CIR News

Committee of Interns and Residents

SEIU Healthcare®

July 2010

New Year, New Friends, New Leadership:

CIR's 2010 National Convention...Page 4

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PRESIDENT'S REPORT

FARBOD RAISZADEH, MD, PHD

A New Residency Year Means New Opportunities

For those of you who are going through the ritual of orientation and making the transition from medical student to resident, welcome! For those of you continuing on with another PGY and another year of clinical experience, welcome back! Every year, June is the month for major changes for resident physicians across the country, and that's true for the union that is run by residents and for residents – CIR.

I'm Dr. Farbod Raiszadeh, and I'm one of those new changes. At the CIR National Convention in May, I was deeply honored to be elected CIR's National President. Previously, I was CIR's Secretary-Treasurer. Before that, I was one of the Regional Vice Presidents for New York. Before that, I was a delegate and member of the negotiating team at my hospital, St. Luke-Roosevelt in Manhattan, where I completed my residency in Internal Medicine last year (I am currently a Cardiology Fellow at Montefiore Medical Center in the Bronx). And before all that, I was exactly where many of you are as you read this issue – trying to figure out whether, with all of the demands on my time, I wanted to become more involved in my union.

PHOTO: BILL BURKE/PAGE ONE PHOTOGRAPHY

I decided to run for CIR President because I've been able to see firsthand how having a strong union and a strong voice in our hospitals can help residents—including me—develop into the leaders our co-workers, our hospitals, and our communities need us to be. By sitting in on multiple labor management meetings throughout the years, I have seen how having CIR changes the tone of the residency program. Instead of the usual doom and gloom, and the resigned attitude that can be pervasive in some residency training programs, residents become active problem solvers in CIR hospitals. I have also seen how giving a voice to housestaff allows a partnership to form between residents and the administration when it comes to improving the quality of patient care.

But I've also seen what residency is like in hospitals where CIR doesn't exist. I've met with the residents at St. Barnabas Hospital in the Bronx, and seen what they've had to go through in the face of entrenched opposition just to have a say when it comes to safety in the Emergency Room, dilapidated and out-of-date equipment for patient care, and basic respect in their workplace. I am convinced that if you do not pull up other hospitals in your region, they will ultimately pull you down. That's why I believe that we all have a stake in making sure that CIR is not only strong in our own hospitals, but that we're growing.

The events of the past year have demonstrated what resident physicians can do when we're involved and engaged. CIR was a leader in the fight for national health care reform. We helped to move the debate away from the political rhetoric and towards the practical effect it would have on residents and our patients. CIR has begun to work with patient safety advocates who had previously overlooked the issue of resident work hours but are now committed to pushing for reform along the lines of the 2008 IOM Report. Our position as front-line providers of care also puts us in an ideal position to tackle the great challenges of transforming our health care system and to offer new ideas on important but neglected issues such as medical malpractice reform. These reforms are essential so our hospitals and clinics can focus on quality of care, not just quantity of care. We should be proud of all that we have accomplished, but there are still more challenges to come.

> "The proof is before us that when CIR members step up, great things can happen."

The proof is before us that when CIR members step up, great things can happen. And when physicians stay silent, their much-needed ideas will be ignored. Getting heard may mean stepping out of our comfort zone, or squeezing a little bit more time out of our already overcrowded schedules. I know doing so has sometimes been a challenge for me, but I also know it's always been worth it. If you have ideas on how CIR can grow and become even stronger or if you just want to share a thought with me, please send me an email at fraiszadeh@cirseiu.org. I would love to hear from you!

PHOTO: PATTY EVANOFF/CIR

Former CIR President Dr. L. Toni Lewis Becomes First Physician to Chair SEIU Healthcare

CIR members have had a front row seat to witness the tireless advocacy of Dr. L. Toni Lewis, whose two and a half years as CIR National President came to an end at the CIR National Convention in May. Now our sister locals in the SEIU Healthcare division will get to know her good humor, inspirational leadership, professionalism, and depth of knowledge on the American health care system. On June 14, Dr. Lewis (here pictured at an event on the steps of New York City Hall in April) was named chair of the union's healthcare division by SEIU President Mary Kay Henry. In her new role, Dr. Lewis will lead the efforts of SEIU's 1.2 million nurses, doctors and other healthcare workers to deliver the benefits of the nation's historic health care reform law to their patients and consumers.

A Greenwich Village Institution, St. Vincent's Closes Its Doors

CIR Mobilizes to Protect Resident Physicians During Hospital's Final Days

A fixture in Greenwich Village in Manhattan for over 161 years, St. Vincent's Catholic Medical Center in Manhattan closed its doors in April 2010. Although there can be no mollifying the heartbreak of those who worked in its halls or the continued health access crisis for the local community, the 370 resident physicians employed by the hospital took comfort in knowing that they had the staff and leadership of CIR on their side and looking out for their interests throughout the hospital's months-long decline.

St. Vincent's has served as the only Level 1 Trauma Center on the West Side of Manhattan below West 59th Street as well as an invaluable birthing center specializing in neonatal care. It had provided care for the victims of the Titanic and 9/11. But the hospital's descent into bankruptcy was the conclusion of years of financial instability and poor management choices by successive administrations, exacerbated by the economic recession. In early January 2010, the *New York Post* broke the story that St. Vincent's was in talks to sell the hospital, and that the new buyer planned to operate an outpatient community health center on the site, closing the rest of the hospital's operations. Although that plan was ultimately scrapped, a new, more severe option took its place: bankruptcy and the closure of the hospital.

At a rally on January 28, a mere two days after the *NY Post* story initially broke, local elected officials and sister-union 1199 SEIU staged a rally at Our Lady of Pompei Church in Greenwich Village. Dr. Angela Ferguson, a PGY 2 in Internal Medicine and Dr. Jay Mathur, also a PGY 2 in Internal Medicine told the stories of patients they treated during home visits in the neighborhood or within the clinics who lack the mobility to travel across town for care. At a subsequent rally in February at the Manhattan office of SEIU 32BJ, Dr. Xavier Jimenez, a PGY 2 in Psychiatry, stressed the urgency of the problem and the need for local government to stand up for the hospital.

"This is an emergency," Dr. Jimenez told the crowd. "In an emergency, the nurse doesn't leave, the doctor doesn't leave in that situation; neither should the government."

