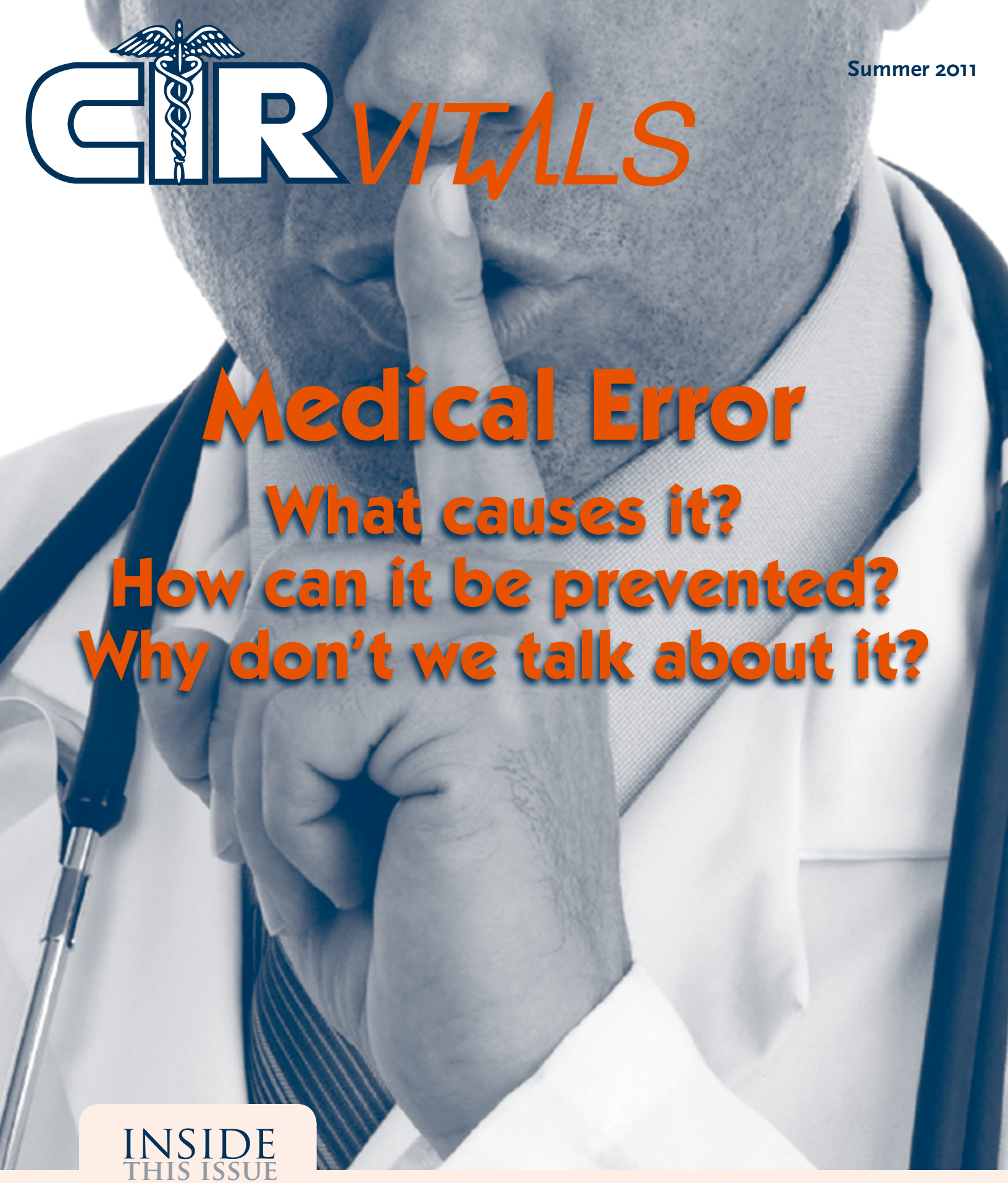
CIR VITALS

Summer 2011



Medical Error

What causes it?
How can it be prevented?
Why don't we talk about it?

INSIDE THIS ISSUE

FARBOD RAISZADEH, MD, PHD

What Makes CIR Vital?

Welcome to the first issue of *CIR Vitals*! I'm sad to say this is my last column as CIR president, but I'm happy to introduce the renamed and redesigned *CIR News*. *CIR Vitals* will continue to serve as a record of the union's activities and provide essential updates about CIR. In addition, we hope to delve deeper into the issues that affect residents across the country.

We are living in a time of tremendous change. The environment in which we work, learn, practice medicine, treat patients, and shape our future is shifting rapidly. Our objective in *CIR Vitals* is to document and analyze the ways medicine is evolving as a profession, the vital part residents can play in work redesign and patient safety, the role of money and politics in health care, and other issues that are critically important to CIR members.

The issues confronting us right now are not small. The last few months have revealed serious threats to many of our hospitals, the patients we care for, and the people who provide that care. As the recession has forced more people onto unemployment and Medicaid, states are slashing their Medicaid budgets and limiting eligibility. With the decline in insured patients, safety-net hospitals lose revenue. As a result, several CIR hospitals are operating in the red and fighting for survival.

