CIR SEIU NEWS
COMMITTEE OF INTERNS AND RESIDENTS December 2006

This issue contains an insert with important information about rights under the VHHSBP, HSBP, PEP and CIRLS welfare benefit plans and ERISA which should be read and retained for future reference.

Protecting Safety Net Hospitals

CIR members throughout the country are working hard to ensure that their safety net hospitals continue to provide vital care. As states trim their budgets, money for care to the underinsured is a tempting target. In California, CIR members helped pass a measure that increased funding; in New York, an executive commission is moving to close hospitals throughout the state, with no input from physicians, hospitals or the affected communities.

Demonstrating the premise that "it's better to light a candle than curse the darkness," CIR leaders have been testifying, lobbying, and taking part in this candlelight vigil on October 26, 2006, to stand up for the safety net hospitals where they deliver care. Addressing the crowd, CIR NY Vice President Luella Toni Lewis said, "Our communities need more, not less health care. We want to send the message, 'Do No More Harm' to our legislators."

It's not too late to make your voice heard on the issue: to send an e-letter to your legislators, go to CIR's website at www.cirseiu.org and click on Take Action, on the left.

In New Jersey, a similar commission was established October 12, 2006 for the same purpose, and has until June to complete its recommendations. *Stay tuned!*

CIR SEIU NEWS
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Page one photo: Cara Metz/CIR

President's Report

SIMON AHTARIDIS, MD, MPH

Charting the Journey of an Activist Physician

Like many medical students interested in health advocacy I read a borrowed, tattered copy of former CIR president Dr. Fitzhugh Mullan's *White Coat, Clenched Fist* during medical school. (See backpage for an interview with Dr. Mullan, who will be a speaker at our next convention.) I was so inspired by it that I ended up Xeroxing the out-of-print book to share it with others (sorry Fitz, I did eventually find and purchase a legitimate copy). It told the story of the challenges faced by a young socially and politically aware doctor. As I read I wondered how this young activist physician found the courage to directly confront the powers that be. I was astonished to read about the remarkable amount of energy that this young doctor possessed, from civil rights work in a hostile Mississippi, to rethinking how medicine should be practiced, to organizing strikes and public exposure campaigns for improving hospital conditions for patients and residents.

When I finished the book, I began to wonder if we, the new generation of doctors had lost some of that spark and passion for positive change that the activist doctors of earlier generations embodied. We are not heading off by the busload to distant states to fight bigotry and injustice, we are not staging sit-ins or large scale protests, and going on strike is virtually unheard of.

In seeing the work of advocates

within CIR, I have come to realize that the nature of activist work has changed. Today's activists work within the system as often as they do on the outside.

Our tools have shifted from banner-making and sit-ins to strongly worded journal articles and editorials, coordinated legislative campaigns, e-activism, media framing, culture jamming,* joining activist doctor groups, and working in broad coalitions with others.

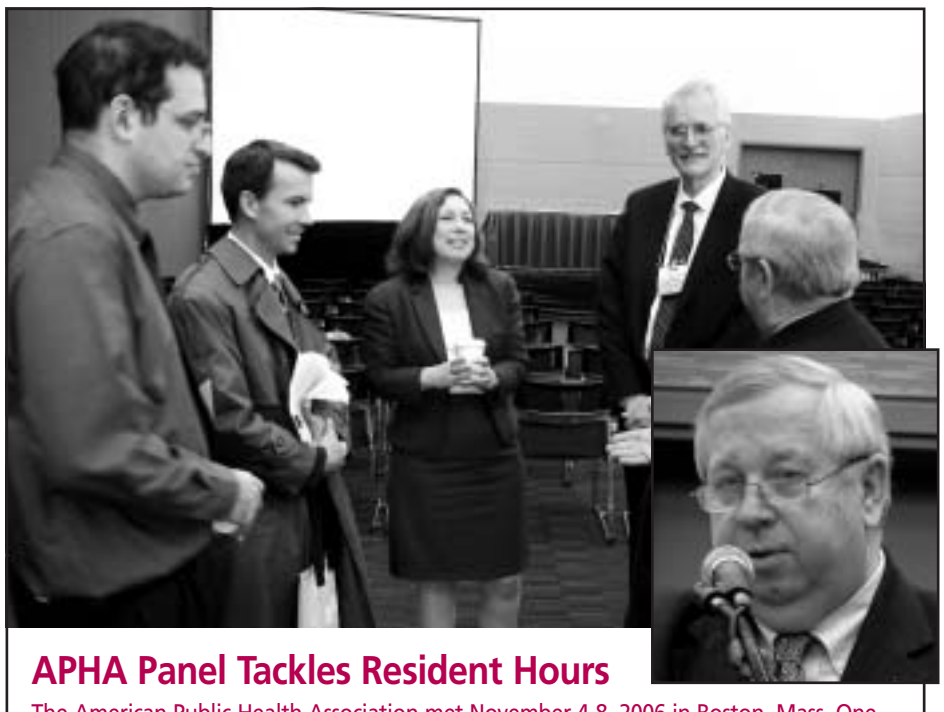
In a turnaround, professional societies and institutions traditionally opposed to Dr. Mullan's views on the role of the physician as a health advocate have recently endorsed the notion that physicians must be actively engaged with the political world around them to maximize their role as guardians of the people's health.

Recent years have brought a number of challenges to the health of the public and the practice of medicine: the increasing corporatization of health care, worsening global and domestic heath disparities, the HIV/AIDS epidemic, and the growing problem of access to care. Our unique perspective on the front lines of medical care offers us a unique opportunity to be change agents.