PHOTO: HEATHER APPEL/CIR

Dr. Xavier Jimenez speaks during a "Save St. Vincent's" rally in February, 2010.

PHOTO: TIM FOLEY/CIR

CIR members from St. Vincent's Medical Center attend a "Save St. Vincent's" rally in January, 2010.

A hospital's last days can be chaotic. While serving the needs of patients, health care workers were also inundated with rumors about the hospital's fate and often had trouble determining fact from fiction. To combat the uncertainty and get advance notice on potential fallout from the crisis, CIR devoted a special section to its website to provide the latest verifiable information and answers to frequently asked questions. At the height of the crisis, that web page was visited hundreds of times per day.

Housestaff were particularly vulnerable to the crumbling finances of the hospital, and thankful to have CIR staff on their side. When residents received eviction notices on apartments in Jersey City that they subleased at a subsidized rate from St. Vincent's, CIR's legal team quickly determined the cause of the problem and ensured the housestaff could stay in their homes. With wide variation in the response of program directors on the imperative of finding new positions for residents when St. Vincent's announced the June 30 voluntary withdrawal, CIR created and constantly updated a list of open residency slots at other CIR hospitals and across the country.

Even with the hospital's closure, CIR continued to keep watch for a host of potential problems stemming from the ongoing bankruptcy proceedings, including ensuring that housestaff with apartments in Staff House in Greenwich Village would be allowed to stay in their homes until the end of the residency year, and making sure that St. Vincent's was abiding by its agreement to pay residents for a set number of weeks once the hospital closed. CIR is also closely monitoring the bankruptcy proceedings with an eye towards St. Vincent's medical malpractice trust fund, as the potential for residents to continue to be exposed to litigation years after the hospital's closure is of grave concern.

In a chaotic and tragic set of circumstances, CIR members had the security of knowing someone was advocating for them in their hour of need.

Kern County Supervisor Sees the Realities of Residency

On March 17, 2010, Kern County Supervisor Jon McQuiston visited Kern Medical Center to get a more complete view of the day-to-day work of the resident physicians at the Bakersfield, CA hospital.

The residents at Kern Medical Center received union recognition on January 12, 2010 and have started the process of bargaining for their first contract. Supervisor McQuiston had expressed interest in seeing firsthand what the conditions are like in the hospital from the point of view of the residents. CIR held him to his word and invited him to shadow a resident.

Dr. Tiffany Pierce, Chief Resident of Family Medicine and Bargaining Committee Chair, hosted the walk-through for the Supervisor. She gave him a tour of where residents eat, sleep, and work – even taking him into the ICU. Along the way, she filled him in on what the educational arc from medical school to residency is for physicians-in-training.

Supervisor McQuiston was very impressed and said he would like to come back to see night shift/calls, and the work of surgery housestaff. He agreed to invite his colleagues on the Board of Supervisors to join the next walk-through. He also expressed support and understanding for the residents' proposals at the bargaining table.

Since Mr. McQuiston's visit, residents have also had one-on-one meetings with Supervisor Michael Rubio, who is running for State Senate, and Supervisor Ray Watson. Negotiations were scheduled to continue through the spring.

PHOTO: JOLLENE LEVID/CIR

Supervisor Jon McQuiston (Republican) shadowed Dr. Tiffany Pierce at Kern Medical Center and expressed support for the resident physicians' contract negotiations.

Above: Acting Deputy Surgeon General Dr. David Rutstein talks with incoming CIR President Dr. Farbod Raiszadeh.

Right: Delegates from across the country listen attentively to residents from around the globe during a lunchtime presentation.

Below: CIR delegates who volunteered in the Haiti Relief Effort were presented with special plaques.

CIR 2010 CONVENTION:

Delegates Celebrate An Unprecedented Year

Guests Include the Deputy Surgeon General and Physicians from Across the Globe

Health care reform. Hospital closures. The earthquake in Haiti. Exciting new leadership for the union. Recounting a year full of challenges and triumphs in the areas of collective bargaining, new organizing, and patient advocacy through political action.

These were the themes as over 160 CIR delegates from across the country came to Philadelphia to participate in CIR's National Convention from May 21-23, 2010.

The national convention is an annual opportunity for housestaff leaders to make critical decisions on the direction of the union and also benefit from educational workshops and discussions on how to be more effective negotiators, organizers and advocates. This year, resident physicians not only compared notes with their fellow members from other states, but international guests as well, including residents from Quebec, Ontario, the Bahamas, and New Zealand.

"You don't have to go to far-flung parts of the world to find huge disparities in health care," said Acting Deputy Surgeon General Dr. David Rutstein, who delivered the keynote speech. Dr. Rutstein relayed his decades of experience as a family medicine physician, working as far away as Micronesia, where he was a National Health Service Corp physician, and closer to home in New Orleans after Hurricane Katrina. After his address, Dr. Rutstein fielded questions about mental health parity, the primary care shortage, and other challenges of health care implementation.

Dr. Rutstein urged residents to be involved in the discussion at the national and state level as the new reform law is translated into action between now and 2014.

Workshops and plenary sessions covered the topics of resident wellness, health disparities, and how to run campaigns to win union recognition and contracts in difficult times. Training workshops on Saturday focused on how to be an effective delegate, how to negotiate a strong contract, how to tell if your hospital is in trouble, and how to address bullying within residency programs.

On Sunday morning, delegates heard from resident leaders at University of New Mexico, Long Island College Hospital (LICH) in Brooklyn, NY, and Kern Medical Center in Bakersfield, CA about their successful campaigns to form CIR chapters. They explained how individual complaints grew into something bigger and motivated them to organize and demand a voice in the hospital.

"I spent months trying to get rid of cockroaches in the call room. It was demeaning," said Dr. Tiffany Pierce, chair of the negotiating committee at Kern Medical Center. "Then they tried to take away our food, and a hungry resident is an angry resident."

The national convention is also the place where official business takes place impacting CIR's policies and goals for the next year. The House of Delegates approved the annual budget and a constitutional amendment allowing dues to be phased in gradually in situations where a new chapter has won a first contract with no economic gains, due to the unprecedented economic crisis facing most counties and states. The delegates also voted to renew Executive Director Eric Scherzer's contract for an additional three years.

It was a bittersweet weekend for many CIR members, who had to say goodbye to several veteran members of the executive committee, including Dr. Luella Toni Lewis, who served as CIR President for two and a half years. Dr. Lewis and the members of the 2009-2010 Executive Committee were sent off in style with a dance and karaoke party on Saturday night featuring DJ Spinderella of Salt-N-Pepa fame.