On top of all that, we are seeing efforts in a dozen states, from Wisconsin to Florida, to strip public employees of their rights to collective bargaining. CIR represents more than 6,000 residents in public hospitals, so this is not an abstract problem for us.

But instead of fearing the worst and bracing ourselves for these threats, I believe this is a chance for CIR to do what we do best. We are being proactive and looking for innovative ways to improve efficiency and patient care in our hospitals. We actually put Quality Improvement on the bargaining table in three recent contracts, and got funding set aside for housestaff incentive programs. We are now using those first-of-their-kind contracts as a model for other hospitals that want to collaborate with housestaff to jointly improve quality.

We are also paving the way on patient safety and work redesign. In March 2011 we convened a one-day conference in the Bay Area for residents, attendings, and program directors to hear best practices from programs that have successfully redesigned their schedules and improved workflow. And we continue to collaborate with major hospital systems in the Northeast to spur patient safety initiatives, some of which you'll read about in this issue.

How are you seizing this opportunity in your hospital? We want to know about your Quality Improvement work, your resident education projects, your unusual Patient Care Fund proposals.

I have just returned from National Convention and am pleased to pass the reins to our new CIR President Dr. Hillary Tompkins and the members of the 2011-2012 Executive Committee. It has been an honor serving as CIR president, and I look forward to staying involved and seeing all the ways you are taking advantage of the unique voice we have as CIR members.

Learn more about National Convention and the 2011-2012 Executive Committee at www.cirseiu.org.

CIR VITALS
Committee of Interns and Residents/SEIUHealthcare

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Through the Healthy Bronx Initiative

CIR Members Serve as Patient Advocates Outside the Hospital

Frustrated with repeat admissions for treatable conditions like pediatric asthma and complications due to obesity, Bronx CIR members launched the Healthy Bronx Initiative in February. Among all New York City neighborhoods, the South Bronx has the highest percentage of people who rate their general health as poor and suffer from obesity, diabetes, and asthma. Other Bronx neighborhoods were ranked the worst 10 of 35 New York City neighborhoods for the same measures.

PHOTO CREDIT: HANNAH THONET/CIR

A student shows off a collage of "good" and "bad" food from photos clipped from magazines.

With U.S. census data showing that 27.3% of Bronx residents live below the poverty line, Bronx health disparities are exacerbated by inequities in employment, education, and housing. On May 12th, residents spoke before the New York City Council at a hearing on the Fair Wages for New Yorkers Act to address the relationship between income-level, access to health insurance, and health outcomes. The Act would require any project receiving contracts or funding from the City of New York to pay employees a living wage-defined by existing NYC legislation as $10/hr with benefits.

"The citizens of the Bronx have an urgent need for improved health outcomes and better quality of care," said Dr. Yusef Williams, a Family Medicine resident at Bronx-Lebanon Hospital. "The Healthy Bronx Initiative is one step in reducing the healthcare disparities that exist amongst impoverished citizens in New York City neighborhoods. Physicians and citizens of the Bronx view these health issues as paramount, so CIR has taken a team approach to winning over the health of our community."

Residents have already completed an educational series on obesity and nutrition at the Bronx-based Mary Mitchell Family Youth Center and will develop a curriculum for a summer workshop at the Point Community Development Corporation. Residents also invited patients to join them at a May 17th walkathon in the Bronx as a way to help jumpstart regular physical activity for members of the community. Dr. Williams added, "From our 'Walk with a Doctor' event to supporting the city's 'Adopt a Bodega' program, the Healthy Bronx Initiative is aiming to galvanize Bronx families to improve health outcomes borough-wide."

Bay Area Conference Looks at Models of Work Re-design

Residents from California and New Mexico gathered in Oakland this past March to discuss strategies and share best practices to re-design their residency programs to improve patient safety and resident education and well-being. Presenters included Dr. Laura Barger, a Harvard Medical School-based instructor and researcher in sleep science; Dr. Robert Bush, a pioneer in residency work re-design and the associate program director of internal medicine at Virginia Mason Medical Center in Seattle; and Dr. Jennifer Domingo, the associate program director of the Ob-Gyn residency program at Santa Clara Valley Medical Center in San Jose, CA, whose program has implemented the Institute of Medicine recommendations on work hours and supervision. Residents then participated in roundtable discussions with these experts to discuss implementing changes in their own programs.

"Residency work re-design improves patient care and improves residency programs by allowing each of us to have a voice in what we want the direction of medicine to be," said Dr. Angela Walker, a resident at UCSF Medical Center who attended the meeting. "There are a lot of changes on the horizon, [such as] work hour restrictions and also implementation of electronic medical record keeping. Looking ahead and being involved is how we're going to make things happen."

PHOTO CREDIT: HANNAH THONET/CIR

Residents from CIR and non-CIR hospitals debate methods for redesigning their residency programs.