We have a very dysfunctional health care system that desperately needs heroines and heroes to address and correct problems. If you want to play a larger role and be a health advocate, talk to people involved in work that interests you, find mentors and get the training that you need to be a change agent. You're well situated for the role, because CIR is one great place to start, or continue that activism, with your colleagues as allies.

**Culture jamming is using and transforming mass media as a commentary on it.*

"We have a dysfunctional health care system that desperately needs heroines and heroes to address and correct problems."



APHA Panel Tackles Resident Hours

The American Public Health Association met November 4-8, 2006 in Boston, Mass. One panel discussion on November 6 was sponsored by the Occupational Health and Safety Section, on the topic of "Reevaluating Current Work Hours Limits: What are Safe Hours for Physicians, Nurses…and the Public?" The presenters were (seen here, left to right) CIR Pres. Simon Ahtaridis, MD, MPH, Christopher Landrigan, MD, MPH, Ann Rogers, RN, PhD, Charles Czeisler, MD, PhD, and Mass. State Senator Richard T. Moore, Chair of the Joint Committee on Health Care (also shown in inset photo).

HEALTH CARE FACTS

Despite spending more than any other nation on health care, the United States stands alone among developed countries in not providing universal access to care.

- **46.6 million Americans are uninsured or 15.9% of the population;**
- **11.2% of children are uninsured;**
- **66% of the uninsured are in families with at least one full-time worker;**
- **14% of uninsured adults have a bachelors degree or higher;**
- **74% of uninsured adults have graduated high school;**
- **46% of the uninsured have family incomes over 200% the federal poverty level.**

Source: *US Census Bureau, Housing and Household Economic Statistics Division, Current Population Survey.*

PHOTO: (TOP) SANDY SHEA/CIR

London's "Hospital at Night"–

A Model for Hours Reduction, Patient Safety & MD-RN Team-Building

Many U.S. residency programs are struggling to reduce resident work hours to limits that the scientific evidence says are safer than what the ACGME now allows. But it is no easy trick to reduce consecutive hours worked to no more than 12-16, while getting the work done, providing quality care and improving, not impeding, resident education. Best practices and innovative problem-solving are in high demand. The one described below – Hospital at Night – comes from the United Kingdom, which has done some serious hours reduction in the last few years.

Piloted in approximately 25 London-area hospitals, the Hospital at Night (HaN) project is now spreading across the UK. In 2006, former CIR President Dr. Barbie Gatton and Senior Area Director Sandy Shea spent three whirlwind days and nights visiting medical educators and HaN teams in three London hospitals to see the idea in action. CIR's hosts stressed that there was no one-size-fits-all version of Hospital at Night. Rather, each hospital must analyze how the work gets done and design their team size and composition accordingly. They also acknowledged that it worked better in some hospitals than in others, but that no one who had experienced it wanted to go back to "the old days." (To read CIR's complete Hospital at Night report, including a list of resources, go to www.cirseiu.org and click "Hospital at Night" under Valuable Resources.)

9 PM: the Hospital at Night team meeting at London's Homerton University Hospital Trust, with former CIR President Barbie Gatton (back row, far right) in attendance.

In 2004, the European Union Work Time Directive went into effect for physicians in training in the United Kingdom. Suddenly, hospitals were required to reduce scheduled in-hospital hours from about 72 per week to 56, with shifts no longer than 13 consecutive hours. The National Health Service, recognizing that hospitals would be strained by this dramatic change, provided start-up funds for the transition.

"The Trusts [hospitals] who just threw doctors at it [the hours reduction] are now trying to pay the bills," said Dr. Wendy Reid, a practicing Ob-Gyn attending and Post Graduate Dean, who oversees the national Hospital at Night project.

But the London Deanery, which trains the largest number of doctors in the UK, decided, according to Dr. Reid, to approach the problem differently. They observed that the hospital generally quiets down by late evening, except for care of the sickest patients, but that every service still had someone in house "watching their patch." Even so, their statistics showed that adverse patient care events tended to happen at night.

London Deanery Post Graduate Dean, Dr. Wendy Reid, heads the national Hospital at Night project.

Why are Nights More Dangerous?

"We tried to look at improving patient care," Dr. Reid explained. "Why are patients at risk at night? We will always have people there waiting for the disaster in those specialties where instant response is vital – anesthesia, emergency medicine…But what are the training opportunities [for other specialties] after hours? What happens in the evening? We've got to stop this business of 'oh I'm just working,' but ask ourselves 'is this going to train you to be a better doctor? We mustn't allow routine work to spill over into the after hours because that ties up people in the wrong places doing the wrong jobs at the wrong time – and that's not safe.'"

Dr. Reid and her colleagues also observed that in general, across specialties, communication – between nurses and residents and residents and attendings – was sub-optimal; that the most junior residents were called first (with several subsequent calls up the chain of command until an attending was consulted); and that all residents on duty at night were constantly paged by nursing staff for questions large and small, interrupting their work and any rest they might be able to get while on call.

It Takes a Team

From these observations, the Hospital at Night project took hold: a multi-disciplinary team of medical and surgical residents, headed by a Clinical Site Manager, usually an experienced critical care nurse. The team identifies all seriously ill patients at two 20 minute hand offs that occur every 12 hours. These hand offs do *not* take the place of the normal handoffs that occur within the medical and surgical teams.

Instead, at about 9 PM the departing day team of medical and surgical residents and the Clinical Site Manager meet with the HaN team coming on duty at night to alert each other to the sickest patients and/or the ones that they are most concerned might become sicker over the night and need to go to the ICU.

