CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the
COMMITTEE ON HOSPITALS
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September 24, 2021
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HELD AT: REMOTE HEARING (VIRTUAL ROOM 1)

B E F O R E: Carlina Rivera,
Chairperson for the Committee on
Hospitals

COUNCIL MEMBERS:

Diana Ayala
Mathieu Eugene
Mark Levine
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

COMMITTEE ON HOSPITALS

A P P E A R A N C E S

Dr. Omar Fattal,
Deputy Medical Director, Office of
Behavioral Health

Jeremy Segall,
Assistant Vice President, System Chief
Wellness Officer

Dr. Donnie Bell,
Deputy Chief Medical Officer

Machelle Allen,
Chief Medical Officer

Tim Johnson,
Senior Vice President at Greater New York Hospital
Association.

Dr. Oluyemi Omotoso,
Emergency Medicine Physician, Lincoln Hospital;
National Secretary Treasurer of the Committee on
Interns and Residents.

Dr. Olga Kobolva,
Psychiatry Resident, Harlem Hospital
(*NOTE TO EDITOR: This doctor's name is spelled *Koblova* on her online/professional profiles as well as the Harlem Hospital website.)

Dr. Yannick Kofi Ralph Jones,
Internal Medicine Resident at Harlem Hospital

Dr. Zadoo Bendega,
Infectious Disease Fellow at Harlem Hospital

Dr. Maham Rehman,
Foreign Medical Graduate, Resident Physician

COMMITTEE ON HOSPITALS

A P P E A R A N C E S (CONTINUED)

Dr. Kaushal Khambhati,
Senior Emergency Medicine Resident at Jacobi Medical Center

Dr. Michael Zingman,
Psychiatry Resident at Bellevue Hospital and NYU;
CIR New York Regional Vice President.

Dr. Lindsay Juarez,
Anesthesia Resident at Metropolitan Hospital

Dr. Dina Jaber,
Internal Medicine Resident at Kings County Hospital

Dr. Keriann Shalvoy,
Addiction Psychiatry Fellow at Bellevue Hospital.

Dr. Leo Eisenstein,
Internal Medicine Resident at Bellevue Hospital Center

Dr. Hannah Marshall
OBGYN Resident at Kings County Hospital

Dr. Michael Del Valle,
Emergency Medicine Resident at Jacobi Medical Center in the Bronx; Regional Vice President of the Committee of Interns and Residents

Dr. Pramma Elayaperumal,
Pulmonary and Critical Care Medicine Fellow at Kings County and Coney Island Hospitals

Michael Leitman,
General Surgeon; Dean for Graduate Medical Education at Mount Sinai

COMMITTEE ON HOSPITALS

A P P E A R A N C E S (CONTINUED)

Dr. Ernesto Blanco,
Internal Medicine Resident at Coney Island Hospital from 2017 through 2020.

SERGEANT BIONDO: According to the computer, begun.

SERGEANT HOPE: (INAUDIBLE 00:00:05) cloud started.

SERGEANT UNKNOWN: Back up is rolling.

SERGEANT HOPE: Thank you.

Good morning, and welcome to today's New York City Council Remote Hearing on Hospitals.

At this time would all panelist please turn on your videos?

Thank you. To minimize disruption, please place all electronic devices to vibrate or silent mode.

If you wish to submit testimony, you may do so at counciltestimony at... counciltestimony@nyc.gov. I repeat counciltestimony@nyc.gov.

Chair Rivera, we are ready to begin.

CHAIRPERSON RIVERA: Good morning, everyone. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals.

And, I want to start by thanking everyone present today. I know for many of you, your presence here is not easy. So, I want to thank you for being here.

I'd like acknowledge my colleagues. I'm just checking to see if any of them have joined us yet.

And, if not, we will be acknowledge them as they show up to the hearing.

We are all here today to discuss the wellness and health of New York City Interns and Residents.

And, I'd like start by acknowledging the incredible work of residents during the COVID-19 pandemic.

Residency programs were already difficult. And, working during the Corona Virus pandemic amplified these difficulties significantly. Resident's anxieties, some new and others longstanding, ran the gambit from concerns about disruptions to their education, to fears of exposure to the virus, due to widespread shortages of personal protection equipment.

As more established physicians and nurses publicly cried out for protective gear and better pay, residents largely suffered in silence afraid that speaking up might cost them their careers.

Even when some residents did demand hazard pay and financial benefits, such as increased disability insurance, they were denied without any discussion.

Today, those of us who aren't in your shoes, will do our best to empathize and understand.

However, I'd like to say up front that we know we ultimately cannot know the depths of the impact of the pandemic on you and your work.

We cannot understand the magnitude of the trauma that you experienced. And, we hope that this forum can help you share and shed some light on that.

Thank you for your tireless efforts. And, thank you for taking the time and for sharing today.

I'd also like to acknowledge the fear of retaliation many residents feel when discussing their working conditions, mental health, and overall well-being. All residents should feel safe providing feedback about their programs without fear of retaliation. I know this isn't the reality.

I want all residents, including those who wish to participate today, and cannot because of fear or because of their schedules, that I see them, and that my thoughts are with them as well today.

That said, becoming a doctor is not easy. It's stressful, it's competitive, and it's expensive.

Residents are inadequately paid. According to a study published in *The American Journal of Surgery*, resident salaries do not reflect the number of hours

worked, and are not comparable to those of other medical staff.

Despite resident's comparatively low salaries, it is expensive to become a physician. A large majority of medical students graduate with debt -- including 73% of graduates in 2019, who had a median educational debt of $200,000.00.

Residency programs are strenuous. Although, there are federal and state level protections in place regarding work hours, it is not enough. The policies are simply not strong enough.

Rates of suicides, depression, and burnout are high. According to a survey of 700 residents performed by The Committee of Interns and Residents, doctors are two times more likely to commit suicide than those in other professions. And, 10% of fourth year medical students, and first year residents, report having suicidal thoughts.

Female doctors are four times more likely to commit suicide than women in other professions. A study released in 2017, found that suicide was the leading cause of death for male residents, and the second leading cause of death for female residents. Drivers of burnout, suicide, and poor well-being in

residency include their work hours and student debt, as well as the culture of hazing and bullying, out of title work, and a lack of mental health services.