Important Victories
CIR Contracts Strong in Weak Economy

Though pandemic budget cuts continue to threaten the rights, wages and benefits of all employees, CIR members are securing important victories with each newly ratified contract. Besides guaranteeing salary, allowance and bonus increases for member residents, CIR negotiating teams have helped maintain quality patient care at facilities with struggling resources, often resulting in innovative new approaches to quality improvement, efficiency, and patient safety.

- At **St. Luke's-Roosevelt Hospital** in New York City, a three-year contract settled in March will give residents a three percent annual pay increase and will double textbook allowances to $200 per year. It will also establish new, collaborative venues for residents to develop quality care initiatives, and strengthen the residents' forum for addressing housing issues by including housing administrators in labor-management meetings.

- Residents at **Kingsbrook Jewish Medical Center** in Brooklyn negotiated an agreement that will award annual lump-sum bonuses to all housestaff officers, provide computer access in call rooms, and establish an incentive program to involve residents in finding cost savings for the hospital, in an effort to improve clinical outcomes and increase patient satisfaction.

- CIR members at **San Francisco General Hospital** successfully negotiated a three-year contract this April that will improve the education expense reimbursement, and ensure residents' housing stipends and salary maintain parity with UCSF.

- A new, three-year agreement with **St. John's Episcopal Hospital** in Queens, NY will give CIR residents a three percent annual salary

Miami's Jackson Memorial Hospital
CIR Docs on a Critical Mission to Tallahassee

Residents from Miami's **Jackson Memorial Hospital** joined forces with about 70 nurses from the hospital and hundreds of activists to deliver pink slips to Governor Rick Scott in the Florida Capitol Building, protesting cutbacks and the loss of government jobs.

Drs. Molly McShane (Psychiatry, PGY 3), Michael Drusano (Family Medicine, PGY 3), and Monique Jones (Psychiatry, PGY 1) had a very personal reason to travel with their nurse colleagues to Tallahassee: Governor Scott and his allies want to privatize the safety-net hospital. Healthcare workers and advocates argue that Jackson Memorial—the only public hospital in the Miami metro area—must remain committed to its mission of serving the entire populace.

Exercising their civic muscle, the three residents embarked on a whirlwind, two-day legislative campaign, sponsored by the nurses' and attendings' union SEIU Local 1991. Day 1 was the warm-up; an early morning flight, requisite photos on the Capitol steps, a press conference focused on saving the hospital.

Day 2 started with a meeting with Rep. Cynthia Jackson, a proven champion who committed to standing with the hospital, adding that she was prepared to join a lawsuit against Governor Scott for a release of the Low Income Pool funds currently owed to the hospital. A less successful meeting followed with an unmoved but still receptive aide to a Republican legislator, but the residents were reinvigorated after many other representatives promised their support. (One supportive state legislator joked that you weren't even considered a native Miamian if you weren't born at Jackson!) And in a *West Wing*-esque moment, Dr. Jones found an impromptu opportunity to slide into a closing elevator with a curious legislator to deliver the pitch.

All told, with weary legs and surging adrenaline, the residents spoke with several representatives of both parties, attended two press conferences, participated in the pink slip campaign, and got a firsthand look at the way policy is made in Florida.

PHOTO CREDIT: CHRIS GORMAN/CIR

Jackson Memorial Hospital residents traveled from Miami to Tallahassee to deliver "pink slips" to the governor and lobby their state legislators to support the safety-net hospital.

"I was energized by seeing the effectiveness of presenting an organized message as we did with CIR and SEIU lobbying together," said Dr. McShane. "We are the future of health care and legislators listen to doctors. It is our duty, as providers, to speak for our needy patients who often do not have a voice."

increase, guarantee reimbursement for hospital-mandated licensure, and expand reimbursement benefits for educational expenses.

- At **Valley Consortium** in Modesto, California, contract teams successfully countered management's stiff demands and preserved important benefits: the new contract will put a cap on members' out-of-pocket healthcare contributions, guarantee meal provisions for all residents when on duty, and maintain a bilingual pay differential.

- CIR members ratified a groundbreaking three-year contract renewal with **Bronx-Lebanon Hospital Center** in New York City. The resulting agreement features a hospital-wide initiative for improving patient care and reducing excess costs. Through the program, residents stand to earn pay increases by working toward targeted improvements in the efficiency, quality and safety of the hospital's patient care programs.

Bronx Politicians Come Out for St. Barnabas Residents

PHOTO CREDIT: ERIN MALONE/CIR

On March 25, Bronx elected officials joined CIR in a press conference to demand a fair first contract for housestaff at St. Barnabas Hospital.

Remembering Dr. Ladi Haroona

It is with great sadness that CIR mourns the passing on February 24, 2011 of Dr. Ladi Haroona, who served as CIR President from 1998-2001. Dr. Haroona leaves behind a powerful legacy from his leadership of CIR and involvement with his local community.