Again in the morning at about 8 AM before going off duty, the night team of HaN residents and Clinical Site Manager meet with the incoming day residents and day CSM to once again alert each other to those patients who are most sick or of concern.

A "No Bleep" Policy

Hospital at Night's most innovative contribution, however, is the unique role of the nurse team leader and the "No Bleep" (aka "page") policy after the 9 PM hand off. "No more getting called at 4 in the morning to be asked to put in an IV," explained Dr. Jeremy Weinbren, Anesthetic consultant (attending) and head of HaN at Hillingdon Hospital, located in a suburb of London. "And you won't get called at 4 in the morning to be told you've forgotten to write an order." The nurse team leader filters all calls. If he or she can answer the question, they will and if it's a request for service, like an IV that can't wait until morning, they will do it. If the call requires a physician, the team leader will contact the most appropriate level of medic on duty – the more serious the situation, the more senior the doctor, thereby passing "the Mum Test," e.g. would I want my very ill mother to be cared for by someone so junior? "It's clear what the lines of accountability are," sums up Dr. Reid. "It's not just the person the nurse manages to get on the phone. That can be very frightening for a nurse not to be able to reach a doctor…HaN is not just about reducing the number of doctors at night. You may need more doctors, but they just might be different doctors. On our Night Team, all can manage an arrest. Each has a role. They are all physicians who've been trained to care for the acutely ill. Nurses on the floors feel supported [by the nurse team leader], and physicians can get their work done, no longer constantly interrupted by pages."

At Guys and St. Thomas Trust, a large tertiary medical center with 1,200 beds at two sites in the center of London, Dr. Diana Hamilton-Fairley, HaN co-director, and Alison Hendron, head of inpatient nursing, marveled at an unanticipated outcome of the project that was echoed in the other hospitals CIR visited: less stressful, more collegial relationships between doctors and nurses. "It's led to a much greater respect," said Dr. Hamilton-Fairley, "and a much healthier, professional relationship."

EMERGENCY MEDICINE →

AT THE BREA WA

CIR Delegate Teri Reynolds, MD

In California: On the front lines at Alameda County's Highland Hospital

"I really like old-fashioned doctoring," says CIR Delegate Teri Reynolds, MD, a PGY 2 in Emergency Medicine at Highland Hospital in Oakland, Ca. "When someone comes to the Emergency Department (ED) you never say, 'that's not my organ, that's not my area.'" Highland is Alameda County's public safety-net hospital. "I never ask if patients have insurance. I spend 90% of my time examining, treating, or talking to patients, and that's what I love," she says.

Dr. Reynolds also rotates to UCSF, which she calls a "high-powered tertiary care hospital." The differences between the two places "are really interesting," she says. "You can send someone home from UCSF knowing that they'll be able to follow up with their primary doctor. You might not be willing to discharge someone with the same condition from Highland, knowing that you're the only doctor they'll be able to see for some time.

"Most UCSF patients have primary care doctors. At Highland, we'll schedule patients for follow-up in the ED, which is a strange thing to do if you think about the ED as a venue designed for emergent care. At Highland, we accept the reality that we are not only serving as an ER, but also as a place for primary care. This is not the case at UCSF."

The bigger picture issues that disturb her are "primary care medical issues that become serious emergencies due to lack of medical care, and boarding, where an admitted patient stays in the ED for hours or days because there's no bed upstairs. The patient will be rounded on by an in-patient team, but it's incredibly unsafe – and it cuts the beds available for other patients."

Dr. Reynolds has a big-picture solution to what plagues EM – "I believe we need a single-payer health care system. The amount of energy, information, and health that we lose due to people changing insurance, or losing their insurance is insane. I don't believe incremental solutions – covering small segments of the population with public funding – will work. We need to put everyone in the same system so there can be no cherry-picking of patients."

The U.S. emergency medical system is "overburdened, underfunded and highly fragmented," the Institute of Medicine declared in its 2006 report. Its two-year study conducted by 25 experts found ambulances being turned away from emergency departments once every minute, patients waiting hours and even days for a hospital bed, and critical specialists often unavailable. Among their conclusions was that, "the system is ill-prepared to handle surges from disasters such as hurricanes, terrorist attacks, or disease outbreaks."

In a study out this fall, The Centers for Disease Control and Prevention (CDC) also examined the state of emergency medicine and came to the same conclusions: overcrowded emergency rooms undermine our nation's ability to respond to disasters. The crunch, the CDC said, springs from a problem of supply and demand, with annual visits to emergency departments rising 18%, to 110 million visits, from 1994-2004. At the same time, the number of hospitals operating emergency departments declined by 12%.

Congressional testimony following on the heels of these reports pointed to a range of remedies, such as:

- creating a financial incentive for primary care physicians to see patients after hours so that fewer people with non-emergency conditions seek treatment at hospitals;
- investing in more nursing education programs, because about 147,000 qualified applicants to nursing programs were turned away in 2004 due to a shortage of faculty and openings; and
- government funding for a network of regional coordinated emergency care systems.

