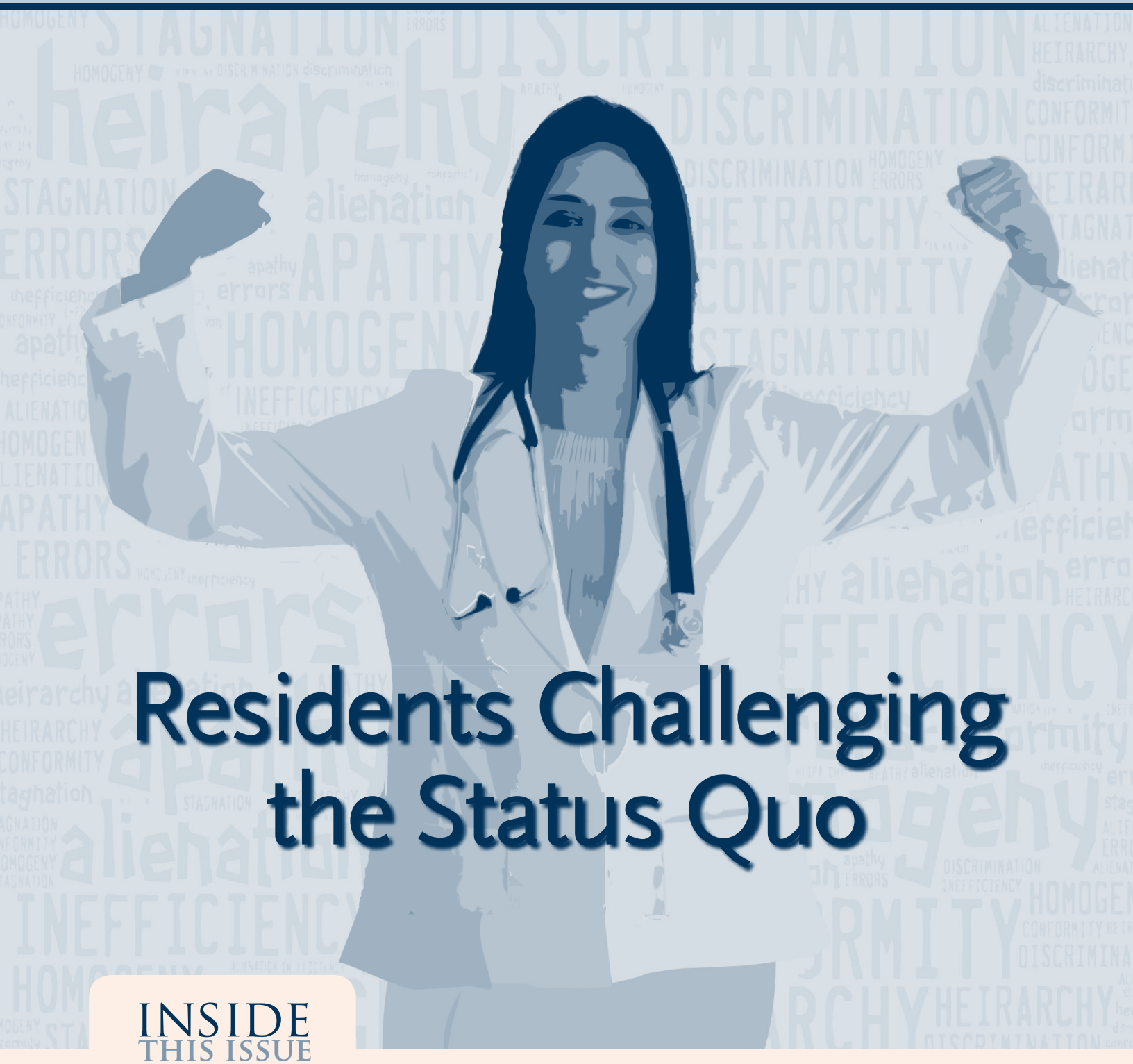
CIR VITALS

Summer/Fall 2013



Residents Challenging the Status Quo

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PRESIDENT'S REPORT | SEPIDEH SEDGH, DO

CIR is a Big Tent

I'm very proud to have my inaugural President's Report appear in this issue of CIR Vitals focusing on women in medicine and the diverse and energized leadership that we need to help improve residency training and transform our ailing healthcare system. CIR is the 'big tent' under which we can achieve many great things.

First, I'd like to tell you a little about myself. I'm a Pulmonary and Critical Care Fellow at Maimonides Medical Center in Brooklyn, New York, where I completed my residency in Internal Medicine and also served as chief resident. I was fortunate to join CIR as an intern and I haven't looked back. I was part of the amazing team that negotiated CIR's first ever Quality Improvement collaboration with our hospital. That contract language produced a hospital-wide project on medication reconciliation that resulted in improved patient care and poster and journal publication!

We can start the culture change that will make medicine a profession where we all have a voice.

For the past three years, I have served on the CIR Executive Committee, working with my colleagues through a process that defined CIR's core values of advocacy, service, community and learning. Those values have really influenced our priorities and programs this year. I've been proud of our advocacy efforts for our patients, our safety net hospitals, and our service to the community. We have devoted energy to building a community among residents in the hospital and beyond. And we continue to promote learning through

conferences, QI initiatives, and teach-ins on the ACA and other policy issues.

We are striving to unite residents for a stronger voice to build a more just and effective healthcare system. And we're focusing on new organizing. Since so many residents outside our hospitals also share CIR's values, it's time we welcome them into our community and see what we can accomplish as we continue to capitalize on the fact we are the largest house staff organization in the country.

CIR also wants to give our members the opportunity to develop into leaders—and that means all our members. When the challenges facing women in medicine come up in our meetings, there are some recurring themes. Most women can recount being called "nurse" by someone on their first day of work (and many times after that). Physicians of color report similar experiences. There's a culture in hospitals that makes it easier for male physicians to automatically be accepted and advance in the profession.

My own experience was no different—it was just accepted that you had to go through a couple of months of proving yourself in order to be accepted. If you showed any emotion during those trying times, you would lose ground.

When we share our experiences as women in medicine, it opens the door for underrepresented minorities in our profession to speak up as well, and encourages all of us to call out harassment and discrimination when we see it. By doing this we can start the culture change that will make medicine a profession where we all have a voice.