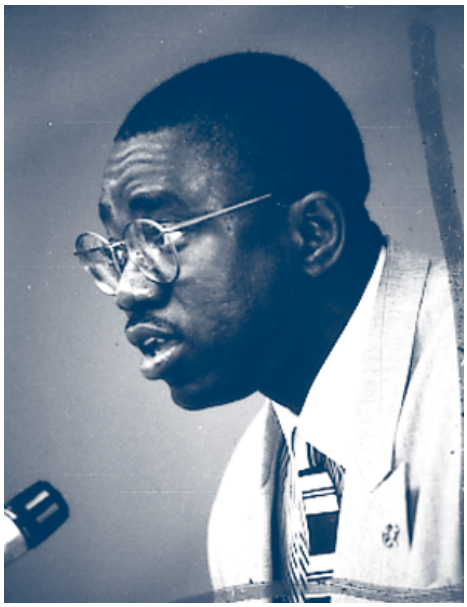
He joined CIR during his internal medicine residency at Harlem Hospital, and went on to train in Pulmonary and Critical Care and Sleep Medicine at SUNY Downstate Medical Center and Newark Beth Israel in New Jersey. He was a founding member of the APCCC Pulmonary Group in Fort Worth, TX, where he lived with his wife and two children. In addition to his medical practice, he was a respected leader at his local Islamic Center.

During Dr. Haroona's tenure as CIR president he oversaw tremendous changes for the union—joining SEIU, winning bargaining rights under federal law for resident physicians, pressing to win the first ACGME limits on work hours and adding new hospitals and members to CIR.

Dr. Haroona followed CIR's activities throughout his career. As recently as fall 2010, he commented on the CIR website on relief efforts in Haiti: "I am happy to see that CIR continues to participate in giving hope to the less endowed members of our communities, and now all over the world."

CIR members and staff who worked with Dr. Haroona recalled his energy and warmth. "Ladi Haroona was one of the most genial and ebullient people I have known," said Dr. Ruth Potee, who succeeded Dr. Haroona as CIR President. "He had a huge smile, an enormous embrace, and was filled with a generous spirit. CIR was lucky to have him at the helm and I was lucky to have called him a colleague."

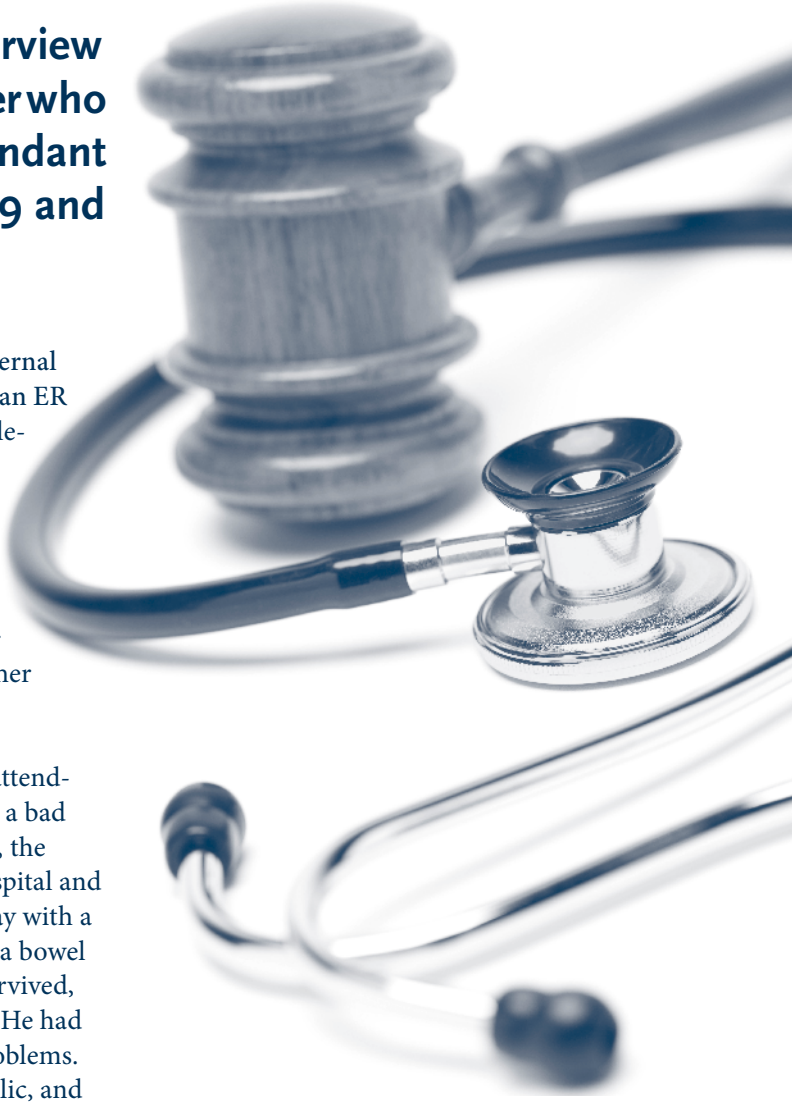
A theme that resounds in his work with CIR was the need to restore honor to the medical profession.