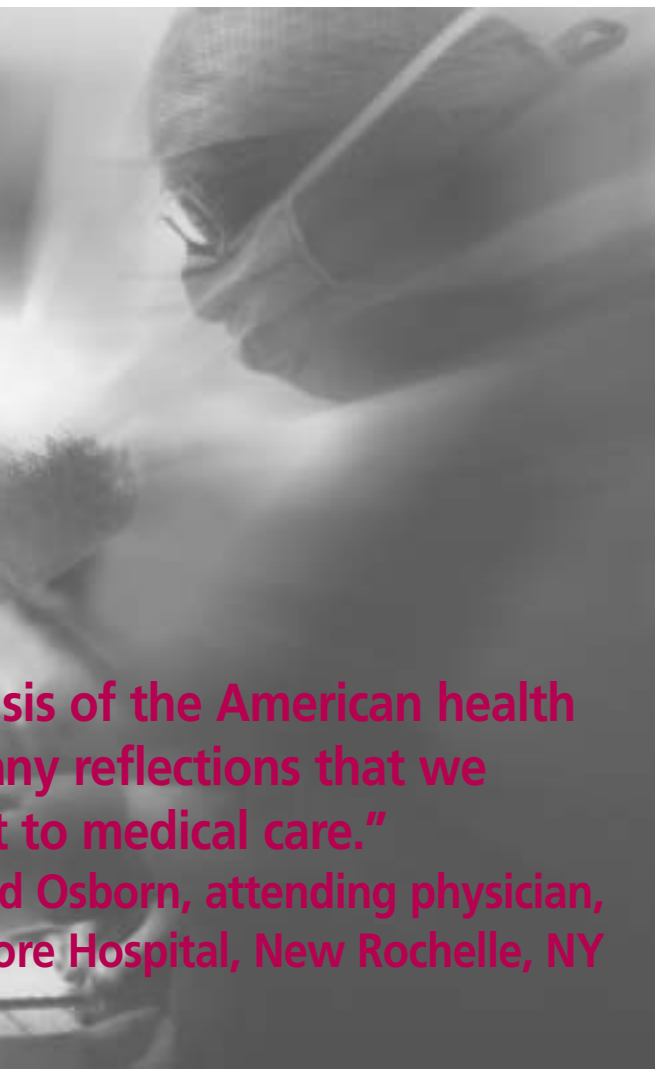
Among CIR's own EM experts — the current and former members who are EM residents or in charge of Emergency Departments — *CIR News* found strong agreement about what is wrong, and how to fix it. "The IOM report was well organized, and articulated concerns that we've had for a while," said NY VP James Rodriguez, MD, a PGY 3 in Emergency Medicine at Bellevue Hospital in New York City. "We've seen this crisis coming – the census is increasing in emergency rooms, overcrowding has increased, and resources are increasingly strained. Now we can quantify and analyze how dangerous the situation is becoming."

"We've seen this crisis coming – the census is increasing in emergency rooms, overcrowding has increased, and resources are increasingly strained."

CIR Vice Pres. James Rodriguez, MD, PGY 3, Bellevue Hospital, NYC

His department director, Dr. Lewis Goldfrank, Director of Emergency Medical Services at Bellevue and a former CIR member, called the report a "roadmap for the future of Emergency Medicine. We need funding, systems, and a commitment to allocating resources effectively," he said, adding that "Emergency Medicine isn't comprehensive universal health care, which is what society needs. If you don't have insurance, people come to the Emergency Department, and we can never fill the gap," he said, adding

AKING POINT...
RNING SIGNS OF A SYSTEM IN CRISIS



that New York's problem is not as large as it is elsewhere in the country. The crisis in emergency medicine has not affected recruitment of residents, Dr. Goldfrank said, because "residents who are drawn to this field are problem solvers, they like to develop solutions and work hard under tough circumstances."

Dr. Harold Osborn, a CIR member in the early 1970s and now an attending physician at Sound Shore Hospital in New Rochelle, a teaching hospital affiliated with New York Medical College and Westchester Medical Center said that, "The [IOM] report is comprehensive and identifies a crisis situation, which is certainly not overstated. With 114 million visits to ERs in 2003, up 26% since 1993, and the number of EDs shrinking because of hospital closures, we're faced with a dilemma. People without insurance increasingly depend on the ED, and people who do have insurance go to the ER on nights and weekends for non-emergency primary care."

One of Dr. Osborne's main concerns is the NY State Hospital Closing Commission, "which will definitely come out with a list of hospitals to close, so this process of overcrowding and overuse of ERs is continuing. We see patients who should be upstairs in the wards, care is fragmented and there is less supervision, because attending physicians are busy taking care of patients themselves. It's hard to function effectively when the system is stretched to the breaking point.

Above: CIR Delegate Vivian Tsai, MD
Above, right: Dr. Sari Soghoian, EM Chief Resident

"Fundamentally, this is a crisis of the American health care system, and one of many reflections that we don't have a universal right to medical care. The ER is the only link in the system that people can access for primary care. Emergency care is an unfunded mandate, and if people had access to care, there would be far fewer ER visits."

> **"If you don't have insurance, people come to the Emergency Department, and we can never fill the gap."**
>
> **Dr. Lewis Goldfrank, Director of Emergency Medical Services, Bellevue Hospital, NYC**

Peter Moyer, also a former CIR member, and now director of Emergency Services for the City of Boston said that, "basically, it's really a pressure cooker for EM, and we need more resources to deal with it. Last year, only one graduating student (from Boston University School of Medicine) went into Primary Care, and without primary care physicians, more patients end up in the ER."

Our EM experts agree that funding, universal access to care, coordination of services, and an increase in the numbers and availability of primary care physicians are essential to fixing our nation's emergency medical system.

In New York: Improved Staffing at Kings County Hospital Brooklyn, NY

Normally, a move to a larger, modernized facility is a good thing. But in the case of the Emergency Medicine Department at Kings County Hospital in Central Brooklyn, there was an increase in beds, going from 40 to 62 overnight, with no parallel increase in staffing.