CIR is a big tent under which all of us can learn and thrive—welcome!

CIR VITALS
Committee of Interns and Residents/SEIUHealthcare.

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Metro NY Labor Communications Council

International Labor Communications Association AFL-CIO/CLC

2013 CIR Convention Highlights

Our National Convention is a time when CIR delegates from across the country come together to review the work of the past year and chart the course for the year ahead. 2012-13 included some big milestones, from advocating on behalf of residents and our patients to implementing life-saving quality improvement projects in our hospitals and strengthening our membership. Resident leaders continue to raise the voice of residents for our patients and our learning and wellbeing.

Right: Dr. Linda Pololi, Director of the National Initiative for Gender, Culture and Leadership in Medicine: C-Change. A nationally-recognized researcher, Dr. Pololi spoke on leadership development and the culture of academic medicine.

Above: Dr. John Schumann, the Internal Medicine Program Director at the University of Oklahoma School of Community Medicine, addressed the house of delegates on the importance of "civil non-conformity" in medicine. Dr. Schumann is a former CIR leader from Cambridge Health Alliance.

Above: Delegates from all seven regions broke out into separate regional meetings. Pictured above, New Jersey delegates met to strategize programming and set priorities for the upcoming year.

Above: Delegates attended workshops to hone their leadership skills for the year ahead. The workshops included themes like treating urban violence, cost of care, quality improvement, media training, patient advocacy and women in medicine.

Right: The 2013 convention saw the very first alumni CME track. CIR alums practicing in the Boston area were invited for a luncheon and talk by Dr. Stephen Martin, a former CIR leader from Boston Medical Center, on the crucial role of safety net institutions in healthcare reform.

CIR Contract Victories around the Country

The Boston Medical Center bargaining team celebrates after another successful round of contract negotiations.

Massachusetts

Tough financial times have beset Boston Medical Center in the last few years, but residents proved how much they can achieve if they stick together. PGYs 1-3 won long overdue salary increases of 2 percent and PGYs 4-8 received a 1.5 percent increase—all retroactive to Oct 1, 2012. Housestaff also convinced the hospital to move their education allowance from a bonus to a reimbursement system. The tax savings mean members will see an over 50 percent increase in the amount of money they receive from the allowance ($750/year per house officer).

Florida

Jackson Memorial Hospital in Miami has struggled financially, and it had been five long years without a new CIR contract. But resident leaders persevered and on May 7, CIR members ratified a contract providing raises, protecting benefits and creating a housestaff community involvement fund.

The hard-fought CIR contract features an approximate 5 percent pay increase for the hospital's 1,100 residents.

Residents also negotiated solutions for housestaff who are too fatigued to drive home after their shifts. The Housestaff Community Involvement Fund of $125,000 paid by the hospital each year will be used for quality improvement, patient care and community health projects.

Residents also were able to rollover funds in excess of $100,000 from the previous patient care fund, which currently has 2 pending projects. "After months of negotiations, not only were we able to keep our excellent benefits, but we were able to get a salary increase and a quality improvement fund. Everyone deserves commendation and recognition for their hard work. It's victories like this that make CIR such a vital organization and make me proud to be a member," said Dr. Matt Carlile, CIR Regional Vice President.

New Mexico

The housestaff bargaining committee at the University of New Mexico continued its tradition of championing resident well-being by establishing a 24-hour gym in the resident lounge. They also were able to double their annual Quality Improvement Fund—now $20,000—to be used on a variety of projects throughout the hospital focused on patient care and satisfaction.

As hospitals continue to utilize mobile technology for both record keeping and patient care, residents used their voice at the bargaining table to make sure they had input on the transition from desktop and paper to hand-held mobile devices. As part of the hospital-wide electronic working group, housestaff negotiated for language in their new contract that ensures computer problems are resolved in a timely manner and reviewed monthly. The final contract also included salary increases for PGYs 1-3 and a $15,000 increase in their Patient Care Fund (now $45,000 each year).

California

As new ACGME requirements put increased emphasis on quality improvement in residency, CIR members found a way to address those requirements at the negotiation table. The family medicine program at Sutter Medical Center of Santa Rosa fought for a contract that included a Patient Care and Quality Improvement Fund of $12,000 for resident "fire-starter" projects. It's the first time the Sutter chapter will have a patient care fund. Residents also won salary increases for all PGY levels and an increased hourly rate of $45 per hour for unscheduled shifts covered on weekends, holidays and weekdays after 7 pm. Each resident will also be entitled to $3,100 annually for medical meetings, professional seminars, examination and license fees, damaged personal property, books/periodicals, medical equipment, electronic equipment, hardware or software.

Washington, DC

St. Elizabeths Hospital residents work diligently to maintain the hospital's public service mission of serving individuals with serious and persistent mental illness. Residents work in a newly built, state-of-the-art hospital and soon will be working under a newly-negotiated contract that features a 3 percent wage increase for the next three years, effective April 2013. The amount of money available to residents to present at conferences nearly doubled to $1,850. Residents voted unanimously to ratify the new contract and were scheduled to receive their wage increases in August.

Kern Residents Win 15% Salary Increase after Public Campaign

The resident physicians at Kern Medical Center in Bakersfield, CA have ratified a new two-year contract that provides a 15 percent, across-the-board salary increase, a one-time travel reimbursement of up to $1,500 for an education conference, and quarterly labor-management meetings.

The contract was settled days after the residents held a letter-writing campaign and rally urging Kern County officials to come to the bargaining table and negotiate a fair agreement.

"Bakersfield deserves well-rounded physicians," said Dr. Sarah Assem, an internal medicine resident and CIR delegate. "They deserve for the competitive residents to come to KMC and then to stay here and open up their own primary care practices, because in the end, that's the goal of having a residency."

Over 80 people, the majority interns and residents, attended the June 4 rally and press conference in front of the hospital. The campaign garnered media attention after CIR leaders presented research showing that Kern County residents were the lowest paid in the country, with interns starting at $40,500 a year.

The nurses' union, SEIU 521, also put pressure on the county to negotiate decent wages for the residents.