"Let the seniors among us take an active interest in the overall welfare of the junior colleagues," he wrote in a *CIR News* column in 2000. "Let us enthrone a safe training environment that upholds the sanctity and dignity of human lives, including those of the interns and residents. I enlist your support in making the medical profession noble once again."

When Residents Are Sued: One p

The story below was taken from an interview with a former Massachusetts CIR member who agreed to share her experience as a defendant in a malpractice suit that started in 1999 and continued through 2009.



Dr. J was a second-year internal medicine resident doing an ER rotation. She saw a middle-aged man who was very ill and had abdominal pain. Over the course of a few hours, she wrote the initial H&P, ordered some tests, and recorded the initial results. That was the extent of her interaction with the patient before another resident and the attending took over.

Three years later, in her first year as an attending, she was served with a summons for a bad outcome and was sued. As it turned out, the man had improved somewhat at the hospital and was sent home, but returned the next day with a rare complication and ended up having a bowel resection and sepsis. Surprisingly, he survived, although the complications were lethal. He had a short bowel, which meant ongoing problems. The man had been homeless and alcoholic, and after the incident he became even more marginalized. He died five years later.

He sued the residents and the hospital, alleging that they should have made the diagnosis, but it was a very rare diagnosis, involving a congenital defect, and would have been very difficult to make in an emergency setting, Dr. J explained. After he died (a year or two after initiating the case), his sister became the plaintiff. Then she died, and his daughters became the plaintiffs, resulting in still more delays. At one point, the plaintiff's lawyer decided to sue someone else—the patient's gastroenterologist. All in all, the case came to trial 12 years after the incident, and seven years after the patient's death.

"The case was like a Hydra," Dr. J said. Every six months, they would send her a letter saying that there was no update, or that the case had gone to probate court and now a new person was the plaintiff. Every time there was another letter she would feel panicked.

The notice of the suit itself came three weeks after Dr. J's second child was born. She found this package by the doorstep and thought, "What the hell is this?" It didn't make sense. The incident was three years earlier, and she saw the patient for three hours; she couldn't even remember him. "When you get the summons, you have to respond within three weeks; you can't just ignore it. With two children, that part of the process was very difficult," she said.

The initial allegation at the trial was not making the correct diagnosis. By the first day of the trial, the lawyer wanted to sue for wrongful death. The judge asked for the death certificate, but

For more personal accounts from physicians who have been involved in malpractice suits, visit http://cir.seiu.org/vitals

hysician tells her story

they couldn't find it. The "records" Dr. J received from the case were a mess. Dr. J had written in the chart that there had been a chest x-ray done on the patient, but they couldn't find the x-ray, so the plaintiff's lawyer could argue that no x-ray had been done. After three years, they found the x-ray.

"It's arbitrary what records can be found on any given day—whoever happens to be the medical records clerk will just send you whatever they can find, but it's possible that pieces of evidence are lost somewhere," Dr. J said.

Before and during the trial, there were all of these questions about what happened and what Dr. J thought at the time, from her own lawyer and then, on the stand, from the plaintiff's lawyer. "You don't want to look like a complete jerk saying you don't remember, but actually it's better; you really didn't know."

Dr. J felt fortunate that the attending on the case was a person with integrity, because sometimes in the courtroom it felt like the plaintiff's lawyer was trying to create a "shoot-out between residents and attendings."

"The case was like a Hydra."

The trial was very difficult, and there was a lot of esoteric medicine brought up, Dr. J recalled. In the end, the jury was somewhat divided, but decided in favor of the doctors; the court ruled that there was no negligence.

"It's a sad story because the man really was injured," Dr. J said. "I didn't think that we could have made the diagnosis, but the allegation that he should have been admitted to the hospital was reasonable. The man was very bitter. He had a very difficult life. In the end, there wasn't any compensation for him."

Reflecting on her own growth as a physician, Dr. J said, "Overall, it made me a better person and a better doctor; you learn things about yourself. I don't think I became more paranoid, but more careful in a sense, even if something seems straightforward." She became more likely to acknowledge uncertainty in diagnosis.

"Patients appreciate being told that 'It's an art, and nothing's a hundred percent, so please call back if something happens or you're worried.' People appreciate hearing your line of reasoning, they're less likely to sue, and it's better medicine."

Dr. J currently works as a primary care physician at a small private practice, focusing mainly on geriatrics and internal medicine. Her name was withheld to protect the parties involved in the case.

For additional resources regarding medical malpractice, the tort system, and disclosure, apology and mediation, visit: http://cir.seiu.org/MedMal

Disclosure & Apology 101

Many CIR members report that their training in medical malpractice issues is lacking. Post-adverse event disclosure and apology is a policy that is designed to address what the tort system fails to accomplish. Consider this a crash course in litigation versus disclosure and apology:

1. **The tort system is broken.** Medical malpractice litigation is not very good at achieving its goals of fair compensation for patients who are injured by medical error or deterring future malpractice.
2. **Ineffective communication encourages lawsuits.** Research shows that the factor that puts physicians at the most risk of being sued is not the quality of medical care or actual negligence, but ineffective communication with patients and their families, who will often sue to obtain "the truth" if they feel the hospital and doctors are being evasive and they are being denied information.
3. **Mediation is affordable, efficient and supportive.** Mediation, often paired with disclosure and apology, helps the patient and defendants achieve a fair financial outcome much faster and much less expensively than litigation, while providing an emotionally supportive element that is missing in litigation.
4. **Disclosure improves health care.** The model of disclosure, apology and early offer of fair compensation can be integrated into a system that encourages and makes use of reporting of errors, near misses, etc. This can help hospitals and physicians become better healthcare providers and more quickly identify and address patient safety problems that are caused by hospital systems, rather than by individual doctors.
5. **Hospitals still practice a "culture of silence."** While many hospitals officially have disclosure and apology policies, fear of litigation continues to inhibit full and effective implementation of these policies.