"We moved into the new building on June 8, 2006," said Dr. Sari Soghoian, a PGY 4 and chief resident in the Emergency Department. "And it was clear to everyone that it was worsening problems of overcrowding, long wait times, and understaffing.

"Our environment felt unsafe to us on a daily basis. We were faced with far more patients in the waiting room, on the treatment list, and in beds blocking up the hallways. There weren't enough nurses to triage in a timely fashion," she said.

Dr. Soghoian posted an online survey where ER residents could describe what they found to be the biggest problems. Based on this data, she contacted CIR and the GME Committee. "This is a success story for how unions can help," Dr. Soghoian said. She mobilized residents and worked with CIR to bring their concerns directly to the hospital's Medical Director, CEO, and GME Committee.

CIR Delegate Vivian Tsai, MD, a PGY 3 in EM, brought Dr. Soghoian to CIR's monthly regional meeting, and credits CIR contract organizer Anne Mitchell with "really helping to get the ball rolling," and working with other unions for a solution. "We involved nurses from NYSNA, and attending physicians from Doctors Council. CIR was proactive throughout the whole process, encouraging us to go to public hearings" and make our opinions known, Dr. Tsai said.

The end result will be 22 nurses, four patient care associates, and a patient care technician hired. An additional three RNs, one per diem RN, one clerk and three LPNs are in the pipeline. "It was a very positive experience," Dr. Soghoian said. "I feared it would be like pulling teeth, but in looking back, I realize it all happened very quickly. If you have the moral high ground, are working hard and asking for stuff you need, you just have to be persistent and you'll get what you need."

Summary Annual Report for Voluntary Hospitals House Staff Benefits Plan (VHHSBP)

This is a summary of the annual report of the VHHSBP, EIN 13-3029280 welfare plan for the year ending December 31, 2005. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The VHHHSBP has committed itself to pay certain claims to cover hospital, surgical and major medical coverage, dental, both short and long term disability, life insurance, legal, and optical benefits. There are no retirement benefits in this Fund.

Insurance Information

The VHSBP has contracts with United Healthcare for medical coverage and paid total premiums of $14,995,657; Aetna for dental coverage and paid total premiums of $1,008,944; Guardian for life insurance and paid total premiums of $276,022 and Guardian for long-term disability and paid total premiums of $256,847. The total premiums paid to all carriers for 2005 was $16,537,470.

Because medical benefits under United Healthcare is an 'experience-rated' contract, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 2005, the premiums paid under such `experience-rated' contract were $14,995,657 and the total of all benefit claims paid under the experience rated contract during the plan year was $13,088,772.

Basic financial statement

The value of plan assets, after subtracting liabilities of the plan, was $10,192,086 as of December 31, 2005, compared to $9,670,742 as of January 1, 2005. During the plan year the plan experienced an increase in its net assets of $521,344. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $18,235,377 including employer contributions of $16,550,012, employee contributions of $499,042, realized gains of $48,981 from the sale of assets, and earnings from investments of $229,521. Plan expenses were $17,714,033. These expenses included $675,648 in administrative expenses, and $17,006,411 in benefits paid to participants and beneficiaries.

Additional Information

The plan received an Insurance Dividend in the amount of $907,821 for the 2005 year end from United Healthcare for favorable claims experience from 2004.

Your Rights to Additional Information

You have 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:

1. An accountant's report;

2. Financial information and information on payments to service providers;

3. Assets held for investment;

4. Fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);

5. Transactions in excess of 5 percent of the plan assets;

6. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call Earl Mathurin, Benefits Plan Manager, VHHSBP, 520 Eighth Avenue Suite 1200, New York, NY 10018. The charge to cover copying costs will be .20 per page.

You also have 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 given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan 520 Eighth Avenue Suite 1200, New York, NY 10018, and at 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, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

NATIONAL PHYSICIANS ALLIANCE
2ND ANNUAL MEETING

Making Medicine Ours Again:
Patients and Doctors United for Health

The National Physicians Alliance is a new national organization that works in alliance with CIR and the American Medical Student Association (AMSA) to reform our health care system and foster a more patient-centered approach to medicine. This **March 10-12, 2007 in Washington, DC**, you can network with inspiring physicians from around the country, reconnect with your passion for better health care, and build skills to advocate for your patients at the second Annual National Physicians Alliance Meeting.

Speakers include **Paul Farmer, MD, PhD,** a Harvard University Professor, attending physician at Brigham and Women's Hospital, and founder of an international nonprofit that treats the poorest of the world's poor for free and helps distribute medicine for TB, AIDS and other infectious diseases; and **Sanjay Gupta, MD**, a practicing neurosurgeon, and the senior medical correspondent for the health and medical unit at CNN. Both speakers are co-sponsored by AMSA, which is having its annual convention at the same location, on overlapping dates. **Register at www.npalliance.org.**

Summary Annual Reports for HSBP, PEP, and Legal Services

Every year, CIR updates and publishes the summary of annual reports for the three city funds. Two of the Plans have reported audit results for December 31, 2005. The Professional Educational Plan, which has a June fiscal year end, has presented the audit results for June 30, 2005. All of the funds have received an unqualified (or clean) opinion from the auditors and each of the funds has made available all of the records to the auditors. The Plans are 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 annual reports have been filed with the Internal Revenue Service.

Summary Annual Report of the Public Sector: House Staff Benefit Plan

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, 2005.

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 reimbursements. There are no retirement benefits in this fund.

