NYC HEALTH + HOSPITALS

New York City Council Hearing

NYC Interns and Residents' Wellness and Health

Committee on Hospitals

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NYC Health + Hospitals

September 24, 2021

Good morning Chairperson Rivera and members of the Committee on Hospitals. I am Dr. Omar Fattal, Deputy Medical Director for Behavioral Health at NYC Health + Hospitals (Health + Hospitals). I am pleased to be joined this morning by Dr. Machelle Allen, Chief Medical Officer, Dr. Donnie Bell, Deputy Chief Medical Officer, and Jeremy Segall, Chief Wellness Officer at Health + Hospitals. Thank you for the opportunity to testify before you to discuss ***NYC Interns and Residents' Wellness and Health***.

Health + Hospitals has a long history of taking care of the most vulnerable New Yorkers. Its mission is to extend to all New Yorkers, comprehensive and equitable health services of the highest quality in an atmosphere of humane care, dignity, and respect regardless of their language spoken, immigration status, gender, sexual orientation, disability, or ability to pay. In the same way that we take care of everyday New Yorkers and patients, it is a critical part of our mission to also take care of our staff and train staff including interns, residents, fellows (also referred to as trainees or house staff).

Through its own sponsored programs, affiliations and away rotations, Health + Hospitals trains approximately 2,700 residents and fellows annually through our GME offices, in addition to medical students. Health + Hospitals is especially unique in that we train a high number of foreign medical graduates, which we are

very proud of. The breadth of training spans from primary care, behavioral health and dental medicine, which are the foundation of health and preventative medicine, to highly advanced specialty and subspecialty services including interventional cardiology, surgical subspecialties and other medical subspecialties. Our trainees have numerous academic publications, awards and honors at national conferences and amongst national professional societies.

As COVID-19 surged and most New Yorkers were urged to stay home, Health + Hospital's health care workers, including its trainees, courageously stepped into the frontlines to battle the virus. The loss of patients and colleagues was devastating, even as the work was unrelenting. Our staff were and still are experiencing an immense amount of emotional psychological trauma and stress.

Health + Hospitals is fortunate to have two strong teams for support programs: Behavioral Health Services and the Helping Healers Heal (H3) program. H3 is the foundational infrastructure for enhanced wellness programming across all service lines of Health + Hospitals to address various needs of all staff. Initially the H3 program focused on adverse events and second victimization, but with the arrival of COVID-19, the program became more holistic, proactive and preventative, reaching out to staff members, establishing relationships, and creating safe spaces to decompress and share personal and professional experiences. In addition to our

standard wellness program for our trainees during pre-pandemic times, we also put in place several support mechanisms for our trainees during the COVID-19 surge including a Battle Buddies program, monthly safe-space debriefing sessions for trainees, town hall sessions to give our trainees a voice, food support and COVID-19 related compensation. Each of our acute and post-acute facilities also set up wellness/respite areas, or designated physical spaces for staff to use as temporary reprieve from work duties. Sites filled their wellness/respite areas with murals, paintings, cards of appreciation, relaxation activities, art therapies, and various snacks and beverages to fortify the staff's morale and spirits. H3 holistic wellness programming has evolved over the last few years and continues to address the emotional and psychological needs of our staff through debriefs, including, but not limited to: acute reaction to unanticipated and adverse work-related events, reaction to stress, secondary, vicarious, complex, and collective traumatization, as well as compassion fatigue, and burnout.

At Health + Hospitals we understand that while residency and fellowship years are a time of tremendous growth and can be very rewarding, they can also bring some challenges. That is why we have developed a dedicated webpage for our trainees to turn to for wellness resources. The webpage, *House Staff Safety & Wellness Resource Page*, is accessible from inside and outside of the Health + Hospitals

network and allows residents and fellows to take advantage of a wide range of services. It is dedicated to all house staff across Health + Hospitals regardless of their academic affiliation or pay line. Services and resources include:

- "Concierge Service" that connects house staff who are self-referred with mental health or substance use treatment services including evaluation, consultation, short-term psychotherapy, counseling, or medication management;
- Information on 1-800-NYC-WELL; a 24/7 crisis and referral line;
- Information on the Health + Hospitals System-Wide Anonymous Emotional Staff Support Hotline (646-815-4150);
- Free and confidential hotlines to discuss challenges;
- eLearning courses to address emotional and psychological distress, depression and suicide, burnout, and promote well-being;
- Peer-to-peer programs that allow house staff and medical students an opportunity to talk with a peer about some of life's stressors;
- Link to the Helping Healers Heal program;
- Trauma recovery network, a local team of the EMDR Humanitarian Assistance Program, which provides pro bono EMDR therapy to first responders and front-line medical professionals who have experienced critical incidents; and

- Residents information portal which provides valuable resources to the house staff including contact numbers, benefits information and other practical resources

In addition, we also have a house staff wellness workgroup that is comprised of: Medical & Professional Affairs/GME, Human Resources, Behavioral Health Services, Care Experience, Workforce Wellness, CIR resident members, as well as several attendings and a frontline nurse that meets the first Friday of every month. The structured workgroup was established in December 2020 to focus on wellness efforts specifically for interns, residents and fellows with the intention of establishing effective community building and communication across all residency programs, to foster a culture of accountability, to enhance pathways to support and treatment, and to nurture infrastructure for information and resource sharing. Recent recommendations from the resident wellness workgroups that have been implemented at Health + Hospitals include:

- A communication campaign to reach the Residents more directly;
- Required onboarding of incoming new Residents to learn about H3;
- H3 trainings for DIOs, GME Directors, APD, PD, and Chief Residents conducted at the facility;

- Leveraging other forums and platforms geared to younger generations as emails are not always the preferred method of correspondence; and
- Building in wellness discussions to protected time/curriculum, and speaking more widely about wellness during Grand Rounds, departmental meetings, morbidity and mortality conferences, etc.

At Health + Hospitals, we value each employee and their physical, emotional, and psychological safety and wellness is our top priority. Health + Hospitals has and will continue to support our frontline workers. We are always looking for ways to improve, in ways that we deliver care to our patients, as well as in the work environment for our trainees and staff. Thank you for the opportunity to testify before you today on this important topic. We are happy to address any questions you may have at this time.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Oversight Hearing of the New York City Interns and Residents' Wellness and Health Council Committee on Hospitals
September 24, 2021

Testimony of Judith Cutchin, RN on Behalf of the New York State Nurses Association
First Vice-President of the New York State Nurses Association;
President of the NYCHH and Mayorals Executive Council

My name is Judith Cutchin and I am the elected First Vice-President of the New York State Nurses Association and President of the NYC Health + Hospitals and Mayorals Executive Council. I am here today as the representative of the nearly 9,000 registered nurses that provide direct patient care in the Health + Hospitals system. In addition to my role as President of the Executive Council, I have ample direct experience of the vital role played by the public hospitals – I was born at Kings County Hospital and have worked as a front line nurse at Woodhull Hospital for more than 25 years.

It is critical that we stand here today in solidarity with our brothers and sisters in CIR. Our issues are often one and the same and we know an injury to one is an injury to all. When we are in need, we know we can always count on CIR to be by our side and we are proud of the work we have done and will continue to do together.

Many of the things that we want to bring to light and want fixed for our residents are similar to things we want remedied for our nurses. Oversight of the residence program in the hospital is sorely lacking. We know how detrimental such oversight can be and how it plays out in the public hospital setting. As many know, nurses across the state, country and world have continued to ask for oversight when it comes to poor nurse to patient ratios. There must be an outlet for continual dialogue between workers and administrators around best practices. There must be a way to discuss issues that arise and ways in which they can be corrected. In an atmosphere that is constantly hectic and busy, it sometimes feels like there just isn't time to do this. We must make the time though, because we know that it will make the system that much more efficient moving forward.

A lot of issues, like short staffing, come about from underfunding. We see underfunding taking place on many levels across the board. We must do more to try and fix this. We are hoping that the new FEMA COVID response money totaling $620 Million that has come into the system will help. We are definitely keeping our fingers crossed that more money will be coming from bills on the federal level that will hopefully pass soon. Underfunding of resources also hurts residents, nurses and patients by increasing wait times and delaying treatment. Ultimately this leads to poorer health outcomes. Additionally, this prevents critical education and training from taking place, use of the latest equipment and fine-tuning one's skills.

Out-of-title work is something that greatly affects residents. We understand how detrimental this can be when you are consumed with things that are not part of your job responsibilities. Nurses are often floated to areas they do not have the expertise in and are often saddled with jobs that do not have anything to do with patient care. Ultimately this haphazard system hurts patients and is unacceptable. In addition to out of title work, the workload that has been heaped upon residents and nurses alike has long surpassed what should be considered a healthy workload. This is causing a lot of distress amongst members who are not only taking on their workload but those of colleagues that have called out sick or are picking up the pieces of other titles that are not staffed appropriately. Essentially, short staffing creates a ripple effect that disrupts the entire system.

We are also aware of the fact that within a system that is not funded right and running smoothly, a toxic work atmosphere can occur and often does. An atmosphere in which supervisors are out of touch with the demands placed on those that work under them and lack an awareness that the mental health of these employees could be suffering. This is compounded by the fact that mental health problems still have a lot of stigma attached to them, especially when health professionals are experiencing them.

We implore you to listen to the concerns that have been highlighted and take necessary measures to correct them immediately. We look forward to working collaboratively with you and the CIR family to implement solutions that will benefits the patients, staff, and the community. We are confident that working collaboratively to address these concerns will result in a better Public Health Care system that our patients need and deserve.

September 24, 2021

Testimony before the New York City Council Committee on Hospitals regarding Interns and Residents' Wellness and Health

Chair Rivera and Members of the Committee on Hospitals and the Committee on Mental Health, Disabilities and Addiction, good morning. My name is Michael Leitman. I am a general surgeon and I have been practicing in New York City Hospitals for more than 36 years. For most of that time, I have also been responsible for the training of interns and residents – this is known as graduate medical education. Graduate Medical Education is the process by which new graduates of medical school enter our teaching hospitals to learn everything necessary to practice medicine in a particular specialty.

I am currently the Dean for Graduate Medical Education at Mount Sinai and their designated institutional official. I have the privilege of being responsible for the largest graduate medical education program in the United States – with 2,647 interns, residents and fellows learning and working at 8 Mount Sinai Health System Hospitals, Elmhurst Hospital, Queens Hospital Center (under the New York City Health and Hospitals) and the Bronx Veterans Affairs Medical Center.

Five and a half years ago, I learned of the death by suicide of a Mount Sinai resident – Esha Baicco. Esha was a beautiful, intelligent, well-liked and well-regarded physician. She had graduated from an international medical school and came to the United States to fulfill her American dream not only to be a physician, but a specialist in gastroenterology and a researcher to find treatments for colon cancer. We never knew that she had any emotional health issues.

She was not the first resident that died by suicide – two residents from New York Presbyterian had done so about a year prior and an New York University resident died by suicide a year later. This year, three residents died by suicide in New York City. A physician commits suicide in the U.S. every day -- the highest suicide rate of any profession. And the physician suicide rate is more than twice that of the general population.

I am grateful for your interest in the well-being of our interns and residents. This is a huge problem that received very little attention until about five years ago. These tragic events are just the tip of the iceberg of a national problem. Until recently, we were focused only on resident duty hours, supervision, patient safety and education. Right now, there are 14,000 interns, residents and fellows on duty on

the front lines at our New York City Hospitals. We are suffering from an epidemic of burnout and depression among our trainees.

Emotional health issues begin in medical school where more than 25 percent of our students are receiving some type of treatment. During internship and residency, the percentage drops to 5 percent, not that students that graduate are freed from this mental health burden. Rather, the majority do not seek help for their underlying behavioral health issues due to their very busy schedules, the stigma of seeking out mental health services, the need to burden others to cover them while they seek out mental health services, and the impact that treatment has on their ability to work and study for long hours.

Burnout is a psychological syndrome that is defined as emotional exhaustion, depersonalization and a diminished sense of personal accomplishment that occurs among various professionals who work with other people in challenging situations. The negative impact of burnout is that it not only affects the physician, it may also result in impact to patients, coworkers, family members, close friends, and healthcare organizations.

Depression among physicians is more than two or three times as common than in the general population and can lead to increased medical errors, lower patient satisfaction and higher rates of turnover. Outside of work, depression can result in broken relationships, substance abuse problems and even suicide.

Burnout and depression are not the result of working excessive duty hours. Rather, they result from the intensity of the work that residents do, the need to study and pass examinations, the moral injury from spending a lifetime to finally reach a point where they are permitted to practice medicine and they become disappointed when they learn that there are limits on the ability of treatments for certain diseases and for patients with limited resources. Interns and residents carry an average student loan indebtedness of more than $200,000 and 25% have student loan debt of $300,000. And they come to realize that at the end of the road of being a student, they often have another 4 to 10 years ahead of them for further specialty training. And when they finally see the light at the end of the tunnel, they realize that their supervising faculty often work just as many hours, work just as hard and also demonstrate resentment about a very difficult way of life.

Working conditions are better than they were generations ago when people like me worked the excessive hours as a resident that were partially attributed to the death

of Libby Zion. There is now around the clock supervision and instruction from dedicated teaching faculty. But the intensity of the work, based upon the need to treat many and very ill hospitalized patients in an ever more complex healthcare environment does take a toll on intern and resident wellness and health.

After Dr. Baicco's death, we first measured burnout and depression utilizing and well-accepted and scientifically validated survey tools. The majority of our residents completed the survey. We found that overall, 57% percent of our residents screened positive for burnout. Forty percent of residents screened positive for depression. In some programs, depression was as high as 80% of residents and burnout was measured to be as high as 92% in some programs. We also found that there were certain factors that caused burnout and depression - like being too busy to attend educational conferences, time spent on the electronic medical record and the need to perform clerical non-professional tasks. We also found other factors that increased well-being, such as having departmental well-being champions, promoting team building, support for families of international medical graduates, investing in food panties and group meetings to learn techniques for building resilience. We invested in well-being self-screening tools, mental health services, supporting interns and residents with physician assistants and nurse practitioners. And we created a position for a Chief Wellness Officer

with the right resources to support ongoing research and support to enhance the professional and personal lives of our interns and residents. And while we continue to see marked improvement in burnout and depression among our trainees, we also realize that the work that they do continues to be even more challenging, especially during a pandemic.

When our house staff graduate and become fully trained independent practitioners, they move into their careers without all the support of our teaching hospitals, and they remain in careers that challenge their well-being. The personal toll of the practice of medicine continues well after training with persistent burnout rates that still exceed 50% in many medical specialties.

There is some good news here. Burnout and depression rates have continuously come down, even during the COVID pandemic. There is now national attention to the issues of intern and resident wellness. We carefully monitor all of our trainless for signs of stress. We and others have done much research into how to mitigate the impact of training on young physicians. Chief Wellness Officers have markedly increased around the country and more of our teaching hospitals have appointed leaders in well-being for their professional staff.

In summary, New York City's interns and residents play an important front line provider role as they underdo necessary training to develop the skills necessary for independent practice. But there is a crisis in the wellness of our junior physicians that takes a toll on their personal and professional lives, negatively impacts patients, and ultimately the health of our city. More research and resources are necessary to understand how to mitigate this problem and invest in a healthier physician workforce and a healthier New York.

The Committee of Interns and Residents/SEIU

Written Testimony
Hearing on Intern and Resident Wellness in NYC

What is Residency?

Residency is a training period in which medical school graduates specialize in their fields of medicine while providing patient care under the supervision of attending physicians. Residency typically lasts from 3-7 years and common specialties include internal medicine, pediatrics, surgery, and radiology.

The Match is an algorithmic process that places medical school students into residency training programs. After a round of applications and interviews, programs and applicants rank each other and submit their lists to the Match. It then uses that information to make the placements. The results of the Match determine the rest of a physician's career and it can be devastating if they are unable to be placed in a program. Each year approximately 2,000 US medical school graduates go unmatched as there are more applicants than available residency spots. In order to change residency programs at any point during residency, physicians must try to match with another program. Unlike other workers, residents cannot simply withdraw their labor and find a position elsewhere.