Since the COVID-19 crisis began, moral has dipped even more significantly.

So, today, I ask, well facing the emotional, physical, and financial stressors of the pandemic on top of typical residency related stress, what additional support have hospitals provided to residents to help them?

Several hospitals have created programming to provide mental health and wellness resources for their staff -- including help in hospitals Helping Healers Heal program and NewYork-Presbyterian's created CopeNYP.

Greater New York Hospital Association formed a clinician well-being advisory group, which focuses exclusively on the issues faced by frontline providers.

We were able to learn about these programs, as well as others, during a hearing in June 2020 -- that this committee held -- about the mental health of frontline healthcare workers.

While these programs seem helpful, I am still concerned. We need to make sure that wellness programs are accessible to residents, and that they are safe spaces.

There is much stigma baked in to the healthcare professionals with regards to seeking and receiving mental health services.

Additionally, no matter how well a person tries to engage with mental health and wellness programming, residents remain over worked and underpaid.

Structural issues within residency programs, such as hours, working conditions, pay, and benefits should also be examined and meaningfully addressed.

Today, we look forward to continuing to discuss how New York City's hospitals have worked to support healthcare workers, specifically residents in their training, with a particular focus on their wellness and mental health.

The committee also hopes to hear more from hospitals about how their programming specifically supports residents and the metrics used to show the success of such programming.

Just the Corona Virus pandemic did not create, but rather highlighted, existing systematic racial and socioeconomic inequalities, it also highlighted systematic issues of medical training.

We as a city, and as a country, must learn from this pandemic and prioritize improving the health and well-being of interns and residents.

I would like to thank The Hospital Committee Staff, Counsel Harbani Ahuja, Policy Analyst Em Balkan, Finance Analyst Lauren Hunt, Data Analyst Rachael Alexandroff, my whole team, especially Isabelle Chandler, and of course the entire council staff, our technical experts, all Sergeant at Arms, for creating this space for everyone.

Thank you all for being here.

I'm am now going to turn it over to our Committee Counsel, Harbani Ahuja, to go over some procedural items.

COMMITTEE COUNSEL: Thank you, Chair.

My name is Harbani Ahuja, and I am Counsel to the Committee on Hospitals for the New York City Council.

Before we begin, I want to remind everyone that you will be on mute until you are called on to testify when you will be unmuted by the host.

I will be calling on panelist to testify. Please listen for you name to be called, and I will be periodically announcing who the next panelist will be.

For everyone testifying today, please note that there may be a few seconds of delay before you are unmuted, and we thank you in advance for your patience.

All hearing participants should submit written testimonial to testimony@council.nyc.gov.

At today's hearing, the first panel will be representatives from the administration, followed by council member questions, and then the public will testify.

During the hearing, if council members would like to ask a question, please use the Zoom Raise Hand Function, and I will call on you in the order in which you have raised your hands.

I will now call on members from the administration to testify.

Testimony will be provided by Dr. Omar Fattal, Deputy Medical Director, and Office of Behavioral Health.

Additionally, the following representatives will be available for answering questions:

Jeremy Segall, Assistant Vice President, System Chief Wellness Officer, Dr. Jeremy Segall, Deputy Chief Medical Officer, and Dr. Machelle Allen, Chief Medical Officer.

Before we begin, I will administer the oath.

Dr. Fattal, Jeremy Segall, Dr. Donnie Bell, and Dr. Allen, I will call on you each individually for a response. Please raise your right hands.

Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to council member questions?

Dr. Fattal?

DR. FATTAL: Yes, I do.

COMMITTEE COUNSEL: Thank you.

Jeremy Segall?

JEREMY SEGALL: I do.

COMMITTEE COUNSEL: Thank you.

Dr. Bell?

DR. BELL: Yes.

COMMITTEE COUNSEL: Thank you.

And, Dr. Allen?

DR. ALLEN: Yes, I do.

COMMITTEE COUNSEL: Thank you.

Uh, Dr. Fattal, you may begin your testimony when you are ready.

DR. FATTAL: Thank you.

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 or Health + Hospitals in brief.

I am pleased to be joined this morning by Deputy Chief Medical Officer, and Jeremy Segall System Chief Wellness Officer of 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 Program (or also known as (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's 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*; 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; 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, and we are happy to address any questions you may have at this time.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'm now going to turn it over to questions from Chair Rivera.

Uh, panelist from the administration, please stay unmuted if possible, during this question and answer period. Uhm, thank you.

Chair Rivera?

CHAIRPERSON RIVERA: Thank you so much. Thank you for your testimony, uhm, I... I really appreciate some of the details that you gave in terms of how you support residents with feelings of burn out and depression.

But, if we can just even go through it even at, I want to say a bit simpler.

So, if someone has these feeling, if someone is looking for support and assistance, what do you recommend that they do as an Intern or a Resident? And, how do you create a safe space for that person -- - If they came to you today and asked for help?

DR. FATTAL: Yes, and that's exactly what the

Helping Healers Heal *program* and infrastructure is set up to do. And, it's a tiered program, where people start exactly with the initial entry, and then it gets escalated as needed. And, for that, I'm going to turn to my colleague, Jeremy Segall, who can walk us through how that happens.

JEREMY SEGALL: Uh, good morning, Chair and council members. Really do appreciate the opportunities to speak NYC Health + Hospitals Enterprise wide Helping Healers Heal, also known as H3 program.

Uh, so, uh, just to give a little bit of framework as to Helping Healers Heal debrief is.

Uhm, it's an emotional support encounter. It's meant to be a peer to peer mutual program, uh, that can be conducted by anyone -- whether they are a license Mental Behavioral Health Clinician, uh, an Environmental Service worker, patient transporter, uh, or even a doctor or resident themselves.

Uh, so an Emotion Support Debrief can triggered in a multitude of different ways. Uh, we have through the Helping Healers Heal website, you have an opportunity to trigger a response support encounter. Uhm, and what happens is, is that at each and every

individual site, we have Helping Healers Heal as well as what we call Trained Peer Support Champions. So, Trained Peer Support Champions are those that have gone through Enhanced Empathy Skill Building training, uh, as well as their trained to cover our concrete resources that are made available to all NYC Health + Hospitals employees and affiliates despite service lines, clinical, nonclinical setting, uhm, as well as site.

