Incredible."

CIR & Labor-Community Coalition Work Pays Off:

San Francisco Increases Access to Health Care for the Uninsured

On August 7, Mayor Gavin Newsom signed into law legislation that will go into effect July 1, 2007, and add San Francisco to the ranks of local municipalities experimenting with ways to offer health care to the uninsured.

CIR leaders sent hundreds of postcards to the Board of Supervisors, and were part of a broader coalition that lobbied and testified before the Board. CIR activists also engaged in a grassroots effort to educate colleagues and coworkers on the legislation and how it would improve access to health care for the uninsured. In her testimony to the Board, CIR VP Christine Dehlendorf, MD, a family medicine physician at San Francisco General Hospital said, "Everyday 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."

Among the goals of the program is for patients to receive preventive primary care early in their illness, instead of relying on emergency care later on, when their illness has progressed to a severe state. Those covered would receive their medical care through the Department of Public Health and SF's public and non-profit clinics and hospital, including San Francisco General Hospital.

The final bill will extend health coverage to 82,000 city residents who earn too much money to qualify for Medi-Cal (the state's Medicaid) but have no coverage. It requires medium and large employers to spend a reasonable amount on health care for their employees. Small employers (20 or fewer employees) are exempt from the legislation, and unlike health insurance plans, participants will be covered only within San Francisco's city limits.

The program is estimated to cost about $200 million annually, which will be paid through a combination of sources including tax dollars, local business contributions and individual premiums. It is already being hailed as a model for other cities and states.

CIR's 50th Anniversary

Celebrating the Past, Organizing for the Future

Former CIR delegates and activists are invited to CIR's upcoming 50th Anniversary celebration May 18-19, 2007, to be held in Philadelphia, Pa, at the Double Tree Hotel and the College of Physicians/The Mutter Museum. It will be a time to celebrate past achievements, and plan for future ones; to reconnect with folks you haven't seen for awhile, and to stay involved in the continuing movement for better patient care and access, and for improved medical training. Along with the toasts and stories, this two-day event will feature guest speakers and engaging discussions with CIR's founders and leaders from all stages of our history.

For more information, email:
kpfordresher@cirseiu.org

Right: Past CIR Presidents Herbert Vaughan, MD, who helped found CIR in 1957, with Dr. Janet Freedman, CIR President from 1986-1988.

CIR Remembers Dr. Dan Lawlor

Former CIR Pres. Dr. Dan Lawlor died at age 51 on June 18, 2006. He was a family practice resident at Bronx Lebanon Hospital from 1988-1991. He served first as a CIR Vice President, and then as CIR President from 1992-1993, during which time CIR concluded successful affiliations with residents' associations at Boston City Hospital (now Boston Medical Center) and Cambridge Hospital.

Dr. Dan Lawlor at a community health rally.

In an interview earlier this year with CIR, Dr. Lawlor recalled how difficult his first four months of residency were. At one point, he recalled attending to 90 patients, because he was covering for two other residents. "I had patients on three different floors, and had to run up and down stairs because Bronx Lebanon did not have an elevator at that time," he said. "Machines were scarce, and I had to leave a cash deposit out of my own pocket to use the EKG machine," he said. When he was at his wit's end, a nurse commented to him, 'Don't worry doctor, you just have to get organized.' He showed her his index cards cataloging each patient's illnesses; the nurse shook her head and repeated, 'You have to get organized.' He took the advice, and met with other residents to organize a physicians' association. From there, he spoke with Dr. Janet Freedman, president of CIR, and residents at Bronx Lebanon soon voted to join CIR. Dr. Lawlor is credited with being one of the major leaders bringing the benefits of union representation to his hospital.

Based on that experience, in his later work, Dr. Lawlor focused not only on organizing, but on building alliances with other hospital workers, unions and community groups. He spent the rest of his career working with the National Union of Hospital & Health Care Employees of the American Federation of State and County Municipal Employees (AFSCME) as an organizer for nurses, doctors and home health care workers. He was also a key organizer of the Physicians Forum and its annual Activist Physician Dinner.