Resident physicians, also known as housestaff, are a unique workforce as they are frontline care providers with full clinical responsibilities- however, they are also learning their specialty and must complete exams, presentations, and research in order to progress through each year. Due to the dual clinical and educational nature of residency training, a hospital is not meant to rely on
residents to provide patient care. Residents are meant to be supplementary.

Burnout and Suicide in Residency

About 50% of resident physicians develop burnout during training and 25% develop clinical depression, a rate that is 3-4 x higher than other workers. Suicide is the leading cause of death for male residents and the second leading cause of death for female residents. Studies have determined that a lack of systematic approaches to reporting and assessing the statistics, cultural attitudes towards determining how suicide is defined, and differing procedures for obtaining evidence about deaths indicate that physician suicide is likely under-reported.

Identified drivers of burnout, suicide and poor well-being in residency include:

- Long work hours
- Culture of hazing and bullying
- Out-of-title work
- Student debt
- Lack of mental health services

The ACGME and medical community at large have focused their interventions to address resident well-being, burnout and suicide on building individual resilience and coping mechanisms rather than addressing the systemic drivers of poor well-being, burnout, and suicide listed above.

The ACGME and "Oversight" of Residency Programs

The Accreditation Council for Graduate Medical Education (ACGME) limits its oversight of programs to accreditation. It exists to ensure that the physician workforce is clinically competent and generally nothing more. Residents are surveyed annually by the ACGME. This process is supposed to be safe and anonymous, but hospital leadership has access to resident responses. Residents routinely feel pressured into responding positively as they are told that revealing negative information would shut down their programs and leave them unable to complete their training.

Residents report having to sit through presentations on how to "correctly" complete the ACGME survey, being watched while completing the survey and even having program administrators publicly and in one-on-one settings try to intimidate residents into revealing who gave bad feedback. The Survey is far from an adequate means of ensuring oversight and providing a safe space for residents to provide feedback on their supervisors and the program as a whole.

Resident Work Hours

Modern day residency training began at John Hopkins Hospital and was led by Dr.William Stewart Halsted, becoming the model for surgical and medical residency training across North America. A brilliant surgeon and anesthetist, Halstead also struggled with addictions to cocaine and morphine; the critical design feature of his residency training model was the extreme delegation of clinical and educational work to trainees in order to help him hide his addictions and cover up gaps in care for his patients. This practice continues today with individual attendings, departments, and health systems relying on residents to cover staffing and resources shortages.

After residents graduate medical school and start work at a hospital, they become part of what's called the "house staff", taking part in the care of patients while learning the particular field of medicine they've chosen to specialize in. For their first year, they're called "interns", and after that "residents" or "house officers." These terms harken from Halstead's era, when young physicians

were actually required to live at the hospital – taking up residence in or near the building where they practiced.

Residents are commonly told they have it much easier than their attendings and even easier than previous generations of physicians who had to live at the hospital. However, modern day patient care is demonstrably harder- trends over time have shown that patients admitted to the hospital are less stable and have more complex diagnostic and treatment needs than in past decades, yet medical technology and issues like the focus on moving care to ambulatory settings and reducing length of stay have resulted in patients' hospital stays being shorter. Your average patient on the medical ward is more like the average patient in the ICU 10-20 years ago, and all this has compressed the time residents have available to complete their work and learn from individual patients.

Here in NY State, a tragedy was borne out of Halstead's model that led to increased public scrutiny. In 1984, the death of a young woman, Libby Zion, was attributed to a medical error borne out of a resident fatigue at New York Hospital. A grand jury trial recommended limiting resident work hours to improve patient care, and in 1987, the New York State Commissioner appointed a committee that recommended major regulatory changes in residents' duty hours. New York adopted the Bell Commission's regulations that limited resident work hours to 80 per week beginning in July 1989.

Facing a threat to their own authority from the Occupational Safety and Health Administration (OSHA), from legislation proposed by Michigan congressman John Conyers, Jr. based on the Libby Zion case, and a potential lawsuit from residents who were organizing unions at the time, the ACGME stepped in and limited work hours.

Hospitals had the burden of having to institute night floats and making attendings be physically present in the hospital at all times, as well as figuring out scheduling for residents to make the # of cases required for clinical competence. In 2014 the Annals of Surgery published ONE study claiming duty hour restrictions do not actually reduce the risk of patient harm, and the ACGME immediately rolled them back. The new proposal allowed residents to work up to 28 consecutive hours and, in a Kafkaesque twist, requires training programs to provide 24-hour access to mental health services in order to deal with the resulting depression and anxiety.

This study was problematic:

1. It only looked at 117 total surgery residents
2. It only looked at interns, who do very little surgery- at most usually just the opening incision
3. The statistical analysis only looked at uncommon types of patient harm (i.e. death) resulting from surgery that the residents were for the most part not doing

4. They study did not examine the impact on residents, with no attempt to identify adverse outcomes occurring among individual residents such as automobile accidents, withdrawal from training, and suicide
5. Stack these results against research demonstrating significant impairment due to sleeplessness. Decades of sleep science are unequivocal: After working 17-23 hours, subjects deteriorated in their reaction time, dual-tasking, hand-eye coordination, vigilance, and spatial memory equal to that of the same individuals when intoxicated. A true concern for patient and physician safety would impose restrictions on physicians, like those that exist for pilots, truck drivers, and soldiers, most of whom are not making the complex, life-and-death decisions that residents are making on a daily basis.

Regardless of what regulations there are around resident work hours, the current system requires that residents self report their work hours. They are required to do this under great pressure to underreport so as not to gain negative attention from the ACGME. Residents who do try to accurately report their work hours are often met with pressure to change them, or are told that their increased hours are due to their inefficiencies or simply a personal choice to stay later and that the resident must improve.

Foreign Medical Graduates

A foreign medical graduate (FMG) is a physician who has graduated from medical school in a different country from where they practice. Considering the acute shortage of doctors across the nation, the U.S. healthcare system is heavily reliant on FMGs who not only make up a quarter of the physician workforce but who also often serve under resourced communities. This is especially true for high density cities like New York City and rural areas around the country. FMGs may have just graduated from Medical School or they may have been practicing physicians in their home country for many years. In order to practice in their specialty in the US physicians must complete residency training regardless of what level they practiced in their home countries.

Most FMGs enter the U.S. on J1 (Exchange Visitor) or H-1B (Specialty Worker) visas. The process for obtaining and renewing these limited visas is lengthy, complex, and costly. These visas are also contingent on the physician's employer which means that the legal immigration status of many resident physicians and fellows is dependent on their training programs. After the validity period of these visas expires, FMGs must either leave the country or find a sponsor for legal permanent residency to remain in the U.S.

Residency at NYC Health + Hospitals

There are approximately 2,800 housestaff in the NYC Health + Hospitals system at Bellevue Hospital, Coney Island Hospital, Harlem, Lincoln Medical Center, Jacobi Hospital, Metropolitan Hospital, Kings County Hospital, Woodhull Hospital who are all covered on a master contract and

an additional 249 residents and fellows at Elmhurst Hospital employed by Mt. Sinai on a separate contract.

These interns, residents, and fellows provide frontline care to the most vulnerable New Yorkers and will most likely be the care providers that those seeking care at NYC H+H will interact with. In addition to providing care at these hospitals, housestaff also rotate to community clinics and other hospitals.

Our city hospitals heavily rely on residents for patient care. They're called upon to fill in gaps in coverage that would be performed by nurses or other midlevel providers and are also expected to teach medical students and junior residents. As such, programs often lack proper teaching as it is frequently sporadic, non-standardized, and absent in constructive feedback. Additionally, many programs lack experiential learning in the systemic dynamics shaping patients' lives,including socioeconomic factors and the health impact of policy and geography.

While H+H functions as a health care system for New Yorkers, the residency programs operate without a system-wide level of oversight. Program administration at each hospital may meet through Graduate Medical Education meetings but there is no overarching H+H GME structure to share best practices, identify issues within programs, and hold them accountable. During the most recent contract negotiations in 2019, CIR won an H+H Resident Well-Being Committee to address systemic well-being concerns. However, the onset of COVID delayed the formation of the Committee and only a small amount of one-time funds was allocated for it.

In New York state, hospitals receive funding to train residents from the Federal and State Government. Both Medicare and the NYS Medicaid program provide Graduate Medical subsidies to hospitals which train residents. Health + Hospitals facilities receive over $160 million per year from the federal government and over $230 million from NY's Medicaid Program.

Medicare Direct GME	**$98,072,117**
Medicare Indirect GME	**$62,992,726**
Medicaid GME	**$230,794,792**
Per Resident/Slot	**$159,092.70**
Residents/Slots	**2387.36**

<u>Resident Well-Being at NYC H+H</u>

Out-of-Title Work and Workload

Residents routinely perform extensive out of title work which is the assignment of duties outside of an employee's title. For residents, these can include IV services, clerical services, routine vital signs and weights, phlebotomy services, discharge planning and services pertaining to the movement of patients and materials Chronic understaffing across nursing and ancillary services at H+H forces residents to take on these duties for the sake of their patients. This is not only disruptive to residents' training but adds additional burdens and high work loads that contribute to stress and burnout.

If a resident calls out sick from work, another doctor is not brought in to cover their clinical duties in most cases. The duties instead fall to the other residents on the service in addition to their already high workloads, breeding resentment and guilt regarding taking necessary time off to care for one's physical or mental health. In 2019, contract negotiations CIR won 4 'wellness' days per year that residents must schedule 30 days in advance with the intention of shifting this culture.

During bargaining, CIR has successfully secured contract language in most shops that institute protocols to prevent residents and fellows from taking on incongruous work and which allow them to file grievances if there is a provable and consistent pattern of having to perform out of title duties. The contract language does not, however, allow a grievance under this clause to go to arbitration.

Lack of Resources

Programs often call on residents to use union funding to offset budgetary constraints. From replacing damaged equipment to helping launch new clinical programs, hospital leaders often pressure residents to request funding from their union - creating additional stress and tension in a notoriously demanding work environment.

Systemic under-funding compels many residents and hospital staff to rely on CIR's Patient Care Trust Fund (PCTF) for even basic medical and safety resources. Each year, house staff across H+H regularly apply for PCTF grants to equip their departments with everything from routine exam room supplies, such as eye charts, otoscopes, and pill boxes, to essential protective equipment including lead vests and goggles to protect radiologists and dentists from harmful x-ray radiation.

Insufficient resources undermine care and safety, limit resident education and training, and reinforce broader health inequalities. When departments lack appropriate clinical resources, patients suffer long wait times, delayed treatment, and poorer health outcomes. At the same time, residents miss out on opportunities to gain skills and exposure to cutting-edge diagnostic and treatment modalities. This intensifies the chronic and complex health challenges already

faced by medically-underserved communities due to the unequal distribution of health and social resources.

Moral Injury

The impact on resident wellbeing and health due to a lack of resources and staffing is exacerbated by the moral injury of practicing medicine in a segregated care system, where the patients residents at H+H care for struggle to receive the same level of care as wealthy white New Yorkers.

Many patients enter H+H hospitals with multiple, overlapping health issues that are directly tied to structural racism and the health impacts of poverty, and residents report the heavy emotional toll of knowing that there is only so much they can do in their capacity amidst such steep inequities. H+H patients also often have low levels of health literacy, but residents are drawn away from time they could be spending with patients to make sure they understand their health plan to do out-of-title work, again, due to understaffing.

Many residents specifically pursued residency at NYC H+H because they wanted to work with underserved patients and contribute to chipping away at inequity in our healthcare system, but no amount of passion for this can diminish the effects of burnout, moral injury and deep exhaustion. Stories from residents who divide their time between Bellevue Hospital and NYU Langone illustrate the tremendous disparities in healthcare in New York City and the impact on residents and our city overall.

Culture of Fear and Disrespect

Residency is an inherently difficult period where residents work incredibly long hours while absorbing incredible amounts of new information at a time. They're often viewed at the lower end of the hospital hierarchy and are treated as cheap, specialized labor. Older physicians, who have a direct influence on the future careers of residents, may also possess a mindset where they feel trainees should "pay their dues" just as they did during their own training despite the fact that the breadth of medical knowledge is exponentially greater than it was even 30 years ago. This situation can lead to a de facto hazing culture.

On top of the innate hardships of residency, some programs can be particularly toxic. Common signs of this are an abusive training environment, unresponsive program leadership, and lack of institutional support. Due to the hierarchical nature of residency, trainees often feel they cannot voice concerns or objections out of fear of reprisal. There is also little formal recourse available to residents to report major issues within their program or hospital. Since completing a residency program is a requirement to practice medicine and it is incredibly difficult to match into a different one, residents are reluctant to take any action that may endanger their place in their training programs.

Mental health needs are essentially taboo in medicine where there is a prevalent “tough it out” culture. Due to work hours, stigma, and many licensing bodies and employers asking what mental health treatments a physician has sought, accessing mental health services is extremely difficult for residents.

Resident physicians are regularly pitted against other healthcare workers. Staffing shortages and a lack of resources can lead to competition with nurses, technicians, and other hospital staff for support and reasonable care loads. Many times in these kinds of environments, doctors are told to work through the hardships by those invoking and exploiting the altruistic aims of the caregiving profession.

Financial Strain

Resident physicians living and training in urban areas face considerably high costs of living. Cities like New York and San Francisco severely lack affordable housing. As residents are required to live near their hospitals in order to respond quickly when on-call, they are heavily rent burdened. Considering the long hours residents work, they often earn what works out to be little more than minimum wage. This situation presents a significant economic burden.

The average medical school debt in the U.S. is $215,0006. With interest accumulating daily, a resident could owe almost double the debt they graduated with in medical school by the end of their residency. The strain of making monthly student loan payments in addition to covering basic living expenses is significant and has a negative impact on well-being as it leads to stress and burnout for resident physicians.

Housestaff at H+H are salaried employees who do not receive overtime pay, weekend pay or additional compensation for being on home-call or back-up call except when covering a call shift or night float for a colleague who is out sick, on maternity, disability, or personal leave.
The lower compensation and lack of additional overtime pay results in residents often feeling less valued than other hospital employees. Through contract negotiations, CIR has secured additional pay for residents who have to cover a ‘call’ for a colleague who calls out sick for their scheduled ‘call’ shift. In the most recent negotiations in 2019, CIR won holiday pay for residents working any of the federally mandated holidays, though this is not an ongoing benefit and is funded by a finite pool of money.

H+H salary Scale

PGY Level	Salary (Effective 3/26/2020)
PGY-1	$66,247

PGY-2	$68,989
PGY-3	$74,469
PGY-4	$77,049
PGY-4	$79,307
PGY-6	$81,403
PGY-7	$85,593
PGY-8	$87,382

*In addition, residents also receive a meal stipend of $3,500 per year paid on top of their salary level.

CIR Programs Working to Address Resident Wellness Needs

Patient Care Trust Fund (PCTF)

CIR's Patient Care Trust Fund (PCTF) is a resident-led fund dedicated to improving patient care and safety in New York City's public hospital system. Each year, we provide house staff at NYC Health + Hospitals (NYC H + H) with critical funding to reduce health disparities, strengthen medical education, and meet the complex health needs of their patients and communities.

Through member engagement and grants for clinical research, medical equipment, and community- based partnerships, we ensure residents from every specialty have a powerful voice to enhance residency and advance quality care for all New Yorkers.

Background

Following the 1970's fiscal crisis, CIR members established the PCTF in 1981 to address the widespread understaffing and chronic supply shortages in city hospitals that endangered public health and patient safety. After a high-profile campaign against a proposed plan to privatize and downsize the city hospital system by 50%, residents secured the Fund in the CIR-NYC HHC (as it was known at the time) union contract. To provide seed money for the first round of grants, residents voted to give up a year's worth of raises—equivalent to $515,000 today.