So, the way it works is if it's, uh, triggered through the portal, uhm, the Helping Healers Heal lead would receive a the encounter request. Which at times can either be done anonymous by an employee for themselves or for someone else; It can be, uh, an encounter for an entire service area unit, or it can be something in terms of you typing in your own name or someone else's name and the best contact number and time to reach that staff member.

Uh, once the encounter is engaged, uh, Peer Support Champion is assigned, or the HP lead will handle it themselves.

Uh, and there's a four step model in terms of Emotional Support Debriefing, which includes an introduction really laying the groundwork or

foundational elements of what a Helping Healers Heal Debrief is, framing it as a nonclinical intervention, uh, that is meant to engage someone with empath, compassion, resource sharing and follow up.

Uh, the second, uh, step to this debrief is really to do the exploration phase -- asking open-ended questions in a more motivation interviewing process, uh, as well as, uh, first aid critical response sensitivity, uh, manner.

The next step, really is the follow up of sharing resources, uh, if a staff member requests it, or if it is recommended.

Uh, and of course, the last step to ensure that there is some connection to an alternate level -- if that is asked for by the staff member.

Uhm, and that's just one way that it can be triggered. We also have operationalized Helping Healers Heal and really have seen maturation and sophistication with the programming over the last three and a half years.

Uh, so often in the morning safety huddles, uhm, if there is an adverse patient event or outcome, uh, if we have learned about a staff member's unfortunate, uhm, ,you know, an accident in the

community, or a terminal diagnosis, or something of that nature, uh, we are much proactive in terms of sending a Helping Healers Heal Debrief there.

Uh, so word of mouth, telephone calls, emails, texts as well as the portal itself is how a Helping Healers Heal Debrief can be triggered.

In terms of a group setting, all know that working across the landscape of healthcare can be exceptionally challenging, especially for our future generations of providers of care. Uh, so, what we want to make sure that this is available across all disciplines, departments, and tours. Uh, so, if there is a patient that came in through the ICU, that multiple tours -- multiple disciplines or departments, uh, supported, and if that patience, unfortunately, succumbs to an illness or an injury, we want to make sure that we can debrief the entire service area. Uh, so that's us really making sure that we remove the staff members from that area if possible, finding a safe quiet, comfortable environment, uh, where confidentially, uhm, it can be upheld, and to really just make sure that we're empathetically supporting those individuals.

And, that's the same thing for an individual debrief. Uh, we try to remove them from that work environment, whether it's s take a walk, sit in a private office, uh, in a staff lounge or one of our workforce wellness rooms. Uh, we want to make sure that we're emphatically connecting.

Uhm, and that's a little bit more about the concrete process of H3 Debrief.

DR. FATTAL: And, if I may add, uh, specifically for Mental Health Services, if, uh, maybe the house staff or resident is interested in talking to someone, we have multiple options for them. They can call the 1-800-NYC-WELL 24/7, and talk to a Crisis Councilor and be connected with services. Or, they can call our internal Health + Hospitals anonymous support helpline and, and they get a call back, and they can talk to a licensed counselor from Behavioral Health, or they can request services directly. And, in that case, they can use the concierge service, which is a person who is dedicated for the services, who's available Monday through Friday 8:00 a. m. to 4:00 p. m. And, that individual will connect the house staff with a therapist or a psychiatrist if that's what the house staff chooses.

So, I think what we're saying is that we have multiple different ways of entry. And, as you mentioned here right at the beginning, stigma is a big barrier. And, once of the ways that we're trying to break stigma is to make it easier to people to receive help by giving them multiple, different options. Some of them are anonymous, some of them are online, some of them are in person, so that they can pick the one that they're comfortable with.

CHAIRPERSON RIVERA: So, the... If I understand, the concierge is service, that you mentioned where there's mental health support and substance abuse support; where you even mentioned medication management.

And, then there are the trained Peer Support Champions, who are assigned.

Are the trained Peer Support Champions, uh, fulltime, permanent personnel? Is there a chance of that person not being the same person?

I'm just trying to lend to consistency, because I also know, you know, the... The stigma is absolutely real. It's cultural as well. And, I... And, I think, you know, uhm, I appreciate the layers, but I also know that sometimes people might be hesitant if

they're, you know, passed from person to person. There is a trust that has to be established there for someone to be truly open.

So, is the trained Peer Support Champion someone, uhm, you know, a permanent, fulltime person? You know, who are they?

DR. FATTAL: Yeah, our fundamental philosophy is that wellness is more than just mental health. And, we, you know, we don't send the message that wellness directly means mental health. And, that's why the wider infrastructure have for the Helping Healers Heal. And, then some people end up, uh, working with mental health providers. But, I would turn to my colleague, Jeremy Segall, who can explain specifically, uh, answer your question.

JEREMY SEGALL: For continuity purposes, each and every single, uh, one of our 11 acute care hospitals, every single one of our five post-acute, uh, and across our ambulatory care as well was community care service lines, we have assigned fulltime employees, uhm, that have additional Helping Healers Heal responsibilities; they are the fixture points in addition to our Directors of Psychiatry where behavioral health services are available.

Uh, in terms of a Peer Support Champion, a Peer Support Champion is a colleague, a peer, literally on the frontline whether they're clinical or non-clinical. And, the idea is that we wanted to have a Peer Support Champion identified in each and every single department, uh, so that there is continuity within their own backyard -- with their own work environment, so that they can be debriefed or be supported by their own, uh, colleagues in and around their area.

Uh, a Peer Support Champion can be assigned to, uh, an individual or a group debrief or a wellness event. Uhm, and, the idea, if they have engaged in that encounter, we would want them to continuously follow up until the encounter closes out. And, usually these encounters usually only one additional followup. Uh, and if at that point and time they are requesting a higher level of support, if you will, and that is not always just a, uh, a licensed mental health, uh, clinician, uh, that could be speaking to Chaplaincy Services or a risk manager, uhm, or the EAP. Uhm, the idea is that we want that same friendly face, uh, that already engaged with them, to be the same person that is following up with them.

The Helping Healers Heal leads and the Director of Psychiatry are those fixed persons that are able to conduct and make sure that the care and support is continuous, if you will.