In New Jersey:

1,100 Residents at UMDNJ Reap New Contract Gains

By August 1st, 2006, residents at the three NJ medical schools that make up the sprawling University of Medicine and Dentistry of New Jersey (UMDNJ) system ratified their new contract, which covers more than 1,100 residents. All three schools – the NJ Medical School in Newark, Robert Wood Johnson University Hospital in New Brunswick, and the School of Osteopathic Medicine in Stratford, South Jersey – had CIR members and delegates involved in the negotiations. Gains include 3% salary increases for each year of the four-year contract; increases in book allowances, which can now also be used for USMLE STEP 3 or COMLEX for the first time; and increases in orientation pay to $450 for the first year of the agreement, and $500, $550 and $600 for the next three years. Additional gains include eliminating clinics for all housestaff who are post-call or following night float; and the meal allowance expanded to cover residents on an overnight shift of six hours or more, or those on an extended shift of 12+ hours.

"This contract should be a model to current negotiating efforts across the country," said Dr. Kennedy Ganti, a PGY 4 Fellow in Family Medicine, and CIR delegate. "Given the difficult financial circumstances that UMDNJ is currently in, our members reasonably held steadfast to key issues such as insuring a better workplace, and patient safety. CIR as a whole is taken very seriously here, there's a lot of respect," he said.

> **"Negotiations were long and grueling, but ultimately rewarding in a huge way."**
>
> **Dr. Cristin McKenna, NJ VP**
> **PGY 3, PM&R**

"Contract negotiations were long and grueling, and sometimes uncomfortable, but ultimately rewarding in a huge way," said NJ CIR Vice Pres. Cristin McKenna, MD, a PGY 3 in Physical Medicine & Rehabilitation at UMDNJ. "Just being in a room with residents from different specialties was great. It gave us a chance to formally engage in a frank discussion of money and benefits in a way that is unusual for those in medical training, and this is a skill we'll need for the rest of our lives."

Of particular concern to Dr. McKenna is Maggie's Law and the UMDNJ response to it. Maggie's Law, a NJ state law since 2003, criminalizes drivers who have been awake for more than 24 hours and caused a fatal crash. Penalties include prison time of up to 10 years, and a $100,000 fine. "We have a letter of agreement that residents and the administration will sit down together to discuss Maggie's Law and driving while drowsy with UMDNJ. We also hope to address residents *working* while drowsy," Dr. McKenna said. "We need to educate our members, publicize best practices for resident work hour reduction, work for legislation that addresses resident's excessive work hours, and negotiate with our hospitals for ways to fix this problem," she said.

Dr. Badar Jan at ratification vote.

The new contract is in effect until October 31, 2009, and includes other gains such as: holiday pay in the event that an alternate day off cannot be granted within two months of the holiday; UMDNJ to pay all NJ state licensing fees for housestaff if licensing is required by the program; UMDNJ to provide free BCLS, ACLS, ATLS, PALS, NALS and recertification courses as required as part of training; and the University to pay costs up to $75 for fingerprinting and other fees associated with required background checks.

In California:

Contract Gains after Santa Clara Residents Turn Up the Heat

Despite a long amicable relationship between residents and hospital administration at Santa Clara Valley Medical Center (SVCMC) in San Jose, California, contract negotiations stalled this year, with an initial offer on the table of a proposed .5% increase over a three-year contract. The 103 Internal Medicine, Radiology, and OB-GYN residents at this County hospital knew that they deserved more, and could do better.

"We started negotiating in April 2006, and by June went to visit the County's Board of Supervisors, who are ultimately in charge of the money and the contract," said Dr. Stacie Carney, a PGY 3 in Internal Medicine, and former CIR delegate who was active in contract negotiations. "About 30 of us went and brought along a petition and letter signed by all of the residents in the hospital supporting a better contract with a focus on raising the intern salaries so we could stay competitive."


More than 30 CIR members shared their stories with the Board of Supervisors.