Today, the PCTF has grown into a highly-utilized, multimillion-dollar nonprofit foundation. We receive over **$4.5 million in requests** and provide **over $1 million in funding**, with only about **$630,000 from NYC H + H**, annually. During the last grant year, including the peak of the COVID-19 pandemic, **the PCTF grants improved the lives of an estimated 423,000 patients (40% of patients) and 1,400 residents (53% of HSO's) at NYC H + H.**

An enduring lifeline for preventive care and public health infrastructure, over the past 40 years,

CIR's PCTF has been developing a strategic model for systems change—one that is evidence-based, community-driven, and laser-focused on health equity. By increasing the City's investment to keep up with demand, **the PCTF is well-positioned to partner with elected leaders to meet NYC's top health priorities**—from improving our COVID-19 response in the short term to renovating our overworked public health system into a robust national healthcare leader for the future.

Grantmaking Overview

Our grantmaking model puts providers and patients at the center of health systems change. Every year, residents from hundreds of departments throughout H + H submit detailed proposals for equipment and research grants to an all-resident Board of Trustees, representing a wide range of PGY, specialties, and neighborhoods. Applicants must identify the specific, measurable impact that their request will have on patient experience, resident education, and health outcomes, as well as receive approval from hospital and clinical leadership, in order to be considered for funding.

This process helps ensure that precious health resources are both equitably and efficiently deployed. Clinical funding decisions are defined by current patient needs and empirical research, not politics or budget constraints. Over the past five years, **the PCTF has invested approximately $6 million in the nine (9) NYC H + H hospitals** where CIR members work, including:

- **$5.4 million in world-class medical equipment and resident training materials** empowering residents to move essential resources to where they are most needed and will have the widest impact in their hospitals. Through new materials and equipment upgrades, grant recipients ensure H + H patients can access services on par with the region's best private facilities.

- **$700,000 for breakthrough clinical research, quality improvement, and community-based health projects** that complement the impact of our equipment grants. As both providers and trainees, research grant recipients work at the intersection of community medicine and clinical innovation. Their innovative scholarly and practical initiatives help address key health determinants through community advocacy and education, pilot novel studies to introduce safer and less invasive protocol in their clinics, and move additional resources to preventive care in medically-underserved communities.

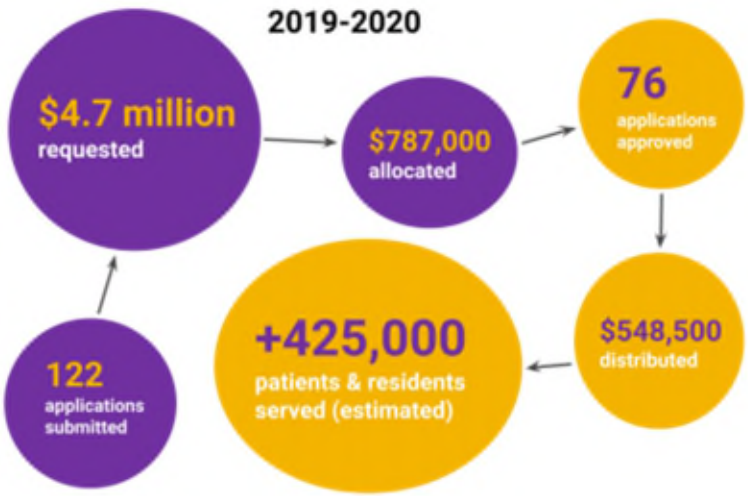
Lastly, while our Board of Trustees devotes most of its budget to upgrading and modernizing
hospital infrastructure, **systemic under-funding often forces residents and hospital staff to turn to the PCTF for even basic medical supplies.** During the last grant cycle, we fielded requests for routine exam room supplies (such as pill boxes, children's books, dental shields, ear candles, etc) at Coney Island, Harlem, Jacobi, Kings County, and Woodhull as well as essential protective eyewear and vests at Jacobi.

Recent Grants

Since 2019, CIR members have donated $548,500 to help remedy the unequal distribution of resources and racial, gender, and economic disparities in the NYC health system by:

- Introducing over $250,000 in state-of-the-art portable imaging technology to bedsides and clinics at every hospital in the system, including a fleet of hand-held Butterfly ultrasounds to Bellevue, Coney Island, Elmhurst, Jacobi, Kings County, and Lincoln hospitals. Enhanced imaging improves diagnosis and clinical decision-making while reducing patient visits and wait times.

- Improving medical education and safety with over $50,000 in cutting-edge stimulation equipment, such as life-sized mannequins and laparoscopic training instruments, for the simulation training centers and multiple departments at Jacobi, Kings County, Lincoln, Metropolitan, and Woodhull. New training resources allow residents to gain exposure and master skills necessary for delicate procedures, which in turn, results in safer, better care options for patients.



Covid-19 Response

Our members care for the patients and communities that have been hardest-hit by the pandemic, including essential workers, undocumented immigrants, and the uninsured. Beginning in March 2020, **the PCTF has committed close to $100,000 in research, equipment, and wellness resources for COVID-19 relief**:

- $25,000 to support empirical research on improving diagnosis and treatment of COVID-19. Alongside research staff and materials, this funding has enabled residents to secure elite data- acquisition hardware to better monitor key health metrics:
    - ER residents at Lincoln Hospital will use a recent PCTF grant to purchase a $5,000 custom-built super computer that will analyze complex health data collected over the past year. Using doctor-designed models to process thousands of secure data points, the computer will help providers better identify hidden risk factors and reduce mortality among high-risk patients with COVID-19.
- $52,000 in point-of-care resources to improve availability and safety of intubation, central line placements, and other complex procedures among critically-ill patients with COVID-19:
    - As the pandemic overwhelmed Elmhurst Hospital in April, the PCTF provided

residents in Internal Medicine, Pediatrics, and Psychiatry with a $15,000 grant to obtain three hand-held ultrasounds, two mobile workstations, and 75 new pulse oximeters. These resources made workflow more efficient and manageable, and more important, helped patients get in and out of the hospital faster.

- $15,000 in food, personal protective equipment, and other wellness supplies to address all-hands-on-deck burnout. Before private donors took action, the PCTF provided two weeks' worth of meals to Internal Medicine, Pediatrics, and Psychiatry residents at Harlem Hospital; gloves, gowns, and face shields to MICU residents at Metropolitan Hospital; wellness resources, including succulents and other plants, for the Kings County OB/GYN Department.

PCTF Grantmaking *January 2016 – January 2021**			**Estimated Impact** 2019-20	
Hospital	**Requested**	**Granted**	**Patients**	**Residents**
Bellevue	$1,676,287	$833,390	2,570	104
Coney Island	$2,586,858	$676,407	5,000	12
Elmhurst	$98,054	$77,942	10,000	141
Harlem	$1,586,695	$425,647	17,618	161
Jacobi	$2,930,234	$741,976	187,500	176
Kings County	$4,682,383	$1,278,142	145,000	314
Lincoln	$1,209,734	$496,370	22,270	220
Metropolitan	$1,563,963	$353,571	22,00	138
Woodhull	$1,177,257	$479,407	11,800	104
Total	**$17,511,465**	**$5,362,852**	423,758	1,370

The Family Health Challenge

The Family Health Challenge (FHC) is a program that began in 2013 as a way to address childhood obesity through partnership, education, and action. Developed by CIR, the Mary Mitchell Family and Youth Center in The Bronx, and the Albert Einstein College of Medicine, the 8 week evidence-based curriculum encourages elementary school students ages 7-11 to adopt healthier nutrition and physical activity habits by making small, gradual changes each day.

Through a partnership with the United Federation of Teachers' United Community Schools, doctors from CIR typically go to community schools in The Bronx, Brooklyn, and Queens, in their white coats and scrubs, to deliver these simple health messages to students while encouraging them to take these messages of health home to their families. We have engaged over 750 CIR doctors and over 2500 NYC school children.

The structure and organization of the curriculum and its components have been instrumental in CIR developing relations with various Pediatrics, Psychiatry, and Emergency Medicine programs across the H+H system, embedding FHC into Community Rotations and/or Ambulatory Rotations so residents can have the opportunity to participate in the program while fulfilling the program requirements. The hospital programs see the value of resident participation in FHC as an important part of their formation as well-rounded, compassionate doctors.

Participating residents have praised FHC, a program funded by the Patient Care Trust Fund, and CIR has received many anecdotes about how the program impacts resident training. In a 2016 research project, also funded by the PCTF, participating CIR felt strongly that they were making a difference through FHC, and adding valuable ways to connect meaningfully with the communities they serve. This type of experiential learning has added much value and a renewed sense of purpose to our members and it is crucial that we continue to support programs like FHC.

Every semester, we collect feedback from our members to make sure they are receiving the benefit from participating in FHC. We do this by sending an end survey where we collect quantitative data, but also ask some open-ended questions. These were some of the residents' responses when asked about their experience participating in FHC:

"I loved the teaching sessions I participated in and hope to continue to be involved!"

"Family Health Challenge was an amazing experience!"

"Great initiative"

"I loved FHC as it allowed me to learn about the lifestyles and knowledge base of my patients. I also built on the patient-physician relationship by interacting with them in their classrooms/communities."

"I really enjoyed this experience."

"The Family Health Challenge was incredibly eye opening for me in terms of the children's knowledge of health and how to help them to learn and implement healthier lifestyles. I will carry the experience with me for decades to come."

Lincoln Walking Tour

The sizeable health disparities in this country- and the economic and racial/ethnic inequities that produce them- are recognized as playing a central role in the health challenges faced by many patients at safety-net hospitals. In response, the ACGME has strengthened its standards requiring resident physician education on those disparities in the communities they serve. Despite these requirements, physicians are not adequately trained to understand the dynamics shaping their patients' lives. Few physician training programs with established curriculum on health disparities exist; experiential opportunities in the communities served by hospitals are even rarer. Lincoln Medical and Mental Health Center is one such program without established curricula or experiential learning opportunities about health disparities in the community. This gap in training is exacerbated by the fact that a small minority of physicians come from the communities they serve.

This year, members of the Committee of Interns and Residents, our house staff union at Lincoln, decided to come together and begin to take action to fill this gap in our training. We used our collective voice to advocate for an experience that would allow our new colleagues to receive an accurate, thoughtful picture of the community they will be training in and caring for. We wanted an opportunity that was compelling for physicians, inspired community service and reinforced the core professional values of altruism and compassion, qualities that can fall by the wayside when we do not understand the context of our patients lives. Not only did this tour help us connect with the community and begin to repair the past wrongs from medical providers, it highlighted the unsung work that community organizations are doing to address the poverty that surrounds the hospital. It made us feel more connected to the history of the South Bronx and more empathetic to the struggles of our patients. The tour also gave us a sense of places we can go to for respite from the demands of residency because of the emotional and mental support they provide.

Hospital Specific Issues and Written Testimonials from H+H Residents

Bellevue Hospital

There are approximately 490 housestaff employed by H+H at Bellevue Hospital, however the number of housestaff working and providing care at Bellevue is much higher (likely double) since the programs are split payroll. Residents are split between NYU and Bellevue payroll with some residents also on VA and New York State payrolls. Residents predominantly provide care at NYU Tisch, Bellevue, and the VA. Some programs also have residents rotate to NYU in Brooklyn and the Brooklyn VA. How residents are split between payrolls differs by program, some will offer residents a choice of which payroll they wish to be on while others will arbitrarily assign residents to a payroll. Some programs will split residents by PGY, for example all PGY1-2 are on one payroll and PGY 3-4 on another. Residents who have to change payrolls report issues with navigating their changing benefits such as health insurance.

Out-of-title Work

Like all H+H Hospitals residents report that out-of-title work is a key contributor to poor wellbeing and stress. The impact is further compounded by the experience of toggling between public and private hospitals and seeing the very real difference in services and care.

Phlebotomy has been a long-standing issue at Bellevue across all departments with residents having to constantly fill the gaps and draw blood and transport samples. Bellevue also suffers from a lack of social workers leaving residents to fill the gap to help their patients who are often homelss, undocumented or incarcareted, and thus requiring addition assistance to navigate the hospital and the services residents try to connect them to.
A lack of transport staff is also an ongoing issue, leaving residents transporting patients themselves for MRI, CT Scans etc. If the residents do not do the transpor, the patient will miss their slot for imaging and care will be further delayed. Furthermore, the lack of support staff for clinics leave residents to undertake clerical work and take vitals for patients, leading to delays and a patient backlog. Residents also lamented not having a Pyxis for meds in MRI
One example of nursing understaffing at bellevue is seen in lactates Nursing and pcts which requires residents to undertake multiple follow up enquiries for their patients which delays care and takes away from other physician duties that must be performed.
Dental and OMFS residents at Bellevue report that there are insufficient dental assistants meaning residents will have to clean and break down their own operatory and take x rays and look for material and supplies which are often not stocked, again increasing workload and hours for residents and delaying patient care.
Residents working the Bellevue Emergency Department report they are running the ER with 5-7 nurses instead of the 16 that there should be, with one nurse having 20+ patients. For residents this is frustrating and frightening to expect one person to be able to handle that amount of critical work. Residents also report staffing issues i the Bellevue PICU where they say resources are limited and slow to mobilize, there is no attending or fellow just a resident in house overnight. Residents also report struggling with lack of clerical and patient support leading to having patients come on time to their appointment but not being roomed until 1-2hrs later leaving residents to constantly be running late and apologizing to patients for their wait.

<u>Equipment/Resources</u>

Residents at Bellevue also reported a frustrating lack of basic resources that delay care and require additional effort and onus on residents, for example residents report a lack of availability of Blood Glucose test strips and that the ED ran out of surgical collars at one point this year..
Residents experienced struggling with a lack of adequate translation services and said they needed greater access to video translation services.
The infrastructure issues at Bellevue, while seemingly minor, continue to cause additional stress. Residents reported that the elevators are often slow or out of service leading to delays in reaching patients.

Residents reported that their call Rooms are not cleaned properly and are not supplied with linens, residents have to source linens from the nursing station where patient linens are kept. Linens are not always available and other hospital staff are not aware that this is the “correct” protocol and will chastise residents for taking patient linens. Used linens are also regularly not collected from call rooms.
In addition to the physical infrastructure issues, residents also reported issues with IT. Dental residents reported the need for a technology update as they still use paper pre-authorizations and paper referrals despite there being programs available like Allscripts where it's easy to type internal consults to PCP and referrals and you can print it out.
Bellevue Residents also reported the lack of imaging services available was a major stressor including there only buying one CT scanner available at night to service the whole hospital. Residents also reported that the MRI services are not adequate for the patient load. Residents report long waits for their patients to receive an MRI and having to wake their inpatients during the night to receive their MRI because MRI slots are fully booked during the day for outpatients.

Culture/Other

As a split payroll hospital with half of all residents not unionized, the lack of union representation and protections when working at NYU and a sense from residents that H+H does not do enough to advocate for them with NYU. Residents reported that NYU has a culture of retaliation for residents who speak out on workplace issues or undertake patient advocacy efforts. This was shown during the pandemic with the response from NYU administration when residents attempted to advocate for hazard pay and against a narrative that NYU had better patient outcomes than hospitals like Bellevue because of “team work”. The fear of retaliation is real among residents at Bellevue and residents feel they need greater support from H+H in pushing back against NYUs actions.

Residents reported deep distress after NYU reviewed the Emergency Department and found that they did not like the program's Social Justice tendencies and have since made a number of changes including no longer having interns work at Bellevue, pushing a higher workload onto the remaining residents and limiting the interns' exposure to only the patient population of NYU. During this review process and in the aftermath the Emergency Department also let go a number of faculty that had been advocates for the residents, leaving residents feeling that this was retaliation for their advocacy and further fearing retaliation themselves
Residents also raised concerns for their safety when leaving the hospital at night, with reports of residents having been mugged and assaulted. The exit to the hospital has a lack of lighting and security personnel and residents have stated that despite reporting these concerns there has been nothing done to improve the safety.