HSBP has an insurance contract with Aetna to pay all dental claims ($1,201,745 in total premiums were paid) and with Guardian Insurance for both life insurance ($290,429 in total premiums were paid) and long term disability ($252,981 in total premiums were paid).

The value of the Plan assets after subtracting liabilities of the Plan was $5,879,748 as of December 31, 2005 compared to $5,531,584 as of January 1, 2005. During the year, the Plan experienced an increase in net assets of $348,164. This increase included both realized and unrealized gains and losses on securities. During the year, the Plan had total income of $3,639,702, which included employers' contributions of $3,582,295, interest on investments of $140,449, COBRA receipts of $24,296, and investment gains of $46,470 (netted for realized and unrealized). A special allocation one time trustee approved allocation to the Legal Services Plan was made for $153,808, which reduced the 2005 income. This charge, however, eliminated the Legal Services deficit and is explained below.

Plan expenses were $3,291,538. These expenses included $2,729,933 in benefits paid (to participants and beneficiaries or on their behalf) and $561,605 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, 2005 with a surplus of $8,870. This was an increase of $162,678 over the prior year, which ended with a deficit of $153,808. During 2005 total employer contributions were $396,592 and included a one-time trustee approved assessment of $153,808 to return the fund to solvency; total costs were $233,914 ($163,698 in benefits and $70,216 in administration expenses.)

Professional Educational Plan (PEP) of CIR

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, 2005 fiscal year with a surplus of $1,448,017 (assets exceeding liabilities). During the fiscal year ended June 30, 2005 the plan reported an operating deficit for the year of ($153,932). Total employer contributions, were $937,890, investments gained $5,301 and earned interest of $82,506, and total costs were $1,179,629 ($1,032,645 in benefits and $146,984 in administration expenses.)

Your Rights to Additional Information

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To obtain a copy of the full annual report, or any part thereof, write or call Earl Mathurin, Benefits Plan Manager, CIR Benefits Plan, 520 Eighth Avenue Suite 1200, New York, NY 10018. The charge to cover copying costs will be .20 per page.

You also have 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 given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan 520 Eighth Avenue Suite 1200, New York, NY 10018.

In Los Angeles

Contract Gains Highlight Salary & Working Conditions

CIR members in Los Angeles know a good contract when they see it – and on October 27, 2006 they overwhelmingly voted in favor of a new 3-year deal with impressive economics and working condition gains that address everything from text pagers to a lack of food on offsite rotations. "The CIR team worked extremely hard…I feel confident that this is a strong contract which allows for growth while protecting us through the changes which will occur over the next three years," said CIR Delegate Suganya Karuppana, MD, a PGY 2 in Family Medicine at Harbor-UCLA.

The new contract, covering about 1,500 residents at LA County+USC, Harbor-UCLA and King/Drew Medical Center provides for a 4% raise back to October 1, 2006, with a cumulative three-year total salary increase of 15.5% through September 30, 2009. And the one-time $1,000 education bonus historically paid to interns on August 15 who stay in the County as PGY 2s was boosted to $2,000. CIR negotiators point to an increase in property tax revenue and a County surplus as two reasons why bargaining over economics came a little easier in 2006 than in 2003.

Still, reaching agreement was no walk in the park. The CIR team met County negotiators twelve times over two months and spent considerable time and energy on hours and working condition proposals to enhance patient care, medical education and house officer well-being. "We were able to incorporate a lot of language into our contract to improve resident safety…and to negotiate salaries which are comparable to other hospitals in Los Angeles. Both of these accomplishments allow us to continue to recruit high caliber physicians to work in underserved communities," said CIR negotiating team member Dr. Karuppana.

Drs. Lian Chien, Mailan Pham, Tom Davidson, Paola Sequeira, Breck Nichols, Suganya Karuppana, Gina Jefferson, Gloria Jimenez, and William Eidenmuller stayed into the late hours of the night to reach an agreement with the County of Los Angeles.

A short, but by no means complete list of contract gains includes:

- Frozen meals for the midnight meal; County to reimburse up to $25 per day for residents on rotation if meals are not provided by the host hospital;
- $20,000 for the purchase of hand-held personal alarms for residents working in the Psychiatric Emergency Room and In-patient wards;
- Additional language to follow ACGME duty hour guidelines and the creation of a working group to study and make recommendations on resident sleep deprivation and fatigue; and
- New wellness language re: medical leave for residents seeking treatment for alcohol or chemical dependence.

The new contract also contains a side letter to address the future of residents at King/Drew Medical Center, which has been beset by financial and graduate medical education accrediting problems. CIR staff and legal resources are focused on ensuring that all affected King/Drew residents are placed in other training programs next July.

In Boston

Back to Basics: Salary, Parking & Hours

It took fifteen evening negotiating sessions over four months – not to mention three months of preparation. All that hard work paid off for the 650 residents on October 31st, however, when CIR negotiating team members at Boston Medical Center saw their new contract overwhelmingly ratified by their colleagues.

The agreement features 3.5% salary increases in each of the contract's three years, boosts to the Professional Education Allowance of $100 in 2006 and another $100 in 2008, a reduction in the increase to health insurance premiums and a small increase in monthly parking (the Hospital had initially pushed for a 100% increase). Another important benefit – extra pay for residents who are required to do extra on-call for an absent colleague – was also preserved and expanded to include residents who take call from home.