The only number that matters regarding hospital-acquired infections is ZERO

Words of Wisdom from a Patient Safety Leader: Dr. Richard Shannon

The incidence of medical errors may be 10 times higher than previously thought, according to a study published in the April 2011 issue of *Health Affairs*. This is a crisis with an enormous human cost. It also poses a huge financial burden for hospitals, particularly safety-net institutions that often operate deep in red ink.

CIR and the NYC Health and Hospitals Corporation co-hosted a one-day conference last October on reducing hospital-acquired infections. As chair of the Department of Medicine at the University of Pennsylvania Health System, keynote speaker Dr. Richard Shannon championed a team-based approach to standardize care and eliminate medical errors.

Here are some highlights of Dr. Shannon's talk. Video clips of his presentation are available on the CIR Policy and Education Initiative website www.cirpei.org.

DON'T SIT BEHIND A DESK

"The only way you can tell if your leader is a great problem-solver is if you see them at the point of care. No problem is solved in a board room. No problem is solved over lunch looking at data…. The problems of patient safety are solved at the point of care…. And you should actively invite your leaders to come and see, and engage in understanding your work."

STANDARDIZATION

"Hospital-acquired infections are not inevitable; they are the product of unreliable systems and a failure of leaders to be accountable for that. They are fully preventable."

Dr. Shannon related the example of a team of nurses who standardized a way to remind ***all*** health care providers (from housekeepers to attendings) to keep the head of the bed elevated. They drew a red line on the wall 30 degrees above each bed and mounted signs reading: If you see red, elevate the head!"

"It's great stuff! Not high-tech. No $2.5 trillion to fix that," said Dr. Shannon.

FLATTENING THE HIERARCHY

"What [great] leaders do is they don't hold power to themselves; they empower every worker to engage in patient safety. If we're going to be high performers, we have to flatten the hierarchy and engage leaders at the point of care to fix this problem."

"Nurses are the guardians of patient safety. Empower your nurses. They are the ones who know what the problems are and they know how to fix them – they need your support to be able to do it."

DATA MUST BE ACTIONABLE

"How can you engage a workforce with a metric that says 'per thousand line days?' These are the games we play when we're not engaged in improving but we're preoccupied with reporting. Data must be actionable!"

Dr. Shannon explained that on seeing the variation of central line-associated infections in his 26-bed ICU, "The first thing we did to dumb ourselves down was we averaged the data; we took away the variation which was the problem. Then you find a comparator against which you compare favorably…

"[But] do you really need to compare Hospital X to Hospital Y, as opposed to saying 'What is the progress that Hospital X and Hospital Y are making to the only number that matters, which is zero?'"

"As a leader I declared that these 26 beds would no longer accept anything but zero; that we would eliminate central line infections in that [ICU] unit within 90 days. This is the leader declaring an unambiguous goal. I didn't say 10 percent in two years, I said zero. People laughed, they said, 'He's out of his mind.' But I would submit to you, if you're not bold in establishing the goal, you will not capture the energy of workers because they have a lot to do. [Patient] Safety must be a precondition of work."

REPORT THAT NEAR MISS!

New York State resident physicians are contributing valuable data to save lives through the Near Miss Project and Reporting System. A project of the NY Chapter of the American College of Physicians and sponsored by the NYS Department of Health, the Near Miss project collects anonymous, confidential accounts related to "near miss" incidents – acts of omission or commission which could have harmed a patient had the mistake not been identified. The data is an invaluable tool for understanding the barriers to safety and for developing effective practice and prevention techniques.

The system is 100 percent secure and confidential. Go to **www.nearmiss.org** and do your part for patient safety!

PERSPECTIVE | Dr. Realba Rodriguez

Language Barriers in Health Care

Adapted from Dr. Rodriguez's speech to legislators in Albany, NY on February 19, 2011

When I was asked to share my experience with language barriers in health care, I felt there was so much I could share, because the lack of physicians who are able to speak Spanish in NYC was my motivation for moving here from Puerto Rico, where I was born and raised. Given that the Latino community is one of the biggest populations in the city, I was amazed at the small number of physicians who could truly communicate with their patients.