That was just the beginning. CIR members and elected officers also met with state representatives, reached out to the hospital's CEO, spoke at a rally of 3,000 held by SEIU Local 715 (which was simultaneously in negotiations with the hospital), and held a lunchtime rally of their own. "We picketed, carrying signs and petitions, and were joined by attending physicians and other hospital staff," Dr. Carney said. "I never thought I would do any of this! It was a great lesson in how things work." Residents and the administration went into state mediation in mid-July. After two sessions, they came out with an agreement both sides accepted.

"We won salary increases of 4%, 7.5% and 3.5% for incoming interns. The rest of the residents will have 4%, 3% and 3% wage increases over the life of the agreement, which is retroactive from July 2006 through June 2009. The big thing we were looking for we did end up getting. Because we wanted our intern salaries to be competitive with other residencies, we got more money for interns, and were pleased with that outcome," Dr. Carney said. "Some hospitals in the area have closed, and we've been busier than other hospitals with their patients since we're the County hospital," she said. To be busier, and paid significantly less than other programs was not a winning combination.

Left to right, Drs. Punit Sarna, Stacie Carney, and Kaveh Hoda, CIR leaders, at a rally before meeting with the County's Board of Supervisors.

The contract was ratified in August. Other gains include residents working nights guaranteed meals, and a clause to cover money for outside food for educational conferences. They also negotiated an improved disability benefit, and improved maintenance and inspections of their call rooms and resident lounges.

"CIR staff was very helpful, and networking with residents from other departments, with attendings and the solidarity with other hospital staff was all important," Dr. Carney said. "We got the message out to key players who are not at the bargaining table – the Board of Supervisors and the public, and that really made all the difference."

PHOTOS: (TOP) CARA METZ/CIR; (BOTTOM) ELEIZA BRAUN/CIR

CIR Leaders Take On the World

There are as many ways to contribute to global health as there are concerned individuals who want to make a difference. These CIR leaders have each found a way to put their concern into service by tackling world health on an elective in rural Uganda, recruiting physicians willing to work with "the poorest of the poor" worldwide, and volunteering to aid survivors of torture who have come to the U.S. seeking amnesty.

Clockwise from top left: Dr. Nailah Thompson, (seen above) bonding with one of her patients, Mary; seen here smiling after her full recovery from malaria; the clinic where Dr. Thompson worked in Soroti, Uganda; and her housing there.

Dr. Nailah Thompson, a CIR Vice Pres. from Highland Hospital in Oakland, California traveled to Soroti, in northeastern Uganda on an elective with a non-governmental organization called *Learning Empowers Uganda* (LEU). "I worked in a medical clinic formed to care for internally displaced persons who otherwise would not have had access to medical care. These are people who had to flee from their homes when the Lord's Resistance Army was ravaging Uganda, killing, kidnapping, mutilating and raping adults and young children, which went on from the late 1980s until 2004.

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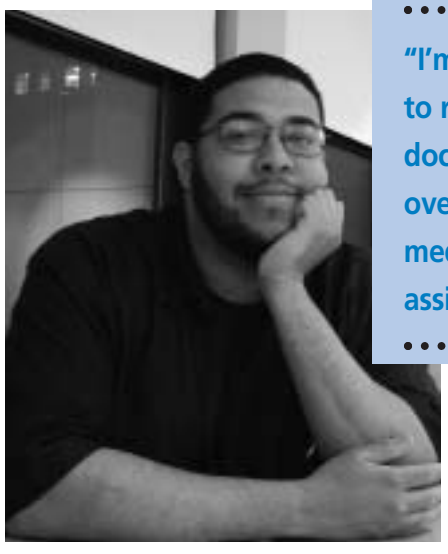
"The medical issues we saw – malaria, meningitis, typhoid fever – are things we don't see at home," said Dr. Thompson. "In Uganda, you have to pay ahead and bring all medical supplies, bed linens, and food for the patient. So, if you don't have money and get sick, you just die. LEU pays about 35 cents for a clinic visit and the medicine needed. Mary, a little girl I saw, (see photo, above) had malaria, and was limp and feverish that first day. (In the next photo) you can see her beaming. For the money it takes to buy one Starbucks coffee, we could treat three people in the clinic.