"Our greatest accomplishment," said Dr. Susie Kim, a PGY 3 Internal Medicine resident and co-president of BMC's CIR chapter, "was pushing for the 16 consecutive hours work limit and post-call taxi program. We hammered away at them for weeks. We didn't give up. We kept bringing in all the literature [showing that 24-30 hour shifts weren't safe]. We talked about how other hospitals were moving in the direction of limiting work hours and providing a taxi service to get house officers home safely post-call, so why not us?" In the final agreement, BMC agreed to pilot a post-call taxi service and to continue discussing work flow and work hour limits. The largest residency program, Internal Medicine, has also begun a complete revamping of their ward rotations, with an eye towards a 16 hour limit.

Negotiating the contract on October 3, 2006 – Boston Medical Center CIR members (from left) Drs. Susie Kim, David Schopfer, Orlando Castillo, Laura Fox, Jori Carter, Deepa Prusty and Peter Smith.

Caucusing CIR members (from left) Drs. Lars Reinhold, MA VP Hillary Tompkins, and Emily Greenbowe.

PHOTO: (TOP) RITA SHARMA/CIR; (BOTTOM) SANDY SHEA/CIR

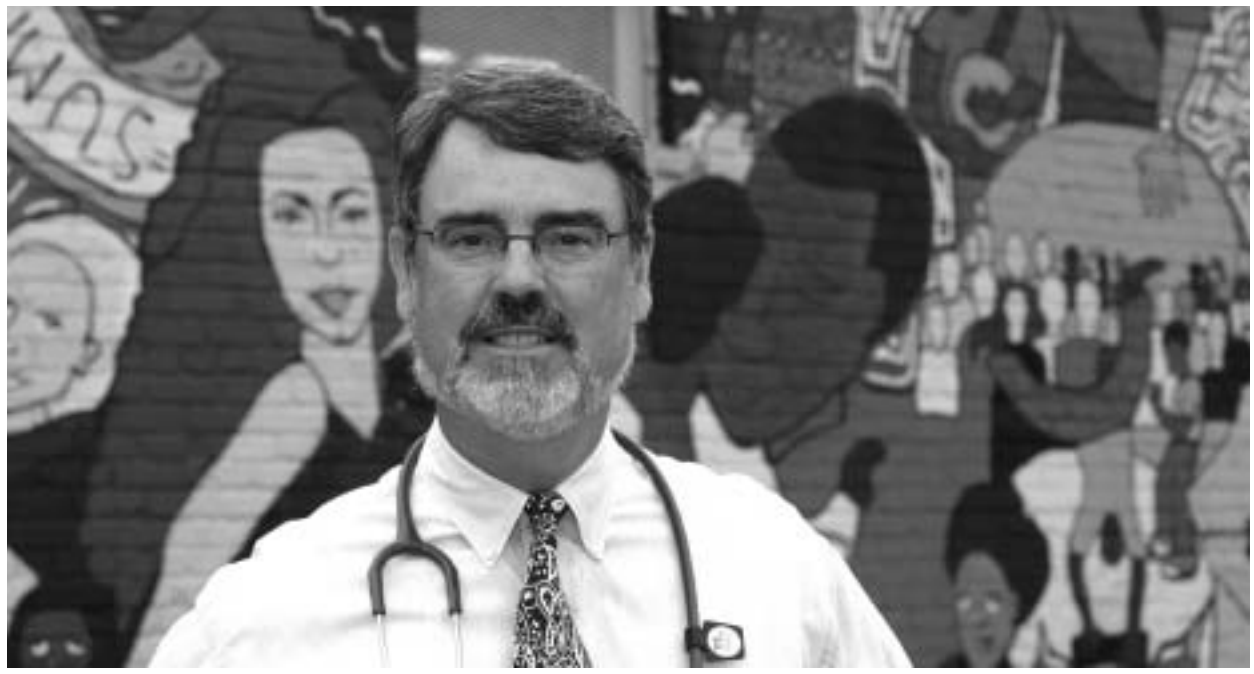
A Conversation with Dr. Fitzhugh Mullan

Former CIR President, Assistant Surgeon General, Author

White Coat, Clenched Fist, originally published in 1976, and soon to be reissued (January '07) by the University of Michigan Press charts the development of an activist physician from his first year of medical school, to his life-altering immersion in the Civil Rights Movement, and an activist residency which included serving as CIR President, organizing a resident's strike, and co-founding the Lincoln Collective in the South Bronx, a resident-driven training program.

The author, Dr. Fitzhugh Mullan went on to publish other books and numerous articles, serve as assistant Surgeon General, and is now a pediatrician at a community health center in DC, and a professor of Pediatrics and Public Policy at George Washington University. He's been on both sides of the great medical divide, as a physician, and as a patient, enduring a two-year bout with cancer at age 32. He coined the terms "survivor" and "survivorship" to define what he went though, and help others facing that test. He makes an impassioned case for the importance of primary care as opposed to the highly fragmented care our system is evolving towards, and has devoted a large part of his career to public service.

