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How We Won Good Contracts



Dr. Lance Weathers, Internal Medicine
St. Luke's-Roosevelt Hospital, Manhattan, New York



Dr. Rajani Bhat, Internal Medicine
Lincoln Hospital, Bronx, New York



Dr. Justo Garcia, Internal Medicine
Our Lady of Mercy, Bronx, New York

As in most things, there's an art to winning a good contract. That's especially true today, a time of widespread financial stress for hospitals both public and private.

Chances are, at some point during your residency, you'll find your CIR Chapter preparing to negotiate a new contract at your hospital.

So read on, and hear what your colleagues in four New York City hospi-

tals have to say about their experience with negotiating new contracts. Their lessons learned can give you the head start

you need when it's your turn to start the bargaining process for a good, solid contract.

See centerfold for more...



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President's Report

Barbie Gatton, MD, CIR President

Fighting Threats to Urban Hospitals

A number of CIR hospitals, from New York to California, are vulnerable to the threat of closure. As physicians in these public and non-profit safety net hospitals, we are very concerned about our patients. Closure means patients will have to travel farther to get care and suffer longer wait times. Statistics show that many will simply give up on seeking care altogether. We are also concerned about our members — those whose training may be disrupted and those who will work harder because their hospitals have picked up the patients displaced by the closing.

In New York, a commission was recently formed to look at closing hospitals as a means to greater costs savings. The people on that commission are not from the communities affected, nor are they drawn from the ranks of hospital administration. They are all from financial institutions. Their initial findings are that 40% of the hospital beds in New York State are unused, which justifies closing some 'unnecessary' hospitals. Here, the commission has deftly confused *licensed* beds for *staffed* beds in its attempt to sell the public on the notion that New York can safely close some hospitals. On the frontlines, we find that ERs are overcrowded, and it can take days to get a patient transferred to a ward, not because of a lack of beds, but rather because we lack nurses to staff those beds. It's also important to know that unstaffed beds are not incurring a lot of costs.

A past experience with hospital closings is illuminating. DC General, located in Washington, DC, was a CIR-affiliated hospital that closed in 2001. The reason given by the mayor was that it was too costly. Instead, a private hospital was tapped to take over, and given \$60 million right off the bat. The mayor promised that through a privatized system, "We can do it better, and cheaper." But in the aftermath, it is generally acknowledged that he was wrong. Now the District is negotiating with Howard University to open a private hospital on the site of the closed DC General. The CEO of a neighboring hospital publicly stated that closing DC General has been "an abject failure." But the damage has already been done.

It's more cost effective — by many millions of dollars — to keep a hospital open, than to close and later rebuild. If a hospital needs to improve its patient care, that is what the focus should be on. Simply closing it down often means that the community goes from "poor care" to no care.

When King/Drew Medical Center in LA recently closed its trauma center, it caused confusion in the surrounding neighborhood. People did-



fessor at Boston University School of Public Health, to talk with our Executive Committee recently. In an interview on the facing page, you can read more about Dr. Sager's findings.

The experience of one of my pregnant patients in the ER shows how lack of access affects even those who do have insurance. She had to travel six hours round-trip, by public transportation, in order to access her Medicaid HMO physician. She lost a day of work at her minimum wage job and had to take her child out of school for the day in order to get prenatal care. This is a very expensive solution, because ER care is expensive in

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"Closure means patients will have to travel farther to get care and suffer longer wait times. Many will simply give up on seeking care altogether."

n't understand the difference between closing the ER, closing the trauma center, and closing the hospital. It was one of the busiest trauma centers in LA, so it has increased the burden on other hospitals to take care of those patients. And in a trauma, the amount of time it takes to receive care can make the difference between life and death.

To help CIR focus our response to the possible closings we face on both coasts, we invited Dr. Alan Sager, an expert on hospital closings and pro-

itself. It's also expensive in terms of disruption to the mother, child, and workplace.

Access to high quality health care is a right and should be a priority in this nation. Just as we claim the right to life, liberty, and the pursuit of happiness, we need to add health care to that equation, because health and happiness are inextricably linked.

**SEIU Leaves AFL-CIO, Forms New Alliance
What Does It Mean for CIR?**

You may have read about SEIU, the service workers' union, disaffiliating from the national AFL-CIO on July 25, 2005. It made front page news at the time, and continued to receive press attention throughout the summer.

CIR is a national affiliate of SEIU, which is one of the largest unions in the country. As a part of SEIU, CIR will also no longer be affiliated with the AFL-CIO. The disaffiliation was the result of differences about how best to organize and represent members. SEIU wants a stronger focus on organizing, with money and resources to back up effective growth. The AFL-CIO, while willing to make some reforms, remained unchanging in most of its traditional structures and approaches.