"People were so grateful. They had such overwhelming needs, had survived trauma, but were also resilient. It makes you appreciate what we have at home, and realize just how much we do have here. I hope to do more international work, because it's part of the reason why I became a doctor – to help people in need – and there are people in need all over the world."

One highlight from Dr. Thompson's time in Uganda came when she was visiting camps for the internally displaced, and was greeted by the shy smiles of the children, who followed her in an informal delegation that kept growing until it eventually reached 75 kids!

For more information, or if you are interested in volunteering, or donating to Learning Empowers Uganda, contact Dr. Thompson at: nthompson@cirseiu.org.



Dr. Joseph Morrell recruits doctors for *Goal USA*, and hopes to be one himself when he finishes his residency.

> **"I'm helping to recruit doctors for overseas medical assignments."**

Dr. Joseph Morrell, a chief resident and CIR department rep in Radiology at Harlem Hospital is involved with a group called *Goal USA*, part of an international humanitarian organization that seeks to alleviate the suffering of the "poorest of the poor" worldwide, with a focus on health. Dr. Morrell has been helping to recruit medical doctors for volunteer work. "Because the headquarters are in Dublin, Ireland, *Goal USA* (there are Goal chapters in many countries) wasn't aware of the requirements here," Dr. Morrell said. "I've been explaining what our protocols and guidelines are for recruiting doctors to work overseas. Doctors are trained by the organization, and reimbursed for their expenses; the second time they volunteer overseas, they are usually given a stipend for the assignment. There are emergency disaster programs with varying lengths of assignment, and ongoing health programs for six months to one year time slots. When I finish my residency, I want to work overseas with *Goal USA*," Dr. Morrell said.

Another post-residency plan he harbors is to send radiology equipment, particularly ultrasounds, to Africa. "Ultrasounds are portable, more affordable than MRIs, and are the best modality for the developing world." For more information, check out *Goal USA* on the web at http://www.goalusa.org/

Dr. James Rodriguez, a CIR NY Vice Pres. and Emergency Medicine resident at Bellevue Hospital has been volunteering with *Doctors of the World* to help people who are seeking amnesty after surviving torture in their home countries. "A psychologist assesses the person's psychological trauma, and as a medical doctor, I assess the scars, wounds, and patterns thereof to determine whether the injuries correlate to what they are describing," Dr. Rodriguez said. While their cases are pending, the people he sees are held in an internment facility in Elizabeth, N.J. "They're in limbo, they're not legally in this country yet, so they can't work, and are not protected. In some cases, this limbo can last for years. By doing physical examinations, we can help speed up the process."

> **"You can do a tremendous amount of good by helping out survivors of torture who are seeking asylum."**

The training includes classes, lectures, and supervision during your first session with an asylum seeker. "One of my first clients was an artist from Tibet," Dr. Rodriguez said. "He was from a long line of artists, and in protest of conditions in Tibet, began to paint pictures of the Dalai Lama, which got him imprisoned. When he was released, it was with the understanding that he would never paint again. He refused to abide by that, and so the authorities amputated his right arm. He snuck out of his country, and when he arrived here, was detained for two years. I could see, based on the stipling on his arm in an X-ray, that someone had cut it, that it was not an accident. He was clearly a very strong person to stand up to his government. He said that what kept him going was the knowledge that this is a country of freedom, but that when he arrived here and was imprisoned, he was devastated. You can do a tremendous amount of good by helping out individuals like him.

"There is always a need for doctors, and it's very flexible, which matches a resident's schedule. If you're having a busy month, you don't have to volunteer that month; if you have more free time, you can add in hours, and work it around your schedule," Dr. Rodriguez said. For more information, see their website at: www.doctorsoftheworld.org.

Dr. James Rodriguez says that the stories he hears from torture survivors lends a new perspective to his own life.