Uh, a Peer Support Champion, again, is someone that has been trained in empathy skill building, uh, as well as the concrete resources, uh, that we offer, as well as signs and symptoms of compassion fatigue -- - burnouts, vicarious complex, as well as collective traumatization, uh, and second victimization, as well as stress on a continuum.

Uh, so these trained Peer Support Champion are really meant to be just anyone -- pedestrians -- anyone in our own, uh, walls within our facilities that are able to to just provide humanity and healthcare again.

CHAIRPERSON RIVERA: Thank you.

I just want to recognize, we've been joined by Council Members Diaz and Ayala.

So, uh, and, I... I appreciate, again, everything that you're mentioning in terms of how you are trying to address the traumatic experiences that interns and residents have suffered. And, when you all testified in June 2020, you did mention this

program, which is peer led, it's a wellness program; it offers emotional first aid to healthcare providers.

Uh, and I guess my question is, how has it changed during the pandemic? What are the changes that have been made since we last spoke?

And, you mentioned the portal quite a bit, which, uh, a great place for resources, but is the program fully implemented in all of the 11 hospitals and other H+H facilitates?

DR. FATTAL: Jeremy, did you want to clarify that one?

JEREMY SEGALL: Yes, absolutely.

So, Helping Healers Heal, uhm, has continued to evolve. Uh, as mentioned back in early 2018, it was started as the Second Victim Response Initiative. Uh, as we began, uh, pick up and support, uh, the concretization of the program across all of our sites, which it does include our 11 acute care hospitals, our five post-acute sites, our Gotham ambulatory care service line, and community care, uhm, all of which, uh, were trained, uh, identified Peer Support Champions. Uh, H3 leads were identified, and then internal H3 steering teams were

established that are, uhm, interdisciplinary multiple... Multi-level, uh, steering teams at each of those sites.

Uhm, the whole thing about Helping Healers Heal is, I come from a quality improvement background, and there's two pillars of quality improvement, One: Respect for people, and two: Continuous improvement.

Uh, so we consistently are crowed sourcing trying to understand how we can continue to enhance our services, and to improve over time.

So, it started second victimization, it began to evolve in to be more inclusive of vicarious traumatization compassion fatigue and burnout, and at the turn of 2020, with, uh, the onset of COVID-19, that is when we aligned to six dimensions of well-being. And, now have aligned to eight dimensions of well-being -- making Helping Healers Heal not just about crisis response efforts and stress on a continuum, but to be more about choice, uh, one that recognizes -- honors -- all experiences, both personal and professional and how that impacts our workforce at their point of entry in terms of wherever they provide services -- clinical or nonclinical.

So, NYC Health + Hospitals created an internal definition, uhm, and so Workforce Wellness is again, not just about mental or an emotional support, it's defined as an active pursuit of new life skills and becoming aware of and making conscious choices toward a balanced and more fulfilling lifestyles to align to our eight dimensions, so that we can support our staff in a more successful existence.

Our goal, ever since the pandemic, is to reach a state of where we are flourishing, no longer surviving but thriving again, to be able to realize our full potentials both inside and outside of work despite our adversities.

So, uhm, throughout the pandemic, we launched our COVID-19 Guidance and Resource page, which had its own wellness page and information that also connects to the House Staff webpage that Dr. Fattal had mentioned.

We launched Just in Time crisis response trainings which was 30 minutes of digestible content by internal and external subject matter experts that were prerecorded, slide decks uploaded that any staff member could watch at their own leisure. We've reached over 63 hundred staff members with these Just

in Time training, which is more about, how can you cope and help someone else cope through challenging moments in life -- both with COVID-19, due to civil unrest due to racial injustice, as well as global affairs.

Uh, we of course had our anonymous counseling, uhm, support hotline that was launched by the Offices of Behavioral Health, that's been utilized over 200 times and connected staff members to the EAP or ongoing therapeutic services. Uh, we launched our wellness respite rooms as well as at times turning them in to mourning rooms. So, we have 31 of those at this point and time.

Uh, we did in kind management of donations in terms of protein shakes, bottles of water, canned goods, grocery bags, things of that nature, as well as establish what we call Proactive Unit-based Wellness Rounds -- Uh, which is bringing the support and care in to their work environment, both clinical and nonclinical areas of all of our sites across all service lines, and established wellness events. Which are events not only for recognition and appreciation of our staff, but nonverbal processies using the healing powers of art and creative

expression, uhm, for further introspection as well as a cathartic experience.

We also established standing debriefs. Uhm, if there are staff members that couldn't receive (INAUDIBLE 00:34:41)... (Cross-Talk)

CHAIRPERSON RIVERA: Just (INAUDIBLE 00:34:42)

Is this how the program has changed? Is this... since 8...

JEREMY SEGALL: This is how it has evolved, yes... (Cross-Talk)

CHAIRPERSON RIVERA: How... How... In all... In these changes, are you incorporating residents themselves in the evolution of the process?

And, I guess, how would you measure the success of the program?

What metrics are you using?

And, would you be able to share those metrics with us?

JEREMY SEGALL: Absolutely.

Uh, so first and foremost, we always the want the voice of the customer, whoever else... who is going to be receiving services, to have a voice in it.

Again, the whole point of well-being is to see your own self represented in those services, so that it can be, uhm, an opportunity for choice.

Uhm, and... And, that's how we build trust and respect. And, that's how we also begin to destigmatize utilization of services.

Uh, so we do have resident members on our Resident Wellness work group. Uh, we also at time have done post-check surveys as, uh system wide and we field a hospital staff Wellness Survey, which receives input from a multitude of department disciplines, uh, as well as roles including residents themselves.

So, to further answer, the program has an evolved to the Eight Dimensions of Well-being, which is us establishing emotional, environmental, occupational, financial, physical, intellectual, social, and spiritual well-being programming. And, this is available to all NYC Health + Hospitals employees.

In terms of measurability, again, I come from a quality improvement background, so if we cannot measure it, how do we know where we are and where we're need to go, and if we are actually improving services.