CIR Wins

Through the PCTF grant process Internal Medicine residents won funding to create and stock a gym room to give residents a space that was accessible to them to exercise and build community. This year Bellevue/NYU psychiatry residents were able to beat back a substantial change in their call volume: The program wanted to increase the call of residents without extra pay, ignoring one fact that the reason call volume had decreased was because of the deleterious call has on resident well-being. Psychiatry residents were able to force the program to agree to make the call voluntary and the volunteers for the call would be paid at nearly moonlighting rates

Resident Stories

"As Bellevue residents, we work both at Bellevue and at NYU Langone. It is a daily distress toggling between these hospitals, seeing and participating firsthand in our city's segregated healthcare system. I'm proud to train at Bellevue and care for the patients there, who are predominantly poor people and people of color, many with no health insurance at all. But there's no denying that because of the profound resource limitations, like shortages of nursing and phlebotomy, the experience of training at Bellevue is one of constant uphill battle. We have to fight tooth-and-nail to advance our patients' care. Meanwhile just up the street at the private NYU Langone, resources abound and the city's wealthy and privately insured patients get expedited, streamlined care. Participating in both of these care environments is a good education in the inequities of our health system, but the moral distress of that experience does take its toll on us." -Leo Eisenstein, Bellevue

"The call rooms at Bellevue are disgusting. Dust everywhere. Impossible to get sheets or blankets. Sometimes have to sleep on dirty sheets or without them altogether. Laundry bins overflowing with dirty laundry. When I see that the laundry bins or trash is overflowing in our resident spaces, it makes me feel like no one cares about the residents and that they are not a priority. It makes me feel like we aren't appreciated. Additionally we're supposed to get blankets and sheets from nursing carts on the floor to make our beds... frequently those nursing carts aren't stocked. We'll use fitted sheets for blankets and sometimes wrap sheets around blankets as makeshift pillows cases. Sometimes I'll sleep on dirty sheets to avoid having to sleep on the bare mattress when things aren't stocked… Again, all this makes me feel like the hospital doesn't care about whether or not I'm able to sleep on a 24 hour call or rest in between cases." -Maximilian Hoffman, Bellevue

"Views are my own and not those of my current or former employers. I was a resident in H+H hospitals from 2014-2018 and rotated in them as a medical student. As a student, I rotated at Bellevue and Woodhull (outpatient psychiatry), and as a resident in pathology at Bellevue I covered pathology lab intake from every hospital in H+H. Though I thank CIR-SEIU for union coverage that got me ~12 outpatient mental health sessions covered per year, I also witnessed 2 medical school classmates and another trainee die by suicide while working in H+H hospitals alongside me. Immediately after my graduation from Bellevue I went straight into 24/7 home call for blood bank for 3 weeks straight and admitted myself for ED evaluation for suicidal

ideation after NYU Langone/H+H refused to take meaningful action in response to my classmates' deaths. My program was comparatively ‘lifestyle-friendly’ when put up against programs like OB-GYN and general surgery and podiatry, but it, too, received pressure to coax residents and fellows to underreport work hours violations. The department struggled to resource or fund labs beyond minimum acceptable standard under CLIA licensing, and was forced to outsource much of its work to private reference laboratories in the metro area because it wasn't given enough money to fund adequate care and staff for it. I trained under some of the most talented pathologists and staffers I've ever met there, with people from all over the world who were renowned experts in special pathogens, blood banking, anatomy, and care for the poor, and none of it wasn't enough to fix the core problem at work. What was that problem? H+H leaves its trainees and staff with the impression that it is indifferent if we live or die on the job. I know residents who have worked multiple days at H+H hospitals with minimal sleep, lived for several days at a time in call rooms during and after divorces caused by job stress at their respective H+H hospitals, and that is in addition to the general culture of overextension, exhaustion, malaise, and lack of morale… Certainly I personally examined persons who died prematurely or did not receive standard of care for communicable or non-communicable diseases in one of the richest cities in the world. All of my observations predate the COVID-19 pandemic, I will add. Bellevue was once an American treasure, but I shudder to think about what is going on at its less publicly renowned satellites, especially now. Only Bellevue's reputation and TV shows keep it afloat, I fear. I speak out to save lives, not to call names. More trainees will die in H+H hospitals if we don't speak out at forums like this one, even if the only thing we get out of it is hazard pay. Thank you. I hope I'm not being melodramatic when I say this issue should be a top priority of the city government.” - Anonymous former resident, Bellevue

As a PGY-1 US grad, my budget as a first year resident was very tight. Not only was I dealing with the in-service clinical workload and research projects, but I was also dealing with the embarrassingly low pay at the time and the financial struggle that comes with it. More than half of my monthly salary would go into paying for my rent, even though I lived in hospital-subsidized housing. Add my student loan payments and the basic living/work expenses to that such as the phone bill, electricity, internet, etc, I was left with very little at the end to flexibly spend for my monthly budget. For most of the year I would buy a $12 bag of frozen dumplings from Chinatown each week and make it last until the next week. The anxiety of not being sure my spending was within budget despite me trying to stretch my dollar to it's absolute limits was enormous, and I would never wish that level in uncertainty and anxiety on anyone else.” - Anonymous, Bellevue

“It is hard to know where to start. I am tapping this on my phone as I leave at 10 pm from a shift that went 16 hours instead of 12 scheduled. Over several years as a resident I have worked many 100+ hour weeks and 30+ hour shifts with no extra pay, rarely any sleep during call, often no time to eat, drink or pee and have then been talked into changing hours reporting under the threat that we would lose resident funding from acgme if we get the programs in trouble. We do

transport, labs, vitals, cleaning. I was most burnt out and hurt when working like this, often sick and dehydrated and dangerously sleep deprived, and trying to get my patients in need the care they deserve as human beings, and those efforts were met with grossly inadequate and unequal resources for our vulnerable patients in poverty, often also incarcerated or homeless. I felt shame and humiliation when I was then chastised and pushed to reform my time wasting - eg slowing clinic by trying to help a cognitively impaired patient recently admitted w life threatening blood clots to navigate Bellevue's exemption system for getting prescriptions. We have completely unsafe and impossible patient loads with inadequate staffing. We often don't have basic equipment like blankets or blood glucose test strips. They shame and blacklist residents who speak out. Our elevators never work and are crowded unsafely, making us unable to reach critical patients in a timely manner. We can't get essential medications like seizure medicines in an emergency on time. The exhaustion and misery are palpable and a good day for me means I had enough energy to get to the shower or couch to cry instead of crying on my floor. I would love to have a child now but do not because it would be impossible in my program though it is not for men. And still I am constantly grateful my life is infinitely easier than the lives of my patients who die of preventable and treatable diseases suffering in unspeakable ways down the street from VIPs down the street. I dream about my patients and I stop on the street to feed them. I feel utterly hopeless sometimes in the face of this all. But my colleagues and I keep showing up with whatever we have. I hope things get better because they just have to." - Anonymous, Bellevue

"In just over a year working as a resident physician at Bellevue Hospital, I have continually felt powerless. My residency started amidst the COVID-19 pandemic and I have not experienced life as a resident in which many of my colleagues are not burned out, exhausted from caring for COVID patients, or angered by being put on the frontlines without proper safety protections or hazard pay. I have seen myself and my colleagues performing out-of-title work like blood draws and transporting patients, and that when residents are too busy and not able to perform these tasks they don't get done. I have seen a tremendous lack of resources and staffing to best care for our patients, including limited MRI and EEG machines causing delays in diagnosis and treatment. As a resident on a split payroll with NYU and NY State, I also recently experienced multiple rapid changes to my health insurance and uncertainty about my enrollment, as well as a one month delay in my payment leading to financial strain." -Michael Zingman, Bellevue Hospital Center

"One of the features of residency has been consistently feeling like my time is undervalued and my labor rights are ignored. If any other employee of the hospital works more than 40 hours in a week, they are paid overtime. I regularly work double the hours of others, even hitting 90+ hours in some weeks. I do this because it is what is necessary to take care of patients. Yet, the system does not take care of me and my colleagues for this grueling work, as it does our colleagues, because we are labeled as 'trainees' and this is considered our education, so labor rights do not apply. I can estimate that 80% of my day is not educational. Most of the time I put in at work is advocating for patients to convince insurance to pay for care, documenting, and making calls to

communicate with other teams. None of this improves my medical knowledge, and so this tradeoff of me sacrificing inhumane amounts of time and not being compensated for it in exchange for education is a farce. We are viewed as cheap labor. If hospitals had to pay us for our time by law, this would no longer be the case. Moreover, we are supposed to be protected from working more than 80 hours by ACGME rules. When I reported I worked more than 90+ hours for two consecutive weeks, I received an email telling me to change the submission. Their reasoning was 'I wan't scheduled for that time and me staying past schedule hours was my choice', even though that was what was necessary with the inadequate staffing provided in order to take care of patients. Even our protections are a farce." -Anonymous, Bellevue Hospital Center

Coney Island Hospital

There are approximately 156 housestaff working at Coney Island Hospital. Residents at Coney Island predominately work in two departments, Internal Medicine and Emergency Medicine. Coney Island has a large number of foreign medical graduates on J1 visas

<u>Out-of-Title Work</u>

Residents at Coney Island have long faced exorbitant amounts of out-of-title work, with residents reporting that they felt the amount of non-physician duties they were responsible for only increased each year. Transport and phlebotomy were reported as the two key areas that residents were routinely having to perform non-physician duties. Residents reported having to regularly transport patients themselves due to lack of transport staff. Residents also reported that phlebotomy services are lacking, leaving residents to regularly draw bloods and drop the blood work off to the lab themselves. Another example of regular non-physician duties is the requirement that residents push medications for patients due to nursing staff and technicians not being trained to push medications. Residents are also required to push contrast for imaging in all patient cases, not just patients deemed unstable, which is not normal practice.

<u>Resources/Equipment</u>

Residents reported chronic under-resourcing at Coney Island especially in regards to diagnostic equipment. Residents reported long waits for their patients to receive CT scans, often 3 days due to a lack of staff. Residents also reported a lack of EKG machines, with only 2 for the medicine floors and a lack of an EKG tech in the evening, leaving this work to residents, that is, if they can access an EKG machine. A severe lack of ultrasound equipment was also identified as a key driver of poor wellbeing, with residents having to spend excessive time figuring out where the ultrasound machines are and hoping one is available.

The physical infrastructure of Coney Island was also identified as a driver of poor wellbeing and burnout. Fellows reported they have call rooms without working locks or blinds on windows,

leaving residents to paper over windows to keep light out as they try to sleep. The lack of parking or safe space to keep scooters or bikes, leaving residents regularly getting ticketed or having their scooters stolen was also identified as a key stressor that hospital administration had failed to address.

Culture/Other

Residents at Coney Island Hospital have feared retaliation for raising concerns by means of schedule changes, electives or vacation requests not being approved, Attendings and Program Administration withholding recommendations needed for fellowships or attending positions, or being put on academic probation and losing their jobs. Residents have also reported a culture of intimidation with senior administrators calling residents in one by one to question their responses to the ACGME survey. Residents reported a culture of verbal abuse from other staff and a lack of communication and cohesion between hospital staff leading to an unhealthy work environment.

CIR Wins

In 2019, the CIR members were able to get the hospital to approve a “Resident Wellbeing Day" which gave residents protected time to build community and discuss wellbeing. The event was funded by CIR and included therapy dogs, nail technicians and food.

Resident Stories

“Too many things to say… No interest in helping from administration, no initiative to educate. In fact education was non-existent. The work hours were in theory in limit, but it's too much. Working 6 days a week for 3 years will wear down anybody. Mental health is not important to them, in fact problems in that area are usually ridiculed. Asking for time off for mental health leads to pressure to return immediately.” -Ernesto Blanco, former resident, Coney Island Hospital

“Having to do things like transport patients from the ER to sonogram, drawing blood. I just narrowly escaped having to clean a patient up after she had a bowel movement after I transported her from the floor to sonogram. It’s also insane that I have to stand around pushing IV medications (including meds that need to be given as slow pushes over the course of several minutes) when there are 8 million other things that I could be and need to be doing… In addition to that, I can count on one hand the number of days I’ve actually had time to eat lunch during a workday in the past month.” -Anonymous, Coney Island Hospital

“As a cardiology fellow, fatigue and lack of sleep usually comes from our 24 hour calls at Coney Island Hospital. Our call room environment does not allow me to sleep in those few hours between consult on these shifts. The call room has no bathroom attached (we use the bathroom stalls 50 meters down the hall from our call room). It is impossible to use the shower in the public bathroom. Our call room is also very far from our patient care areas. The call room is on the 10th floor, only accessible by stairs or 1 specific elevator in the hospital. Our CCU, cardiology office, echocardiogram, and cath lab is on the 6th floor and Emergency room (which we frequent on calls for consults) is on the first floor. We also do not have access to drinking water, microwave, or fridge in our call room. We have to traverse to the 6th floor for microwave, water, food and fridge use. The call room also does not have a lock on the inside so we get walked in on by custodial staff at 3am almost every shift. The call room also does not get cleaned, ever, and has no trash can inside. The fellows do the cleaning ourselves when we have time. We do not have shades on the windows. Right now we make do by taping paper over the windows. As cardiology fellows, we are in the hospital 12 hours a day and when on call, 24+ hours in house. However, we do not have parking facility available and we always have to risk getting tickets for street parking (alternate side parking, street cleaning etc). Some of our fellows have gotten into minor accidents due to lack of parking and the stress of having to look for street parking every morning. I have a bicycle and electric scooter, but our administration banned us from bringing our electric scooter inside the building. The public areas to lock our bicycle and electric scooters are not monitored and I had my bike seat stolen after a regular day shift. Other residents have had their electric scooters stolen from the same lock area. This has been brought up multiple times but nothing has been done to improve the security of the lock areas or address our stolen bikes/scooters. This adds to financial stress and forcing us to drive every day and deal with the impossible street parking in the area. We also do not have support staff in our clinics that can help with regular device checks or social work support. We often find ourselves doing device checks during regular clinic visits (which are only slotted 15 min), thus leading to backlog of patients having to wait a long time for their appointment. We also have to play social worker often times in clinic. Patients have to traverse to different areas in the building to make their appointments which have led to adverse outcomes, due to lack of support staff to help make appointments.” -Anonymous, Coney Island Hospital

“Some of the attendings, especially radiology, are very impolite. I discussed with them about patients and they hang up the phone in the middle of the conversation. When I want to consult with them, I will be under a lot of stress to even talk to them. They treat us in a bad way.” -Anonymous, Coney Island Hospital

“Every ward has to have at least one EKG and ultrasound machine. There is only 2 machines that one of them is in CCU, and we have to beg CCU to borrow that. After 4 pm, there is no technician to do EKG. This is technician's job. This is overload work for residents to do EKG. The same thing for ultrasound machine. Only 2 for whole hospital! One more thing is about the blood draw. Phlebotomists only come 3 times a day! Other times residents have to do it! And the most stupid thing is that we have to drop the blood to the lab or blood bank! This is really not the

resident's job and we do not have enough time to just drop the blood to the lab!!!" -Anonymous, Coney Island Hospital

"A big one is out-of-title work, we do a lot of social work, phlebotomy, sometimes nursing work… You'll hear attendings also tell residents 'figure it out' without guidance… God forbid a poor outcome occurs- then it's an M&M and they humiliate the residents in a conference setting and drop all the 'should haves' and 'could haves' when the poor resident did all of the above but had no support or documentation proof that they did the above. They say it's anonymous but we all know the resident who messed up. Rumors spread fast. Attendings and nurses talk poorly about residents to other residents. It's a very 'figure it out on your own' environment , which hurts our patients at the end. It only works out if the resident is strong enough and experienced enough to know how to handle the situation, or if the attending is good and caring enough to intervene (which we do have a few but just not enough of). The environment is not a teaching environment at all. The tension trickles down to patients. I've had social workers make me call for ambulances to arrange for my patients to go to their nursing homes. I've had SW make me call drug companies to set up infusions at home. Worst part is I don't even fight it anymore because I learned If I don't do it, who will? We've all escalated and nothing's happened. And you escalate too much and it'll come back to haunt you. Having an opinion is unprofessional. Advocating for your patients is unprofessional if you have to confront someone higher than you. They tell us we don't do 24hrs, but many of us actually have been told to stay the night shift after a day shift and we complied. And if you bring this up to the program directors telling them you're exhausted because you worked 24 hours, they'll say that's impossible. You tell them well chief made me do it, they'll say 'no that didn't happen, I don't know what you're talking about.' You tell them you're burnt out they'll say 'it's all in your head.' After acgme survey results returned that apparently the classes from the year prior filled it out poorly, they interviewed all of us individually to ask us 'how can we make the program better' but as you give recommendations as residents, they became defensive and said 'our residents who filled the survey don't know how to read the questions , or are depressed and vindictive from covid surge and that's why they ranked the program bad, we're actually a great program, be grateful. It was way worse before you started.' There are other hospitals that are under-resourced that still know how to treat their residents properly. We're all happy to work for our patients, but not in a toxic environment… Even residents turn against each other. Which kind of program makes seniors use limited vacation days for virtual interviews? Of course all this comes down to residents feeling like what's the point in putting more effort than you have to for this program. So then over time, people put the least amount of effort in place to just finish the day, which is wrong too. there's no drive to be better." -Anonymous, Coney Island Hospital

Elmhurst Hospital

Out-of-title work is of course, a significant and pressing issue that is forcing residents to take time away from their patients. Instead of diagnosing and creating medical plans, residents are transporting ICU patients to imaging, placing tubes, drawing labs, perform COVID tests, pushing

medications. In addition, the clerical duties like calling outside offices to obtain records, make appointments for patients, faxing discharge summaries and more.