Finally, the uncontested candidates for the new executive board of CIR were sworn in at the end of the convention. They are: Dr. Farbod Raiszadeh as President, Dr. Hillary Tompkins as Executive Vice President, Dr. John Ingle as Secretary-Treasurer, Dr. Jay Bhatt as Massachusetts Regional VP, Dr. Kelly Liker as Florida Regional VP, Dr. Michael Core as Southern California Regional VP, Dr. Tony Tarchichi as New Jersey Regional VP, and Drs. Greg Dodell, Sepideh Sedgh, Ian Wittman, Thaddeus Lynn, and Bijay Acharya as New York Regional VPs. In the following month, elections for the two contested positions were held by mail ballot. Dr. Alisha Parada and Dr. Nick Nelson were elected Regional Vice Presidents for New Mexico and Northern California, respectively.

Residents enjoying the presentations during plenary sessions and conversation during the breaks of the CIR National Convention.

PHOTOS: BILL BURKE/PAGE ONE PHOTOGRAPHY

Welcome to the National Voice of Housestaff

PHOTO: COURTESY OF DR. DAUPHINE

Congratulations! You are about to begin what will be the most exciting, harrowing, excruciating and thrilling experience of your life. You are now a resident physician!

Congratulations, too, to those of you who arrive as fellows, beginning another arduous but rewarding year of training.

Fortunately, the Committee of Interns and Residents, the oldest and largest union of housestaff in the U.S., will be behind you as you face each new challenge. For 53 years, CIR has been the national voice of residents and fellows, protecting and advancing housestaff rights, education and working conditions, and defending quality patient care.

This Special Orientation Section of CIR News will help acquaint you with CIR. We urge you to take time to read these pages to learn about your rights and benefits as an employee of your hospital, the history of CIR, and some of the current issues confronting housestaff. Learn how you, as a member, can participate in CIR within your department, your hospital, and as a representative on CIR elected bodies.

Who We Are & What We Do

An informed and involved membership is our greatest strength. Below is some information to better acquaint you with CIR.

Who We Are

CIR—the Committee of Interns and Residents—is the oldest and largest housestaff union in the United States. CIR represents 13,000 interns, residents and fellows in New York, New Jersey, Massachusetts, Florida, California, New Mexico, and the District of Columbia. Since 1957, CIR has negotiated collective bargaining agreements, now with over 70 public and private hospitals. These agreements improve housestaff salaries and benefits, hours of work and working conditions and the quality of care we deliver to our patients.

In 1997, CIR affiliated with the 2.1 million member Service Employees International Union (SEIU), with more than one million healthcare workers across the country. As a national affiliate of physicians within SEIU, CIR housestaff continue to set our own policies, decide our own priorities, elect our own officers and negotiate our own contracts—all with considerable economic and political back-up from SEIU, which adds to CIR's own resources.

Why We're Needed

Housestaff across the country need an organized voice to stand up for our rights and the rights of our patients. CIR enables residents to voice their concerns as a group. CIR collective bargaining agreements carefully spell out housestaff rights and benefits. Experienced staff work with residents to improve and enforce the gains negotiated in each contract. Because residents are at an important and busy stage in their careers, they find that being in CIR is an effective way to work together for improvements in working conditions, residency programs and patient care. In addition, established due process provisions, including grievance procedures, arbitration, and representation rights, ensure that each housestaff officer gets a fair hearing when he or she needs that kind of support.

Look What We Have Achieved

CIR has 53 years of experience with the problems and concerns of housestaff in public and private hospitals. This organizational experience is critical.

- CIR contracts set the standard in their geographic areas, with higher than average salaries and benefits, including, in many hospitals, CIR's own comprehensive health and welfare plan.
- CIR's groundbreaking work on resident hours reform eliminated, across the board, every other night call in New York in 1975. We spearheaded New York State's landmark hours regulations in 1987. We've worked with SEIU to put added teeth into those regulations in 1999. CIR's current contracts provide additional limits on excessive work hours and an internal enforcement method.
- CIR's negotiated "extra on-call pay" is a first in the nation. It guarantees that hospitals pay housestaff additional salary when they are required to cover for an absent colleague.
- CIR's contractually negotiated Patient Care Funds funnel millions of dollars of hospital funds to the patient care needs that housestaff are best able to identify.
- CIR is in the forefront of efforts to support hospital funding, access to care for the uninsured, and to oppose the ravages of managed care and hospital mergers. We work for quality patient care and superior residency education.

Is your hospital in compliance with hours limits?

If not, contact your CIR organizer and check out the HoursWatch website.

www.HoursWatch.org is co-sponsored by CIR and AMSA.

Today, through CIR collective bargaining agreements, more than 13,000 interns, residents and fellows in New York, N and working conditions that are the envy of their colleagues in non-unionized hospitals. They also have a strong, u care policy is forged. But it wasn't always that way. Getting to this point has taken 53 years of commitme

1957: CIR founded in New York City's public hospitals to improve salaries, working conditions, and the quality of patient care delivered by the city's 2,000 resident physicians. One year later, their first contract brings salaries up significantly, affiliates the public hospitals with medical schools to improve education and patient care, establishes a grievance procedure, and improves call rooms.

New York Post

HOSPITAL STRIKE

DAILY NEWS 15¢

3,000 DOCS OUT AT 22 HOSPITALS

DAILY NEWS 15¢

AMA SUPPORTS STRIKING DOCS

1970: In NYC, CIR Branches out from the public hospitals and begins organizing in the private or "voluntary" hospitals.

1976: The National Labor Relations Board (NLRB) in the Cedars-Sinai decision, rules that housestaff are primarily "students" rather than employees. CIR maintains recognition at some voluntary hospitals, but loses others.

A TIMELINE OF CIR HISTORY

1965: First "Heal-In" held in Los Angeles County Hospital, as residents refuse to discharge patients. They garner massive press attention, and win raises and improvements to patient care. They also help to usher in a decade of resident activism nationwide, with other Heal-Ins held at Boston City Hospital in 1967, and at DC General in Washington, D.C. in 1968. All three housestaff groups will affiliate with CIR in the 1990's.