"When you're walking down a road, and the signposts keep telling you it's the wrong direction, you have to get off, and walk in the direction of hope," SEIU Pres. Andy Stern told CIR and other SEIU locals on the eve of the disaffiliation. "The way we've been going is not a good direction for working people in America. We're trying to build a stronger SEIU. I'm sad that we came to this moment in time, but also incredibly hopeful," he said.

For many years, CIR was an independent union, and was not part of SEIU, or the AFL-CIO. Since joining SEIU in 1997, CIR has drawn more on SEIU resources and expertise than on AFL-CIO resources. The labor movement and the needs of working people are much broader than any one organization. SEIU and CIR will continue to play an important role in the labor movement, build stronger alliances with issue-oriented organizations, and work in coordination with the AFL-CIO on common issues ranging from hospital closings (see President's Report, above) to strengthening labor laws.

PHOTO: PAGE 2: BILL BURKE/PAGE ONE PHOTOGRAPHY; PHOTO: PAGE 3: CARA METZ/CIR

AN INTERVIEW WITH ALAN SAGER, PHD

Urban Hospital Closures Accelerate: Impact Vulnerable Patients and Vulnerable Hospitals

Many CIR members work in urban safety net teaching hospitals that serve vulnerable populations. Often these hospitals are just as vulnerable as the patients they serve. More and more we find ourselves struggling with hospital administrators, local governments, federal legislators and the White House to adequately care for our patients – the uninsured and the insured, as well. At its summer meeting, the CIR Executive Committee invited Alan Sager, PhD, a noted expert on urban hospital closures, to present his research. His data revealed some startling findings and we thought it important to share with all CIR members.

CIR News interviewed Dr. Sager, a professor at the Boston University School of Public Health, in his office on August 1, 2005.

You've been studying urban hospital closings for many years. Can you predict which types of hospitals are in danger of closing?

Our model is fairly accurate. It uses data from the beginning of each decade to come up with a predicted chance of closing or survival. The main factors we use to predict are:

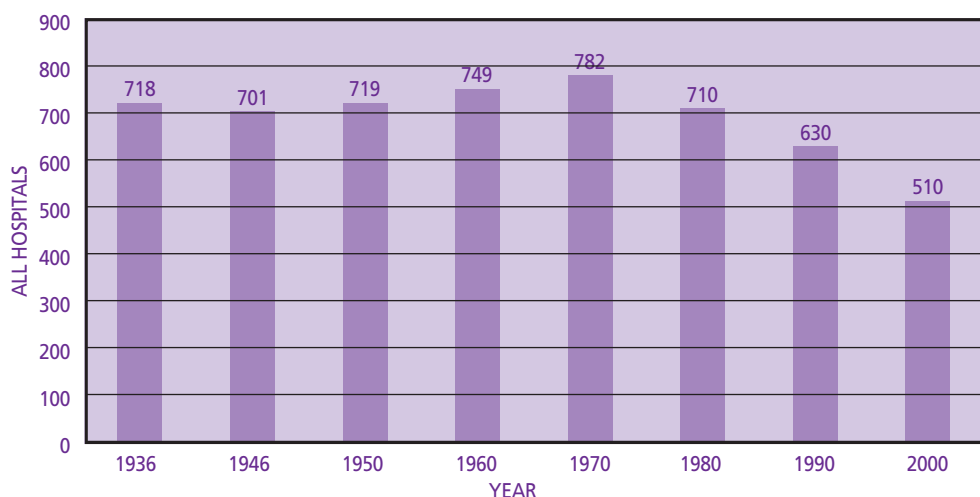
- Number of beds a hospital has – smaller hospitals of about 100-200 beds are more likely to close;
- Racial mix of the people who live in the census tract surrounding the hospital – hospitals in black neighborhoods close more often than hospitals in white neighborhoods;
- Hospital wealth – hospitals with smaller financial reserves also close more often.

Our research began in 1973 and examines the years 1936-2005, or about 70 years. Our analysis and predictions are done decade-by-decade. In the last 20-30 years, the factors I just listed are quite pronounced.

Interestingly, efficiency never predicts survival.

Total Hospitals, 52 Cities, 1936-2000

The number of urban hospitals, as measured in 52 cities, has declined from 1936 to today, and is much lower than at its peak in 1970.



That's surprising. How do you define hospital efficiency?

We use a conventional formula – the cost per adjusted discharge, controlling for case mix.

Your research includes public, non-profit and for-profit hospitals. What specifically can you say about public hospital closings?

Public hospitals may be judged by a different standard. You need to look at five factors: political support; perceived quality of medical care provided; hospital finances – revenues and expenses (as well as the condition of the city or county government that the hospital is part of); the condition of the hospital's physical plant; and perceived inefficiency. Public hospitals often seem less efficient than they really are because their patients are often much sicker than is indicated by the conventional severity measures.

All of these factors influence whether a public hospital is closed, converted to a non-profit or for-profit hospital or affiliates with another institution.

How does closing a hospital make a community's problems worse?