Elmhurst residents also deal with insufficient facilities. Residents reported inadequate call rooms including a lack of bathrooms in the call rooms themselves, leaving residents to use the publicly available bathrooms that are often dirty as they are not cleaned until the morning.

Residents do not feel supported or valued by either Mt Sinai or H+H. They report changes to work schedules, elective rotations and vacation time that were adopted during COVID peak but have been continued, leaving many residents with longer schedules and less educational time.

Sinai is often in the role of “middle man” as an employer with limited control over resident workplace issues, and H+H often defers on workplace issues because residents are not employed by them, leaving residents with little accountability for necessary changes

Here are stories from the interns, residents, and fellows at Elmhurst Hospital:

“I believe the lack of adequate pay is what bothers me the most. We live in one of the most expensive cities in the world and our paycheck deserves to be higher (especially with those of Columbia, Cornell, MSH). We also have student loans to pay off and it is hard to do so with this salary. Given the amount of hours we work a pay raise I believe is in order. We also need to hire more residents in our class. With the hospital capacity hitting its limits multiple times this academic year, it shows how much more man power we need. Teams are constantly being capped with patients with admitted patients spending days in the ED. At least 5 more categorical residents per year should help.” Anonymous

“Because of the new system at our hospital, the third year residents lose most of their weekends, the hours on the floors are extended, and there is significantly less free time. Overall, burn out is worsening, and no one is listening.” Anonymous

“Elmhurst has relied on its residents to address their shortcomings. This was exposed during the initial stages of the pandemic. Since then residents and fellows have been tasked to do more out of title work / ancillary tasks such as serving as transporters, pushing IV medications, administering blood products, nasal swabs. This is an inappropriate use of a limited resource. When necessary, residents will and have stepped up to go above and beyond the call of duty. However, out of title work has now become an expectation. Nursing administration is more concerned about PUI (patient under investigation) for covid than keeping a patient comfortable and allowing them to spend time with loved ones before their untimely and inevitable death. My program leadership is supportive and receptive to feedback. Often attending physicians need to remind ancillary staff of the protective time for the residents. As we are in training and require dedicated didactic sessions which are frequently interrupted by menial inquiries. Compensation is also a major stressor that affects many residents. Anyone of us can carry upwards of

$200,000 in student debt that just continues to build interest because more than 1/2 our salary goes to rent. Residents are too scared to speak up in fear that their careers will be jeopardized. Many of the residents have high aspirations for competitive fellowships and attending positions in the nyc area. This has led to residents putting their heads down and taking the abuse. These working conditions are not ideal to train the future physicians of America. This pandemic has taken enough from us. It is time we take care of our future." Anonymous

"The lack of resources training at an H+H hospital has been an understatement. We are not only carrying the clinical responsibilities of being a physician, but we are also being asked to be our own social workers and secretaries as well. Also, having to do prior authorizations with insurance companies. In addition, the expectation our attendings have of us studying on our own. As trainees we have to manage all of this. While we are supposed to be receiving mentorship, teaching, and professional enhancement in return for our services none of this actually materializes. The attendings do not have time to teach us and there is a greater clinical burden that has been placed on trainees since the pandemic. Our hospital system has been hit the hardest as many of the surrounding clinics have closed their doors. Many of us are scared to speak up about feeling fatigued/burned out due to the toxic environment the medical field has created. Many of us fear that if we do speak up we will be labeled as "difficult" or "not a team player" or "selfish." While other disciplines of social work and psychology have tried to have caps for their patient load in order to avoid burnout, this has not been the same for the physician trainees. The very field that is supposed to help other physicians with burn out has been one that has promoted burn out. The Department of Psychiatry at Elmhurst has continued to pressure its residents/fellows with increasing high volumes of patients without proper support or at times supervision from attendings. In addition, when you try to tell attendings or PDs you are reaching your maximum capacity, you are again thought to be "weak" or "not a team player." In addition, there have been some attendings who used this as an opportunity to bully their trainees. That has been one of the most mind-boggling experiences where this field that helps so many patients with bullying they themselves bully others. One of the worst experience I had heard that happened to one of my colleagues during the pandemic was when a Psychiatry CPEP attending had told the resident that they left a consult pending for 8 hours as the attending "did not feel it was appropriate for them to be exposed to the COVID virus." However the resident being exposed was not of concern? This toxic environment has led to fatigue, stress, and burnout. Often times trainees are invalidated when they try to raise issues. How are we supposed to help our patients if we do not have the adequate staff and resources to do so?" Anonymous

"People often think psychiatry residency is a walk in the park. In fact, it's quite the opposite. It's been an extremely grueling and isolating experience. Working at elmhurst hospital one of the largest mental health h+h providers has made it that much more excruciating. We constantly work 24 hour shifts with no sleep and no help. There is a serious lack of resources and we often have to take on the extra roles of clerks , case coordinators etc. These extra roles take away time from our learning and patient care but also lead to burnout. There is also little help from

administration which makes us feel that much more defeated. I'm counting down the days to get out of there." Anonymous

"Regardless of how hard we work or how passionate we are for learning, the house staff at Elmhurst Hospital are set up for failure. There are two main causes to our systemic burn out and depression: 1-excessive non-clinical non-educational duties which take up the majority of our days, and 2-lack of support. Non-clinical duties 1-Transport services: We serve as transport because transport is commonly available and understaffed. In the ICU, a member of house staff must accompany patients to all studies, from the ED, and even to procedures, often taking hours from our day and away from patient care. At most other hospitals, it is the ICU nurse's responsibility to transport the patient. Not only does it take house staff away from patient care and educational opportunities, but it also sacrifices patient care. There is only one resident on for the night shift, so scans are rarely performed overnight because it is unsafe to have the resident leave the remainder of the unit unoccupied. When on specialty service with cases in the OR or endoscopy, again it falls on the house staff to transport the patients to and from all procedures. 2-Nursing services: Besides the above transport of critically ill patients, there are countless jobs that are generally performed by nurses that are expected to be done by the house staff: placing all nasogastric tubes, drawing all ABGs if no arterial line in place (generally done by respiratory or nursing), removing routine access including all arterial and central lines, personally administering commonly prescribed medications such as beta blockers or morphine (even on step down level of care a resident much push this). At codes, the residents generally push the medications while the nurses only perform hands off jobs like recording and time keeping. I have been at intubations when a nurse cannot be found to assist in the process. 3-Respiratory services: The respiratory therapists are often very hard to get ahold of and the house staff perform many of their duties. We consistently put the patients on weans, change the settings on the vent/bipap/high flow, and are responsible for almost all respiratory care. The respiratory therapists have been known to take over one hour to bring ventilators to critically ill patients requiring emergent intubation, and the residents and fellows have to care for and bag the patient until they arrive. 4-Bedboard services: It is the job of the house staff to find a bed for the patients. At most times, the stepdown and ICUs are full, meaning if you need to upgrade a patient, there is physically no way of doing so. The patient remains at an unsafe level of care with inappropriate supervision until a bed opens up, sometimes taking days. In the interim, the house staff are frantically trying to get the patients the care they need, calling bedboard, every ICU, and stepdown over and over hoping to find a bed open up. We feel a tremendous burden to try to get our patients the care they require, which is often impossible to find, and we end up having no choice but to accept inferior care for our patients. Our excess time spent performing the duties of other services has become so routine that we commonly answer our pages or phone calls saying: "Transport, how may I help you?" "Nursing, how may I help you?" "Respiratory, how may I help you?" "Bedboard, how may I help you?" Lack of support We get little support from our superiors and are often made to feel bad for minor mishaps or things we have yet to learn. The support we do get appear as band-aids to keep our ACGME recognition. For example, some of our programs are presented a power point on wellness, some get it in the

form of an email; either way it talks about methods of dealing with stress, avoiding burn out, and a list of resources. However, our superiors have not asked us directly if we are experiencing burn out or what changes could be made to improve our well being. But when the ACGME survey comes out, the program can check off the box saying they addressed wellness. Another example, we had an NP pass away in the bathroom of the ICU under questionable circumstances. The following day, a meeting was held to express any feelings or speak out if needed. Not many did, and after that it was not brought up again. They "dealt with the issue" - checked off another box - but they did not truly seem to care if their house staff was okay or dealing with issues of their own. In conclusion, we all want to help our patients and advance through training, so we deal with the above non-clinical duties and lack of support. We keep performing these duties without any educational advancement from it, and often we are met with so many road blocks and so little support that we end up unable to provide our patients the care they need. It is disheartening and demoralizing, and most house staff lose their excitement for medicine in their time here. We give up trying because trying does not help the patient; it only leaves us feeling inadequate. Residency and fellowship at Elmhurst is a sentence to be served instead of an opportunity to advance our education while helping others. It is a means to an end, and most of us would not choose to pursue training here, or even at all, if given the opportunity to choose again. Due to fear of retaliation, I respectfully request that the above information be kept anonymous. Thank you for taking the time to read our story." Anonymous

"My experience working at Elmhurst Hospital thus far has been exhausting. As a public hospital, we are often understaffed yet overworked so we can meet the demand of the large underserved population in queens. As residents we are front line providers constantly being exposed to covid. During surges of the pandemic we are seeing covid patients instead of patients with other medical conditions, which is limiting the breadth of our training. At various points we have been pulled out of elective blocks and golden weekends to cover the overflow of covid patients. There have been many weeks that I have worked > 100hours, with little time to sleep much less spend time with family and friends. Financial hardships have also placed a strain as it is hard to get by with our currant wages with NYC rent prices. I have over 400K in student debt and with this salary(average 15 dollars/hr), survival is tough and paying off my debt is unthinkable. Knowing this debt is awaiting me upon graduation makes it tougher to get through moments of fatigue, burnout that encounter on an almost daily basis." Anonymous

"The emphasis placed on wellness seems so ingenious when they make it so hard to actually ask for a wellness day or half day by requiring notice months in advance and approval by multiple parties, and then they have the audacity to balk when you remind them of that upcoming time off. Either way, they still keep you working past the time you asked to be off so all that effort was for naught." Anonymous

"My hours provide the greatest amount of stress, particularly during my short-call inpatient days. Our Residency Program has recently implemented mandatory noon conference and mandatory teaching rounds, each being one hour long. While having formal medical education

is necessary for our training, having so much lecture time cuts into our clinical work. This leads to consults, orders, and time with patients to be reduced which delays care, and ultimately delays discharges from the hospital. Additionally, our short-call inpatient day has been extended from 3PM to 4:30PM. Due to the accumulation of delays and lectures throughout the day, most short-call residents do not leave until at least an hour later. Our short-call days are important for self-care, including exercise, home chores, research, and other activities. Unfortunately, we have significantly less time for ourselves, despite being reminded by our Program about the importance of reducing stress and burnout." Dr Judah Kupferman

Harlem Hospital

There are approximately 215 housetaff at Metropolitan Hospital who are predominantly Foreign Medical Graduates.

Out-of-Title Work

Like residents at other H+H hospitals, Harlem residents struggle with the amount of out-of-title work they are forced to take on due to chronic understaffing. The hospital has no dedicated phlebotomists, and the lack of nursing leaves residents to regularly undertake blood draws, IV placements. Residents face long work hours due to over- scheduling of patients, coupled w/out-of-title work demands such as the above. Residents often miss out on education time, as they are held back to perform more patient care tasks as opposed to participation in education sessions.

Resources/Equipment

Residents report high patient loads and lack of support. The lack of Behavioral Health Assistants on CPEP (the Psych emergency room) at night leading to residents feeling unsafe and struggling to provide care to all patients. The lack of surgical supplies on the 12th floor leaves residents to repeatedly search on other floors for supplies. Residents also reported that they are then chastised for taking supplies, resulting in a lose-lose situation. Residents report a need for more surgical PAs or NPs in the 12th floor or surgical department, as oftentimes there is no provider coverage on the floor due to residents being in clinic, the operating room, or in trauma.

Culture/Other

Residents reported poor modes of communication between teams and between residents and other hospital staff; some residents described the work environment as toxic. The lack of parking for residents who drive leaves residents to get ticketed or towed because they cannot afford the cost of the garage. Residents reported call rooms not being cleaned, leaving them to sleep in unhygienic call rooms. Surgery and Oral Surgery Residents have to share a call room leading to nights when there are not enough beds for all the residents on call, causing residents to miss out on what could have been crucial sleep. A lack of food resources at the hospital

forces residents to leave the hospital to buy food. Many do not have the time to do this or are able to leave their patients and will simply go without eating. Residents reported a lack of access to drinking water that they did not have to pay for There is also a credible fear of retaliation from attendings if residents speak up. Residents reported intimidation and retaliation on the part of attendings, with attendings pressuring residents to “correctly” fill out the ACGME survey and publicly asking who gave negative feedback.
Residents report a punitive teaching and learning environment. Residents are expected to be perfect at tasks, even though they are learners. Residents reported attendings yelling at residents during rounds in front of nursing and other hospital staff.
Residents are coerced, even coached, to respond positively on ACGME surveys; they are chastised when they report honestly.

CIR Wins

In response to CIR campaigning for more spaces for residents to build community and meet basic needs like food and drink, hospital management has agreed to set up a resident lounge-wellbeing center. In addition to this agreement management has also made verbal agreements to provide adequate on-call room space for surgery residents to ensure proper sleep hygiene. In response to advocacy efforts to reduce non-physician duties residents are performing nursing management has given a verbal commitment to work to ensure nurses are performing their assigned duties and not requiring they be performed by residents.