1975: CIR leads the first multi-hospital strike of doctors in U.S. history, affecting 15 voluntary and six city hospitals. The strike, which uses the slogan, Our Hours Make You Sick, gains the support of the AMA and local media. The settlement is a landmark victory that eliminates every other night on-call, and improves working conditions. In California, L.A. County housestaff create the first-ever Patient Care Fund to address unmet patient needs. That fund grows to $2 million per year, and inspires other CIR members to create funds of their own.

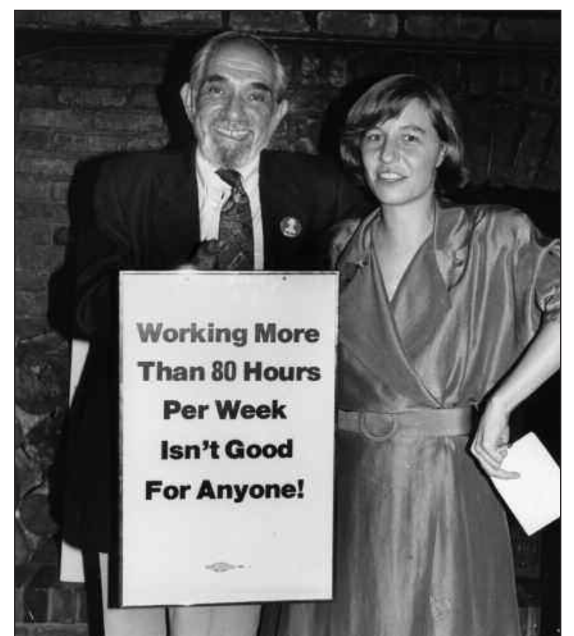
1978: Over 900 housestaff at the College of Medicine and Dentistry of New Jersey (now UMDNJ) vote to join CIR.

1989: CIR helps to establish the 405 or "Bell Regulations," and New York becomes the first state to set limits on residents' work hours at 80 per week, averaged over four weeks.

BCH Near Capacity In Reverse Strike

'Heal-In' Loads Hospital Beds

Interns and residents began a round-the-clock "heal-in" at Boston City Hospital to dramatize demands for higher salaries by jamming the hospital with patients. Dr. Philip Caper, president of the House Officers Association, is shown (second from right) with a group of interns and residents. (UPI Telephoto)



New Jersey, Massachusetts, Washington, D.C., Florida, California, New Mexico, and Puerto Rico enjoy salary, benefits unified voice to advocate for their patients in their local hospitals, and in the state and federal arenas, where health nt and collective activity by housestaff in public and private hospitals across the country. Here is our story.

1993-1998: Housestaff at Cambridge and Boston City Hospitals, and several California hospitals vote to join CIR.

1996: Nearly 1,000 residents at Jackson Memorial Hospital in Miami vote to join CIR by a 4-to-1 margin.

1997: A CIR-initiated campaign succeeds when NY's Supreme Court blocks Mayor Guiliani's plan to privatize NYC public hospitals. In Los Angeles an independent housestaff association, JCIR, joins CIR. At CIR's 40th anniversary, delegates vote to join the Service Employees International Union (SEIU).

1999: CIR and Boston Medical Center housestaff file a legal challenge to overturn the 1976 Cedars-Sinai NLRB decision. The challenge is successful with the NLRB ruling that private sector housestaff are employees, and thus guaranteed collective bargaining rights.

2001-2003: 1,000 new members organized in several hospitals in the NY region.

2007: CIR celebrates 50th Anniversary, and a new chapter at the University of New Mexico Hospital (UNM) in Albuquerque. Residents in New Mexico ratify their first contract, improving conditions for 500+ housestaff.

2009: CIR adds a new chapter at New York Downtown and wins an election at Long Island College Hospital. CIR creates an OR Safety Task Force, and participates in events with Health Care for America Now! across the country

2010: Residents at Kern Medical Center in Bakersfield form a new CIR chapter. NLRB reaffirms the rights of residents to organize as St. Barnabas Hospital in the Bronx achieves an election victory.

Frequently Asked Questions About CIR

How are CIR contracts negotiated?

All CIR members are covered by a collective bargaining agreement—a contract between CIR and your employer that spells out your salary, benefits and working conditions. CIR collective bargaining agreements usually cover a two to three year period. Toward the end of that period, housestaff at each hospital decide what to include in their proposals for a new collective bargaining agreement. They also select a representative group of their colleagues to work with experienced CIR staff on the negotiating committee, the group that sits down with the hospital's representatives to discuss the terms for the contract. The committee draws upon a full range of CIR research, legal, media and technical resources, as needed.

After the negotiating committee determines that it has reached the best possible agreement, the members covered by the agreement vote to ratify or reject it.

How is CIR governed?

Each CIR hospital elects its own local leadership. Elected delegates meet regionally to discuss ongoing issues at their hospitals and to focus on advocacy in their regions. At the annual national convention, CIR delegates come together to discuss issues of housestaff concern and set the direction for the coming year. This Executive Committee —made up of a president, executive vice president, secretary-treasurer, and regional vice presidents — is elected by members of CIR and serves as a steering committee between annual conventions.

Who are the CIR representatives at my hospital?

In addition to the CIR delegates from each hospital who attend the annual national convention, each CIR hospital, or chapter, has its own structure to determine policy on local matters. Some chapters elect colleagues to serve as co-presidents and department representatives and most choose members to serve on the Graduate Medical Education Committee and other hospital committees. Local chapter representatives determine the collective bargaining proposals and negotiations process at their hospital.

CIR assigns a staff person to each of the hospitals it represents. The staff person, called an organizer, helps coordinate chapter activities and assists housestaff communications between departments. The organizer works with delegates and department representatives to insure that the collective bargaining is professionally negotiated and enforced. In addition, the CIR organizer handles grievances and other problems that residents may encounter.

What Is a grievance?

One of the ways to resolve disagreements about your rights or conditions of employment is the grievance procedure contained in your CIR contract. Each CIR contract contains a definition, but generally, a grievance is a complaint that your hospital or department has neglected or a right or benefit guaranteed by your CIR contract that is not provided.

Grievances can be filed by an individual or a group of residents, or by CIR, about almost any matter covered by your CIR contract, but they must be filed within a specified time. (Check your CIR contract for the time limit applicable to your hospital.)

Written grievances are usually preceded by informal attempts to resolve the question or disagreement with your department or hospital in forums such as "labor-management" committees. Once the grievance is in writing, the CIR contract requires that the hospital adhere to specific procedures and deadlines for responding.