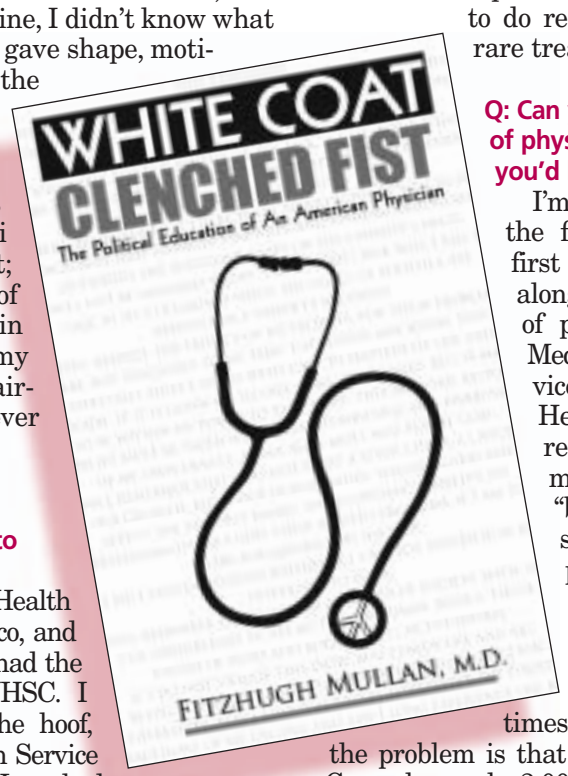
His book *White Coat, Clenched Fist* grabs the reader with its immediacy and deeply felt descriptions. As the newly revised preface indicates, the next 30 years of Dr. Mullan's professional life have been devoted to finding ways to bring a sense of shared compassion and mission to the field of medicine, remaking it in the process into a more humane system in all senses of the word.



Dr. Mullan outside the clinic where he works.

Q: How did your time in Mississippi during the Civil Rights Movement affect your future career?

A: Mississippi was the seminal experience for me, probably the single most important event in making me a doctor. My father was a doctor, so I followed, but once in medicine, I didn't know what I wanted to do. Mississippi gave shape, motivation and direction to the career choice. The absence of care, and the disparities between the world I knew and what African Americans experienced in Mississippi was so colossally far apart; it really took the question of fairness in medicine and in life, and put it squarely in my vision. That passion for fairness has been with me ever since.



Q: Can you tell us how you went from activist resident to Assistant Surgeon General?

I went into the National Health Service Corps in New Mexico, and then came back to DC and had the opportunity to run the NHSC. I learned management on the hoof, and found the Public Health Service a wonderful place to work. I worked closely with Dr. Koop, and was subsequently appointed Assistant Surgeon General responsible for the Bureau of Health Professions, dealing with educational funding and policy for medicine, public health, and nursing. I worked under liberal and conservative administrations – Presidents Carter, George H.W. Bush, and Clinton. The PHS was a place where you could do good work, interesting work, and reduce disparities in health care. It was a place to put equity principles to work in a government harness which still pulled. I am afraid this environment is gone under the current administration.

Q: You are also a prolific author of books and policy articles. How does writing fit into your life? Did you start as a resident, or begin writing seriously before then?

From the age of three, I wanted to be a writer. My grandfather, Seamus McManus was an Irish storyteller, poet, novelist and historian. He was enormously prolific. For me, writing is usually an add-on to a daytime job. Few of us can make a living as a writer, artist, or musician, but I'm a firm believer in the importance of creativity in life. So I scribble in the early mornings, late evenings and weekends. For one year, my job was to write. *Plagues and Politics: The Story of the United States Public Health Service* was the end result. I would wake up in the morning and go the library to do research or write. That was a rare treat.

Q: Can you talk about the direction of physician training, and what you'd like to see in the future?

I'm cautiously optimistic about the future, largely based on my first 10 years in medicine. I came along in the middle of the advent of programs like Medicare and Medicaid; the National Health Service Corps and the Community Health Center program… More recent medical signals are mixed. We have the advent of "boutique" medicine and "lifestyle" subspecialties. Young physicians are abandoning primary care, because it's too tough and they don't get paid enough. Their colleagues in radiology are earning five times as much…Another part of the problem is that the National Health Service Corps has only 2,000 slots out of 800,000 physicians. Only one-third of 1% of physicians in America are in the NHSC, which is not enough to be a major re-balancer. Many more doctors would opt for the program, but there aren't the slots.

Q: What are some of the differences you see between the social activism among young residents and doctors today, and during the 60's and 70's?

The late 60's were a time when social tectonic plates were moving and everybody felt the rumblings. Objection and challenge were much more typical and frequent, ranging from mild to crazy stuff like the Yippies. Medical student protest was fairly restrained, polite, and strategic. Most of my colleagues were focused on curricular change, bringing medicine into all communities, and we were increasingly concerned about the war in Vietnam, and the role of the medical community in that war. It wasn't always easy to be an activist, but I was far from alone.

It becomes more difficult for students to be activists in a quieter time, but it remains important. No part of how we do business (as doctors, as citizens, as people) doesn't need challenge – medicine tends to get less responsive to the needs of others without that. It's healthy to raise challenges, and one of the roles of young people and students is to bring challenges to the system. People say 'you're young, you're naïve,' but these are positive attributes in my opinion, not detriments. The role of new players, youth and residents is important to raise issues of focus, equity, and direction.

Q: What advice do you have for residents who want to be activists and change the health system?

I'd congratulate residents on having achieved a level of clinical competence and having the ability to contribute clinical care to patients. Residents can be commentators and reformers in whatever system they're in, whether it's macro– the world – or local, their hospital. You have clinical standing to raise issues of inequity and reform. And I would urge each resident to raise these issues – the healthiest profession is that which engages in constant improvement. I would encourage young doctors and residents to consider themselves agents of change to make the system better, fairer and more efficient.

CIR has a long history of raising issues that need reform, and effecting change and improvements through collective bargaining. CIR becomes a bulwark for monitoring and commenting on the hospitals, and health care in the community. In many chapters, CIR has taken the lead in improving nurse staffing, and quality of care; that tradition, both within the context of collective bargaining and during in-between times, is one of the very important contributions of CIR over the years.

Look for White Coat, Clenched Fist *at your local bookstore in January '07, or order online through www.press.umich.edu or from Amazon.com.*