“Lack of nurses, therefore having to do out of title work like IV lines, blood draws, during emergency situations waiting for nurses to do things. I think hiring phlebotomists with a set lab schedule will help the nurses and the doctors. The lack of parking for commuters, I’ve had my car towed and ticketed way too many times because there’s not enough spaces and the garages are just way out of budget for a resident. The cost of living has increased in this country tremendously and especially in NYC, therefore some of my bills have suffered and as a result, I’ve had my cable and internet shut off and in danger of my electricity shutting off too. As well, as sometimes I go without food because it’s just too pricey to purchase food everyday. Is there a way to bring the cafeteria back? There are plenty of residency programs around the country that actually provide their residents with meals once or twice a day, not just a meal fund to make sure they are taking time out of a very busy schedule to nourish their bodies. Plus, no actual cafeteria for coffee, water and fresh food isn’t great for patients families’ either. Resident safety in general, the streets walking to the hospital are increasingly becoming more dangerous and not well lit at night. Also, on the floors, patients who are emotional and psych unstable, that are deemed not fit for psych IP admission, are placed on medical floors with other patients that have put residents, nurses, staff, other patients’ and my life at risk numerous times by becoming violent, aggressive or disturbing everyone else by screaming/shouting and throwing objects. Residents, nurses and staff who aren’t in the psych program/floor aren’t trained to be able to handle these situations. Yes we can try to talk patients down, but that really has only gone so far.” -Christina Padron, Harlem Hospital Center

“Abuse, disrespect and insults from attendings, verbal abuse 2. Attending doctors bullying people in front of others about things you’re supposed to be learning. No one gets up and says they want to be a bad resident- teach them; don’t abuse and demoralize. 3. Residency not treated as a learning environment. Grown men and women are treated like animals. I have seen attendings treat grown men and women like animals. 4. Attendings make people feel insufficient and demoralized 5. If you stand up for yourself, you are punished. So residents do not want to talk, out of fear of retaliation.” -Anonymous, Harlem Hospital Center

“I applied for the FICA exemption during my first month of residency since that was our deadline. I was told that the FICA tax would stop being deducted from our paycheck afterwards. It is not 2 or 3 pay periods after I applied for the exemption, my paycheck now continues to deduct the FICA tax, and also withdrawing funds for the Roth IRA. Each week my paycheck is less than before, I’m continuing to lose money to the tax when I opted out and preferred to contribute to the Roth IRA. I would not have had money removed for the Roth IRA if I knew I would have to continue to pay the tax. It is very frustrating that I’m losing money in this way especially since I’m living paycheck to paycheck as an intern.” -Anonymous, Harlem Hospital Center

“Another contributing factor to fatigue is lack of food resources at the hospital , having to leave the hospital daily to get food off the compound can be a burden. I believe programs like ours need a cafeteria where residents can go and have lunch, availability of water to drink without cost.” -Anonymous, Harlem Hospital Center

“1. Work hours- we are required to log work hours for monitoring but those are official hours. In reality, we continue to work, often times 2-3 hours beyond official times to complete notes, charts, run errands. So the logged hours are definitely not reflective of the actual workload and burden residents have. Working beyond official hours are sometimes blamed on efficiency which is always not the case. The work load is just too much. 2. Workload in clinics - regularly overbooked. They assign patients to residents in numbers that are not safe. We still are a training program but bec of the number of patients we have to see and the limited time we have, we tend to skip teaching and just focus on getting the work done. Even our attendings are frustrated about this. The surge is real especially after COVID. Clinics are saturated and we seldom get lunch breaks. 3. We have ‘protected time’ for noon conference but would appreciate if they would provide food or allow us to eat so it can serve as our lunch break. Often times after noon conference we just go back to our work and sneak in 5-15mins to grab food while working. They say this is how residency works but isn't it time to change things and focus on physician wellness? Food and water breaks are basic needs.” -Anonymous, Harlem Hospital Center

“At the end of the day, it is good that we are trying the best for our patients but at the same time we need to take care of ourselves, we need time for us but leaving late for this events we just get home to sleep and come back the next day.” -Anonymous, Harlem Hospital Center

“Everyday is a struggle trying to get the best patient care. We spend so much time on mechanical work like getting lab done, IV lines, giving us less time to do actual medicine and learn the process of managing patients correctly, and patient care is sometimes affected by this, since everything takes more time to do. Also, we never have protected weekends when in clinic, we work 6 days a week, the burn out and stress is difficult to cope sometimes.” - Anonymous, Harlem Hospital Center

“What has contributed to lack of additional fatigue/ burnout in my experience is the lack of support for residents well-being or lack of tolerance for limitations due to medical/mental health issues. After the initial covid wave I realized my health was never the same- multiple hospital visits with little resolution dealing with ongoing health stressors. My determination to complete my training kept me going, however the response from program was not encouraging. Most days I was judged and made to feel like I was inconveniencing the program while working with unavoidable limitations. This makes it difficult to ask for help when needed as precedent is set when a resident needs some accommodations and generally seemed to be frowned upon. Lucky to have a few colleagues who are trying to be supportive, but imagine going through this immense amount of stress without any support, fear of retaliation, this is crippling for your mental health. There have been an alarming amount of resident suicide and I believe support from programs is necessary to curtail some of this traumatic incidents.” -Anonymous, Harlem Hospital Center

Jacobi Medical Center

There are 439 housestaff at Jacobi Medical Center. While the majority of residents are in programs at Jacobi Medical Center, seven residency/fellowship programs (ED, OB/GYN, PM&R, Surgery, Neurology, Dermatology, Pulmonary Crit Care, Gastro-Enterology,) are managed by Montefiore Medical Center, contributing to split payroll in which Jacobi Hospital pays from some of Housetaff Officers in these programs. Jacobi has a mix of foriegn medical graduates and American medical graduates.

Key issues at the hospital

Some of the key issues at Jacobi include the fact that they are a level 1 trauma center with only one MRI machine, rampant out-of-title work for residents, safety in the emergency department, issues with cleanliness and a lack of dedicated education time for dental anesthesia residents. They also face retaliation for speaking out and disrespect from other hospital staff.

Out-of-Title Work

Patient transport at Jacobi is understaffed, leaving residents to transport patients or risk the patient not receiving imaging or other care. There is also a lack of nursing and phlebotomy, leaving residents to draw blood and deliver samples directly to the lab. Residents report having

to regularly place and remove IV lines, and due to a lack of nursing and ancillary staff, residents report having to change and clear patients or else risk leaving them in their own excrement and culture that assumes residents will place foleys or do EKGs.

Anesthesia residents report that a lack of CRNAs who staff overnight has left their duties to fall to residents and increased the number of overnight calls the residents have to undertake. Residents also report that they are regularly unable to transfer patients from the ICU to medical floors or accept patients from the ED because there are only one or two nurses working on the floors.

A lack of administrative staff leaves residents to undertake the coordination of patient care, such as scheduling imaging, or setting up referral appointments. Residents report a lack of clerical staff to provide support to fellowship programs, leaving fellows to undertake paperwork to coordinate electives, taking time away from patient care. Finally, residents reported inadequate staffing disbursement across adult and pediatric EDs with some residents overloaded with patients and others without the ability to undertake graduated responsibilities due to a lack of patients to distribute between residents. In other words, a lack of nurses means some services cannot fill up all their beds and residents lose the chance to treat patients and learn.

Resources/Equipment

The hospital only has one MRI machine, which is now old and not always in service, this is inadequate for a level 1 trauma center and residents report struggling to get vital imaging done and having to “fight” to get imaging. Residents also report that they will struggle to get CT scans overnight with regularly only one CT scanner available leading to a delay in patient care

Culture/Other

Residents reported lack of respect and bullying from other hospital staff towards residents, and despite residents directly raising these concerns regarding their treatment by radiology techs, the hospital failed to take action. This left residents feeling completely undervalued and with a sense that their concerns are not taken seriously by administration.

Residents also report being verbally abused by patients or patients’ families and not receiving adequate support from their program, and a culture of treating residents who speak out as a problem, for example through retaliation in the form of scheduling choices or bullying.

In terms of cleanliness, residents report cockroaches in call rooms and patient rooms. Ater raising these concerns they saw no action taken, further leading to a sense that resident concerns are not taken seriously.

CIR Won Improvements

This summer CIR began a program where residents would meet with the CNO in order to present concerns, ask for clarification around policies, and make suggestions about how to improve patient care.

We saw some immediate improvements and through continued meetings have made more progress. Residents doing blood draws and sample collection in the ED has decreased. IM residents now have clarity about what medications nurses can push through IVs. Rehab wait times also decreased dramatically through improvements in communication and staffing.

This is a relationship that will require maintenance and enforcement by the residents. At the beginning of the year we saw some regression in IM where residents believe this may be because the nurses were taking advantage of the new residents.

Resident Stories

“My name is Michael Del Valle, and I am a member of the Committee of Interns and Residents/SEIU (CIR/SEIU) which represents medical interns, residents, and fellows throughout New York City and the rest of the nation. I am a fourth year emergency medicine resident working at Jacobi Medical Center in the Bronx. I understand the concept of what a medical resident is may be unfamiliar to some, so allow me to briefly explain who we are and what we do. In order to become a physician in this country you typically acquire a post-secondary degree and apply to medical school. A medical student then completes four years of training prior to obtaining a medical degree and becoming a doctor. One must then proceed to complete a residency program in the field of their choosing in order to be eligible to practice. Through an incredibly demanding application process (costing between $4000-$6000) a medical graduate creates a list of programs with which they have interviewed and programs create a list of residents they have interviewed. An esoteric computer algorithm then matches graduates to programs through a process known informally as The Match. Once this young physician has been matched with their program, they are unable to transition to another without significant, high-risk effort. We cannot easily switch employers, we carry an enormous debt burden, and our employers frequently take advantage of our vulnerability which results in unsafe working conditions, harmful hierarchical structures, and blossoming mental health disorders. The average base pay of a resident physician in New York City is approximately $63,000 per year while working 60-80 hours per week. In 1978, the average student debt in the U.S. amongst medical school graduates was $13,500. That’s just under $54,000 when adjusted for inflation. Current medical graduates sit at an average student debt of $250,000 and medical residents annually accrue $13,000 in interest each year on average. We are not the high-powered independent physicians with six digit salaries that the general public thinks we are. For four to seven years, thousands of residents struggle to manage the high cost of living and extreme work hours while maintaining the well-being of themselves and their families. A simple google

search reveals an annual surge of queries on how to make this balance possible from those who have matched into New York City residency programs and are now faced with insurmountable debt and the highest cost of living in the nation. Seriously. Go look. Add to this the extreme physical and emotional toll of working in a gravely overwhelmed healthcare system during a historic global crisis that was centered right on top of us and suddenly it becomes easy to understand why New York City residents suddenly feel unsupported, unseen, and without hope. We are modern day indentured servants, a statement said with little hyperbole, and it seems that we are consistently overlooked by those in power because of the high earning potential of our predecessors. The days of free haircuts and entrepreneurial networking are old wivestales as far as the current generation of young physicians is concerned. We aren't sipping champagne and buying boats - we are living paycheck to paycheck and dealing with traumatic stress disorders. Disillusionment intersects with vulnerability resulting in a vicious cycle which strips us of our capacity to advocate and stands to further destabilize our current patchwork system of healthcare. Critical understaffing, poor emphasis on preventative medicine, fear of retaliation—this is all a simplified introduction into our day-to-day lives, and when we struggle our communities suffer. We are here, now, asking you for help. Will you listen?" -Michael del Valle, Jacobi Medical Center

"As a resident at HHC I'm privileged to take care of vulnerable patients. I want to do everything I can to help them get great medical care. However, I can only do so much before I too am burned out. My burn out comes from being under-resourced and doing excess out of title work. Example #1: I had a patient that needed a CT scan for 8 hours as an intern, 8 hours with no possibility of scan because we had traumas all night on one scanner and another scanner unable to be used to to either no tech availability or an issue with the scanner itself. One CT scanner overnight at a busy level 1 trauma center is simply not enough. The patient eventually got a scan and ended up with a perforation but he likely did not have one when he arrived, an earlier scan would have gotten this man to the OR before this complication Every single day in the ED I undress patients, I pick up discarded urinals, I clean stretchers so that the patient who is bent over and vomiting can have one, I put my own sheets on stretchers, I do blood draws, I clean the GYN room after others have used it due to not having staff for room turnover. This is no exaggeration, this is every day life. I came into medicine to help people by making sound medical decisions. Every single sheet changed, bed cleaned, room turned over is one less patient I get to see and one less patient I get to help medically. I have transported my own patients to radiology an innumerable number of times, with all that time who is to say how many patients I could have seen and helped using my full medical training? Every single job in the hospital is valuable and necessary but why as a resident does the onus fall on me to do all of them? I want the best care for my patients and for this to happen, we need to be supported as residents. So no more single CT scanner for an entire ED, no more one tech for 30 patients, no more 2 nurses for 30 patients, this is not safe and cannot be tolerated. Our patients deserve better. -Anonymous, Jacobi

“I have started working as an intern since July, I chose my program out of 18 programs across the US with the hope that coming to NYC H+H gives me the opportunity to learn a lot from the diverse amount of cases. I regret to see that understaffing and out of title work here leaves you with no opportunity to learn and only what you bring home every day is the fatigue and sense of burn out. It’s sad to see my patients are not satisfied with the care they receive and that their concerns are valid. When my patient tells me she refused her water pill since there is no nurse to help her with urination and she has to be in her urine for hours it makes me sad and feels I have failed my patients.” -Anonymous, Jacobi

Kings County Hospital

Number of Housestaff: 483 (CIR Members)

Residents in programs at Kings County work at both Kings County and SUNY Downstate, and SUNY Downstate is the sponsoring institution for the Housestaff. Residents are on a split payroll with some employed by H+H and others employed by Downstate. How residents are split between payrolls differs by program, some will offer residents a choice of which payroll they wish to be on while others will arbitrarily assign residents to a payroll. Some programs will split residents by PGY, for example all PGY1-2 are on one payroll and PGY 3-4 on another.

<u>Out-of-Title Work</u>

Residents regularly make appointments, answer phones, follow up with patients for their appointments, draw labs, place IVs, transport patients from one place of the hospital to another, do phlebotomy, starting fluids, obtain food for patients, get blankets, coordinate with family members to pick up their loved ones, and fill out discharge forms.
Residents report that the work of a surgical coordinator falls on residents, including booking appointments and following up with the patients after appointments. They say the front desk does not function as a proper front desk: Staff there are unable to coordinate certain activities, make proper appointments, or field patient issues, such as arriving to the wrong appointment or showing up hours late and residents pick up the slack.

Lack of social workers also adds work to residents’ load and takes away from time caring for patients: One resident described calling a patient’s insurance company three times in order to obtain a breast pump for a new mother. “Our patients need case managers and navigators to help them figure out the complex medical system. Many of our patients' health issues are inextricably linked with the socioeconomic context of their lives.” They report an understaffed psychiatric emergency room on some weekdays and weekends.

Residents say they also need a budget for assistants. In the oral surgery clinic they should have two assistants working, however, because the assistants are spread too thin, they “barely have

one." Without assistants the procedures take longer, the turnaround time takes longer, and this all negatively impacts patient care.

One anonymous resident says: "Without enough ancillary staff, residents fill in the gap, and our 10-hour shift that occurs 5-6 times per week, turns into an 11-12-hour shift."

Resources/Equipment

Residents at Kings County say they don't have enough dental instruments and there are times when they run out of syringes and other basic supplies until they are re-sterilized. In that situation, they are forced to improvise.

They say the equipment in the hospital is often old and unreliable, and some of the lights in the patient rooms don't work. There is slow, inefficient technology for reviewing EEGs, and some diagnostic equipment is running on Windows XP, an operating system which is no longer getting security updates.

Residents complain of how the use of a third party maintenance and service provider means when scanners go down residents and other staff wait for weeks for repairs. They also report a lack of clean and available drinking water and a shortage of supplies, like cables for monitors.

They note a lack of available ultrasound machines, including one working ultrasound for a department that cares for up to 200 inpatient beds at a single time. There is a lack of child life services in pediatrics for in-patient adolescent patients, which puts a burden on residents to provide counseling support. Residents petitioned management to provide child life service but they asked for resources from union.

Culture/Other

Residents report a "completely unfair vindictive attitude towards calling out," accusations of not being actually sick or feeling unwell when calling out and demands to reveal personal medical information after reporting feeling unwell.

Residents say they fear speaking out about problems because there is this "everyone has gone through this" mentality. Speaking out against the norms, they say, runs the risk of making you the "squeaky wheel."

Wins at the hospital to highlight

Residents have protested and engaged in campaigns to demand the reinstatement of gynecologic oncology services, which resulted in a commitment from H+H to hire oncologists and ancillary staff and reinstate services, but that has not yet been done. While residents are

still waiting for this to be realized, they have been told H+H is in the process of interviewing candidates.