All grievance procedures provide for appealing an unfavorable decision to higher hospital authorities. Most grievances not settled at the hospital can be submitted to a neutral arbiter who will render a final decision, which is binding to both sides.

The union contract is also an essential guarantee of your due process rights to review your personnel file, dispute a complaint about your performance, an evaluation, probation, non-renewal, termination or any other problem you may have with your department.

It is important to act quickly when you have a question, or a problem, even if you're unsure about whether it's a grievance or a due process disciplinary matter. Your CIR organizer will assist you in determining the appropriate steps. Also, if you misplace the CIR contract that is given to you during orientation, ask your CIR organizer for another copy. Read your contract and use it.

What about dues?

The elected House of Delegates decides membership dues, which provide the major source of income for CIR to pay for staff and all other expenses necessary to negotiate and enforce our collective bargaining agreements and to run this national organization. CIR dues are set at 1.5 percent of a house officer's salary, are paid through payroll deduction from members' paychecks. As with our medical training, so with CIR: the more we as residents stick together, pool our resources and work "as a team," the more we will accomplish and the stronger we will be.

CIR Says, "Check Your Personnel File"

Sometimes adverse letters from patients, hospital staff, or supervisors that make misstatements or are very one-sided find their way into your file. Incident reports and departmental evaluations that you should have been shown (and weren't) may be put in your file.

While the specific language may vary among different CIR contracts, CIR members are guaranteed the right to see and respond to materials put in their files. Frequently you are entitled to photocopies.

CIR staff can assist you in deciding what action would be most appropriate in responding to adverse documents. You might want to insert a written rebuttal, or file a grievance to have the document modified or even removed. CIR can represent you in these steps.

With increasingly stringent credentialling and more aggressive malpractice litigation, you don't want any surprises lurking in your file. You initiate the process of examining your record; we can help after that.

Your right to examine your file may be important to your reputation and your career. Use that right to check your file regularly.

PHOTOS: VAN NGUYEN/CIR

Residents Use Patient Care Funds to Improve Quality

Blanket-warmers, portable dopplers, discharge medications for the indigent – these items are a given in many hospitals, but are often missing from the safety-net hospitals that CIR resident physicians call home. That's why housestaff in several CIR chapters have negotiated Patient Care Funds (PCFs), dedicated money that the hospital sets aside to pay for equipment and services that can help residents better care for their patients.

Often, the funds help address a glaring need. At Alameda County Medical Center, residents requested life-saving equipment, including a glidescope, which has drastically improved the way that patients are intubated in difficult cases.

At University of New Mexico and Children's Hospital Oakland, it was frustrating for housestaff to see indigent patients stay longer than necessary because they couldn't afford discharge medications. So they used their PCFs to provide for discharge medications for patients who have no other options.

In other cases, the PCF is used to help ease barriers to access and to enhance community health, prevention, and quality of life for inpatients. At UNM, the Patient Care Fund has grown from $25,000 to $75,000 as the CIR chapter has gotten more established over the past three years and negotiated for a larger investment on the part of the hospital. Projects funded by the UNM fund include the Native Health Initiative, a program founded by CIR member Dr. Anthony Fleg to address health inequities affecting Native Americans, as well as helmets for skateboarders, and purchasing Nintendo Wiis for children with epilepsy who are hospitalized.

At San Francisco General Hospital, the PCF has paid for bus tokens for patients who would otherwise not be able to get to and from the hospital.

At Boston Medical Center, PCF funds have supported the Boston Center for Refugee Health and Human Rights, which offers comprehensive medical, mental health, and dental care, coordinated with legal and social services to nearly 600 refugees each year.

At Jackson Memorial Hospital In Miami, the PCF committee decided to invest some of their funds in the Great American Smokeout, an annual event that provides resources to help patients stop smoking and to learn about healthy lifestyle choices.

It is no wonder that Patient Care Funds are popular with residents. Nevertheless, it can be challenging to establish them at hospitals through the collective bargaining process.

Boston Medical Center residents use their patient care fund to support the Boston Center for Refugee Health and Human Rights.

"Our PCF is unique in that we fundraise for the money rather than the hospital funding it," Dr. Mike Favazza, a resident at Children's Hospital Oakland explained. "All the money goes toward paying for discharge meds for our patients who can't pay for them."

Despite the hospital's refusal to create a hospital-funded patient care fund as part of their first contract at Children's in 2005, residents physicians felt so strongly about the need for such a fund that they used their negotiated backup call bonuses to start one. They have raised money through other channels, including weekly happy hours, marathons, and other events. By June 2010, the residents had raised over $111,000.

This year, the residents at Children's Hospital are back at the bargaining table. Having demonstrated that the patient care fund serves a vital function, they are pressing for the hospital to follow the example of so many other employers and offer a hospital-sponsored fund like those that exist at dozens of other CIR hospitals.

For more information on Patient Care Funds, including how to submit a request if there's already a fund at your hospital, go to http://cir.seiu.org/pcf.

Advisor to BMC-CIR Minority Physician Recruitment Program Named Pentagon's Top Doctor

Boston Medical Center's loss is most definitely the country's gain. In late April 2010, President Barack Obama chose Dr. Jonathan Woodson to serve as Assistant Secretary of Defense for Health Affairs, colloquially the Pentagon's "top doctor." Dr. Woodson was Senior Vascular Surgeon at BMC, and Associate Professor of Surgery and Associate Dean at Boston University School of Medicine, where he oversaw the recruitment and retention of minority students. For more than 20 years, the triple-boarded (internal medicine, general and vascular surgery) African-American physician, who trained at Massachusetts General Hospital, was also a guiding force behind BMC and CIR's innovative Minority Physician Recruitment Program.

The MPRP was the brain child of a handful of minority resident physician union members in the late 1970's who were frustrated with how few minority housestaff were training at Boston City Hospital. This public hospital served a diverse patient population in a city that at the time was capturing national headlines for a violent school desegregation battle. The union (the House Officers' Association, which affiliated with CIR years later) paid for the residents to attend the annual Student National Medical Association conference, among other actions.

In 1980, the residents put a proposal on the negotiating table to establish a formal recruitment program. The proposal was a hit. From a $15,000 item in the 1980 collective bargaining agreement, it grew to be a more than $150,000 commitment from Boston Medical Center in 2010. Along the way, the MPRP established its Subsidized Elective Program to attract medical students of color to BMC for 4 week electives in the residency program they are interested in. The result: as of July 2010, 21 percent of BMC residents and fellows will be under-represented minorities.