First, costs may be high in a particular hospital, but they may be even higher at the alternative hospitals that in practice, are willing and able to accept these displaced patients.

Quality may be bad, but what's the quality of care in the alternative hospitals, particularly for the medical problems of the patients served by the endangered hospital? Patients served by vulnerable hospitals very often have multiple, complex clinical problems, associated with poverty and work-related disability. These problems are often diagnosed late and can be compounded by social factors like homelessness. Patients often have Medicaid or no insurance or all. The hospital functions as ambulatory care



Dr. Sager at CIR Executive Committee meeting.

provider as well as a provider of inpatient care. It is inherently very expensive to care for these patients.

If there are empty beds available at other hospitals, doesn't it make sense to use them?

Hospitals are not interchangeable parts. Other hospitals in a community may trumpet their willingness to take care of the patients from the closed hospital, but in practice they may be very selective, based on insurance and type of clinical problem.

Second, it may be widely believed that there are extra beds, but the bed figures most often quoted are *licensed* beds, not *staffed* beds. In today's world, no hospital can afford to staff empty beds. The truth is, either the beds no longer exist or they exist but they are not staffed. It's very expensive to staff beds.

What does a hospital closing mean for patients?

Patients displaced by a closing often take months or years to re-weave the fabric of their medical services. Thirty percent simply cease obtaining inpatient care. Vulnerable patients are made more vulnerable when hospitals close, especially public hospitals.

We also know that race matters. Hospitals that close are more likely to be in African American communities, serving minority patients. We know that black Americans depend on hospitals for ambulatory care far more than whites. Almost 33% of all doctor visits by African Americans are at hospital emergency rooms and clinics compared to 15% for whites.

When a hospital closes, patients lose both inpatient and outpatient care. Surrounding health centers lack the capacity to fill in the gap.

What conclusions have you come to based on your study of hospital closings?

First, recognize that we have

closed so many hospitals that now every hospital should be considered needed unless proven otherwise.

Next, understand that the estimates of excess beds or overbedding are greatly exaggerated.

And finally, recognize that the savings from closing hospitals are also greatly exaggerated.

If there are empty beds, it makes more sense to "mothball" them, not close them, because the percent of older Americans is going to skyrocket. An estimated quarter of a million more staffed hospital beds will be needed in the next 25 years. Building new hospitals has been estimated to cost about \$1 million per bed. It is much cheaper to mothball the beds now, particularly since we have found that hospitals that close are just as efficient.

I imagine you're aware that a commission has been formed in New York to look at closing hospitals as a way to save money.

Yes, I'm concerned about the political coverage it gives to hospital closings. If a hospital has a quality problem, do you shoot it or fix it? I'm very concerned that this will result in a continued concentration of hospitals in more well-to-do New York communities. The cumulative closing of one hospital here, one hospital there, is not noticed, but decade after decade the effect of these closings is astounding. We are inches away from losing the last hospital in the entire eastern half of the District of Columbia and many nearby suburban hospitals are in terrible condition. Detroit has eight hospitals left to serve almost 1 million people. New York State should not repeat the mistakes that have allowed or spurred the closure of so many hospitals in minority communities.

[For more information about Dr. Sager and the extensive research he has done on a variety of issues, log on to www.healthreformprogram.org.]

THE EIGHT KEYS TO SUCCESS



"We signed a petition and brought it to the administration to fight against the health care givebacks. We walked into the Vice President's office, and placed it on his desk surrounded by a number of residents. There were so many signatures there. The administration responded by eventually dropping the demand."

Dr. Chilembwe Mason

PGY 3, Emergency Medicine Chief Resident,
Saint Luke's-Roosevelt Hospital, Manhattan, New York



"When you get involved in the negotiation process, you get to know people from administration. I've been going to negotiations every month, so the administration begins to know you and respect you."

"Before, residents were not called by administration when issues came up, and now we are. If not me, they'll contact another CIR delegate and explain what their plans are and discuss ideas. Some residents have the feeling that you get in trouble if you become involved with CIR. Actually, it's the only way to get out of trouble. If we are all separate individuals, it is much worse for us."

Dr. Justo Garcia

PGY 3, Internal Medicine
Our Lady of Mercy, Bronx, New York



"Residency is a fleeting experience – we're not going to be here forever, we're here three, maybe four years. There are not many contracts you'll negotiate in that time period. So you need someone like CIR with the experience to show you the ropes, advise you, tell you not to panic on this issue, things like that."

Dr. Louis Belcastro

PGY 4, Podiatry
St. Vincent's Catholic Medical Center, Brooklyn-Queens Division



"The most important thing is to remain steadfast. You're going to hear the word 'no' a lot. You need patience, because there are times when the process seems to be going nowhere fast. But we saw that each side did want to come together and reach an agreement."