Resident Stories

“Non-clinical scut work; a completely unfair vindictive attitude towards calling out; accusations of not being actually sick or feeling unwell when calling out; demands to reveal personal medical information after reporting feeling unwell. Non-physician works I’ve been made to do include making appointments, following up with patients for their appointments, drawing labs, placing IVs, transporting patients from one place of the hospital to another and being made to see adult patients in the emergency room (I am a pediatric patient and therefore adults are not part of what my training or scope entails). It definitely makes me feel disrespected, undervalued and as a tool more than a person or trainee. I feel sometimes the hospital would not work if residents were not constantly made to do these types of things, and because of that they have become part of ‘what simply is.’ I spend a significant amount of time doing things unrelated to actual clinical training, but if I didn’t do them, not only would they never get done, I’d also be blamed for it.” -Anonymous, Kings County Hospital Center

“Financial strain of residency—residents are not paid enough. In fact, what we take home at the end of every two weeks is laughable for how hard we work and our level of experience. I understand the idea of a graduated pay increase, but it’s still too low for all resident years.” -Mark Goodenough, Kings County Hospital Center

“In the main ED, my routine duties, in addition to seeing patients, documenting the encounter, and creating a treatment plan, might involve phlebotomy, IV placements, starting fluids, getting sandwiches, getting blankets, coordinating with family members to pick up their loved ones, and filling out discharge forms. At times I find myself weighing how best to be productive: do I try to find the nurse/LPN/phlebotomist who is caring for my patient so he/she can perform their task, or do I just do it all myself? Often, we are short-staffed, and nurses will go on break. When this happens, there are often no nurses to replace them, and the remaining nurses generally share the burden. Likewise, when the ED explodes with 32 in the waiting room, and when it seems as though there are as many patients in the hallway as there are in rooms, I rarely see a rise in nursing to accommodate the change in patient load. While it may not seem like much to have to put in an IV or draw blood, each of these tasks takes time, between ordering the labs, printing the labs, and performing the task. Wheeling a patient to the CT scan is another 10-15 minutes. An IV and blood draw may take 15-20 minutes depending on how easily the veins can be seen. After I see a patient, I still have to go on and discuss the case with an attending, so each additional non-physician task I perform pushes this essential/rate-limiting task further and further... It’s a no-win situation with regards to efficiency—we gamble on whether performing the non-physician task will help us discharge the patient quicker so that we can clear out the ED. When we prioritize tasks over documentation, we invariably stay well past the end of our shifts to complete documentation for patients we may have seen 1-3 hours beforehand, and trying to

remember each detail of an encounter, scrambled within the facts of each patient case and encounter in between, compromises the integrity of our documentation, and overall the safety of the patient, as their medical documentation for future providers suffers… Without enough ancillary staff, residents fill in the gap, and our 10-hour shift that occurs 5-6 times per week, turns into an 11-12-hour shift. The 11 hours away from home turns into 13 hours away from home. The 8 hours of sleep turns into 6 hours of sleep. We are supposed to have 24 hours off for every 6 days we work, and often that 24-hour period falls between a shift that ends at 7 pm on a Monday, and a shift that starts at 7 pm on a Tuesday (or vice-versa). And with our free time, we are still expected to study, read papers, write evaluations, prepare presentations for our conference, and be actively engaged in the residency program. In short, the poor staffing of the hospital eats into the already limited "free" time we have. Lack of Resources: I work both in the ED and on the Internal Medicine service. As a veteran, I am fortunate to have the GI Bill to fund my residency, and I can carry around a portable ultrasound and purchase other supplies that a hospital generally should have, such as working otoscopes or ophthalmoscopes, without it affecting my financial stability. The equipment in the hospital is often old and unreliable. Some of the lights in the patient rooms don't work. I watched a nurse once hang a bag of medicine on a light switch that she had flipped into the 'on' position to treat one of our patients with a critical electrolyte abnormality because the wards had run out of IV poles. There is a King's County 'Where is the ultrasound' Whatsapp group, as there is a single ultrasound available to service three floors of the internal medicine wards. This is a critical tool for both placing IV lines and performing procedures. Again, without the necessary resources, tasks such as IVs and blood draws get delayed, dispositions are delayed, and then we end up staying later to both complete the tasks (when the ultrasound becomes available), and to finish documentation. Knowing that we serve an underserved Black and immigrant population and then hearing time and time again about healthcare disparities creates an emotional injury. We loudly bemoan how terrible it is that Black people are disproportionately affected by death and disease, we decry the racism of Donald Trump and his followers, and then in a city as wealthy as NYC, we allow the hospital that provides for them to become run down, ill-equipped, and poorly staffed. Culture of Fear and Disrespect: I go to work every day anticipating a negative interaction with at least one person. I don't consider myself a negative person, and I think that my time in the service exposed me to many good and bad leadership styles that have left me very adaptable. As it pertains to internal medicine, our program leadership is absent. I do not fear reprisal, I anticipate apathy. The internal medicine program director held a town hall where he shamefully spent approximately 30 minutes touting his successes while downplaying our concerns… The nursing culture at King's County is tainted: we have drained and shattered our nurses. The travel nurses will be the first to tell you the same. And as the backbone of the hospital, they are the ones that we, the residents, need to interact with to get patients the care that they need and deserve." -Shane Solger, Kings County Hospital Center

"Out-of-title work, lack of clean water, inefficient technology. I am a clinical neurophysiology fellow. I worked as a child neurologist in Ohio for the four years prior to starting as a fellow this year. I completed my training in Texas and Florida. I was shocked after admitting a patient who

presented in status epilepticus that I was told to place the NG tube and then to remove it after the patient got better. In all my years of clinical practice as a resident and as an attending in three different states (Florida, Texas and Ohio) I have never been asked to do these things. In all these above contexts, nurses without hesitation would perform those tasks of placing and removing NG tube. The fact that nurses don't do such basic tasks is below national standards of care. We recently ran out of drinking water. Water was previously brought to our workspace. Legionella was identified at Downstate months to years prior to when I started. I have heard differing responses but there has been no official response that it has been cleared. I have been to multiple different nursing stations looking for clean water to drink. I should now bring my own water on my more than one hour public transport commute. My biggest frustration has been the significantly inefficient technology with which I have to read EEGs at Kings County. When I was reading EEGs at Kings County (switch between KCH and Downstate every month) I would on average spend at least an hour a day waiting on studies to load. I have reviewed EEGs as a child neurology resident in Texas and as a child neurologist in Ohio and I have never seen or dealt with such slow software. This is such a waste of time. Instead of that hour spending time with my young child and family I am waiting for software to work which should be a given in the year 2021! I never anticipated that I would deal with such issues. This will definitely affect the questions I ask at job interviews. This has definitely impacted my care for patients. I have been unable to open EEG studies on a timely basis! For certain patients we like to review their EEGs another time after coming home to check for seizures and there have been multiple times when the software will not open even after multiple attempts for over 30minutes. This without a question is well below standards of care and needs to be remedied immediately. Thank you for caring to ask of our concerns." -Nancy Philip, Kings County Hospital Center

"Healthcare disparities did not arrive with the COVID pandemic; the pandemic has only widened and greater revealed existing healthcare disparities between hospitals. As a former medical student and current resident at Kings County Hospital, I've come to realize certain areas of insufficiency that have affected my training and well-being as a physician. These areas largely include out-of-title work and understaffing at Kings County Hospital. Despite acknowledging these insufficiencies, I chose to continue my medical training at Kings County Hospital because I saw and continue to see its potential for greatness in serving low-income patients. The following will highlight how these areas of insufficiency negatively affect my responsibilities and wellbeing as a physician. Although Kings County Hospital provides open arms to all types of patients, insured or uninsured, simply providing access to healthcare does not adequately address health disparities. One of my major responsibilities as a physician is ensuring that my patients have the capability to comply to medical recommendations. Capability in the form of health literacy is closely linked to treatment success and preventing hospital readmission. There are many instances in which I would like to spend longer durations with my patients with poor health literacy to discuss the importance of medication adherence, lifestyle modifications, outpatient follow up, and return precautions. Unfortunately, when my responsibilities broaden to include out-of-title work such as nursing roles, phlebotomy, patient transportation, and clerical tasks, all of which are largely due to staffing insufficiencies, I find it difficult to properly assess

and address my patient's capabilities to adhere to medical recommendations. These inefficiencies also affect my wellbeing. When I am unable to effectively fulfill my responsibilities as a physician, I either suffer with a guilty conscience or extend my uncompensated work hours. I see the same consequences in many of my colleagues who choose to stay long hours after their shift ends to ensure proper completion of their tasks. It is becoming increasingly frustrating and disheartening to see bright-eyed interns slowly lose faith in their ability to adequately care for their patients due to institutional shortcomings. I appreciate CIR and the New York City Council for their time in hearing the concerns of their medical residents. The COVID pandemic has shown that adequate staffing and proper distribution of resources can drastically improve a hospital's efficiency. It shouldn't take another disaster to instill permanent change. I hope these hearings and statements will motivate administrators to increase funding for Kings County Hospital or better allocate our resources and budget to regain Kings County Hospital's reputation as an institution that provides high-quality patient care." -Christopher Kiang, Kings County Hospital Center

Lincoln Hospital

There are approximately 317 resident physicians at Lincoln Medical and Mental Health Center. The hospital is located in one of the poorest counties in the U.S. and patients come to the hospital with many overlapping issues related to the health impacts of racism and poverty. Low levels of health literacy are common among patients at Lincoln. Residents there are passionate about serving their patients but are often frustrated with the lack of resources and staffing to do so without exhausting themselves completely.

<u>Out-of-Title Work</u>

Residents at Lincoln Hospital are faced with a tremendous amount of out-of-title work that keeps the doctors away from their patient care responsibilities. Examples of out-of-title work include transporting patients, retrieving food for patients, looking for blankets, drawing blood, doing IV lines, administering medications, and taking blood samples to the lab. One resident stated "As an example, on a busy weekend call (we work 24 hours in one go, which no nurse/ PCA does) I spent an hour and a half of precious time trying to replace an IV line on a difficult patient, which could have been done by a professional trained for exactly that."

From an anonymous resident at Lincoln: "One day I was on call at the hospital. My job was to screen patients to decide admission to ICU, general floors and others. I was informed by the admission department that most of the patients that were in the ED were going to stay there as there was no nursing staff on the general floors. When I spoke to the head nurse on the floor, they informed me that they only had four nurses (including the charge nurse) for a total of 20 patients. For a great part of the day, we were unable to admit patients to the floor units or downgrade patients from the ICU. Also, in the ED the same day, they also had nursing staff issues."

Staff shortages in the hospital particularly with nurses contribute to the out-of-title work for resident physicians and is one of the major stressors that contributes to resident fatigue and burnout.

Culture/ Other

The work culture at Lincoln is toxic and not conducive to good patient outcomes or physician wellbeing. Resident says “H+H is complicit in tolerating and sustaining a culture of disrespect and unprofessional conduct towards housestaff.” These issues are not documented or even spoken about because of the intense fear of speaking up and “getting into trouble.” Despite receiving little mental or emotional support to deal with the toxicity of their programs, residents must complete long, stressful shifts on a regular basis. “We are working 24+3 hours continuously without even having 15 minutes to grab a bite.” This pace is what is being normalized at Lincoln. One resident described the impact this work culture has on other providers and patients themselves. “When everyone is burned out, overworked, and unhappy, it further creates an unhealthy environment for everybody.” As many residents have reiterated, resident wellbeing is patient wellbeing. “There is a fine line between patient care that a physician can provide and abusing the physician to an extreme extent to provide that patient care that burns them out.” Residents need to be valued and their needs met in order to provide the best care possible for their patients.

Wins at the Hospital

In response to the excessive out of title work CIR leaders undertook a campaign similar to the successful Woodhull campaign. Members undertook a month of tracking out-of-title work, that is, residents self reporting their doing blood draws, placing IV lines, transporting patients, cleaning beds and stretchers, acting as social workers, and more. The residents met with Lincoln's CEO, CMO, CNO, DIO and director of labor relations on Wednesday, Sept. 1 and submitted their findings and asked for a memo exactly like that issued by Woodhull. The administrators made the commitment in the meeting to get the memo to the residents by Tuesday, Sept. 7. The administration followed through on their commitment and delivered the memo. Residents report that so far nurses have been abiding by the memo, and that they are continuing to push the administration to provide a timeline for when they will hire phlebotomists and transporters.

Resident Stories

“I want to stress the importance of doing out-of-title work. I do not mind it—I have transported patients, got them something to eat, ran around looking for blankets: when I know there are other people who can do this, but I do have some free time. And then: I draw blood, put IV lines, administer medications because I have come to believe it is my job. As an example, on a busy weekend call (we work 24 hours in one go, which no nurse/ PCA does) I spent an hour and a half

of precious time trying to replace an IV line on a difficult patient, which could have been done by a professional trained for exactly that. Unless we work as a team, with each person doing what they are assigned to do, this health system will not sustain. And then of course , because we as physicians always have the responsibility of the patient, and feel that guilt (you know what I am talking about) when our patient does not get their medication on time... and on top of that we are working 24+3 hours continuously without even having 15 minutes to grab a bite… We are all humans, yes, doctors too, and we need our rest to be able to function. I say 'good night' and 'good morning' to the same person as they go home and return in the morning while I'm still at the hospital without a minute of sleep. Out-of-title work is something I feel very strongly about: especially on the busy days." -Anonymous resident, Lincoln

"H+H is complicit in tolerating and sustaining a culture of disrespect and unprofessional conduct towards housestaff." -Anonymous resident, Lincoln

"Out of title work has been the biggest contributor to burn out. The residency hours are long, but working with colleagues makes this tolerable. The population we serve is a difficult one, underserved, and often come agitated to the hospital due to multifactorial origins. These come with the job and play a smaller fraction of burn out… There is pressure by the attending physicians for the tasks to be done, so ultimately residents are responsible. Tasks include but are not limited to blood draws, IV placement, transportation, taking blood samples to the lab, pushing medication, and more. Several excuses and phrases are used to justify this 'It's important for the patient,' for example. However, this implies that only residents care for the patients and the ancillary staff do not. The current CEO believes that his approach, which is similar to the failed approach of his predecessor, will yield a different result. He refuses to look at better functioning systems, and learn what makes them successful. The current culture lacks accountability by all staff. Phlebotomists is an easy solution to a big problem, yet he refuses to consider it because his advisors lack the insight to the huge culture problem that won't be solve without improving accountability." -Anonymous, Lincoln

Metropolitan Hospital

Approximately 247 work at Metropolitan Hospital. In addition to serving patients at Metropolitan, residents also rotate a several outside clinics and healthcare facilities. Residents operate on a split payroll across facilities. A large percentage of residents at Metropolitan Hospital are Foreign Medical Graduates. They typically serve a large number of patients with mental health challenges and/or patients who are unable to go to other hospitals due to a variety of social and economic reasons.

<u>Out of Title Work and Understaffing</u>

Inadequate staffing is a serious issue that directly impacts patient care, wait times and doctor's ability to practice. Currently, residents are required to consistently call services such as radiology and echocardiogram to get imaging done even after placing an order in the system. This delays patient care and causes longer wait times.

Understaffing in phlebotomy is another critical issue which delays care. Often, when residents can't find phlebotomy staff, they are left to draw blood themselves which detracts from them administering care to their patients.

Residents report contract violations in coverage. Their contract states that they're not supposed to have more than 10 night shifts in a 28 day period. Residents have reported 12 and sometimes more within that timeframe. Out of title work is especially an issue during night shifts when residents must do blood draws, IV placements, and much more.

The safety of resident physicians is also impacted due to inadequate staffing. Because of the large number of patients with mental health challenges, many residents have been assaulted by patients who have become agitated because of slow responses from supportive staff--many of whom are stretched too thin to come to the units quickly enough. Recently, safety in the psychiatric department has become more unsafe for residents.

Resources/Equipment

Since Summer 2020, many residents have been experiencing ongoing difficulties obtaining scrubs which are required by hospital policy. Consequently, many have had to wear disposable paper scrubs which are inappropriate for long-term work. The hospital has been unresponsive to this issue.
Residents have also reported "restrictions" on supplies. Some have even been unable to do things like replace a patient's wound VAC.

The absence of a cafeteria inside the hospital leads to stress and added burden as physicians have little time to go outside in order to eat during their long shifts. Additionally, call rooms are usually not cleaned, linens are changed infrequently and fridges in the hospital often don't work which exacerbates the issue of having no cafeteria.

