CIR News
Committee of Interns and Residents
SEIU Healthcare®
December 2007

Note: Page 3 of this issue contains important information about rights under the House Staff Benefits Legal Services Plan and ERISA. Please retain for future reference.

Surgery Residents & Needlesticks

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- For 53%, the injury involved a high-risk patient; and
- Of the most recent injuries, 51% were not reported to an employee health service.

From *The New England Journal of Medicine*, June 28, 2007

See story, pages 4-5

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Committee of Interns and Residents
of SEIU Healthcare
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Cover photo: David Joel/Getty Images

President's Report

SIMON AHTARIDIS, MD, MPH

Why Physicians Need Unions

Recently, the Centers for Medicare & Medicaid Services released a rule declaring its intention to cut payment for physician services by 10% across the board. The reason given is to combat rising healthcare costs, yet no effort has been made to control spending for drugs and biotechnology, for which Americans pay premium prices. Although the AMA and medical specialty societies are scrambling to fight the new cuts, they lack the unity, power and money that Big Pharma and other healthcare interests have at their disposal.

The insurance industry is no exception. Most efforts to expand health access rely on expanding the private, for-profit insurance industry which is more expensive, and less efficient at delivering care than conventional public programs.

Over the past 20 years, physicians have increasingly been subject to health insurance and government policy that necessitates 15-minute patient visits, endless paperwork, prior approvals and other cost-containment strategies. While this has been taking place, pharmaceutical and insurance companies have been making previously unheard-of profits. Insurers achieve these astronomical sums by limiting and denying patient care.

Physicians are frustrated with long hours in private practice and the stress of managing a money-losing business. Their solution has been to seek employment in large multispecialty groups and hospitals. However, these changes have led to further demands to increase patient volume with concomitant decline in physician salaries as hospitals negotiate profitable arrangements with physician groups.

Patient care and physician job satisfaction have both suffered. Surveys reveal that most physicians would not choose medicine as a career again, nor recommend it to their children. Physicians have always suffered from a sense of learned helplessness when it comes to the business and politics of medicine. This stems from an inability to organize, unite and negotiate.

How did we get here? How is it that we commit ourselves to long years of grueling training and a phenomenal amount of debt only to regret our career choices? The truth is that medicine can still be a rewarding profession, but physicians need to find a way to have a greater voice in the way it is practiced. Right now, hospitals, insurance companies, for-profit pharmaceutical companies, and government officials are dictating the terms and pricing without any understanding of what it is like to actually take care of patients.

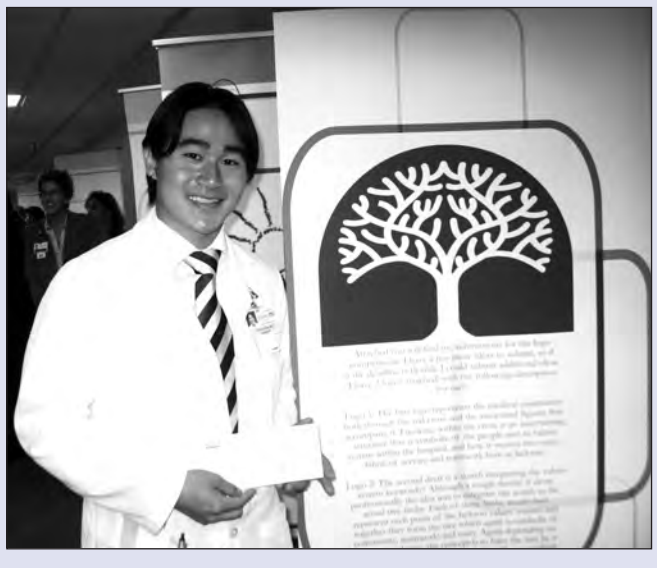
The time has come for physician unionization. For many years, both CIR and nurses' unions have advocated for our professions and for patient safety and the public health. More and more, physicians are salaried employees, which makes them eligible to join unions and negotiate for better terms. However, few physicians realize they have this option. It is our job to educate residents to understand the tools they have at their disposal to make change now, and as practicing physicians, later.

It is equally important to find ways to unite so that we can influence health policy. Currently, physician interests are splintered among more than a thousand medical specialty societies, all with different agendas. A national physicians' union, responsible for the health of the public, is the only way to ensure that our profession has a role in the future of healthcare.

I look at my experiences as a member of CIR as a critical part of my medical training. While my residency and my chief residency taught me how to care for patients, my CIR experience has taught me how to defend patients' and physicians' rights among healthcare "power players" who have no stake in the quality of patient care.

If you're interested in this topic, contact **info@cirseiu.org** to share ideas.