Dr. Lance Weathers

PGY 3, Internal Medicine
St. Luke's-Roosevelt Hospital, Manhattan, New York

Do you have a new CIR contract in your future? Do you turn to negotiate a new contract, or to provide a negotiating team that is tackling the job at your hospital? You are in some form of financial distress. Yet that did not stand against any contract givebacks, and coming away with Care Funds, more money for licensing exams, food, and other benefits to residents everywhere.

How did they do it? We interviewed residents from both sides who wrapped up their negotiations. They are from both Saint Luke's Hospital in Manhattan, St. Vincent's Catholic Medical Center at Mercy, in the Bronx, and all the CIR-affiliated hospitals in the system. They learned a lot, gained a lot of concrete benefits, and what they know with you. Out of a series of wide-ranging keys to success you'll need to know before you take

1. Identify your issues. Which are hospital-wide, which are department-wide, which affect only one person? Know what you will stand firm on, and where there's wiggle room. Have a representative and informed committee.

2. Prepare for a long process. Although everyone hopes to wrap up negotiations quickly, it doesn't always work out that way. Keep everyone informed of the latest developments every step of the way. Make sure to keep up the resolve, interest and participation of your colleagues throughout the duration of the process.

3. Solidarity = strength. This is such a truism that it is the basis of most union work. If you allow yourselves to become divided you will lose the power and strength you have as a large, collective group. Build your support from other unions at your hospital, too. When administration sees nurses and aides wearing CIR buttons, you have just increased your visibility many times over. And don't forget to draw on the years of experience of CIR staff when questions arise.

4. Learn negotiating skills. The negotiating committee and CIR staff can educate management to housestaff concerns, and explore ways to find mutually agreeable solutions at the bargaining table.

Saint Luke's-Roosevelt, Manhattan, New York Contract Highlights

Salary Increases:

October 1, 2005: 3%
October 1, 2006: 3%
October 1, 2007: 3%

Health Benefits: Continuation of fully paid health insurance with no reductions and no additional premiums.

Step 3 Reimbursement: (A new benefit) Full cost of the exam covered when passed within the first 18 months of training.

Meal Vouchers: (A new benefit).

Patient Care Fund: Renewed \$100,000 each year for life of the agreement.

Chief Resident Differential: Increased to \$3,000.



Saint Vincent's Catholic Medical Center, Brooklyn-Queens Division Contract Highlights

Salary Increases:

February 1, 2005: 3% (retroactive)
February 1, 2006: 3%
February 1, 2007: 3%

Meals: Effective January 1, 2006, a meal allowance of \$60 per week will replace the current meal card system.

Health Plan: Hospital will pay the full cost of Benefit Plan increases.

Education Equipment Allowance:

Expanded to pay for books, medical audio and videotapes, PDAs, journal subscriptions, etc.

Conference, Board Review and Exam Allowances: Increased 3%.



S AT THE BARGAINING TABLE

At some point during your residency, it will be your support and a show of strength to the CIR negotiation hospital. Many of the hospitals who recently settled do not stop these residents from drawing a line in the way with good raises, improvements to their Patient vouchers, and other issues of universal importance

from four hospitals in New York City who recently public and private hospitals — St. Luke's-Roosevelt Medical Center, Brooklyn-Queens Division, Our Lady of hospitals that are part of the public hospital (HHC) system. Benefits and improvements, and are happy to share ranging conversations, we've summarized the eight your place at the bargaining table.

5. Take action when needed. Buttons, leaflets, petitions that are hand delivered en masse, attending GME meetings — all have their place when talks at the table seem to stall. All show that the outcome is important to residents.

6. Be prepared to fight another day. Have you resolved everything except for one difficult, hard-to-resolve issue? Sometimes you can sign a contract and set up a labor-management committee to continue working on that issue. Collect data, build support, and next time you're in a stronger position to win it in your contract.

7. Negotiations change the power dynamic at your hospital. Just by taking part in negotiations, you become a leader, and gain the respect of your colleagues and hospital administration, and change the nature of those relationships in a positive way.

8. Spread the message to colleagues at non-CIR hospitals of what you were able to gain in your contract. The more residents and hospitals are affiliated with CIR, the greater the influence these higher standards will have over residents nationwide.

"By getting involved in negotiations, you become a conduit. Residents from other departments now call me. As a result, you learn about things you wouldn't otherwise know. My knowledge has expanded tremendously. I've also made life-long friends, so it makes the hospital a little more of a workable community, which is important at Bellevue, an immense hospital in an immense HHC (public hospital) system.

"We've even made connections beyond our hospital. We're working on getting together an Emergency Medicine baseball game between Bellevue and Brooklyn Hospital. CIR is a way for these things to happen. In regional meetings every month, we learn that everyone is having the same problems. You learn that your hospital isn't an island unto itself. It has given me a new view of the city, and the health care system."