"When I heard that our physicians-in-training are the lowest paid in the nation, I was appalled," wrote Carmen Morales, a nurse practitioner and Vice President of Local 521, in an op-ed. "I value their strong work ethic and consider them to be steadfast teammates at KMC. Kern County faces a physician shortage, and residency serves as the best recruiting tool for bringing high caliber doctors to the region."

The new contract took effect July 1, 2013.

Kern County residents rally outside of the hospital for equitable pay and working conditions.

CIR Members Help Pass Paid Sick Days Bill in NYC

New York CIR members saw more than two years of activism and advocacy pay off in a major victory for their patients and the city as a whole. On June 27, the New York City Council voted to overturn Mayor Bloomberg's veto to make paid sick days a reality for all New Yorkers.

To help pass the Paid Sick Days bill, CIR members engaged in a campaign to help local officials understand the depth of the public health crisis caused by a lack of time off when ill and its great effect on some of the city's most precarious workers. Dr. Michelle Espinoza, a Family Medicine resident at Jamaica Hospital, spoke out at a rally of healthcare professionals in favor of the new law.

"I've had multiple patients experience complications because they could not follow up with me, their primary care doctor," said Dr. Espinoza. "One of my patients used all of her time off to take care of her daughter with cerebral palsy. When we discovered that she had lupus, she needed to come in for even the slightest cold yet she wouldn't take time off for fear losing her job. She ended up in the ER with severe complications."

Starting in April 2014, the law will require that businesses with 20 or more employees provide five paid days of sick leave. In October 2015, the requirement expands to small businesses with 15 or more employees. The law also protects workers from being fired for taking sick leave and also allows them to choose to work extra hours instead of taking sick time.

"I'm hopeful that this will really change things for my patients," said Dr. Espinoza. "Our patients have been dealing with these struggles for so long, and I was glad that I could speak up and have some impact on this issue.

"When I tell my colleagues about my experience delivering a speech on the steps of city hall, I can tell they find that a daunting prospect, but my experience was positive. We get so bogged down in our day-to-day work that we don't see how we can make a broader impact. But we are the future leaders in this changing profession. We have to speak up."

Introducing the CIR Network

At the 2013 National Convention, the CIR House of Delegates voted overwhelmingly in favor of creating a brand new membership category for CIR—The CIR Network. The Network provides a way for interns, residents and fellows to join CIR individually at hospitals that do not already have a CIR chapter with a collective bargaining agreement.

A Path to Physician Leadership

"The idea to create this new membership category stems from the strong interest we see among residents and fellows who have joined us in our advocacy work," said Dr. Flavio Casoy, CIR Vice President. "These residents identify with CIR values and care about issues like quality improvement, access to care and health disparities, but many train in hospitals where it will be difficult to organize a traditional CIR chapter. The CIR Network will allow those residents to participate in

"CIR is also a pathway to being a better advocate for our patients."

and support that work they find so vital to our profession and our patients."

CIR Network members will be able to vote in CIR elections, run for CIR office and have access to member-only discounts. Their dues will help sustain CIR work and allow the Network to grow into a powerful voice for residents nationally. Since Network members are not training at a hospital with a traditional CIR chapter that has collective bargaining rights, they will not have the contractual benefits that members in existing CIR hospitals currently have.

A Home for Healthcare Advocates

Dr. Ismet Lukolic, chief resident in Internal Medicine at SUNY-Downstate, got to know CIR through his connection to the chapter at Kings County Hospital.

Dr. Ismet Lukolic, SUNY Downstate, IM Chief Resident, addresses houses of delegates on the value of membership for potential CIR Network members.

"I've been active in CIR through the Healthy Bronx Initiative. CIR has demonstrated commitment to the community and I see it as a valuable asset to residents and hospitals," said Dr. Lukolic. "I'd like to see CIR more inclusive of non-members like myself because it's not just about collective bargaining. CIR is also a pathway to being a better advocate for our patients."

Dr. Jessica Eng served as a strong political advocate during her residency at Boston Medical Center. Most notably, she visited the White House to lobby against cuts to Medicaid and Medicare. She says the network will allow her to maintain a connection to the union and the advocacy she valued during residency.

"CIR has become an integral part of who I am as a doctor and I've really learned a lot throughout my time as a member," said Dr. Eng, who planned to join the Network in order to continue supporting CIR political advocacy work through the Political Action Fund.

"What I love about CIR is the way it helps me advocate for my patients," said Dr. Eng, now in her second year of a patient safety fellowship at the VA hospital in San Francisco, CA. "CIR really helps me find the opportunities so I can use my time wisely. I really treasure that time when I'm able to go outside the hospital and make a difference for my patients."

A Strong Voice for All Residents

"The CIR Network is primarily about building a stronger resident voice in turbulent times in healthcare," said Dr. Rick Gustave, CIR New York Regional Vice President.

"Our training is undergoing major changes, access to healthcare is expanding for patients and our hospitals are facing increasing financial challenges. Both as present-day trainees and physician leaders of the future, we need to be present in all of these discussions. Having a larger membership puts us in the best position for a seat at the table as these developments unfold. In time, we could even see a critical mass in our Network members that would give them the strength to become traditional CIR chapters with collective bargaining rights."

While residents and fellows can join the CIR Network immediately, a public launch of the membership category will take place in Fall 2013. If you have colleagues that might be interested in joining the network, you can point them to **www.cirseiu.org/network**. If you'd like to be involved in helping to grow our membership, contact **info@cirseiu.org**.

WOMEN IN MEDICINE

The 2013 class of medical students has a special distinction. While women have been pursuing medicine in increasing numbers in the past several decades, this the first class that contains more women than men. The trend raises a number of questions about the future of the profession.

How far do women physicians still have to go to gain parity with their male counterparts?

A 2012 study by University of Michigan professor Dr. Reshman Jagsi found that over their careers, women doctors lose $350,000 to the gender wage gap. That study controlled for work hours, area of specialty, and all other career and life choices and found that women still made about $12,000 less each year than similarly qualified men doing the exact same type and amount of work.