I started rotations throughout different hospitals in the Bronx in my third year of medical school. Immediately, attendings and residents were requesting my help with their Spanish-speaking patients. The frequency of their requests quickly became overwhelming: "Can you please explain this procedure?" "Can you tell him he is going home?" "Can you tell her she has CANCER…?" As my years of medical school came to an end, my concern about language barriers grew stronger. How will physicians know what is wrong with their patients? How will physicians understand them? Their language? Their culture?

As a resident, I witness more and more of my colleagues struggling to convey important information to their patients, sometimes even wondering why their patients do not follow up as advised. Facing this situation on a daily basis, I was inspired to start a medical Spanish class for my colleagues. My primary goal was to teach them how to ask for common complaints and understand key words during their interviews. To my surprise, residents, fellows, and even attendings began participating in the class.

To date, we have carried out almost two years of classes. Considering the improvements I see every day in my "students," I believe there should be some formal training for physicians and health-related professionals in cultural competency. New York City is called "the melting pot of cultures," but we as physicians are sorely lagging behind. Let's get educated on more than just blood pressure management or the newest chemotherapy available. Let's train ourselves to communicate with our patients and fulfill our mission to serve them.

I know that new policy proposals or regulations to reduce language barriers will lead to some resistance. And we as physicians are often the most rigid participants when asked to adopt new changes. It seems that unless the government is strongly behind these new policies, and there are changes in the system to ease the transition, the vast majority of physicians will not adopt them.

To encourage healthcare professionals to learn other languages, we first need to address those predictable causes of resistance, such as:

- **Lack of available time.** Use simple lesson plans that can be practiced in short periods of free time.
- **Cost.** Courses are expensive. Government should offer some type of reimbursement or incentive.
- **A steep learning curve.** Make available lessons designed by experts on teaching Spanish for medical professionals.

We must take a step back and ask ourselves, "How many Spanish-speaking residents and fellows practice medicine in the Bronx and in other heavily Latino or Hispanic communities? Why do we not include more doctors-in-training who speak the predominant and diverse languages of these underserved areas?"

These are just some of the ideas that we can propose to our colleagues and to the legislators to help healthcare professionals overcome language barriers with their patients. The non-English-speaking community continues to grow, and we will need more physicians that can serve them and serve them well.

Dr. Realba Rodriguez is a PGY 3 in Internal Medicine at Montefiore Medical Center, North Division, Bronx, NY.

In an effort to help residents learn the languages of their patients, CIR has negotiated a significant discount on Rosetta Stone for all CIR members. Visit http://cir.seiu.org/RosettaStone2011 for more information.

Expanding Cultural Barriers

54.9 million Americans speak a language other than English at home (19.6% of U.S. residents)

A growth of 17% from 1990-2000

24.1 million Americans speak English with limited proficiency (8.1% of U.S. residents)

A growth of 9.5% from 1990-2000

2009 America Community Survey

SPOTLIGHT ON | DR. MATT VASEY

Making Medicine Fashionable – Lincoln Doc Adds Celebrity to Health Education

In the tents at New York's Spring and Fall Fashion Weeks, it's not unusual to see models, actors, designers, paparazzi, and of course, cameras. But only one of the people behind those cameras doubles as an emergency medicine doctor at a South Bronx hospital.

Dr. Matt Vasey, a PGY 1 at Lincoln Hospital, produces and edits an online publication, the *New York Journal of Style and Medicine* (www.nyjsm.com), featuring celebrity interviews, photos and research studies designed to capture the attention of young adults and educate them on preventive medicine.

Dr. Vasey's drive to reach out to young people about health issues started in medical school. "I was on the inpatient service and I realized how sick the patients were, and you really do a lot of symptom management and getting them back to baseline so they're able to resume their lives," he explained. "But if you want to make a change, you have to start in the 20s and 30s."

With that goal in mind, the "celebrity consults" on the site feature stars like Denise Richards, Kelly Rowland, Nigel Barker, Vanessa Williams and Brook Shields, calling attention to a health issue or a cause they're involved with. Dr. Vasey hopes that the entertainment value will attract people who in turn become intrigued with a medical topic on the site and leave a little more educated.

Dr. Vasey's reputation is growing. He has appeared twice on The Tyra Banks Show as a medical expert. In an effort to build his brand, he's developing a line of clothing, named Bardini after his mother's maiden name. For each $30 t-shirt he sells, he's donating $1 to the Emergency Medicine program at Lincoln Hospital.

It sounds like a lot to balance. But for Dr. Vasey, it provides an outlet for the pressures of residency.

"It helps me cope with some of what you deal with in the Emergency Department," he said. "If someone dies, you can't change anything about it…but to come home and write an article about why someone died, the science of how you can die from an asthma attack or a drug overdose, it's very rewarding."

D.C. Housestaff Tell Fellow Hospital Employees "You Rock"

PHOTO CREDIT: ERIN MALONE/CIR

The pediatric housestaff at Children's National Medical Center make sure that their fellow hospital employees know they are appreciated. Every month the housestaff vote to recognize a support staff member that has gone above and beyond the call of duty to make residents lives a little easier. Each honoree gets their own special rock painted by the housestaff and a $10 Starbucks gift card.