Dr. James Rodriguez

PGY 3, Emergency Medicine
Bellevue Hospital, HHC, Manhattan, New York



"Many issues were acknowledged, and some we're still working on. There's a big problem with visas and HHC acknowledged this, and agreed to create a committee to look into it. Residents with one-year visas have to go back each year to their country, to get it stamped. Multi-year visas could save residents money and legal expenses, and HHC paperwork and the trouble of having to cover for people with difficulties getting back into the country on time."

Dr. Rajani Bhat

PGY 3, Internal Medicine
Lincoln Hospital, HHC, Bronx, New York



"You have to be able to create a united front, even if there is a division of opinion on some issues. You have to come to a consensus and consider what is in the best interest of all residents, not just what is best for one group.

"We can use this contract to show that things can only become better if you are part of a union. Our contract is significantly different and better than what is common in neighboring states where residents do not have a union. We've widened the gap on safety, and that's a real plus for us."

Dr. Alfred Malomo

PGY 3, Internal Medicine
Harlem Hospital, HHC, Manhattan, New York



HHC, New York City Contract Highlights

Salary Increase:

July 1, 2004 (retroactive): 5.06%

Signing Bonus: \$1,000 for all housestaff on HHC payroll as of June 23, 2005.

Chief Resident Differential Increases:

5.06% effective July 1, 2004 (retroactive).



Our Lady of Mercy, Bronx, New York Contract Highlights

Salary Increases:

February 1, 2005: 3.5%

February 1, 2006: 4%

October 1, 2006: 2%

February 1, 2007: 4%

October 1, 2007: Parity with CIR New York median.

Holiday Pay: (A new benefit).

Full days for any holiday; hourly pay for any holiday worked under 8 hours.

Meal Cards: For breakfast, lunch and dinner.

Patient Care Fund: Increased to \$22,500 for 2005-2006; and \$25,000 for 2006-2007.

Up-to-date software installed on library computer.

Improved job security language.

No reduction in health care benefits.

Multi-year H-1B visa renewals.



CIR & AMSA Testify before MA Committee Focused on Resident Work Hours Limits

CIR members backing proposed resident work hours legislation in Massachusetts testified before not one, but two hearings on Beacon Hill this spring and summer.

Simon Ahtaridis, MD, CIR Secretary-Treasurer, joined the Legislative Affairs Director of the American Medical Student Association (AMSA) to speak in favor of legislation on resident work hours that was included in a larger bill addressing health care access in the Commonwealth.

“What, you may wonder, is the issue of excessive resident work hours doing in a bill about access to care?” Dr. Ahtaridis asked members of the Health Care Financing Committee on June 8, 2005. “In a word, the answer is quality. Accessible and affordable care is of the utmost importance, but so is accountable care. Every patient who walks through the door of a Massachusetts teaching hospital

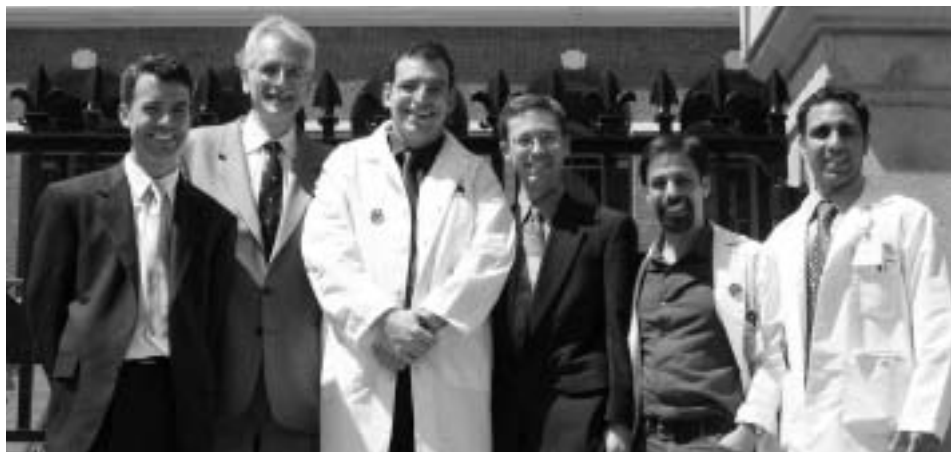
deserves to know that the resident physicians taking care of them are well rested and able to provide safe, quality care.”

In arguing for state oversight of work hours, AMSA’s Christopher McCoy pointed to the inherent inability of the medical community to enforce its voluntary hours limits when the only penalty is program probation or loss of accreditation.

“A year ago,” testified McCoy, “the ACGME reviewed programs for compliance to the new regulations. Through interviews of thousands of residents, it found 834 instances of residents working more than 80 hours each week. Yet only 53 complaints had been filed by residents over the course of the year. Many programs are in violation, but few residents report it to the ACGME.”