Culture/Other

There is a general disregard for issues that affect resident physicians. When residents have voiced concerns over safety issues while commuting to outside rotations, they were told to take Ubers. When the exorbitant cost of frequent Uber rides was brought up, residents were told that they were made aware during interviews on which sites they would be rotating, so it's their

responsibility to get there on their own. The costs of outside rotations has been a major issue of concern and stress for resident physicians.
Residents have faced numerous payroll issues that the union has had to repeatedly escalate and fight. Recently we have seen the following issues:

Approximately 20 residents were being paid at the wrong PGY level

- Residents not getting holiday or call pay
- The hospital incorrectly deducting FICA
- A chief resident was not receiving their chief pay,
- And one resident was accidentally removed from payroll.

Resident Stories

“The singlest biggest stressors in my time at Metropolitan has been the fact that, despite being promoted to the level of second year resident, I continue to be paid at the intern level. Despite repeated assurances by HR that this would be corrected, I have now gone two months without my collectively bargained pay raise. The level of incompetence is absolutely staggering. Living in New York City, as many know, is not easy. The city has some of the highest costs of living in the US; this is especially challenging given that resident salaries vary little across the country and therefore relative to cost of living residents in New York City make effectively less than our counterparts in other areas. Given this, it is incredibly frustrating that we have not been granted our PGY-2 pay raise as was collective bargained for by CIR. This is important not only due to the ever-increasing expense of living in the city but also because it demonstrates a failure on the part of Metropolitan Hospital and New York City Health + Hospitals to honor their commitments to residents. I truly do love my job, and I am honored every day to help to take care of a challenging but rewarding patient population, but I expect to be paid a decent wage that is commensurate with my increased experience for doing so.“ Anonymous

“My paycheck is incorrect as I am not receiving the correct payment; it has been an ongoing problem for the past 2.5 months. The hospital payroll department and HR department have continued to turn me away, not respond to emails or phone calls. I consistently have to take time out of day to attempt to correct this issue and still nothing gets done. Instead of concentrating on my patients and their care, I must instead deal with the logistical inadequacies of this hospital, taking much time out of my day multiple times, which invariably leads to frustration and stress... which is added on to the other stressors of residency.” Anonymous

“The absence of a cafeteria inside the Hospital is stressful, just the fact that you might need a coffee and you are not able to get it inside the Hospital, and have to go to one of the locals outside, or sometimes not being able to because what if a patient needs you and you are outside the Hospital at that moment? And for the long calls having to prepare not 1 but 3 meals for 24 hours because if not the only thing you can get will be something from a vending machine.” Anonymous

“There are two issues facing residents we'd like to discuss at this time. The first is access to hospital-issued scrub attire and the second is an issue of mandatory outside rotations for which residents are subjected to undue safety issues and financial hardship. Since the end of summer 2020, surgical and anesthesiology residents have bene plagued by constant interference with their ability to obtain hospital-issued scrubs from the scrub machine, which institutional policy requires all OR staff to wear. At this time, ID badge access to the machine is frequently revoked and scrub credits disappear without any notification to the affected user. When someone is unable to obtain scrubs from the machine, the only alternative is to wear disposable paper scrubs, which are designed to be worn over one’s street clothes and are made available in the OR so that visitors (such as medical/surgical device representatives or shadowing students) may enter the operating rooms as needed during the day. While paper scrubs offer an acceptable solution in the rare event that an unexpected problem with scrub access arises, their bulky fit, loose elastic waist and tendency to tear (often just from sitting down) make them generally inappropriate for all-day use by hospital staff working in such a high-acuity environment as the operating room. Over the last 12+ months, repeated inquiries have been made to the single person responsible for scrub access via telephone, email and personal visits, and each is met with the same response: “I’ll have to look into it” and/or “I’m busy right now”/ ”I haven’t had time yet”/ ”you’ll have to come back later”. After weeks to months of follow-up requests, no justification or resolution is ever provided by this person. Each user is supposed to be allotted a minimum of 2 credits, so that a clean pair of scrubs can be readily obtained in the event that one’s current pair becomes soiled with any number of bodily substances. A large number of residents are currently limited to a single credit after discovering an unexplained credit loss at some point, only to have repetitive requests for clarification or resolution ignored. In one instance earlier this year, an attending surgeon arrived in the morning to discover his scrub access had been revoked without notification, and was directly denied restoration of his access, even temporarily, until days later after the issue had been elevated to departmental leadership. Numerous inquiries made by the anesthesiology department’s residency program manager were met with similar repeated promises to investigate, and when ultimately pressed for answers, the man in charge reported that each lost credit was associated with an incidence of scrub removal without return, but could not provide any further information or evidence to support his claim. Just recently, a Metropolitan anesthesiology resident on rotation at an outside hospital was scheduled to spend 2 days covering cases at Metropolitan on short notice. She was denied scrub access by the responsible party as well as any kind of temporary, good-faith loan of a single pair of scrubs to wear and return after her 2 work days. One day in advance of her return, the resident was instructed to wear paper scrubs for the time she’d be working at Metropolitan. As the sole authority over staff access to scrub attire required by the hospital, this one person’s inappropriate and problematic gatekeeping of staff scrub access has remained completely unregulated. Management of staff scrub access needs to be reliable and accurate, with the delivery of a timely and transparent resolution for issues that arise. We request that the linens department prioritize the timely resolution of all outstanding discrepancies affecting current residents at this time, so to ensure that each resident is restored both their allotted

scrub credits. Furthermore, we feel that any future changes to a staff member's scrub access (specifically including the loss of a scrub credit or revocation of badge access to the machine) should be accompanied by an email notification to the affected user, citing the reason for loss of their machine access or scrub credit as well as evidence showing that the offending event has been reviewed and confirmed (electronic log of affected user's scrub removal/return or photo from the scrub machine's camera, etc.). In regards to the issue of mandatory outside rotations, our program requires residents to travel to outside hospitals for the entirety of their PGY-3 year. This was not disclosed to us during the interview or onboarding process. One of these hospitals is Montefiore Medical Center, where we spend a minimum of 2 months during the PGY-3 year. We travel to Montefiore for our cardiac anesthesia rotations (2 months), where we're required to arrive at 5am for setup and, due to the lengthy nature of cardiac cases, often do not finish the day until 7pm-8pm at night. Travel to Montefiore takes over an hour on public transportation, requiring the resident to enter the subway around 3:30am and travel home in the dark evening hours as well. When this issue was brought to our program leadership, the concerned resident was told simply to take an uber, which is $60-80 each way. Multiple concerns have been raised in writing with program leadership, ultimately culminating with a written letter by program leadership explaining that we were made aware during interviews which sites we would be rotating to and that it was the resident's own responsibility to get to each rotation on their own. Concerns were raised not only about safety and resident wellbeing (insufficient time for studying and sleep) but also the $1200-1400 per month that were being spent on ubers, as was suggested by our program leadership. We desperately need to either reschedule these rotations at a closer hospital or arrange for travel reimbursement for residents who are required to be on these outside rotations." Dr Lindsay Juarez

"I am writing this to bring up my concern about the night shift schedule at the Metropolitan hospital. In our contract: No more than 10 night shifts should be scheduled in 28days. However, I, as a prelim intern, have 12 shifts in 4 weeks. Weekly hours are 72 with the current schedule, almost hit the cap of ACGME regulations. Internal medicine Categorical interns may have 24 night shifts in 28days. It is a violation of our contract. As we all know, city hospital lacks skilled nursing staff, Residents covering the night will need to do so much nursing work, including but not limited to the blood draw, IV line placement, etc. The current schedule will make this problem worse. This may contribute to physician burnout, and ultimately this may compromise patient safety." Anonymous

"I appreciate the efforts my program makes to comply with ACGME regarding the working hours. But residents and employees in Metropolitan don't have access to on-site food. Imagine working 24h being hungry, and there is no place to eat or buy food. Even our patients struggle with this. My second concern is about the commute to our Outside rotation in Valhalla. We, as residents, have to cover the commute expenses every year. And sometimes, with weather impacting public transportation, we are forced to take private rides paying close to 100 dollars per day. This affects our budget! I hope this hearing can make a change!" Anonymous

“During my training, I have done my best to provide patients a therapeutic experience. However, there are several undeniable issues that creates strain in the process. These include understaffing that creates higher stress and burden for existing staff. Short staffing also creates safety issues, as agitated patients are less likely to be calmed down, because of slow response from supportive staff , who are stretched too thin to come to the Units quickly enough. Several residents and attendings have already been physically assaulted by agitated patients. This has created a tense environment for clinicians, coming into work with anxiety at the prospect of another potential assault. And this has all occurred in the last 2 months. It begs the question, how much more potential violence, as well as potential legal action, will be necessary to address staff shortages and safety hazards in the psych inpatient units ?” Anonymous

Woodhull Hospital

There are 146 housestaff at Woodhull Hospital. In addition to providing care at Woodhull hospital, residents from Woodhull regularly rotate to Bellevue Hospital, Gouverneur Healthcare Services, SUNY Downstate, and New York University Hospital. Woodhull has a mix of foreign and American medical graduates who primarily serve disenfranchised communities in Bedstuy and Bushwick.

Out of Title Work and Understaffing

First year residents were assigned to independently cover ICUs at the time when the volume of covid-19 patients was at its peak. Residents are still asked to work several night-shifts every other two weeks for up to three months and are still being called from virtually any rotation to cover residents that feel fatigued or sick.

Resources/Equipment

On-call rooms where residents are supposed to rest are unkempt, the fridges often don’t work and contain spoiled food, and there is always a lack of clean linen. The only available free drinking water in the hospital is located on the 9th floor.

Culture/Other

Only lip service is paid to physician wellness. Residents are reminded to take breaks during their 12 hour shifts but the hospital has not provided the staffing needed to cover patients so that residents can actually rest or take breaks. After a suicide attempt by a resident was reported, the hospital’s response was shallow and dismissive. Residents report bullying by attendings and a culture of retaliation and abuse with threats of having bad performance reviews or even dismissal.

Wins and Improvements

In October of 2020 CIR leaders at Woodhull Hospital launched a campaign to remove routine out-of-title tasks from resident workloads. In their demands the residents called for:

- The hiring of more ancillary staff- nurses, PCAs, phlebotomists, and transporters
- The training of nurses and PCAs
- The publication of a list of nurses and other ancillary staff and their training and certification in phlebotomy, heplock and other relevant skills
- The institution of accountability and reporting systems that would hold staff accountable to perform their tasks.

The campaign included a petition to the Chief Medical Officer, a meeting with the Chief Executive Officer (CEO), the GME Director, the Hospital's Medical Board and individual Program Directors. Residents also engaged in data collection to show the amount and frequency of out-of-title work that they had to perform.

After months of campaigning, on May 24, 2021 Woodhull agreed to take action to reduce out-of-title work and issued a memo to all nursing staff. The memo eliminates any resident responsibility for phlebotomy and heplock, except in emergency situations. It also established a chain of accountability within the nursing department for such tasks. New protocol for reporting of attempts to draw blood or place heplock in medical records was required. In addition, the hospital identified 9 nurses for additional training to ensure there was adequate nursing staff trained to perform these duties.

In October 2020 Woodhull residents leaders also demanded that hospital administration improve the ventilation system in resident and patient areas. The demand was made as a result of knowledge that the COVID-19 virus spreads more rapidly in poorly ventilated areas and that improved ventilation would significantly cut the spread of COVID-19 indoors. The residents presented a list of rooms that they believed needed improved ventilation systems. The residents' demands led to a study that tested for Colony Forming Units (CFU'S) or general bio burden, and specifically for MRSA.

Following that study the hospital secured:

- Several compact air filters/purification units and installed them in several resident and patient care areas to "address the residents' concerns." These Caspr units are 'plug and play'

- Following a 4-month testing of the efficacy of the filters, it was found that “all levels of microbial burden, prevalence of MRSA, and average monthly hospital acquired infections (HAI) were all significantly lowered:”
    - 95% reduction in average microbial burden (CFU's)
    - 81% reduction in the prevalence of MRSA
    - 54% reduction in healthcare-onset HAIs.

The Dental area required complete reconstruction of the entire ventilation system. To address the residents in the dental suite, the dental clinic suite underwent a renovation of the HVAC system that covers the dental suite to include but not limited to:

- Ability for each patient room to become negative pressure as needed
- Electronic plasma filtration in the air handler unit
- UV lights for greater sterilization in the air handler unit
- Bipolar Ionizers in the AHU
- HEPA filtration in the AHU
- and installation of humidifiers for the new air handler unit.

Resident Stories

“There aren’t any communal areas to have lunch or build community. We are often locked out of the conference room and there is nowhere to eat lunch! Residents are forced to eat on chairs or outside in the hallway with nowhere to put their food or drink. Also, nowhere to really build community. Additionally, there is no drinkable water on the first floor. We have to take the elevators to the 9th floor in order to fill up our water bottle with only 50% of elevators working and an average of about 10-15 min wait to ride the elevator, it isn’t feasible to even refill our water bottles if we wanted to. These are basic workplace essentials: a place to eat lunch and water and Woodhull has not been able to provide those to us thus far.” Anonymous

“Burnout Trauma from COVID experience Work Thank you for all those who take physician wellness and mental health as a priority. I am a resident at Woodhull Medical Center, deemed “a community hospital of excellence” according to the mission statement found on the hospital’s website. We primarily serve disenfranchised communities in Bedstuy and Bushwick. In response to the covid-19 pandemic in late March 2020, our rotation schedule focused on providing comprehensive exposure to educational opportunities mandated by the American College of Graduate Medical Education – ACGME was disrupted and changed to an emergency schedule to redistribute the resident workforce to the multiple makeshift intensive care units in the hospital due to the unprecedented surge of critically ill patients afflicted with covid-19 pneumonia.I still remember the palpable sense of fear in the Woodhull auditorium when we were told that the hospital was “getting ready for the worst”. Due to lack of staffing, first year residents were assigned to independently cover ICUs at the time when the volume of covid-19 patients was at its peak. At that time all first year residents still required at least 4 months of

training before graduating to our second year as more independent residents; the undue emotional stress of garnering this new sense of responsibility without any choice in the matter lead many of us to develop post-traumatic stress as we watched several of our patients die under our care. Although our patients come first, as physicians, our emotional and psychological wellness must also be protected.I can think of many instances where our wellness has been discounted. During the pandemic, for example, we were told via email that ''we should try to take breaks during our 12-hour shifts," when realistically, the vast majority of ventilated COVID-19 patients were too sick to be left unattended. Ventilator alarms and vital signs alarms went off constantly making breaks impossible. Furthermore, when the rare moment presented itself where we could try to get some rest, there were no comfortable options for reprieve since the on-call rooms were unkempt--and continue to be this way. Mattresses are dirty, fresh sheets almost never offered, rooms are never cleaned, the fridge never worked causing our donated food to spoil. A year after the first covid surge, life in the hospital has reportedly returned to normal according to our supervisors. Although we survived the pandemic, we fulfilled our oath and served our patients with compassion and resilience, the emotional scar remains. The weight of seeing young people dying, of hearing family members crying over the phone because their loved ones would never come back home, of never being able to say goodbye remains heavy. As residents, we often gather to go over our experiences, almost as if we were sharing our war stories. We decompress, we process, and at least try to move on. I am particularly concerned that many of my co-residents who might be suffering in silence do not understand the impact of accessing the social or mental health resources that allow for healing in this once in a lifetime traumatic experience. Last year, all the residents in the program received emails and text messages from fellow residents that shared their suicidal ideas and sadly in one instance one suicide attempt. The leadership's response was dismissive, shallow and infuriating at best. An email with mental health resources and a shallow claim of support that feels more like a liability control. Now when gladly the COVID-19 deaths in NYC remain low. We are still push to fill the gaps in staffing at expense of our educational experience and wellness. We are still asked to work several night- shifts every other two weeks for up to three months. And we are still being called from virtually any rotation to cover residents that feel fatigued or sick. We didn't ask to be heroes. We just wanted to be residents. We assumed the responsibility put on our shoulders but we are human. Healing will take time but in the meantime, we should start with resources to address the mental health toll that the pandemic left behind, better call rooms, more physicians facilitating our learning and more night staffing.Thank you." Anonymous