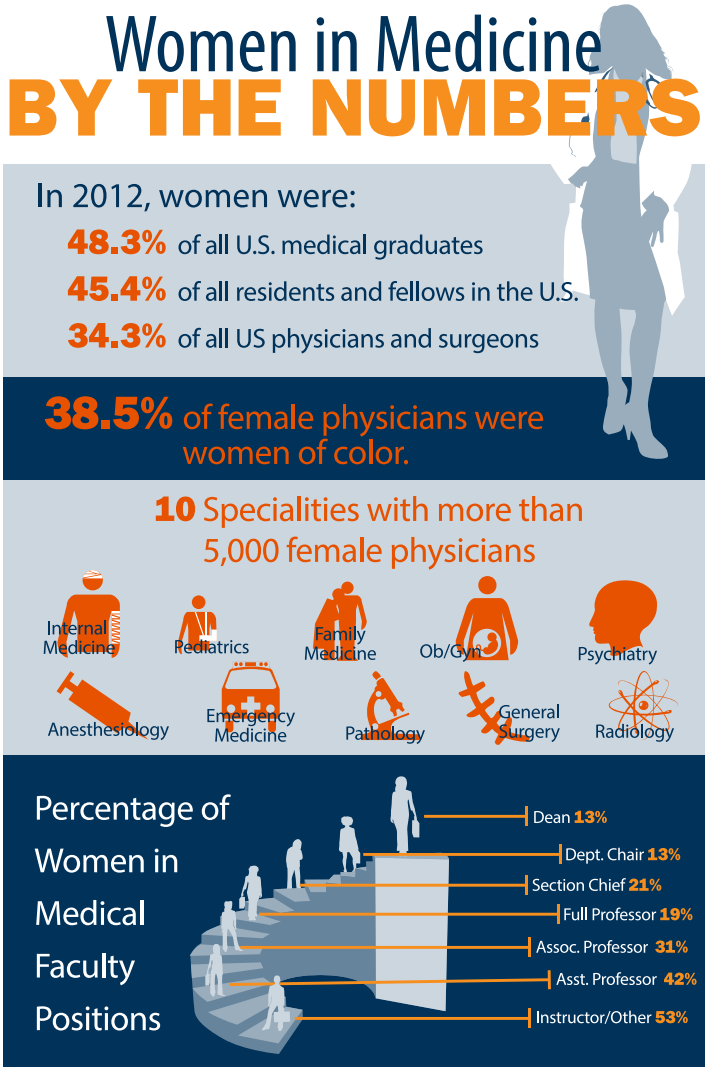
Similarly, in a number of studies, women report a high rate of gender-based discrimination and sexual harassment, compared with their male counterparts, and in some cases, harassment affected women's choices of specialties and ranking of programs. According to a 2000 survey of more than 3000 full-time faculty members at 24 randomly selected U.S. medical schools, about half of the female faculty experienced some form of sexual harassment.

Will medicine and medical education need to undergo a culture shift?

In "Changing the Culture of Academic Medicine" Dr. Linda Pololi examines the medicine though the lens of female faculty. Interviews with these physicians revealed a number of disturbing observations, among them:

- Faculty who profess a love of teaching, research and clinical practice experience a high level of burnout, contemplate leaving academic medicine and would not recommend to others that they become physicians.
- Faculty note an erosion of idealism among medical students and wonder what the implications are for their future practice of medicine.
- Faculty also reported a startling level of unethical behavior among medical researchers.

CIR members' responses to a 2012 survey on resident values corroborate those findings. Of the 324 respondents, 83 percent of the women respondents said they had witnessed colleagues lose sight of values they once held. Female residents rated burnout and quality of life as their number two concern when thinking about their future in medicine. Male residents rated it fourth.



Source: www.catalyst.org/knowledge/women-medicine

How can we develop leadership that matches the demographics of the profession?

While women may start to surpass men in the early stages of the medical career, physician leadership is still male dominated. One other key concern in Dr. Pololi's research is the advancement of women to leadership positions. Women still represent a small fraction of physician leaders in both academic medicine and the healthcare industry yet the record numbers of female medical students show this fact is not due to pipeline issues. How can we ensure that the growth of women in the profession continues up the leadership chain?

These questions raise many concerns about the future of the profession for all physicians. *CIR Vitals* found that doctors and policymakers are working hard to find legislative, collective bargaining and professional development solutions to these challenges.

Gender Equity in Academic Medicine: What are the Remedies?

According to the U.S. Census Bureau, in 2011, women who worked full time earned, on average, only 77 cents for every dollar men earned. The figures are even worse for women of color. African-American women earned only approximately 64 cents and Latinas only 55 cents for each dollar earned by a white male.

Women physicians are no exception. While women have made great strides in academic medicine, the persistent gender wage gap is hard to ignore. While there are no legislative or policy prescriptions that specifically address gender inequities in medicine, there are some national and local remedies that apply to all workplaces.

The Lilly Ledbetter Fair Pay Act

The Lilly Ledbetter Act, signed by President Obama in January 2009, makes clear that pay discrimination claims on the basis of sex, race, national origin, age, religion and disability "accrue" whenever an employee receives a discriminatory paycheck, as well as when a discriminatory pay decision or practice is adopted.

Ledbetter was one of the few female supervisors at a Goodyear Tire plant in Alabama, where she worked for close to 20 years. She filed a complaint after learning that her male colleagues were getting paid much higher salaries for doing the same work that she did. While she won back pay initially, the case was overturned by a higher court, and the Supreme Court ruled that employees cannot challenge ongoing pay discrimination if the employer's original discriminatory pay decision occurred more than 180 days earlier, even when the employee continues to receive paychecks that have been discriminatorily reduced. The 2009 Act restores longstanding anti-discrimination provisions dating back to the Civil Rights Act of 1964.

The Paycheck Fairness Act

This bill, introduced by Senator Barbara Mikulski (D-MD) and Representative Rosa DeLauro (D-CT), would make it harder for employers to hide pay discrimination, help train women and girls about salary negotiation, support government collection of critical wage data, and reward employers that have good pay practices. The bill has been introduced multiple times in both chambers but has been blocked by House GOP members.

Status Of Women Physicians Linked to Advancements in Women's Health

In 1995, the Commission on Graduate Medical Education (COGME) in its Fifth Report, Women and Medicine: Physician Education in Women's Health and Women in the Physician Workforce, reviewed evidence that women physicians have been agents of change in medical education, research, and practice. The report drew attention to the shortage of women in academic leadership positions.

COGME recommended widespread examination of gender pay equity, efforts to increase women's participation in biomedical research, and "potent mechanisms for eliminating gender bias and sexual harassment" of women physicians.