So, in terms of our score card, uh, that we bring in to every single Workforce Wellness Task Force, this is something that's also shared across all our H3 Steering Committee of... Which is the enterprise level as well as the individual facility level, as well as brought in to the Resident Wellness Work Group. Uh, so visits to wellness rooms from January 2020 to July 2021, we've had 83,187 visits by staff members. And, again, those are physical spaces that are enhanced to offer debriefing support or just a respite area for staff to relax and rejuvenate and reconnect to themselves.

In terms of the proactive unit based wellness rounds that I was mentioning, since January 2020 up until July 2021, we've had 34,648 proactive wellness rounds, which again, are proactive psychological supported discussions with staff, uh, that regularly occur in their own areas.

Uh, our anonymous support hotline, uh, we've had 200 calls, uh, since the inception. And, again, this is internal support H+H Hotline for all employees and affiliates that are staffed by licensed mental health clinicians to provide physiological and emotional support and referrals to other services if needed.

In terms of the H3 foundational elements of emotional support debriefing, we track out all of our encounters, so, and, again, the encounter can be either a one on one debrief, a group debrief, a wellness event, or a combined type as we call it.

So, from January 2020 to July 2021, we have had 1,814 individual debriefs; we've had 2,920 group debriefs; and we've had 327 wellness events.

Uh, in terms of the combined type, we've had 346 combined types of either one on ones that turned to group debriefs or group debriefs that turned in to one on ones. And, we have touched over 5,407 staff members with these encounters.

We also track how many Peer Support Champions we have across the system that have been trained with our Helping Healers Heal or Healer New York training. Uh, from January 2020 to July 2021, we've had 923 Peer Support Champions train, and of course this is a number that fluctuates and goes up and down.

The Battle Buddy Support Program that Omar... Uh, Dr. Fattal mentioned in his testimony, uh, that was launched in November of 2020. And, what this is, is it's an informal additional layer to our three tiered process for peer support. Uh, which is an

additional safety net, if you will, of eyes, ears, arms, and hearts on the floor. So, if I'm a Resident and want to speak to another Resident in another program within the same facility or a program at another facility, or even a different discipline, we've had 574 staff members utilize this service.

And, so, what it is they fill out... (Cross-Talk 00:38:44)

CHAIRPERSON RIVERA: Can I... Thank you so much for these numbers.

I guess my... My question is also, how often residents are surveyed about these programs and their experiences using these programs? Eighty thousand visits is... Sounds like a very, very impressive number, of course. These are... They're also spaces where people can relax and take a minute.

So, my followup question... Also, in addition to how often are residents surveyed about these programs and their experiences using these programs, is how do you ensure that interns and residents are able to access the program, especially with their busy schedules?

JEREMY SEGALL: Uh, thank you for that question. These are great questions.

So, uhm, we survey at a system wide of enterprise wide level once a year.

Uh, so we launched our 2020 NYC Staff Wellness survey back in late September through the beginning of November.

Uhm, we are currently -- two dates right now -- we have our Employee Feedback Survey, which has specific wellness questions as well as crisis response questions at active right now. Uh, that's meant to close October 4th, with an opportunity to extend for an additional week.

Uhm, within those surveys, there are embedded questions -- not only matrix questions on a Likert scale that they can answer in terms of awareness of programming, participation in programming, but also the efficacy of the program. But, we also have open ended questions for them to share what are the most successful aspects of programing; what are some of the barriers to those programming and the like.

Uhm, to be able to share some of the data, if you will, from our previous Staff Wellness Survey, uhm, in terms of our coordination of food and beverages and donations, 47% of our residents that took the

survey, uh, stated that it was very helpful or extremely helpful.

Uhm, we also took a look at temporary housing and how many people were utilizing that and what the appreciation was that, uh, 26% said that it was extremely helpful.

Uhm, as well as wellness events and moral boosting events, 23% stated that it was extremely helpful.

In terms of our respited wellness rooms, 23% of residents, and this is just Resident specific data, stated that it was, uhm, very helpful to extremely helpful.

And, in terms of the proactive unit based wellness rounds, uh, 33% said it was moderately helpful, and 14% said it was extremely helpful.

Uhm, so, we continuously are trying to really dive in to the experience of the residents and answer the call to actions, and say, how can we continuously improve for them? In terms of utilization of (Cross-Talk 00:41:06)

CHAIRPERSON RIVERA: Are those visits... Uh, are those figures mostly all staff visits? Because, you said 23% is extremely helpful, which I imagine, even

though the number doesn't sound high, I'm trying to imagine that the other ,you know, 77% is ,you know, I don't know moderately helpful?

I guess while the percentage of what people responded is great, and I'm glad that you're bringing numbers, I guess I want to know, what are people saying to improve on? What are you working on to address what is clearly a tragic, comprehensive challenge and problem that we are having in taking care of these individuals.

Quantitative is fantastic. You need some part of this program to be date driven, but qualitatively speaking, if you're surveying the individuals and ,you know, a quarter of them do find it extremely helpful, what are we doing to get the other 75% to feel like this program is truly in place to help them?

Uhm, I also wanted to ask if you track what percentage of residents completed the surveys. And, if you tracked from the H3 engagements, how many are from residents?

JEREMY SEGALL: So, uh, to answer some of your questions, the data that I was just providing in terms of the efficacy or satisfaction to the program,

that was all Resident date. That was not full enterprise wide data. And, it's broken down by: not at all helpful, slightly helpful, moderately helpful, very helpful, and extremely helpful.

Uhm, we have so many faceted aspects of the programs, so, uhm, qualitatively speaking, each and every single Resident that took the survey had an opportunity to share the successes and the... The opportunities for growth or improvement for every single element of our programming.

Uhm, and absolutely, the narrative, the stories, the lived experiences of our residents is exactly why we have these programs... This programming in place. Uhm, and we of course capture their thoughts. And, that's definitely brought in for problem solving and performance improvement and process improvement work for our programming.

In terms of utilization of services, and we are trying to get around some of the barriers, if you will, that's where the (INAUDIBLE 00:43:26) community directors, the program directors, and Chief residents really come in to play. Uhm, that's where we really want to make sure that we have visual management flyers , posters, uhm, tri-fold brochures

in services consistently delivered to our Resident population.

Uhm, we know that the barriers often tend to be scheduling conflicts, so that's why we're really looking to embed this in operations within the programming -- the Residency programming itself -- to be during didactic time, uh, protected time for conferences and the like.