Dr. Woodson was an Army Reserve Brigadier General and served tours of duty as a surgeon in Central America, Saudi Arabia, Kosovo, and the wars in Afghanistan and Iraq. The Assistant Secretary of Defense for Health Affairs is the principle advisor to the Secretary of Defense on health issues and oversees the entire U.S. military health system and its $590 billion budget. This includes the care of war wounded, and basic health care for 9.6 million active and retired service members and their family members.

As CIR member Dr. Bernadatte Gilbert, a PGY 2 family medicine resident who also encountered Dr. Woodson when she was a medical student at BU, put it, "Dr. Woodson is an excellent motivator and inspiration to young physicians. You can't help but feel if he can manage marriage, fatherhood, deanship, his administrative duties as assistant chief medical officer, and a demanding military career as a Brigadier General, then certainly I can manage the various rigors of medical school and residency by following his example of organization and diligence."

> **"Dr. Woodson is an excellent motivator and inspiration to young physicians."**
>
> **Dr. Bernadatte Gilbert**
> **Family Medicine Resident**

Remembering Dr. Vajinder Toor

Housestaff, attending, nurses, and other healthcare workers at Kingsbrook Jewish Medical Center in Brooklyn, NY were shocked to hear of the death of former member Dr. Vajinder Toor on April 26, 2010. Dr. Toor had been a popular delegate, the chief of the negotiating committee at Kingsbrook, and an active member throughout his residency, which he completed in 2008. At the time of his death, Dr. Toor was a fellow in Infectious Diseases at the Yale School of Medicine. He was tragically shot to death outside of his home in Branford, CT while leaving for work.

Dr. Lishan Wang, who was arrested and charged with Dr. Toor's murder, had been a resident at Kingsbrook and a CIR member before being terminated in 2008. Dr. Toor had been involved in the dispute that led to Dr. Wang's termination from the hospital.

Dr. Toor leaves behind a wife and three year-old son. His wife is currently pregnant with their second child. On behalf of the residents of CIR, a financial donation has been made to Dr. Toor's family. In addition, CIR worked with the hospital to rename the housestaff lounge at Kingsbrook in Dr. Toor's honor.

California CIR Members Leading the Way on Resident Work Hour Redesign

CIR members in California are engaged in discussions and, in some cases, pilot programs to determine the best ways to implement the recommendations outlined in the 2008 Institute of Medicine report, *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*. The ACGME is expected to release new guidelines later this year, and CIR has actively weighed in on the best ways to protect resident physicians and patients and to balance the needs of medical education with the realities of human limitations.

Dr. Chris Landrigan, a Harvard sleep scientist who has done extensive research on the effects of sleep deprivation on physician and patient safety, spoke to residents at Harbor-UCLA on March 17, 2010. He reviewed the scientific evidence on fatigue and patient safety, and urged residents to start thinking about how their programs could move away from 30-hour call schedules.

"Dr. Landrigan presented a balanced and evidence-based assessment of the issue of resident work hours," said Dr. Linda Sharp, an Internal Medicine resident at Harbor-UCLA. "With concern for both patient and physician safety, his talk shows us that we need to critically review the way we structure residency training."

> **"Resident input is very important, as residents know the ins and outs of their schedules and where their training is lacking and can identify areas of improvement."**
>
> **Dr. Marisa Chavez**
> **OB/GYN resident**

Dr. Emil Avanes, another Internal Medicine resident, called the evidence "clear, objective, and overwhelming" on the risks associated with 30-hour work shifts during residency training. "It was interesting to hear that the post-call hazards I experienced as an intern are also experienced by an extraordinary number of others," said Dr. Avanes.

In San Jose, the Obstetrics and Gynecology program at Santa Clara Valley Medical Center has developed a pilot program to implement the IOM recommendations, which call for maximum shifts of 16 hours, 12 hours off between shifts, and one full weekend off a month.

> **"It was interesting to hear that the post-call hazards I experienced as an intern are also experienced by an extraordinary number of others."**
>
> **Dr. Emil Avanes**
> **Internal medicine resident**

Prompted by the evidence on patient safety and 24-hour shifts, the program director at Santa Clara decided to implement the IOM recommendations before the ACGME made a decision. CIR delegate Dr. Marisa Chavez said the response from members has been positive because of the active engagement of resident physicians in the process. Three residents served on the Work Hours Committee, one from each year. "There was initial hesitation with handoff times and vacation scheduling," Dr. Chavez said. But weekly meetings with residents to discuss proposed changes and concerns helped ease the transition.

Dr. Chavez believes this can be done in other programs as well. "It requires creative thinking, advanced planning, reorganization and consultation with other programs with similar program sizes for schedule models," she said. "Resident input is very important, as residents know the ins and outs of their schedules and where their training is lacking and can identify areas of improvement."

For more information on the IOM recommendations, go to the Policy section on www.cirseiu.org.

Proposed Changes to Santa Clara OB/GYN Program

- A block schedule, which includes a vacation block of three weeks with one research week; residents have ability to "swap" vacation weeks with one another so that they can space out their vacations during the year.
- Maximum of 80 hours per week with no averaging beginning July 1, 2010.
- At least one day off (24 hours) per week and one 48-hour period off per month.
- Maximum 16-hour shifts. The program decided not to institute 30-hour shifts with a five-hour sleep period because it was logistically impossible, given the small program size.
- Weekday calls eliminated secondary to institution of night float system; weekend coverage by non-night float residents with most residents covering one weekend shift; ambulatory residents cover Friday night shift and Sunday day shift three times a month, and have one weekend off.
- Minimum time off remains at 10 hours after day shift; the program has not yet adopted 12 hours off after night shift (this was a resident decision) because of desire for fair distribution of total hours per week and strong desire to minimize number of patient handoffs; currently night float has 10-11 hours off between shifts.
- Moonlighting not allowed.

CIR Hosts Screening of the Movie *Money Driven Medicine* at St. Luke's-Roosevelt Hospital Center

The U.S. spends twice as much per person on health care as the average developed nation, yet our outcomes, especially for chronic diseases, are often worse. How did we get to this point? That's the central question that Maggie Mahar set out to answer in her book *Money Driven Medicine: The Real Reason Health Care Costs So Much*.