The Employment Non-Discrimination Act (ENDA)

ENDA would prohibit employment discrimination based on sexual orientation and gender identity in most American workplaces. The legislation is scheduled for a vote in the House and the Senate this fall. If passed, it would extend fair employment practices to gay, lesbian, bisexual and transgender people.

Harnessing the Power of Collective Bargaining to Change Residency Culture

CIR members understand the power that comes with the ability to advocate for themselves and their patients through collective bargaining. In addition to negotiating over concerns such as salaries, work conditions and availability of medical equipment, many housestaff have used their bargaining power to help establish a more equitable workplace.

Many of the contract benefits focus on the challenges faced by residents who begin families during their training. For women who wish to have children, deciding whether to conceive during residency can be a difficult decision. It's often a choice between delaying training, managing the hectic work schedule and possibly damaging relationships if their programs are unsupportive or, on the other hand, postponing motherhood and risking lowered fertility, pregnancy complications and reliance on technology.

From maternity leave to child care, residents have used the power of collective bargaining to begin to change the culture of residency that makes the decision all the more difficult.

In Boston, residents at Cambridge Health Alliance have negotiated six months of maternity leave to help foster a culture where residents can take leave without fear of repercussions. Boston Medical Center housestaff negotiated for a new mother room that features pumping machines, a refrigerator and a couch. Residents also have access to the Parents in a Pinch program, which provides affordable backup childcare when regular childcare options fall through.

Mentorship for the Next Generation of Physician Leaders

While physician leaders are forging ahead with policy solutions for profession-wide and industry-wide change and CIR members are using the power of collective bargaining to make inroads at the hospital and program levels, an interpersonal approach to shifting the culture of medicine occurs in offices, clinics and operating rooms every day. For years, women physicians have handed down career advice and personal wisdom to prepare the next generation to carry on and face new challenges. CIR members offered the best pearls of wisdom they have received from mentors and their views on being mentors themselves.

Ask for what you want

Something my mentor once told me has really stuck with me—don't be afraid to ask for things. I realized it was a weakness of mine, and I think it's something that a lot of my female colleagues struggle with. We think: "I'm going to prove myself, I'm going to do a great job with the task that you've given me, and then clearly you'll recognize my excellence and thus promote me, or thus give me the next opportunity." Whereas a male counterpart may say "I'm going to do this job and I'm going to do a good job and then I'm going to remind you what a good job I did and I'm going to ask for that promotion or I'm going to ask for that next step." So something my mentor did with me every time we met, she'd say, "You have to ask me for something today. I don't care if it's big or small, I'm going to make you practice."

—Ashley Prosper, Radiology, LAC+USC, PGY2

On the CIR Women in Medicine Retreat

Overall some of the main takeaways for me have been just seeing women leaders in medicine, hearing about some of their challenges but also hearing about the different approaches that they've used to manage challenges and manage success. It was great to see mentor-type figures and successful women who were willing to share their stories. And then from the contract negotiation standpoint, a lot of the terminology was brand new to me, so just having somebody spell it out and also having a person who's familiar with it say "watch out for these specific things"—that was useful.

—Renee Betancourt, Family Medicine, UCSF/SFGH, PGY2

Mother to daughter wisdom

I think as a minority woman in medicine my mother has been a trailblazer for so many people to follow in her footsteps. When we were starting to talk about contracts, she said, "I'm going to sit down with you and tell you this: ask for what you want, ask for what you deserve, and don't accept anything less." I'm so fortunate to have her in my life and to realize these things.

—Kayla Enriquez, Emergency Medicine, Highland Hospital, PGY3

Crashing the Old Boy's Club

We all know medicine is really like an old boy's club, especially an old white men's club, and although many, if not most, of my coworkers at this point tend to be women, the leadership roles in my hospital and in most hospitals are occupied by men. For a woman, especially a woman of color, if you are seeking higher positions, if you are looking for mentorship or leadership roles there's not a lot of people to look to. I don't think we acknowledge how much that affects women both in their day-to-day workplace and in achieving their career goals.

I look forward to being a mentor for other people. We have a program where high school kids from the community are linked to our hospital. They're interested maybe in health careers and they're from underrepresented minority groups. They come around with us for one afternoon every other month. It's not something they're required to do, it's something they like to do. I know CIR is invested in that pipeline work. . . And there are folks in my residency program who came from the community in Oakland that we serve. You know, sometimes just being who you are is very inspiring to the person you're taking care of.

—Almaz Dessie, Pediatrics, Children's Hospital Oakland, PGY2

On the West Coast, Alameda County Medical Center over the years has gained lactation rooms, a strong maternity leave policy, and has established a diversity fund to recruit physicians from groups underrepresented in medicine.

Successive bargaining teams at Children's National Medical Center in Washington D.C. enshrined rights in both the Federal and the District of Columbia Family Medical Leave Acts in their contracts.

New York residents have created and negotiated their own benefits plans that feature benefits especially for pregnant residents and parents. The public hospitals' benefits plan includes access to HHC daycare programs, a paternity leave and maternity leave policy that addresses rescheduling taxing rotations, relief from some night calls, and use of paid sick time for parental leave.

The voluntary benefits plan, which covers residents in New York's private nonprofit hospitals, offers a new mothers program that includes a $1,000 reimbursement for newborn expenses, well baby care and childbirth education. The supplementary obstetrical benefit covers additional costs like breast pumps, lactation classes and supplies.

CIR Members Join Campaign for Equal Access to Transgender Healthcare

March 2013 marked the launch of the first-ever National Month of Action for Transgender Healthcare—a campaign to make transgender-inclusive healthcare more common, accessible and affordable. The national effort was organized by a number of labor and community organizations, including CIR's national affiliate, Service Employees International Union.

CIR joined in the conversation with Dr. Madeline ("Maddie") Deutsch, a former CIR delegate and founder of the Transgender Health Program at Alameda County Medical Center (ACMC).

After attending the Gay and Lesbian Medical Association conference in San Francisco in the fall of 2012, CIR members from ACMC became interested in finding ways to work more closely with the LGBT population. Dr. Deutsch presented "Transgender Patients & Health Care Providers: How to Become a Better Provider to Your Patients." It was a discussion that provided strategies for care and data on the economic, social and political realities for the diverse transgender communities throughout the U.S.