Uhm, stigmatization was obviously talked about by Dr. Fattal in his testimony. Uhm, we have done... And are continuously are trying to really target socialized as well as individualized stigmatization about utilization of services, which are not always just about Helping Healers Heal debriefs, again we have a lot of other services that are not just about emotional support encounters.

Uhm, in terms of the Resident's stories themselves, how we utilize them, we took a look at the trends that were coming, uh, qualitatively , not quantitatively , uhm, to say , okay , what's the trend that' s coming up, and what are the root causes or the barriers to that, and how can we actionably , uh, approach this?

And, so some of the barriers that came up, were, uhm, we weren't providing some of these services, or they weren't as prevalent on overnight tours or during holidays and weekends... Uhm, a lot of other uhm, barriers have really come up that we're really trying to specifically target, so that access and equity to support is there for all residents across all tours.

CHAIRPERSON RIVERA: Okay, thank... That's very helpful. And, I imagine... I have... You know, I had a feeling, just by nature of, uhm, were a lot of administrative staff is and, you know, a lot of people are there during the day. Clearly we have overnight, uh, workers and people inside these facilitates. So... (Cross-Talk)

DR. FATTAL: I can add, uh, something very quick about the barriers. That one of the barriers that came up when talking to residents is pay. A lot of our residents, you know, when they want to see someone, they don't want to have to worry about insurance and coverage. And, that was a major barrier of them finding someone who accepts the insurance, so that they don't have to, you know, do the out of pocket. And, through the concierge

service that we established, it takes that problem away. So, that Resident doesn't have to worry about finding someone in network. We take care of that. All the Resident has to say is, I would like to see someone, and we have pre-screened the providers that we refer to, to make sure that they accept the insurance of that specific Resident. So, I think that that was one of the major barriers that came up as well.

JEREMY SEGALL: And, if I might add, just to give another concrete example of how we were listening to the residents.

Uhm, so when we established the wellness rooms and the standing debriefs, we had heard from Residents, well, I can't get off the floor, obviously due to patient care demands at that time during the first and second surges of COVID-19. So, that's what actually gave, first to our proactive unit based wellness rounds, we heard from them that they couldn't get off the floor. And, we wanted to bring the support to them -- including what we called Compassion Carts, stocked with some of the things that were in those wellness rooms, like the protein shakes and the bottles of water and the like. So,

that was actually listening to our house staff and trying to come up with a solution and an improvement effort.

Uh, and again, those proactive unit based wellness rounds, 33% said it was moderately helpful, and 14% said it was extremely helpful -- And, that's residents.

CHAIRPERSON RIVERA: I understand, and in... I going to get to, I think that, uhm, I think protein shakes, water, I think yoga, I think it's a very small component. I appreciate you mentioning it.

I think we ... I'll get in to something a little bit more serious, because that... Those are... Those are helpful things, but these are... What people are going through in these spaces is so detrimental to their health that they no longer want to live.

And, I have to just pivot a little bit away, and I... And, again, everyone needs a little bit of help. Of course groceries are helpful. Being paid what you're worth, your value that is the bare minimum that we can do. And, I realize there are changes that we have to make systematically, not just

in the city, but across the country on how value these individuals.

So, in an article in The City, on July 29th, 2021, Dr. Wade (SP? 00:48:06) was quoted saying that, "Helping Healers Heal immediately deployed to Lincoln in the aftermath of the deaths, sending grief counselors and other mental health aid to staff." But, he acknowledged that the program is and, I quote, "Not meant to address suicide." And, said, that "H+H officials are considering whether to change that going forward."

Does the H3 program, as is it currently designed, address suicide? If not, why not?

Are there any efforts to include this in future programming?

And, how does H+H respond when a Resident dies?

DR. FATTAL: I can say that I think the wording is... Uh, is interesting, because I can understand the code. I think Helping Healers Heal in of and of itself doesn't address suicide. However, Helping Healers Heal is a layered model, which is a three tiered model that definitely would escalate, whenever it is needed, to mental health services that does address suicide.

I think... The way I would understand that statement, is that the debrief itself is not a clinical encounter and cannot be a clinical encounter for HIPAA reasons, for medical legal reasons, for all kinds of reasons.

However, the debrief is designed to immediately go to an advanced debrief, and definitely to bring in Behavioral Health Services if there's any concern about mental health challenges or suicide.

But, I want to let Jeremy talk more about that, because he really does oversee the Helping Healers Heal. And, he oversees that transition from a debrief to bringing in Behavioral Health to address any serious issues. So, we work together in that sense to address serious scenarios like that.

But, I'll let Jeremy, uh, elaborate more.

JEREMY SEGALL: Absolutely, uh, and, Omar, thank you. I think you, uh, absolutely captured that.

So, Helping Healers Heal is based off of a three tier model. The first tier of the foundation of this pyramid, if you will, if having general awareness across all service lines as to what signs and symptoms of compassion fatigue, burnout, trauma, and second victimization are.

The second tier, on top of that, is our trained Peer Support Champions that conduct the debriefs are all staff members.

The third tier, which Omar was just referencing, is what we call an Expedited Internal or External Referral Network.

And, so a trained Peer Support Champion, part of the trainings that we go through, and that we are continuously improving over time, absolutely speaks to signs and symptoms of suicidal risk or harm.

However, again, because it is not a clinical intervention, if a staff member vocalizes any thoughts in terms of suicidal or homicidal ideations, with a plan, that is when it is immediately escalated to tier three, uhm, and/or the staff member is, uh, supported, uhm, by our CPEP's or PES's, uhm, or connected to ongoing outpatient treatment, depending on the level of risk.

So, we don't ask the trained Peer Support Champions to do any clinical assessments, uh, or anything of that nature. But, if they start to see signs and symptoms of suicidal ideation or homicidal ideation, they are then triggering that tier three response.

CHAIRPERSON RIVERA: Okay, so, I understand the tier three response. I just am having a hard time understanding what exactly that is.

So, I'll... And, I'll just give you an example of something that I read and that our team put together in terms of, "The American Medical Association provides a toolkit outlining best practices around a response of physician suicide that recommends implementing logistical support for the effected department."