On April 7, 2010, CIR hosted a screening of the documentary based on Ms. Mahar's book, *Money Driven Medicine*, at St. Luke's-Roosevelt Hospital Center in New York City. Resident physicians, nurses, and community members came out to see the film and to participate in a question-and-answer session with the author.

The film depicts the human cost of the focus on profit over health through the stories of patients and doctors who find themselves ensnared in the system. One of the most commanding interviews in the film involved Dr. Donald Berwick, president of the Institute for Healthcare Improvement and now President Obama's nominee to lead the Centers for Medicare and Medicaid (CMS). Dr. Berwick provided many thoughtful examples of how the business incentives of medicine warp the practice of medicine.

PHOTO CREDIT: HEATHER APPEL/CIR

CIR Regional Vice President Dr. Greg Dodell introduced author, journalist and blogger Maggie Mahar.

The resident physicians who attended the film said they found it provocative. "They talked a lot about the oversupply of health care and the disparities between the ability to deliver the basic necessities of health care versus super-high tech, marginally beneficial health care," said Dr. Patrick Coady, a PGY 1 in Internal Medicine at St. Luke's-Roosevelt. "The point of the movie is it's driven by the medical-industrial complex."

Dr. David Dada, a PGY 2 in Psychiatry at Harlem Hospital, appreciated the comparisons to other countries' health care systems, having trained in family medicine in Nigeria and surgery in the West Indies . "The film is excellent. I would like all the doctors and the executives of Harlem Hospital to watch this," he said. "I've been talking to those in Internal Medicine about primary care and its importance."

While the examples in the film are troubling, Ms. Mahar was optimistic about changes to come through the new health care reform law, as well as the new leadership of Medicare under Dr. Berwick. She emphasized benefits like the large influx of money expected for scholarships and loan forgiveness, which will make it more possible for doctors to go into primary care. She was also hopeful about the creation of new community health centers under the law, which she said will be well-funded and can serve as models of patient-centered medical homes. Perhaps most importantly, she said, Dr. Berwick, if confirmed, can use Medicare as a lever for improving the quality of health care, by reducing inefficiencies and rewarding programs and providers who achieve good outcomes.

Change Is Coming to St. Barnabas Hospital

Legal Victory Paves Way for Residents' Voices to Finally Be Heard

Almost a year after the resident physicians at St. Barnabas Hospital voted on whether to join CIR, their votes were unsealed and counted on June 11, 2010. With 119 voting in favor of the union and only two against, it was a resounding victory for the residents who have fought for almost two years for a union. An additional 47 ballots were not included in the vote count because of legal challenges from the hospital.

For the residents who started the organizing campaign in 2008, it was a sweet victory. Many had already started to discuss concrete improvements they could negotiate when the hospital comes to the bargaining table.

"The approval of union status will not only strengthen our ability to make improvements, but ultimately will allow us to better serve our patients and our community," said Dr. Wanda Espinoza, a PGY3 in Emergency Medicine. "It's a win-win for residents and also for our patients, and therefore the hospital through which we provide our services."

The Bronx doctors originally voted to join CIR after a ruling by the Regional National Labor Relations Board (NLRB) on May 22, 2009 gave them the right to hold a secret ballot election within 30 days. The residents participated in the NLRB-authorized election on June 18, 2009, but hospital administrators then appealed the NLRB's decision, clinging to their argument that residents are students and not employees. The votes were impounded and could not be tallied until the NLRB ruled on whether it would hear the hospital's appeal.

On June 3, 2010, the national NLRB in Washington DC declined to review the case, citing the precedent of 1999's decision in the Boston Medical Center case, which established that medical residents are employees under labor law and entitled to full labor rights. "That decision, which remains the law, is directly on point," read the NLRB decision – one of the first issued by the board under the Obama Administration. That decision paved the way for the votes to finally be counted.

Despite the hospital's efforts to stall the process, St. Barnabas residents did not let the year-long delay stop them from addressing urgent issues in the hospital. Throughout the year, they identified problems with equipment, translation services, ancillary staffing, and security in the hospital. By bringing those issues to light within their departments and with outside regulators, they were able to win some small victories for safer working conditions and better patient care.

On April 27, 2010, residents, guards, and nurses submitted a joint complaint to the Occupational Safety and Health Administration (OSHA) outlining hazardous working conditions evidenced by an increase in workplace violence. Between 2008 and 2009, the number of patient assaults on hospital employees increased by more than 300 percent: from 13 in 2008 to 44 in 2009.

The spike in violent incidents also got the attention of a local ABC News reporter, who interviewed residents and a former guard about the lack of security. A St. Barnabas resident speaking anonymously on camera stated, "[Residents] are working in an environment that is not safe; security is not enough."

Now that the votes have been counted, residents are hopeful that they will have a greater voice and a stronger ability to address ER safety and many other issues.

PHOTO: HEATHER APPEL/CIR

CIR Meets with Japanese Delegation

Outgoing CIR President Dr. L. Toni Lewis met with hundreds of Japanese doctors and nurses visiting New York City on May 4, 2010 as part of an anti-nuclear weapons delegation to the United Nations. The health care providers are part of MIN-IREN, the Japanese Federation of Democratic Medical Institutions, which formed in response to the dwindling number of public hospitals and the increasing health care and social welfare needs of working people in Japan. At the event in New York City, they discussed commonalities and challenges of the Japanese universal health care system and the American health care system pre- and post-reform.

Harbor-UCLA Residents Head Off Parking Disaster

This spring, Harbor-UCLA Medical Center in Los Angeles started construction on a new Emergency Room. The plans for development, however, would have eliminated 250 of the already-scarce parking spaces across from the campus. Although the County planned to begin construction of a new $10 million parking structure at the same time as it began building the ER in May, the county had made no interim parking plans for staff. It was looking like the best option for resident physicians was to park at a K-Mart shopping center one mile away from the hospital.

CIR leaders collected stories from resident physicians about how the parking situation would affect their work and might hurt patient care, and demanded that their concerns be addressed.

During March and April, they met weekly with the parking committee and presented proposals to the CEO and COO of the hospital. The residents won a series of changes that greatly improved the situation, including two seats on the hospital's parking committee, the preservation of designated physician parking, designated spots for a number of emergency residents, a parking attendant on duty to enforce reserved parking rules, expanded shuttle services, and a plan to demolish unused barracks to make room for new parking spaces.