Adding significant weight to the hearing were Drs. Charles Czeisler and Christopher Landrigan from the Harvard Work Hours Health and Safety Group. They presented data on the increased incidence of medical errors and post-call car crashes when the medical interns they studied worked greater than 24 consecutive hour shifts. Both Harvard researchers stressed that the ACGME-approved limits of 30 hours were unsafe and urged that residents work no more than 16 consecutive hours at a time.

On July 13, 2005, CIR was back up on Beacon Hill to testify before the Public Health Committee – this time on a “stand alone” resident work hours bill (S. 1263). Harvard sleep researcher Dr. Landrigan returned to urge this committee to also put an end to “marathon shifts” of 24 or more hours. Cambridge Hospital CIR delegate Varsha Vimalananda, MD and



From left, Drs. Christopher Landrigan, and Charles Czeisler from the Harvard Work Hours Health and Safety Group, join CIR residents Drs. Simon Ahtaridis, Matthew Ehrlich and Philip Cefalo and AMSA Legislative Affairs Director Christopher McCoy (third from right) at the June 8th State House hearing.

Erica Wilson, MD, also testified.

“Exhaustion takes its toll,” explained Dr. Vimalananda, a PGY 2 Internal Medicine resident. She explained that “not long ago, a resident at a non-CIR Boston teaching hospital left work after a 30 hour shift, walked to the parking lot, turned on the

wanted to be his patient?”

Dr. Wilson, also a PGY 2 Internal Medicine resident, noted that for years, the trucking and airline industries have had hours regulations to protect the public. She ended her testimony – and brought a hearty laugh from the crowded hearing room –

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“Every patient who walks through the door of a Massachusetts teaching hospital deserves to know that the resident physicians taking care of them are well rested and able to provide safe, quality care.”
 —Simon Ahtaridis, MD, CIR National Secretary-Treasurer

engine and then fell asleep – until the next morning when he woke up to find his gas gauge on empty. Would you have wanted to be on the road with this resident if he had managed to drive away that day?” she asked the Committee members. “Would you have

when she said, “Finally and most importantly, I appeal to your ‘Red Sox Pride.’ For fifteen years, New York has been the only state with regulations on the books limiting excessive work hours for resident physicians. We know Massachusetts can do better!”



From left, Drs. Erica Wilson and Varsha Vimalananda testify at a second hearing on July 13th. Both are residents at Cambridge Hospital.

Residents in Puerto Rico Take a “BIG Step” Towards CIR Recognition

In Puerto Rico, nearly 300 interns and residents from the University of Puerto Rico Medical School system, and the Rio Piedras Medical Center (UPR/RCM) staged a one-day work stoppage on June 29, 2005. When their demands were not met, they followed up with a three-day stoppage July 13-15, to draw attention to problems with working conditions, terms of employment, and the University’s refusal to recognize CIR, which they have been seeking for over a year.

Residents are in a bind, because though formally employed by the University, they work in Dept. of Health (DOH) hospitals. The DOH said in meetings that if residents were on their payroll, they would be eligible to join a union. However, on University payroll, residents need to seek volun-

tary recognition. Residents have shown their desire for a union by declaring CIR their *bona fide* organization, and voluntarily paying dues. They also met with representatives from the legislature to state their case.

They received widespread press attention and public support for their actions this summer, and for now, have compromised with the creation of a permanent GME subcommittee that includes both residents and University administration meeting to try to resolve resident work issues. The first subcommittee meeting is scheduled for August 26, 2005.

The GME subcommittee is “one mechanism for solving our problems,” said Dr. Alfredo Tirado, PGY 3 in Emergency Medicine at UPR. “I think it opened the door for negotiations,

and that’s what we want – our goal is a collective bargaining agreement,” he said, “but that will take time. We have no way to make any changes now, everyone has an individual contract but there’s no collective contract.”

The work stoppage was “a big step,” he said. “It was not an easy step, but a big one, and we got a good response from the community. We were exposing people to what residency is. Most people in the community don’t know what a resident is, what our duties are.”

Some of their key issues, Dr. Tirado said, are improved “health insurance, because our current plan is not accepted in most hospitals, including our own, and has no prescription coverage. Also, we need maternity and paternity leave, an increase in



From left to right, Drs. Gilberto Alvarez, Alfredo Tirado, and Maria Ocasio, all CIR delegates, explain resident issues to the press.

salaries (their last raise was three years ago), and CIR recognition,” so that residents can continue to work towards improvements in their work environment, and patient care.

'Best Practice' at Coney Island Hospital Dubbed a '10 out of 10' New Medicine Schedule Caps Shifts to 12 Hours

The Medicine Department at Coney Island Hospital, in Brooklyn, New York, is a place determined to make changes in resident work hours. Towards that end, they invited Dr. Steven Lockley, assistant professor of Medicine at Brigham and Women's Hospital in Boston, Mass., and a member of the Harvard Work Hours Health and Safety Group, to give the Grand Rounds presentation on July 28, 2005, and share his knowledge in the field of sleep research. The Harvard Work Hours Group is known for its groundbreaking studies on the increased risk of medical errors and car crashes among sleep deprived medical interns published in the *New England Journal of Medicine* this past year.