"The truth is that medicine can still be a rewarding profession, but physicians need to find a way to have a greater voice in the way it is practiced."



CIR Doc's Designs are Rooted in Values

CIR member Halland Chen, MD was awarded first prize in the Values Symbol Design Contest at Jackson Memorial Hospital in Miami, Florida in early November, 2007. The contest asked Jackson Memorial employees to design a unique and simple symbol to represent the Hospital's values, which inform its mission, approach to patient care, and commitment to public service.

Dr. Chen, a PGY 2 in the Department of Physical Medicine and Rehabilitation, represented these values with the image of a tree. "Each limb represents the Jackson Values," he explained, "and together they form a tree that represents growth, unity, development, community, and steadfastness."

PHOTOS: (BOTTOM) MARYJANE BARRY/CIR; (TOP) SANDY SHEA/CIR

Joining Forces to Fight Medicaid GME Cuts

CIR joined forces with the National Association of Public Hospitals on Capitol Hill September 19, 2007 to lobby against impending – and quite devastating – cuts aimed at public and safety net hospitals.

The cuts, amounting to $4 billion over five years, are the result of a Bush Administration rule change which would reduce Medicaid payments to public hospitals and eliminate Medicaid GME payments to all teaching hospitals.

Congress, in opposition to the rule change, passed a one-year moratorium on the cuts last spring, but unless that moratorium is extended, the cuts will still go into effect on May 26, 2008.

NYC Health & Hospitals Corporation invited CIR representatives to join the NAPH Lobby Day to help congressional representatives understand the real life implications of such cuts.

"I told them that GME money isn't spent so that residents can sit in the library all day studying," said Dr. Kate Aberger, an Emergency Medicine resident at Lincoln Hospital in the Bronx and CIR NY Vice President. "We are providing critical patient care in underserved areas. If we aren't there, services will have to be cut and patients will be hurt."

CIR and HHC lobbying together against devastating cuts to public hospitals on National Association of Public Hospitals Lobby Day.

> **"We are providing critical patient care in underserved areas. If we aren't there, services will have to be cut and patients will be hurt."**
>
> **Kate Aberger, MD, CIR New York VP**

CIR was welcomed by the union's other hospital partners, as NAPH is a "who's who" of the nation's public hospitals, where CIR is well represented. Other hospitals participating included L.A. County hospitals, Westchester Medical Center, Jackson Memorial Hospital, and the University of New Mexico. "It was a long day of lobbying," said Dr. Aberger, who was joined by CIR Executive Director Eric Scherzer and Political and Policy Directors Pat Fry and Sandy Shea, "but it was a great opportunity to work together for a common goal – saving our safety net hospitals."

NY Congressman Eliot Engel has filed the "Public Teaching Hospital Preservation Act" [HR 3533] to extend the rule moratorium by one more year.

CIR at SEIU Presidential Forum in D.C.

In anticipation of the 2008 presidential election, the Service Employees International Union (SEIU) held a Member Political Action Conference on September 17 and 18, 2007. CIR Executive Committee members Drs. Luella Toni Lewis, Rajani Bhat, Kate Aberger, Nailah Thompson and CIR leader Elizabeth Burpee joined some 2,000 other SEIU members representing union locals across the country.

"2008 is an incredibly important election year for healthcare reform, and although CIR as a union doesn't have a history of endorsing presidential candidates, we thought it was important to attend this conference," said Dr. Lewis, CIR Executive Vice President.

Five of the presidential candidates addressed the Washington, DC meeting. Although all Republican and Democratic candidates were invited, only Senators Hillary Clinton, Barak Obama, John Edwards, Christopher Dodd, and Governor Bill Richardson completed the prerequisite requirements to "Walk a Day in My Shoes" with an SEIU member, be interviewed in person by the union's members and Executive Board, and submit a healthcare plan.

> **"It was an awesome event, with so much information packed into such a short time."**
>
> **Luella Toni Lewis, MD CIR Executive Vice Pres.**

At the end of the day, participants' straw poll indicated a preference for John Edwards. The SEIU Executive Board met over the next two weeks. With much discussion, aided by professional polling of the union's 1.9 million members, the E-Board decided that, given a strong field and diverging opinions, it would not endorse a presidential candidate until after the primary season. A number of SEIU state councils have voted to endorse in the primaries.

From left, Drs. Kate Aberger, Rajani Bhat, Elizabeth Burpee, Nailah Thompson and Luella Toni Lewis, CIR leaders, came to learn and share at the Political Action Conference.

"It was an awesome event," Dr. Lewis said of the MPAC conference, "there was so much information packed into such a short time. We had 'hang time' with the candidates – I was with Edwards' group, in a room with a lot of strong leaders….We had a great exchange. When you say that you work a 24-hour shift with no mandatory break or overtime, everyone gets that, it automatically puts us on a level that everyone understands."