So, this could include assigning colleagues outside the work unit to provide patient coverage, someone to take care of emails, even silencing pagers during notification meetings and memorial services for example.

Would it be possible to implement this at all H+H hospitals? Is this... Does it sound like something that is incorporated in this tier three response?

DR. FATTAL: So, that... Actually that protocol that you mentioned is definite something that we follow. It's on the webpage that I mentioned as a guide. And, we have a link to it, and it's actually, uh, out there for anyone to see, because we have had questions about that before. And, we wanted it to be

available in case, god forbid, there is, uh, a negative outcome or a, you know... However, uh, in the specific case of Lincoln, we definitely did that as you were describing it. And, I'll let Jeremy describe more of the details. But, this is almost exactly what happened. Uhm, and I'll let Jeremy elaborate more.

JEREMY SEGALL: Absolutely, so that checklist that you just mentioned is absolutely shared with all of our medical and executive leadership, uh, if and when there is a death by suicide.

And, we also, a central office, trigger support, uh, for instance, when speaking about one of our facilities, Dr. Fattal and I actually went to ground and debriefed every single Resident across all the Residency Programs, not only personally ourselves, but brining some of those grief counselors with us as well. I am also a licensed mental health clinician.

Uhm, in addition to that, uh, we wanted to take an individuated approach to this as well. So, after the group debrief across the residency programs it occurred, we followed up individually with the residents themselves as well, uh, further communicating all of the resources, internal and

external, to our system, as sometimes, you know, we don't want our residents or fellows to feel as though it's a punitive process to attain services. So, we're often offering services at other H+H facilities outside of their own residency programs -- or externals to our system as well.

CHAIRPERSON RIVERA: Okay, so how are residents in addition to Helping Healers Heal, uhm, I imagine real... You have other programs that you're certainly working with. We certainly have very, very talented community based organization, nonprofits, experts who can give a lot of time and attention, and on the ground lived experiences.

So, with those programs and with Helping Healers Heal, how are residents made aware of these programs?

DR. FATTAL: Like I mentioned in my, uh, testimony, we do recognize, and like you mentioned, Chair Rivera, that the, you know, the schedule and the pattern of their work, it's challenging, and we cannot rely on the one way of communication.

And, what we've been doing is really use a variety of techniques, so we can capture as many people as possible.

So, we definitely do direct emails. We do in person meetings with groups of residents. But, we also try to share the information with people who interact with the residents like DIO's, Program Directors, CMO's, leaderships at the hospitals and the facilities, so that their aware of these resources so they can share them with the residents and the house staff.

So, to answer question, it's really in multiple different ways including email, including having that information on the main landing page... The main website for NYC Health + Hospitals, we have a direct link to... Well, maybe I can take a step back, and the step back is that we pulled all these resources and put them together in one place to make it easier for the house staff to find them. So, that was step number one.

Step number two, is we took that one place, which is that one webpage, and we tried to share it with as many people as possible, in as many different ways as possible, to make sure that everyone knows about it. And, that's something, like Jeremy said, we're constantly trying to improve that. By no means we're saying that we've achieved that, there continues to

be a lot of work that needs to be done. And, there needs to be other work done on stigma to make sure that people are aware of the resources to pick up the phone and call.

CHAIRPERSON RIVERA: I appreciate that. And, I wanted to just ask, because I know, I mentioned Interns and residents a lot. But, I also know our doctors, our nurses, every single person within a hospital, is part of the most important eco system. You know, public health is everything. Uhm, and, as I think what really determines the well-being of the entire city of our society. And, it's certainly how we measure our own success and how we treat each other.

So, in terms of what was deployed to Lincoln, in the aftermath of the deaths, is the same protocol implemented if there is a suicide of a doctor -- for example?

DR. FATTAL: Yes, and, uh, that' something that, you know, we have a very large system. And, we have so many different programs and so many different divisions, and obviously there is some variations. But, ultimately, that's really the protocol that we follow as system. And, that's, like you mentioned,

is protocol that based on the ACGME, that's followed by other systems as well. And, you know, we've had other suicides happen in sister systems in the past, and we've learned from them a lot, because they had to deal with the same thing very recently. So, we know that this protocol not only comes from a place of, you know, that we trust, but also we know that it has been implemented. We've implemented it in our system, and we know that it works. And, that is the protocol that we follow.

But, I want to ask Jeremy if he has anything else to add to that?

JEREMY SEGALL: I think you absolutely stated all of that correctly. Uhm, no matter what department or discipline, any death of an employee across NYC Health + Hospitals, uhm, impacts us all. And, we want to make sure that all staff members have an opportunity to express, to mourn, greave together, but collectively, uh, build resilience through these tragedies.

Uhm, so the same protocol does happen. We send emotional support debrief, both triggered at the site level themselves. Central Office also sends support. Uh, and we're in the process of finalizing a distress

algorithm, communication and response standard work. Uh, again, why Dr. Fattal mentioned variation, because there's different sized services, different compliments of H3 staff at each of our facilities. Uhm, we want to create a guideline, if you will. Uh, we're also in the process of hiring a Crisis Response Education lead as well. Which would be, uh, a five year PHD that can then also be sent to the site level, uh, if and when a tragedy occurs.

DR. FATTAL: Yeah, and just so clarify the variation, meaning exactly that, so, in some places, we send support like we did with Lincoln, is there was support that came from Central Office and from other facilities. At some facilities they might have enough people at the moment, and they might not need as much support, but ultimately, the work flow is the same. The variation would be in who exactly is doing it.

CHAIRPERSON RIVERA: Okay, so, you are in the process of hiring a Crisis Response Education Lead? You said someone with a PHD education in order to, uh, do what exactly?

JEREMY SEGALL: So, the Critical Response Lead would be additional support utilizing their

psychological background, uhm, if a site needs additional support in terms of emotional support debriefing, uh, one on one support in terms of being able to asses risk at the site level. And, just to be an additional workbench, if you will, uh, to support the sites. Because, we know how hard it can be to cover such large ground while clinical services are in operation.

CHAIRPERSON RIVERA: So, this will be one hire? Or, are you gonna... It... Is this gonna be a team of people? Because, there are so many, uh, workers inside of your system. I mean, if you're getting, you know, thousands and thousands of visits, you know, and there's... How are you going to kind of make that role successful?