The tradition has existed in the residency program for a number of years. "It's really a fun thing," said Dr. Robert Kavanagh, PGY 2. "When you start residency you quickly realize that it can be adversarial but this helps people get along. If someone's nominated that you don't know, you make an effort to look out for them in the future."

D.C. FACTS

Hospital: Children's National Medical Center

CIR Chapter Founded: 1991

Location: Washington, D.C.

Number of Housestaff: 90

Specialties: Pediatrics

Academic Affiliation: George Washington University

Fun Fact: In a tradition dating back to Bess Truman, each Christmas the First Lady pays a visit to the pediatric patients at the hospital.

Understanding Medicaid: The Lifeblood of CIR Hospitals

Most CIR resident physicians train in safety net hospitals, caring for patients who often have nowhere else to go. Medicaid coverage is a lifeline for many of our patients—and it's also the lifeblood for our hospitals, covering 60 million low income Americans, including seniors, children and those with disabilities.

The slowly recovering economy continues to put stresses on Medicaid like never before. For one thing, healthcare costs continue to rise faster than inflation. The cost controls of the recently passed *Affordable Care Act* will give some relief in the long term, but those that most directly impact Medicaid will not be implemented until 2012 and beyond. Secondly, Medicaid serves an expensive population; nearly two-thirds of the program's cost goes to provide care for only about one-fifth of the patients covered – the elderly and those with disabilities, particularly if they need long-term care.

Finally, the demand for Medicaid increases when times are bad because more and more people lose their benefits with their jobs, or because their income drops dramatically. But when times are tough, states look for ways to tighten their belts since they generally cannot borrow money to balance their budgets. As the second most expensive line item in most state budgets, Medicaid is an inevitable target for cuts.

Medicaid is a joint federal-state coverage program, meaning that the federal government matches each state's funding to cover the full healthcare costs of eligible patients. Since the economic crisis of 2008, most states have cut their Medicaid budget, effectively creating a double cut as they also lose the matching federal funds. The American Reinvestment and Recovery Act ("the stimulus") provided extra federal dollars to the states for Medicaid, softening the financial hit, but that program expires this year and its renewal is unlikely, given the political and economic climate. That means our states are being forced to make very tough choices, but CIR residents are speaking up to defend their patients and their hospitals.

PHOTO CREDIT: BILL BRADLEY/CIR

Dr. Nate Link, Pediatrics resident at UNM, speaks out against Medicaid cuts.

In New Mexico, attempts to cut coverage for thousands of people and significantly pare back physician fees was rebuffed, thanks in part to the advocacy of CIR residents in Albuquerque and Santa Fe. But the fight is far from over, and CIR leaders at the University of New Mexico continue to share the stories of the patients who are hardest-hit by impending cuts.

In New York, Governor Cuomo convened a Medicaid Redesign Team to not only cut $2.3 billion from the state's share of Medicaid, but to fundamentally transform the program to improve patient care. Throughout the process, CIR leaders were an important voice, sounding the alarm about the potential dangers to safety-net hospitals from further across-the-board cuts, and insisting on reforms that emphasize quality improvement and the elimination of health disparities.

In California, the state has repeatedly cut services, including caps on the number of prescriptions filled or doctors' visits for beneficiaries, and CIR physicians have been among those explaining the dire repercussions such limits would have.

"What is most striking over the last three years has been the influx of MediCal patients into LA's public hospitals," said Dr. Michael Core, CIR Regional Vice President for Southern California. "Where once they might have gone to another private hospital, MediCal patients are now overwhelming our subspeciality and surgical services. Few subspecialists seem willing take MediCal these days because of significant and repeated cuts to physician reimbursement. It is so poor that few private primary care providers are taking new MediCal patients either. The percentage of MediCal patients seen in my county primary care clinic increased two percent in one year. That may not seem like much, but that is approximately 1,200 extra patients being seen in an already overwhelmed system."

"Let me be clear—these are just the results of state cuts to MediCal," Dr. Core added. "But now we're hearing rumblings from Washington about draconian cuts at the federal level as well. Simply put, this would be a disaster."

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Top 5 Tips from the CIR Post Residency Workshop

Each year CIR hosts Post Residency Life Workshops, educating residents on financial planning, asset protection and negotiating individual employment contracts. If you missed out, here are a few of the major takeaways from the experts:

1. **Financial planning is about making set, defined, time-specific goals** for yourself and your family, and then sticking to them. This can be done whether you have accumulated large amounts of wealth or are struggling to pay off student debt.
2. **A physician's earning potential is his/her greatest asset.** Disability insurance is a key method for a physician to protect that asset.
3. **Creating a trust is an important way to protect money and assets** from potential creditors and liability claims.
4. **An employment contract may sometimes be written by an entirely different person or group than the one that offered you the job.** Keep track of what you are being promised during the recruitment process so that you can compare and make sure that the things you are promised have been included in the written contract. If a promise by the employer is not written into the contract, it doesn't exist.
5. **Have a lawyer review any employment contract you're offered**, because it is likely that the contract was drafted by the employer's lawyer.