"It was interesting meeting people from other unions," Dr. Bhat, CIR's Secretary-Treasurer said. "A wall goes up when you first say you're a doctor. 'It's about time you doctors joined a union,' some people said to me. "And we told them, 'It's a 50-year-old-union,' and they didn't know that."

House Staff Benefits Legal Services Plan As a public sector plan, the House Staff Benefits Legal Services Plan is not required to release a Summary Annual Report (SAR) under the Employment Income Security Act (ERISA), but elects to do so. The SAR for the year ending 12/31/06 published in the 9/07 CIR News contained some wrong numbers. There is a greater surplus than first reported. The following report has the correct numbers, followed by the previously published numbers in brackets [ ]:

The House Staff Benefits Legal Services Plan covers certain basic legal services for members. The Federal ID number is 13-3011915. The Plan ended December 31, 2006 with a surplus of $36,092 [$27,758] (the value of plan assets after subtracting liabilities). This was an increase of $27,222 [$18,888] over the prior year, which ended with a surplus of $8,870. During 2006, total employer contributions were $247,968 and total costs were $221,516 [$229,851] ($156,058 [160,422] in benefits and $65,458 [$69,429] in administration expenses).

You have a right to receive a copy of the full annual report, or any part thereof. To obtain a copy, write or call Earl Mathurin, Benefits Plan Manager, CIR Benefits Plan, 520 Eighth Avenue, Suite 1200, New York, NY 10018, phone (212) 356-8180. You also have the right to receive a statement of assets and liabilities, and/or of income and expenses, with accompanying notes. The charge to cover copying costs is 20¢ per page. You have the right to examine the annual report at the Plan office at 520 Eighth Avenue, Suite 1200, New York, NY 10018.

PHOTO: (BOTTOM) JIM TYNAN

NEJM Study Reveals High Rates o

Changing Systems and Cultur

"The stick I got as a med student was during an intense cardiac case. The attending was not sweet. There were multiple sutures that had to be done very quickly. He tossed the needle driver and it landed on my hand. I was unable to report it until 9 hours later. No one said I couldn't go, but all hands were needed doing the case. It's understood in that type of situation that the patient comes first. I was also trying to get a residency in surgery and a good rotation grade, so I stayed."

Susana Wishnia, MD
PGY 3 Surgical Resident, Boston Medical Center

"I'm really glad that the *NEJM* article came out. It [a needlestick] certainly happened to me before, and I didn't report it…. After reading the *NEJM* article, I went through the whole process of reporting, and two other colleagues who were working on the same shift with me did, too. I insisted that they report right away. Before the article, I had a reluctance to do so."

Vaughn Whittaker, MD
Surgical Chief Resident, Harlem Hospital

PHOTOS: SANDY SHEA/CIR; CARA METZ/CIR

The study of needlestick injuries among surgery residents was comprehensive: 17 medical centers, 699 respondents and a 95% overall response rate. And the results, published in *The New England Journal of Medicine* on June 28, 2007 were eye-popping:

- 83% of surgery residents had had a needlestick injury during training;
- For 53%, the injury had involved a high-risk patient;
- By their final year of training, 99% of surgery residents had had a needlestick; and
- Of the most recent injuries, 51% were not reported to an employee health service.

Eye-popping, that is, for just about everyone except surgery residents. "The article pretty much mirrored my experience so far," commented Dr. Susana Wishnia, a general surgery resident at Boston Medical Center. "I'm a PGY 3 and I've been stuck three times, once in med school on the west coast and twice since I've been a resident here."

"The study is true," concurred Dr. Vaughn Whittacker, a PGY 5 in Surgery at Harlem Hospital in New York. "It reflects our experience very closely."

"Once a week, or once every two weeks someone is stuck," said PGY 2 Orthopedics resident Dr. Matthew Harris from Westchester Medical Center in New York. "We don't talk about it. I've seen attendings and residents stick themselves. It's just very common. We keep it among ourselves – there was no surprise in that *NEJM* study to us."

When asked the perceived cause of their injury, surgery residents declared the lion's share (57%) were attributed to being "rushed."

"In a recent study of a general surgical service in an urban academic hospital, 20 to 38% of all procedures involved exposure to HIV, HBV, or HCV."