Dr. Madeline Deutsch addresses CIR doctors on transgender health.

According to recent research, about 1 in 200 to 1 in 300 people fall on the transgender spectrum. According to a study by the Transgender Law Center transgender people are twice as likely to be unemployed compared to the general population, and transgender women are 34 times more likely than the general population to contract HIV. While the overwhelming majority of transgender people lack health coverage, it is estimated that 76 percent gain access to hormone therapy either via a medical professional or on the black market. Dr. Deutsch's talk also provided important tips on how physicians can create a more trans-friendly atmosphere in their practice.

What you need to know about treating transgender patients

The National Transgender Discrimination Survey reported that 50 percent of transgender patients reported having to teach their providers about transgender health. The study also showed that transgender people of color have an unemployment rate of up to four times the general population.

Here are some key terms and concepts to help you better treat your transgender patients:

- Transgender is an umbrella term for people that have some type of gender presentation or gender identity that's different from what you would expect from someone born in that body.
- If a person is born female and presents as male then they are a transgender man.
- If a person is born male and presents as female they are a transgender woman.
- Some people may or may not have a gender presentation that is discernible.
- People whose sex match their gender presentation are cisgender.

Best Practices For Physicians:

- Identify people by their gender presentation.
- Remember that if the person has an organ, it must be screened.

Author and CIR Doctor Empower Patients with Resource Guide on Transgender Health

Fourth-year NYU/Bellevue psychiatry resident Dr. Laura Erickson Schroth has witnessed the failures of the medical profession to cater to LGB and especially T (transgender) patients. Inspired by "Our bodies, Ourselves," published in 1971—a groundbreaking book published in 1971 on women's health and sexuality, Dr. E. Schroth was inspired to write a book specifically addressing the needs of transgender individuals in North America. "Each of the chapters is written by a trans or genderqueer* author," said Dr. Schroth. The collection of essays, "Our Trans Bodies, Our Trans Selves," is set to hit bookshelves in Spring 2014.

CIR: How did the idea to put together this book come to you?

I was in medical school and at the time a couple of friends were coming out as trans. I was also talking to friends who often told me they were afraid to go to the hospital because they thought they would be treated badly. There's all this history between trans people and physicians that makes it really difficult for people to interact. There wasn't a comprehensive place for people to go—a resources guide.

CIR: What do you see as physicians' role in social justice?

It's different for different people. Some people are more into public health or into advocacy and others are more into clinical work. Both are valuable because when you meet someone clinically you're changing someone's life a little but when you do advocacy work and teach other medical providers about LGBT health, it can change lots of people's lives at a time.

CIR: Were there essays or stories that surprised or stood out to you?

There's a story in our health chapter about a trans man who becomes pregnant and has an abortion. These are just issues that you don't necessarily think of but that have happened to a number of people. There's another story about a guy who had grown up in Africa. Within his tradition there was a naming of the child ceremony and a connection to the ancestors. People from that particular region and this person talked about the family receiving messages from this trans man's ancestors that showed that the ancestor he was most connected to was male; that helped the family to understand that his soul or his spirit might be male. It provided a way for him to explain who he was in a way that made sense and connected him to his family and his culture.

Dr. Laura Erickson Schroth, author of *Our Trans Bodies, Our Trans Selves*

CIR: What types of solutions do you think would help alleviate some issues for trans communities in accessing quality healthcare?

We're not trained well in medical school to understand the basics of sexuality versus gender; the same goes for race and ethnicity. Because of the discrimination trans people have faced in the healthcare profession, many end up using street hormones or injecting silicone, which can be very dangerous.

There's a lot of talk within trans communities about the effect the Affordable Care Act will have on trans patients. There's also a bill that's been pending for a long time called the Employment Non-Discrimination Act (ENDA), which would prohibit discrimination against LGBT workers — the same way that we protect classes like sex, race and religion. On another track, there are systems in which you don't have to pass legislation to make changes. For example, the LCME or ACGME can make requirements for what physicians are being taught and have residency programs follow them.

**Genderqueer is a catch-all category for gender identities other than man and woman, thus outside of the gender binary.*

- Ask, "Do you have a name that you prefer" if your patient presents a different gender than what your chart tells you.
- Remember that transitioning isn't just a medical process, it's also social and cultural.

Five Transgender Patient Needs

1. Primary, preventive, sexual healthcare, just like everyone else.
2. Healthcare that is covered/paid for.
3. Accepting administrative and clinical staff.
4. A welcoming and inclusive clinic environment.
5. Open-mindedness of others to not only accept, but incorporate the bodies' differences into everyday medical care.

For more information on the needs of transgender patients including treating transgender children, coding and billing for trans patients, transitions and best practices for healthcare providers see Dr. Maddie's discussion with CIR at bit.ly/drmaddie.

CIR Represents at AAMC QI Conference

Eight CIR members were among top physicians around the country presenting their Quality Improvement projects this summer at the Association of American Medical Colleges (AAMC)'s Integrating Quality Meeting in Chicago. Housestaff presented posters and shared strategies for enhancing the culture of quality in clinical care and health professions education.

CIR members had the opportunity to highlight their work at five hospitals: Harlem Hospital, Bronx-Lebanon Hospital Center, Maimonides Medical Center, Woodhull Medical Center, Bellevue Hospital Center and Boston Medical Center.

In total, CIR presented seven posters and gave one panel presentation by Dr. Michael Kantrowitz, Chief Resident in the department of medicine at Maimonides, on a partnership approach to aligning hospital and housestaff quality goals.

"These kinds of forums allow us to network with people from different facilities, learn from them, take it back to our hospitals and apply it to our unique population. Even though we have different challenges, we all have one goal and that's patient safety," said Dr. Renee Jones-March from Harlem Hospital.

Drs. Eduardo Martinez and Jones-March presented "Improving the Quality of Care at Harlem Hospital," a project headed by their patient safety council in which residents from each program, a patient safety officer, administrative staff person, the director of the GME and CIR delegates hold monthly meetings to identify areas of need, sources of near-misses and medical errors.