"In our meeting with the hospital administrators, we all breathed a sigh of relief and smiled enormously after learning that there will be parking for everyone—doctors, nurses, staff, patients, and their visitors—during Harbor-UCLA's major expansion project," said emergency medicine resident Dr. Stephanie Donald. "In my experience as a CIR leader, I have learned that when we are informed, motivated, and active in our community's most pressing issues, our voice is heard, and we have the power to effect change in so many positive ways."

Glendale Health Center: SAVED!

PHOTO CREDIT: IVY QUICHO/CIR

On April 22, 2010, Dr. Jose Luis Hernandez, a CIR delegate from LAC+USC, delivered a moving speech before a crowd of 80, including Glendale Mayor Frank Quintero, community allies, patients and clinic staff outside the Glendale Health Center, at a rally against the proposed privatization of the clinic. After a two-year campaign to block the proposal by the LA County Board of Supervisors — a move that would potentially disrupt services and access to care for more than 3,000 patients — Supervisor Mike Antonovich announced in early May that the proposal to privatize the clinic had finally been taken off the table.

Doctors Take to the Streets to Celebrate Passage of Health Care Reform

No issue commanded so much attention throughout 2009-2010 as the national debate on health care reform. CIR, working with other physician organization, was on the front lines every step of the way, demanding that the reform proposals moving through Congress focus on incentivizing quality of care, not just quantity of care, growing and nurturing the physician workforce of tomorrow, particularly in the areas of primary care and prevention, and protecting the most vulnerable patients and families that resident physicians see every day.

As such, it was fitting that during the final few days of action in Washington DC before health reform became law, CIR was there!

On Sunday, March 21, 2010, the House of Representatives voted on *the Patient Protection and Affordable Care Act*, which had previously passed the Senate, and sent it to the president for his signature. The very next day, CIR, together with partner organizations ranging from Doctors for America and the National Physicians Alliance to the American Medical Student Association and SEIU Nurse Alliance, organized the "Health Professionals March for Reform." The event brought together hundreds of physicians, nurses, medical students, health professionals, and other reform advocates from across the country to the nation's capital to celebrate the passage of health care reform and urge their senators to finish the job by passing the fixes contained in the *Health Care and Education Affordability Reconciliation Act*.

PHOTO: SEIU

Even the rain couldn't dampen the spirits of hundreds of physicians, nurses, and other health professionals as they marched in Washington DC to celebrate the passage of health reform on March 22, 2010.

The day began with a rally at Freedom Plaza in Washington DC, just a few blocks from the White House. Despite the rain, then-CIR President Dr. L. Toni Lewis and Regional Vice President Dr. Vaughn Whittaker took their turns on the megaphone to fire up a crowd where white coats alternated with rain coats. Shortly before noon, the health professionals began the march from Freedom Plaza to Capitol Hill. The imagery of so many doctors and nurses with handmade signs and jubilant spirits marching down Pennsylvania Avenue in a rainstorm to celebrate the passage of health care reform was dramatic enough to be used on the homepages of Politico.com, NYTimes.com, and WashingtonPost.com, as well as the front page of the *Los Angeles Times*. Additionally, the cable networks MSNBC and CNN carried live video of the march.

At the other end of Pennsylvania Avenue, the health professionals gathered for a press conference with elected officials inside the Senate Hart Building. They serenaded the elected officials sharing the stage with cheers of "Who's got your back? We've got your back!", and applauded as Rep. Jan Shakowsky (D-IL) and Rep. Jim McDermott (D-WA) expressed their admiration and gratitude for the support that so many physicians groups had given to reform efforts all year long. Also on hand was Sen. Jeff Bingaman (D-NM), who for months had been on the receiving end of phone calls, emails, and press events spearheaded by the CIR resident physicians at the University of New Mexico. Sen. Bingaman congratulated the representatives and pledged that the Senate would finish the job by passing the Reconciliation Act. (The Senate did so that same week.)

Even more movingly, Dr. Judith Palfrey, the president of the American Academy of Pediatrics, Dr. Lori Heim, the president of the American Academy of Family Physicians, and Dr. Frederick Turton of the American College of Physicians, took the podium to each tell the story of one patient who had been denied coverage or care because of the abusive practices of the private insurance industry, but who now had hope and protection, thanks to the passage of health care reform.

The bills that became law this year will not solve every problem, and their benefits will be phased in over a number of years. Frustrations and problems with the American health care system will persist. But the doctors, nurses, medical students, and advocates who had invested so much in the fight took the day to appreciate the historic moment.

New York Downtown Docs Win Raises, Rent Protections

After more than four years with no raises, resident physicians at New York Downtown Hospital ratified a contract that guarantees them rent protection, bonuses and raises, among other gains, on May 19, 2010.

The 64 internal medicine and obstetrics/gynecology residents at New York Downtown affiliated with CIR in April 2009, after their independent housestaff association had struggled and failed to get administration's attention on negotiating a new contract. Organizing committee members were motivated by uncompetitive salaries, a punitive policy on sick days, and a sense that they had no voice at their workplace. After 10 months of negotiations, the CIR leaders felt that they had a contract that adequately addressed those issues.

"All the housestaff felt it was a strong contract with a lot of protection for both current residents and also incoming residents," said Dr. Peter Wong, a member of the negotiating committee.

"The good thing was it allowed us to come together as a group and to be one voice, and stand up for what we really believed was important."

Dr. Peter Wong
Member of the Negotiating Committee

The new contract provides bonuses for all current residents, additional bonuses in January 2011 and 2013, and 2 percent salary increases in 2011 and 2012. The hospital also agreed to major rent protection for the residents' low-cost housing next to the hospital. Additional gains include covering transportation costs for away rotations, providing meals, reimbursement of board review courses and exams, and a grievance procedure to enable CIR to enforce the contract.

In December, the residents worked with the nurses at the hospital to deliver a basket full of holiday cards with personal messages to the CEO, asking him for a fair contract.

"There were good times and bad times, like with anything," said Dr. Wong. "The good thing was it allowed us to come together as a group and to be one voice, and stand up for what we really believed was important."

In the end, Dr. Wong and his colleagues found that the time they dedicated paid off when they voted on their first CIR contract.

"It marked a moment in the residency at New York Downtown Hospital," Dr. Wong said, "Now we're affiliated with CIR, and we're actually able to implement some change, which was not there before. So we're proud of that moment."