"Needlestick Injuries among Surgeons in Training"
***The New England Journal of Medicine*, June 28, 2007**

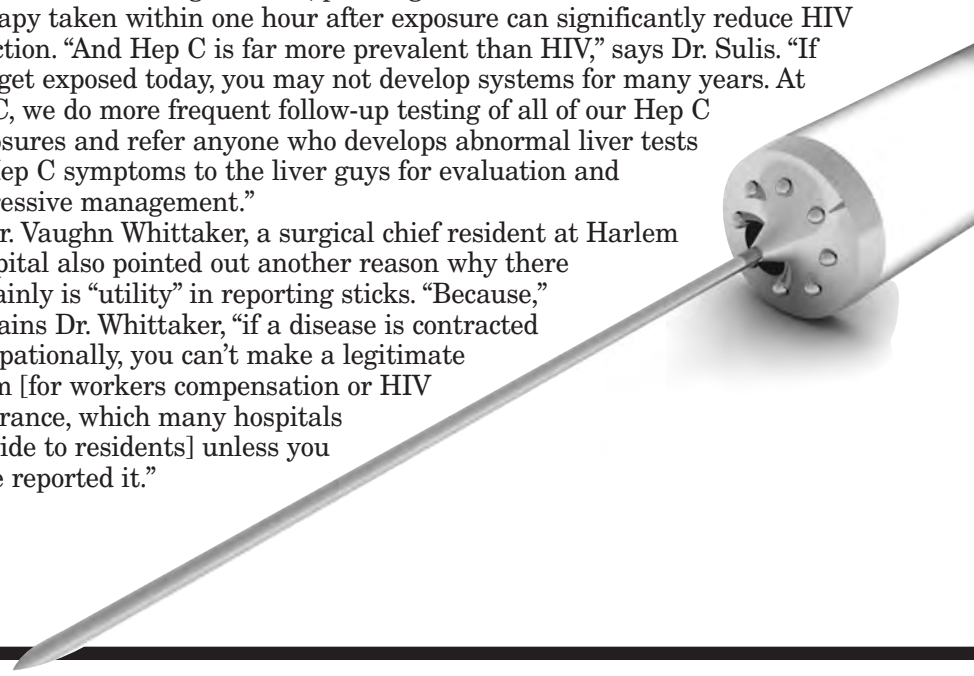
"There are two main reasons you may have to rush," explains Dr. Wishnia. "If it's an emergency and you're suturing quickly so that the patient won't lose so much blood or if you're going too slow, the attending might take the case away. You don't want that to happen. You want to impress them so that they won't take the case away."

A lack of time was also the leading reason given in the *NEJM* study for

"No Utility in Reporting a Needlestick?" Don't Believe It!

Twenty-eight percent of surgery residents surveyed in the *NEJM* study said they didn't report a needlestick because "there was no utility in reporting." Dr. Carol Sulis, hospital epidemiologist at Boston Medical Center couldn't disagree more, pointing to the fact that anti-retroviral therapy taken within one hour after exposure can significantly reduce HIV infection. "And Hep C is far more prevalent than HIV," says Dr. Sulis. "If you get exposed today, you may not develop systems for many years. At BMC, we do more frequent follow-up testing of all of our Hep C exposures and refer anyone who develops abnormal liver tests or Hep C symptoms to the liver guys for evaluation and aggressive management."

Dr. Vaughn Whittaker, a surgical chief resident at Harlem Hospital also pointed out another reason why there certainly is "utility" in reporting sticks. "Because," explains Dr. Whittaker, "if a disease is contracted occupationally, you can't make a legitimate claim [for workers compensation or HIV insurance, which many hospitals provide to residents] unless you have reported it."



# of Surgery Resident Needlesticks

re Seen as Keys to Prevention

the failure to report injuries.

"The reason people don't report is that it occurs during a case," said Dr. Whittaker, "and to stop the rhythm of the case, in your mind, you figure you'll be out for the whole day, it will interrupt you, so you think, 'This too will pass, nothing will happen.'"

Dr. Carol Sulis, hospital epidemiologist at Boston Medical Center, has studied needlestick exposure and prevention on a hospital, state and national level for more than 20 years. She had déjà vu all over again when she saw the *NEJM* data. "We studied needlesticks at BMC ten years ago and found similar rates of exposure for surgical residents. Other residents get stuck too, but it's worse in surgery. We also found gross under-reporting. We observed 874 surgeries in a row and found clear breaches – and only 5% were reported!"

She noted that the hazard of injury to surgical residents is made more serious because of the frequency at which they are exposed. "We need to tackle the 'I'm too busy, it takes too much time' reason head-on," said Dr. Sulis. "Procedures should be in place everywhere to deliver meds to the OR if a physician can't leave. And rapid HIV tests are now widely available, so residents shouldn't have to wait days to find out the infection status of the patient whose blood they were exposed to."

Dr. Whittaker agreed. "It seems it's too much of a hassle to report. The mechanism – how to report, who to report to – isn't clear. Hospitals can do a lot more with workers and surgeons especially. It should be something as easy as picking up your paycheck. Everyone should know how and there should be no reluctance. We need to foster an atmosphere where reporting is so much easier."