Drs. Bibi Ayesha and Aisha Siraj focused their QI project at Bronx-Lebanon Hospital Center on physician communication skills. After attending a one-day physician-patient communication conference sponsored by the CIR Policy and Education Initiative in 2011, residents set goals of increasing their HCAHPS scores around communications, reducing length of stay, reducing denials of payment by improving documentation and reducing unnecessary reference laboratory testing.

Thanks to the hard work of residents working closely with the hospital staff, preliminary 2013 HCAHPS scores showed a 14 percent improvement in doctor communication.

"You have to have good communication at every level: communication among the healthcare team, with the patient; at the resident level with the nursing staff, with the doctors, with the attendings, with the social workers," said Dr. Ayesha from Bronx-Lebanon Hospital.

Residents were able to attend the AAMC conference thanks to grants from the CIR Joint Quality Improvement Association, the Patient Care Trust Fund and the CIR Policy and Education Initiative (PEI).

To view CIR projects presented at AAMC, visit **bit.ly/aamc2013**.

CIR asks, What's your QI IQ?

On April 13, the CIR Policy and Education Initiative (PEI) partnered with the Healthcare Transformation Project of Cornell University's School of Industrial and Labor Relations to sponsor a one day conference for residents and medical students on the topic of resident physician leadership in quality improvement and patient safety.

The conference, entitled "What's your QI IQ?" featured interactive didactic sessions led by Dr. James Pelegano, Program Director for the Jefferson School of Population Health's Master's Program for Healthcare Quality and Safety; small-group breakout sessions that allowed participants to practice and refine methods; a panel discussion with residents on current QI projects in their hospitals; and a hands-on workshop on the formulation and writing of QI/Patient Safety project funding proposals.

Are you new to QI? CIR leaders provided the following tips for beginning to address quality and safety:

- First, physicians have to discover a common purpose. It is imperative that physicians understand the organization's culture, legal opportunities and barriers.
- Once a QI team is established, both residents, administration and other healthcare providers can work to reframe values and beliefs that support patient safety.
- Provide information all the way up to the board of directors. This will help ensure that residents and administration are united in improving safety for patients.
- Finally, the team should be engaging—involve housestaff from the beginning, and work with leaders and early adopters. Make physician involvement visible to administration, build trust among the team with each quality initiative, and communicate candidly and often.

SPOTLIGHT ON Fred Powell, MD, PhD

Building Relationships with Hospital Administration: a BMC CIR Leader Reflects

"My journey to medicine wasn't one that I chose," said Fred Powell, MD, PhD, a PGY 3 in Anesthesiology at Boston Medical Center. When he was 10 years old and living in North Carolina, his father suffered a heart attack. "I pretty much grew up in a hospital environment from that day forward," Dr. Powell said.

Both his experiences with his father and his interest in biology in school solidified Powell's dream of going into medicine. Dr. Powell has been a leader on CIR's contract negotiations team for the past two years. Through his involvement in CIR, he has come to recognize the opportunities that a resident union can provide in helping to create physician leaders.

"I would say to residents who don't have a union, 'what would you be doing as a group, how would you negotiate, how would you bargain?' CIR gives us the chance to develop relationships with leadership in the hospital and be able to work with them to problem-solve and troubleshoot issues that come up with residents, Dr. Powell said."

During his first round of negotiations, Dr. Powell was often frustrated with the response from hospital administration and the constant give and take that seemed to be chipping away at residents' demands. Like many at the negotiation table for the first time he wanted "all or nothing." However, after time what he gained professionally was an understanding of how hospital systems work.

"Administration sees you as a leader when you're able to bring solutions to the table. It's always good to come up with solutions for issues, and when a body of residents and hospital staff work together it creates better experiences for patients—that's ultimately what we care about."

BMC members have used their labor-management meetings to build relationships and create systems that improve workflow. One of their recent victories was establishing pager etiquette for residents. Though it may seem a trivial problem, explained Dr. Powell, ancillary and nursing staff were misusing the pager system and not providing enough adequate information to help the workflow of residents. "These situations can be frustrating but by working together we just implemented a new protocol to everyone's benefit," he said.

For Dr. Powell being a part of CIR has provided the opportunity to get involved in the issues the hospital is facing and in the lives of his patients. "Our CIR organizer is always working with me and keeping me involved. She took my energy that was very unfocused and helped focused it."

He is also active in minority physician recruitment and programming at BMC through a collaboration developed over 30 years ago by the union and the hospital, and he plans on continuing to strengthen and build relationships with BMC administration through labor-management meetings.

THE QI GATEWAY IS NOW ACCEPTING PROJECTS!

Are you a resident or fellow involved in a QI project at your hospital? Check out CIR's new clearinghouse for residents www.QIgateway.org. Publish your findings, get ideas for starting projects in your departments and connect with residents in hospitals around the country.

www.QIgateway.org

Empowering Patients Who Are Victims of Violence

"If I look at every single thing I've done (and there are so many different things!) I see them as a Venn diagram with 3 basic tenets: social justice, advocacy and peace; peace in peoples' lives so they can hopefully thrive."

If ever there was a physician who understood the humanistic and therapeutic importance of connecting to the lives of patients, it is emergency medicine physician Dr. Thea James. Dr. James trained at Boston City Hospital and was an active member of the House Officers' Association, an independent union that affiliated with CIR in 1993. Today she is associate professor of Emergency Medicine and assistant dean for the Office of Diversity and Multicultural Affairs at the Boston University School of Medicine.

At the CIR convention in Boston this year, Dr. James ran a workshop on *Treating Urban Violence: Transforming Vulnerable Moments into Opportunity, Impact and Positive Outcome*. She is a a founding member of the National Network of Hospital-Based Violence Intervention Advocacy Programs. At Boston Medical Center Dr. James runs this innovative emergency department-based program that helps guide victims of community violence through recovery from physical and emotional trauma. Using a trauma-informed model of care, the program empowers clients and families and facilitates recovery by providing services and opportunities that bring hope and healing to victims and their families.

Dr. James spoke to CIR Vitals recently about physician activism.

What made you become a physician activist?

I haven't thought about it much, but I guess it was instinctive. My father always taught me to reach out and help people—and not to be judgmental. If he took me to the Burger King and the cashier was unfriendly, and I made a comment about it, he would say, "you have no right to judge—you don't know that person's life."