It's how you cut hours that matters

"It's not just a matter of cutting work hours, but *how* you do it, taking into account the body's natural circadian rhythms," Dr. Lockley said. "An 80-hour work week doesn't take into account the need for sleep." The intervention schedule pioneered at Brigham is a traditional on-call schedule split in two, (with an 8 hour, and a 15-hour shift) with Q3 split among 4 interns, creating a day call and a night call (with nap time before the night call). "This schedule requires interns to work as a team, and have well-structured hand-offs," he said. "The transfer of knowledge about patients admitted by other interns is critical, and we found that 'buy-in' by attendings is also critical for success."

Despite skepticism among some supervising attendings, their study found that when residents worked less, they did, in fact, sleep more. Some of the future goals of the Harvard Work Hours Group include expanding their study to other specialties (beyond

Medial and Coronary Care Units), including senior residents in their studies, and improving the sign-out and rounding processes.

Dr. Darshan Godkar, CIR delegate, and a chief resident in Internal Medicine at Coney Island Hospital was instrumental in getting Dr. Lockley to speak at his hospital. "I went to the CIR Convention in May and heard Dr. Czeisler's presentation (of the Harvard Work Hours Group, who was the keynote speaker). I was inspired by it, and came back and spoke with my program director, and he was very interested."

Dr. Godkar was lucky to have more than an ally in his program director, Dr. Selvanayagam Niranjn, who was a former CIR resident himself at Coney Island Hospital. "He was determined to cut our work hours, and cut down on the non-physician work," Dr. Godkar said.

Introducing a new schedule

By July 1, 2005, Dr. Niranjn had instituted a new schedule of 12-hour shifts for all Medicine residents, with one 24-hour on call shift per month. Dr. Godkar was the first one to try the new schedule, volunteering to "go through the routine myself first."

His findings after living with the new schedule for one month? "I was fresh through the night and day call, and never felt sleep deprived. I was able to monitor and treat MICU patients much more aggressively. Previously, when I did 24 hour calls, by around 9 PM, I was so exhausted that now I feel guilty that I might have compromised patient care. Overall, I give this system a 10 out of 10."

Coney Island Hospital adopted a different intervention schedule than the Brigham Hospital schedule described by Dr. Lockley. The Coney Island schedule is very simple:

New schedule:

- Six 12-hour shifts per week: 12-12-12-12-12-12-0 (for a total of 72 hours worked per week.)

Old schedule:

- 24-0-10-24-0-10-24 (for a total of 68 hours one week, and 92 the next, averaging 80 hours per week.)



Dr. Stephen Lockley (center) of the Harvard Work Hours Group gave the Grand Rounds at Coney Island Hospital on sleep research and the intervention schedule they devised at Brigham and Women's Hospital. Left to right, Dr. S. Niranjn, Program Director for Internal Medicine, Dr. Amit Patel, Chief Resident, and Dr. Darshan Godkar, CIR delegate and Chief Resident, shared information about their new schedule, which is different than Brigham's, but also cuts down hours.

The upside of the new schedule is that with the exception of one 24-hour call, there are no shifts of over 12 consecutive hours. The downside is that residents don't get a full weekend, or two consecutive days off. "I like it a lot better than the old schedule," said Dr. Emmanuel Akinyemi, a PGY 2 in Medicine.

Overcoming resistance to change

In his talk, Dr. Lockley explained that their research has found that "sleep consolidates memory, and without adequate sleep, you don't learn."

Program Director Niranjn was also concerned about residents learning, and having slept enough that they would be able to retain what they had learned. In an interview with *CIR News* following the Grand Rounds, he credits the Chairman of the Medicine Department, Dr. Robert Cucco, with giving him the autonomy and support to make these changes possible.

"Change is not easy," said Dr. Niranjn. "The departing residents did not want this change. We all think about ourselves more than the big picture, and so some residents liked the previous schedule because after the on-call, you're off the next day." For Dr. Niranjn, just getting residents to overcome their resistance to change was his initial hurdle. "It's always eas-

ier to go with what you know, but if someone does this new schedule, everything falls into place."

"I have a lot of personal commitment to this hospital," said Dr. Niranjn. Residents always worry about change because usually it means more work. But not in this case. We'll send out a survey after six months and get everyone's feedback on it. If I had this when I was a resident and fellow, I wouldn't have been so tired. I would have had a better quality of life and would have done a better job."

Propositions 75, 76 Would Turn Over Unprecedented Power to the Governor

California Special Election Threatens Unions, Health Care

Resident physicians in California are keeping a close watch on a special election called by Gov. Arnold Schwarzenegger. Scheduled for November 8, 2005, the ballot has two measures of particular concern to union members – Proposition 75, a proposition that limits a union's ability to fund legislative initiatives, and 76, a proposition that significantly expands the power of the Governor to cut programs in a fiscal crisis.