According to the study, a key factor in determining that an injury was formally reported was the fact that another person knew of it. Most frequently, this other person was an attending physician, though it was also often a nurse or another resident.

The *NEJM* authors pointed to the need for both systemic and cultural change in surgery: "coverage systems to facilitate prompt reporting, curricula that include specific instruction and credentialing on safe techniques [and] other system level changes," e.g. needlestick hotlines and routine prompts on post-op check lists, as well as "peer education to create a culture that encourages speaking up."

Bottom line, says Bill Borwegen, Director of SEIU's Health and Safety Department, "People are in this profession because they care about their patients, but you need to also care about yourselves. Patient safety and provider safety go hand-in-hand."

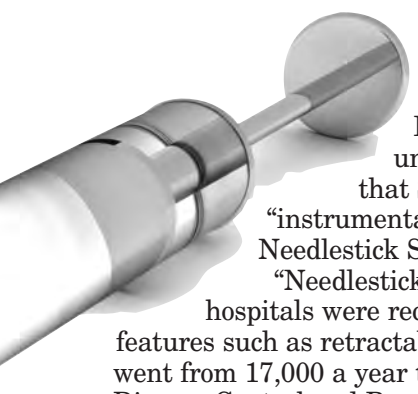
"Time, fear, and familiarity play the biggest part in somebody shrugging off a needlestick and saying, 'this is probably just a poke and not a true stick.' You'd be amazed how much rationalization drives this decision."

Mathew Harris, MD
PGY 2, Orthopedic Surgery,
Westchester Medical Center

"We need to tackle the 'I'm too busy, it takes too much time' reason head-on."

Carol Sulis, MD
Hospital Epidemiologist, Boston Medical Center

Know Your Rights: Safe Needles are the Law



CIR's national affiliate, the Service Employees International Union (SEIU) is almost two million members strong, and its Health and Safety Department is one of the most active among unions in the U.S. Director Bill Borwegen points out that SEIU, including CIR resident physicians, were "instrumental in helping to achieve passage of the federal Needlestick Safety and Prevention Act of 2000.

"Needlesticks dropped in half since the law was passed and hospitals were required to use needles with integrated safety features such as retractable syringes," says Borwegen. "And cases of Hep B went from 17,000 a year to less than 300, according to CDC [Centers for Disease Control and Prevention] data."

"And yet, we have to be eternally vigilant," warned Borwegen. "Is my employer using the best safer needles available in the marketplace? If not, that's what CIR and SEIU are there for – to help work with members to press employers to make sure that the best technology is used. There are disposable scalpels with retractable covers, blunt suture needles, and many other advances on the market today. But the law is only as effective as its enforcement. We have more fish and wildlife inspectors than OSHA inspectors today. That is why residents need to know their rights to demand protection."

WHAT SURGERY RESIDENTS SAID ABOUT THEIR INJURIES

Perceived Cause of Injury*:

Rushed = 57%
Fatigued = 15%
Lack of Skills = 12%
Lack of Assistance = 9%
Not Preventable = 20%

* Respondents could select more than one response.

Reason For Not Reporting Injury*:

Takes Too Much Time = 42%
No Utility in Reporting = 28%
Do Not Want To Know Results = 6%
Afraid of Stigmatization = 5%
Other or No Response = 23%

* Respondents could give more than one response.

— *NEJM*, June 28, 2007

Push for Children's Healthcare Continues

CIR and SEIU Healthcare's joint campaign in support of the State Children's Health Insurance Program (SCHIP) came to a head this fall, with a strong push to override President Bush's veto of the legislation to insure 10 million kids.

On September 18, 2007, members of SEIU Healthcare gathered on Capitol Hill to hand deliver to Congress the million-signature SCHIP petition that CIR doctors and SEIU Healthcare members across the country collected this summer. They were assisted by dozens of small children who dragged, pulled and pushed little red wagons filled with the thousands of pages of signatures.

CIR NY VP Kate Aberger, MD addressing an SCHIP rally on Capitol Hill on September 18, 2007.

CIR NY Regional Vice Pres. Kate Aberger, MD, of Lincoln Hospital in the Bronx, NY, was on hand to speak to the crowd about what happens to children when they don't have reliable health insurance. She was joined at the podium by Sen. Richard Durbin, Sen. Amy Klobuchar, and Rep. Jan Schakowsky.

The House and the Senate responded a few days later, passing SCHIP by broad, bipartisan margins on September 25 and September 27, respectively, thus setting up a showdown with the President, who had vowed to veto the legislation. On October 1, 2007, CIR Delegate Shubhada Hooli, MD, a Pediatric resident in Washington, DC, addressed a rally outside of the White House demanding that President Bush not veto SCHIP.