This particular hospital—Boston Medical Center—nurtured my activism. There is a culture of it here. As an intern we were taught that we could make a difference. We couldn't discharge a patient until we made sure they had a place to go, that they had their meds and a follow-up appointment. We were taught to care. And to put a mirror up to ourselves and ask—what would we want for our loved ones or ourselves? Why would we accept a standard of care that was lower than that for other people?

CIR grew me—this union helped me be the person I am today.

What advice would you give to residents who want to become activists?

Many times I was told that I needed to choose one thing, I needed to focus on one area to make a difference or to be successful, but I've never been able to do that. And yet—if I look at every single thing I've done (and there are so many different things!) I see them as a Venn diagram with 3 basic tenets: social justice, advocacy and peace; peace in peoples' lives so they can hopefully thrive.

I also found with people that it's best to listen and find out what they need or want, not what I think they need or want. I sometimes just say to my patients: What could we do today to make you feel satisfied when you leave here? Medicine is so doctor-centered that we forget to ask. For example, we're looking to expand our outpatient care, but have we thought about evening and night clinics? We're told—oh, there are so many no-shows during the day, but did anyone think that might be because they needed to come at another time?

To learn more about Dr. James's work, visit **www.nccdglobal.org/blog/emotional-and-physical-healing-in-the-emergency-room**

Immigration Reform and Health Care: What You Need to Know

CIR members across the country have been speaking out on the need for commonsense immigration reform. Our current immigration process, which forces so many individuals and families to rely on emergency room care as their only option, is bad medicine and an unnecessary financial burden on safety-net hospitals.

The Border Security, Economic Opportunity and Immigration Modernization Act, S. 744, was passed by the Senate on June 27 with strong bipartisan support. The bill awaits action by the House of Representatives. Throughout the summer and fall, CIR will be working with allies to push the House to engage in this debate and, ideally, to build on a decent Senate bill to make it much stronger.

Below are some commonly asked questions about the immigration reform bill passed by the Senate:

Does this bill create a roadmap to citizenship for undocumented immigrants?

Yes. The process could take up to 13 years, but is achievable. The bill proposes a process by which undocumented immigrants would apply for provisional legal status (Registered Provisional Immigrant) with a minimum wait period of 10 years until individuals may apply for legal permanent residence, and an additional wait of three years until they are able to apply for full naturalization and citizenship.

Does the Senate bill include the main components of the DREAM Act?

Yes. This bill creates a faster, five-year road to citizenship for people who arrived in the U.S. before they were 16 years old, graduated from high school in this country (or received an equivalent degree), and have attended at least two years of college or served four years in the military.

Does this bill help keep families together?

The legislation aims to eliminate the backlog of immigrants who have applied to come here legally and have been languishing for years, waiting for green cards.

The bill would also allow an individual who qualifies for the new roadmap to citizenship — but has been deported for non-criminal reasons — to re-enter the country as a Registered Provisional Immigrant as long as the individual has a spouse or child who is a citizen or lawful permanent resident.

However, the bill would eliminate family visas for siblings 18 months after the law takes effect. About 65,000 such visas are available each year currently. Instead, it would create a new merit-based program for foreigners to become legal permanent residents, with family ties being a part of that equation.

Will individuals with provisional status be eligible for the Affordable Care Act or federal benefits?

No. Under the current Senate bill, individuals in Registered Provisional Immigrant (RPI) status are not eligible for ACA subsidies or any federal benefits available to low-income people. For example, they would not be eligible for Medicaid, food stamps, temporary assistance for needy families, low-income assistance in the prescription drug program, federal housing aid or receive earned income tax credit (EITC).

The bill maintains the five year ban on Lawful Prospective Immigrant (LPI) eligibility for Medicaid, and time spent in RPI status would not count towards the five years. Immigrants in RPI status would be eligible to buy into the health care exchanges created under the ACA, but would have to pay the full cost of premiums with no subsidy assistance.

Absent reform, how will our current immigration laws affect our hospitals when the Affordable Care Act is fully implemented?

Members like you have shared stories about patients who are shut out of our healthcare system because of their country of origin. Hospitals have also raised concerns about the exclusion of undocumented workers from accessing coverage under the Affordable Care Act.

At the same time, Disproportionate Share Hospital Funding will be cut in proportion to drops in the statewide uninsurance rate beginning in 2014. Public institutions like HHC in New York, University Hospital in Newark, Jackson Memorial in Miami, the Los Angeles County System, UNM in Albuquerque, and San Francisco General are anticipating that their volume of uncompensated care will remain the same or rise at the same time the federal funding to relieve them of some of the fiscal burden will be cut. Private community-based safety-net hospitals are under the same pressure.

Does the Senate bill help or hurt our hospitals?

On the whole, the Senate bill represents a step forward for creating a difficult but achievable roadmap to citizenship for aspiring Americans who would otherwise be trapped out of our healthcare system. However, the road to citizenship is very long—thirteen years without access to primary care, prevention, and regular doctors' visits is too much to ask any of our patients. Moreover, although it would improve the long-term prospects for safety-net hospitals, it offers little short-term relief.

We will continue to share our perspective with members of Congress while pushing for a commonsense reform of our immigration system that lives up to our values.

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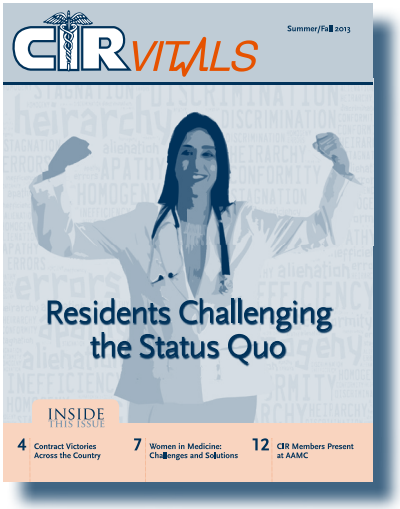

NEW BENEFITS

CIR Member Only Benefits

CIR members are entitled to a host of special benefits including:

- Discounts on Online Degrees from Jefferson School of Population Health
- Educational Debt Assistance from GL Advisor
- Legal Services Discounts
- Apartment Search Assistance
- Reduced-Fee Gym Memberships

To learn more about your member-only benefits visit www.cirseiu.org/membersonly

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