These two measures directly affect CIR, and all union members in California. Proposition 75, also known as, "Silence Our Voices" makes it difficult for health care unions to make gains for better quality patient care and access.

If faced with passage of Proposition 75, unions would have to create bureaucratic structures to reach each and every member for their consent for the release of funds for every political

voices" and limits our ability to act and react to an already rapidly changing health care system.

Voters also face Proposition 76, known as the "Power Grab"

in a fiscal crisis. A fiscal crisis could be declared if the state falls out of budget by 1.5% or if California's Senate fails to reach agreement on the budget after 45 days (not uncommon occurrences in California). For California's health care system, the measure could destabilize state funded health programs.

CIR housestaff in both the Northern and Southern California Regions have been gearing up for the election by registering and mobilizing their colleagues to vote. On June 25, 2005, CIR California housestaff also participated in a statewide conference with other public sector health sector workers to strategize about the special election.

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Proposition 75, also known as, "Silence Our Voices," would make it difficult for health care unions to make gains for better quality patient care and access, as we have in the past.

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campaign. Both California Measures A and B, which saved safety net trauma centers in 2002 and 2003, would never have happened if this proposition were in effect. The proposition "silences our

Initiative. The proposition broadens the fiscal power of the Governor greatly. Unprecedented in its scope, the Governor would have the unilateral authority to cut any budget item

CIR PROFILES RESIDENT CARTOONIST

"Laugh It Off" with Val Jones, MD

POST PARTUM



"Dr. Smith wasn't sure how to break the news to Mrs. Gordon that her medical insurance company had not approved her to give birth."



"In a bold, anti-hospital gown initiative, Mr. Smith adds the 'Half Monty' to his parallel bar routine."



RECOVERY ROOM



"Helmets and chin straps were provided to patients as part of the decreased hospital length-of-stay initiative."



"With the Pavlovian spirit, medical intern, Ari Friedman, springs into action at the sound of a series of pager-like beeps."

Just walk into Dr. Valerie Jones's office, and you know there's something very different going on here. While the rest of the hospital, including wards, hallways, and offices, is an institutional off-white color, her space is awash in color, a beautiful, inviting blue.

Now chief resident in the department of rehabilitation medicine at Saint Vincent's Hospital in Manhattan, Dr. Jones, self-starter that she is, took it upon herself to paint her own office. And as you talk with her, you get a sense that this former graphic designer is filled with a million ideas, combining a wide range of interests, for redesigning the world and making it a better place.

And as a sideline she's a freelance cartoonist, with a series, "Laugh It Off" that spoofs the medical world. "I've been drawing since I was a kid," she said. "The cartooning I do now is niched for other doctors – they appreciate the whimsy in what we do. I believe that doctors need a regular dose of laughter to help them through all the tragedy they deal with each day. Studies have shown that laughter in itself can be very therapeutic. We all need a

way to 'laugh it off,'" she said.

Her series has been picked up by Medscape/WebMD, and the alumni newsletter of her alma mater, Columbia University College of Physicians and Surgeons. She also exhibited her work at the American Pain Society's annual meeting in April, 2005, to good review. "People laughed out loud, and dragged their friends over to look at it."

She is currently working with hospital administration to add the St. Vincent's colors – blue, orange and yellow – to other areas of the hospital to warm it up and make it a more friendly place for patients. She has been in talks with her administration, and a medical technology company to set up a partnership with a neighboring school of design to combine beautiful interiors with cutting edge MRIs and CTscans that display light shows during imaging procedures. "It can be an enjoyable experience, rather than a terrifying black hole," she said.

She loves the field of rehabilitation medicine because "You're helping people get back to their life again, with their disabilities. We always focus on the positive, and work from that. I'm always think-

ing, what can you do, not what can't you do. This field will become more and more needed as the American population ages." It's well-suited to her varied interests. "It's a broad field, with pediatric rehab, sports medicine, and geriatrics." And to stretch the envelope just a little farther, Dr. Jones brings an interest in nutrition to the field.

"We need nutritional rehab, because the obesity epidemic affects people's rates of rehabilitation. If you're obese, you'll have more trouble with arthritis, and other health related problems. Twenty-four-hundred years ago Hippocrates said, 'Let food be your medicine,' but the medical field hasn't paid enough attention to that. Exercise is half the equation, which rehab works on, but nutrition is the other half," she said. Towards that end, Dr. Jones has been researching whether a dietary intervention can decrease the negative consequences of chronic sleep deprivation, working with residents on night float as subjects. Dr. Barry Sears, of Zone Diet fame, is one of the sponsors. Dr. Jones is the lead author, and their first paper has been submitted to the *New England Journal of Medicine*.