> **"We save not only thousands of dollars by averting hospitalizations, we save lives by giving our children the regular access to healthcare that they deserve."**
>
> **Shubhada Hooli, MD**
> **PGY 2, Pediatrics**

"Managing the health of a child is a challenging task that requires constant care and vigilance," Dr. Hooli told the assembled crowd.

"And when that care falls through, we are left to hospitalize the severely ill, often resorting to measures such as mechanical ventilation to bring these children back from the brink. We save not only thousands of dollars by averting hospitalizations, we save lives by giving our children the regular access to healthcare that they deserve," she said.

The following day, CIR members at Oakland Children's Hospital in Oakland, CA joined their attendings and others at a noontime rally for SCHIP outside the hospital. "This could impact the entire family," said CIR Delegate Rachel Kreps-Falk, MD about the President's threatened veto. "Families could be forced to make decisions about whether they spend money on healthcare or food or clothes or fall behind on their rent," she said.

Despite the pressure, President Bush went against public opinion to veto the SCHIP legislation the following day on October 3, 2007.

As the House prepared for a veto override vote, CIR members took action in congressional districts whose representatives had voted against SCHIP in September. CIR members at Bergen Regional Medical Center in Paramus, NJ held an SCHIP call-in day in the hospital cafeteria to the office of local Rep. Scott Garrett. In southern New Jersey, Mark Reutter, DO of UMDNJ School of Osteopathic Medicine represented CIR at a vigil outside of the district office of Rep. Jim Saxton.

CIR Delegate Shubhada Hooli, MD, a pediatric resident in Washington, DC, talks with a local reporter about the importance of SCHIP.

This young girl was among those enlisted to help deliver the million-signature SCHIP petition to the White House on October 1, 2007.

Despite these efforts, on October 18, 2007 the House fell a mere 13 votes short of the two-thirds majority needed to override the SCHIP veto. However, the fight is far from over, as Congressional leaders from both parties have vowed not to let a handful of people stand in the way of health coverage for 10 million children, expanded from the 6.6 million currently covered by SCHIP.

In New Mexico, CIR leaders Drs. Jesse Barnes, Tasha Ludwick, and Juan Gallegos appeared on a community television program on October 26, 2007 to talk about SCHIP and its importance to children throughout New Mexico.

CIR and SEIU Healthcare have pledged to continue their work to make this legislation a reality. "We cannot let politics get in the way of priorities," said Amy Garcia, MD, a CIR leader and pediatric resident at the University of New Mexico. "There are millions of uninsured children in this country who are depending on us, and we will not rest until they get the coverage they need."

> **"We cannot let politics get in the way of priorities. There are millions of uninsured children in this country who are depending on us, and we will not rest until they get the coverage they need."**
>
> **Amy Garcia, MD**
> **PGY 2, Pediatrics**

Speaking Up for Access in NY State

With close to 2.5 million New Yorkers uninsured, despite spending more per capita on healthcare than any other state in the nation, Governor Eliot Spitzer convened public hearings to gather data and input on how best to reform NY's healthcare system, with the goal of ensuring access to all.

CIR NY Vice Pres. Karen Morice, MD, a PM&R resident at St. Vincent's Hospital-Manhattan, took the opportunity to testify on November 2, 2007, and share her knowledge of what goes wrong for patients with Medicaid and Medicare, patients with no insurance, and even patients with healthcare coverage, including residents and attending physicians.

"An elderly patient with multiple medical problems is covered by Medicare, but although she has a prescription plan, because of the number of medications she needs and the fixed income she lives on, she can't afford many of her medications…Whenever she comes in, the doctor gives her free samples of whatever medication is on hand. When she comes back for her regular appointment, she has run out of free samples, her blood pressure is in the 200s, and her sugars are also through the roof. She gets whatever free samples they have, which are once again different medications, and now she is confused about what she's supposed to take, and what the dosage is," Dr. Morice said.

In her conclusion, Dr. Morice said that, "Our goal is to expand access to care, and every step in the right direction, that gets more people covered, is the direction we want to go. Personally, I like the idea of Medicare for All…I think it could provide a good model for how to go about expanding coverage."

Dr. Karen Morice testified on behalf of greater access for all New Yorkers.

PHOTOS: (CLOCKWISE FROM TOP) KEITH MELLNICK/SEIU; CARA METZ/CIR; JIM TYNAN/1199

New Contract Solidifies Gains at Brooklyn's Maimonides Medical Center

For the 384 residents at Maimonides Medical Center, located in the Borough Park neighborhood of Brooklyn, NY, their second contract brought solid economic gains in the form of raises from 12-13%, depending on PGY year, an improved education allowance, and either a day off, or extra pay for those who work on holidays. The three-year contract was ratified on September 24, 2007 and expires on October 31, 2010.

"This was my first time involved in formal negotiations," said Dr. Jack Braha, a PGY 2 in Internal Medicine. He found it "enlightening," and said he gained a perspective that "you don't get working in your daily rounds…I'm a math person, so I understood the number crunching…I learned how much the hospital spends on residents outside of the paycheck – on benefits, healthcare, dental, and other costs that you don't realize," he said.

Dr. Jack Braha, a PGY 2 in Internal Medicine, chatting with colleague Dr. Vishesh Paul, a PGY 1 in Medicine, said that the new contract, "feels like I'm helping out the next generation of residents."

"We have very good benefits provided by CIR, and our contribution will be entirely eliminated by the end of this contract, which is wonderful." Another gain, he said, "is the education allowance of $500 a year for the last two years of residency."

The salary gains of 12-13% over the life of the contract, depending on PGY year are, "a good percentage," Dr. Braha said, "one of the highest this hospital has ever given. There's always room to grow, but this is definitely something to build on, and it's only our second contract with CIR. It feels like I'm helping out the next generation of residents at Maimonides and improving benefits so we can recruit desirable residents."

For Dr. Amy Lavorato, a PGY 2 in Pediatrics who was also involved in negotiations, the surprise was "how good the settlement is overall. We negotiated for five months, meeting about every three weeks." Based on her experience, Dr. Lavorato said she would recommend to other housestaff who are just beginning negotiations, "don't give up!"

> **"If anything, CIR has made our program stronger, and communication between programs and administration stronger."**
>
> **Jack Braha, MD**
> **PGY 2, Internal Medicine**

Dr. Braha's advice to other residents would be to, "first, absorb the big picture, and realize the costs beyond paychecks. Make reasonable propositions, keep in mind that you're negotiating a contract for many years in length, and negotiate for your future colleagues and not always for your class. Have your contract appeal to applicants for residency – this is almost a form of advertising for the next generation of residents. This contract will last after I'm done with my training.

Dr. Amy Lavorato, a PGY 2 in Pediatrics and member of the negotiating team.

"Negotiations weren't tense," he said. "The hospital has a vested interest in us, and we have a vested interest in the hospital. We just had to make residents' voice heard, and the hospital wanted us to see the bigger picture."

He credits CIR representatives with, "being incredibly supportive and teaching us a great deal about negotiation tactics. If anything, CIR has made our program stronger, and communication between programs and administration stronger. Residents in different programs, and hospital leadership working together, make for a better program. We're doing very well together."

Mass. Resident Work Hours Bill Clears First Hurdle

Safe Work Hours for Physicians in Training and Protection of Patients (S.1247) jumped its first hurdle in the Massachusetts legislature when it was voted out of the Joint Committee on Public Health in late October.

At a hearing on October 10, 2007, Dr. Christopher Landrigan, Director of Sleep and Patient Safety at Brigham & Women's Hospital declared the Accreditation Council on Graduate Medical Education's current hours limits "unsafe," pointing out that "24-30 hour shifts exceed those established in other safety sensitive industries on the basis of the best available scientific evidence."

> **"There is simply no advantage to reporting [hours] violations – in fact, it's quite the opposite."**
>
> **Erica Wilson, MD**
> **Chief Resident, Internal Medicine**
> **Cambridge Hospital**

The ACGME's enforcement mechanisms were also criticized. "The only penalties…are to put a residency program on probation – or worse, take away accreditation," testified Dr. Erica Wilson, CIR member from Cambridge Hospital. "That penalty only hurts residents – there is simply no advantage to reporting violations – in fact, it's quite the opposite."

CIR members Mike Mazzini, MD and Erica Wilson, MD testified for resident work hour reform.

Hospital opposition came from the Council of Boston Teaching Hospitals and the Partners Healthcare VP for Graduate Medical Education, who told the committee that the ACGME was the proper venue for hours reform. But their arguments appeared to have little traction with the committee.

"We've heard data today that medical errors are increased with these long hours," said Rep. Alice Wolf. "We've also heard today that there is a conflict between truthful reporting when the punitive action seems to be in conflict. These young people are at risk when they drive home and patients are at risk. This is a system that could use more oversight."

S.1247 authorizes the Department of Public Health to begin the process of regulating work hours for the Commonwealth's 4,000 resident physicians by forming an advisory committee to represent the stakeholders. Committee recommendations will assist DPH in establishing an evidence-based standard for resident work hours that promotes patient and resident physician safety.

CIR is confident that the bill, now before the Health Care Finance Committee, will be amended to remove language which labeled residents who work in violation of work hours as "mistreatment of patients." In his testimony on October 10, CIR's BMC Co-Pres. Mike Mazzini, Cardiology Fellow, told the Committee that, "We do believe there should be some teeth in S. 1247, but the penalty should be placed directly on the hospitals which schedule the hours, not the residents who are scheduled to work them."

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

CIR WESTERN REGIONAL ROUND-UP:
Charting the Year Ahead

On November 3rd, 2007, 40 leaders from the three chapters that make up CIR's Western Region — New Mexico, Southern, and Northern California — came together to meet, share news, and make plans for accomplishing their goals in the year ahead.

Reporting Back

The meeting began with each CIR hospital chapter sharing the events and challenges of the last year. Delegates from the University of New Mexico (UNM) spoke about their successful campaigns to join CIR and negotiate their first contract. "Our organizing campaign and victory at the negotiating table got our voices heard where they should be heard," said Dr. Medhi Yazdanpanah, a PGY 4 in Psychiatry at UNM.

> **"If you refuse to talk about politics and the way it shapes the delivery of healthcare, you are just letting other people make the decisions for you."**
>
> **Dr. Jennifer Blair**
> **PGY 2, Family Practice**
> **SF General Hospital**

Having this voice not only led to a great first contract, which won significant raises and a patient care fund, but also put management more in touch with the reality of resident life. "We were talking about the lack of food available after 10 PM when the cafeteria closes, and management didn't believe it," said Delegate Dr. John Ingle, a PGY 2 in Otolaryngology. At a late-night negotiating session, residents took the administration to the cafeteria to discover that it was closed.

Other chapters spoke about challenges relating to the precarious financial situation of their hospitals. In Santa Rosa, CA, Family Medicine residents had to fight to keep their program and clinics alive after Sutter Health, the private hospital chain announced that the hospital was closing.

Uniting with fellow hospital employees, "we were able to form a coalition with the broader concerned community, including labor, state politicians, neighborhood and religious groups," said CIR Delegate Erin Lundee, MD, of the Santa Rosa Family Medicine Residency Program. Due to this community-wide effort, the program will continue providing healthcare to the community.

At Harbor-UCLA Medical Center in Los Angeles, the recent closing of a neighboring hospital created the greatest present challenge, as the community turned instead to Harbor-UCLA, increasing its Emergency Room patient volume 40%, and its wait-times by 70%. CIR is working closely with the L.A. County Department of Health Services to deal with this crisis.

Turning An Eye Toward Politics

Later in the day the discussion turned to important state and national political issues. CIR members talked about their work supporting the State Children's Health Insurance Program and the California Statewide Campaign for Universal Healthcare.

"You can ignore it and pretend you can practice medicine without it, but you can't be involved in patient care without being involved in politics," said Dr. Jennifer Blair, a PGY 2 in Family Practice at San Francisco General Hospital. "If you refuse to talk about politics and the way it shapes the delivery of healthcare, you are just letting other people make the decisions for you."

Drs. Elizabeth Burpee and Nailah Thompson, CIR leaders, reported on their experience at the SEIU Member Political Action Conference in Washington, DC in September. They emphasized that SEIU is determined to make universal health coverage a key political priority in the 2008 election season, and in a testament to SEIU's importance, the Conference was visited by five Democratic presidential candidates (See story on page 3).

"Smart, Strong Organization Works"

Tying the chapter reports and the political discussions together, keynote speaker Phil Caper, MD elucidated the secret to both making concrete improvements in our residency programs and having an impact in the political arena: "Smart, strong organization works."

Dr. Caper knows this first-hand — during the 1960s he was the president of an independent housestaff union in Boston which later affiliated with CIR. In 1967, the union organized a "Heal-In" at Boston City Hospital, during which residents refused to discharge patients. "As a result of the 'Heal-In', the $2,500 yearly salary of a housestaff officer was increased to $10,000, which had a national impact on resident physicians' salaries," he said.

Dr. Caper also addressed how strong organization can help doctors stand up for their patients in the political arena against HMOs and pharmaceutical companies which don't always have patients' best interests in mind. "Doctors have credibility and have a union," he said. "With power and authority, you can make a difference."

The meeting closed with a media training on how physicians can effectively advocate for healthcare issues. Having charted a course for the next year, CIR's leaders went forth ready to make continued improvements for residents and patients.

The New Mexico contingent met during a regional session.

Left: A different kind of Bingo used Q & As from participants as an "ice breaker" exercise, as members from different chapters got to know one another.

Northern California members take a moment to relax.

Members from the Southern California chapter during a regional break out session.

PHOTOS: JUSTIN TIBBITS/CIR; AMY HALL/CIR