JEREMY SEGALL: So, again, it's an additional support role. Again, we have capacity at the site level. And, again, Behavioral Health Services provides support of social workers, psychologist, and psychiatrist on demand at the site level. But, this is in addition to. Because, we don't want to burn people out with wellness. If they're trying to continuously support others, we want to say that we

can also support them. Uh, but there is a team at Central Office.

CHAIRPERSON RIVERA: Okay, well let's go to burnout, because I think, you know, we mentioned one of the big issues is pay. Of course there's the underpay issue. There's also student debt that a lot of these individuals, including doctors and nurses, are saddled with. But, when it comes to time, being overworked, if interns and residents, or anyone, have issues with rotations or with hospital specific polices or scheduling, how do they raise these concerns with their superiors? And, are there feedback mechanisms in place that they can utilize?

DR. FATTAL: Yes, uh, we definitely have that. And, uh, we definitely follow the ACGME's. Same way we follow the ACGME guidelines for if there was a case for suicide. We also follow them when it comes to matters of duty hours. And, I'm going to let my colleague, Dr. Donnie Bell, uh, elaborate more on how we follow that.

DR. BELL: Good morning, Chairwoman Rivera, and thank you for the opportunity to testify to the council this morning. And, good morning to the council members as well.

Uh, we certainly have a process for all of our trainees to reporting the issues they may have scheduling or their work and learning environment. Which typically goes up through their chief residents, their Program Coordinators, and Program Directors. They can escalate to their chairs. We also have a Graduate Medical Education Committees at our facilities that are composed of residents. And, there's also a designated institutional officer at our facilities who are always open to address any questions or any feedback on ways that we can improve our programs as, uh, that's a continuous process that we seek to do every day.

Uh, we also have Residency platforms that enable us to get feedback and evaluations for both our trainees as well as faculty. Uhm, that feedback is anonymized within these platforms to minimize the concerns from our trainees about retaliation. And, uh, we leverage those platforms as well to garner feedback.

CHAIRPERSON RIVERA: So, the Residency platforms, the... Some of the feedback is anonymized, which I understand and I appreciate. Uhm, is there oversight of these processes as well as the feedback process?

DR. BELL: Sure, so... So, there's... I guess there's several layers of oversight. The first, again, is at the institution level, with the graduate medical education committee, uh, for each institution. Of course there's also external oversight via the ACGME, which does annual surveys of institutions in some... and programs. Uh, so, I think those are the two primary, uh, leavers.

CHAIRPERSON RIVERA: And, I think some of this feedback, uhm, some of it I've received through my conversations with doctors and residents and Interns themselves. And, just, uh, one thing that they mention are, you know, like wellness days or mental health days to take care of themselves.

Uhm, do... Is that something that you all offer? Is that something that they can request and approve?

And, I don't mean to get so in to the, uh, the weeds on this, but, like, if I need a mental health day, it's not necessarily something I think I can schedule in advance. I don't... I don't know how I'm going to feel. And... And, is it... Is it simple to request that? Uh, because we have heard some concerns that, uhm, a mental health day, if you

want to call maybe the night before, it becomes a sick day. And, I know that's, uh, getting a little bit in to again the details of it. But, are these things that you offer individuals, uhm, who clearly need them?

DR. BELL: Well, uh, Chairwoman, of course. I think, uhm, you know, wellness days are not gonna be something that you can schedule. And, so, uh, we try to be as flexible as we can, uh, to allot those and to, uh, ensure that we have clinical coverage to allow our trainees, residents, fellows, to be well. And, so, uhm, to that end, we do have dedicated wellness days for our trainees that (BACKGROUND NOISE) (INAUDIBLE 01:04:56) some variation there based on the sponsorship of the trainee program. Uh, but we try to make it as easy possible to utilize those days. And, uh, we try to, without compromising, uh, the delivery of patient care to our patients.

So, the process typically, uh, involves the chief residents or the administers within the programs or the departments. And, uh, again, you know, we try to remove as much stigma via the efforts that Dr. Fattal

has already mentioned, uh, and make the logistics and the process... (Cross-Talk 01:05:39)

DR. ALLEN: (ANSWERED PHONE CALL)

CHAIRPERSON RIVERA: Sorry about that.

DR. BELL: Yeah, no worries.

CHAIRPERSON RIVERA: It's okay, she was just muted. I think we all appreciate a second for Mom.

Okay, so, thank you, I appreciate the comment on feedback. Uhm, I guess, uh, with all of the programming that you're trying to implement, and the evolution of it, and clearly the improvements that have to be made, and the consideration and feedback that you'll get from these individuals, uhm, and we're gonna hear from many people... Uh, well some people. Some... Some, to be quite be frank, some are afraid to testify. So, the people that are here, I have to give a lot of credit to, uhm, for taking the stand and for being upfront.

So, I guess my last question is, we know there is a stigma with mental health. We know that when we use the word cultural, it is about the cultural inside a facility, but it is also, uh, culturally in communities, and in ethnic communities as well. So, how do the various programs take cultural competency

and humility in to account? And, how do incorporate diversity, equity, and inclusion programming and components?

DR. FATTAL: Yeah, definitely, and thank you for bringing this up, because that is a major challenge -- the stigma part.

As far as cultural competency, what... In the case of Health + Hospitals, like I mentioned in my testimony, this is in the fiber of who we are as a system. Whether it's for, uh, our patients, whether it's for all New Yorkers, and definitely for our own staff and trainees, and that's something that we take extremely seriously. It's in the core, core of who we are, and in the core of our identity. And, to give more specifics, in the case of our programming, I'm gonna let, uh, Jeremy give some details and talk more about that.

JEREMY SEGALL: Thank you, Omar.

Uh, and I just want to second what you... What you just said. So, social and racial equity is the foundational element that drives our mission vison and values for our system.

Uh, we do have, uhm, and Diversity, Equity, and Inclusion Officer, and an office within our system

that works, uh, collaboratively with Behavioral Health Services as well the Helping Healers Heal Workforce Wellness programming.

So, aside from our annual mandatory training, uh, that all staff members must go through, uh, we are doing some really incredible work. Uh, not only do we have an Equity and Access Counsel, uhm, to the board, uhm, we also have, uh, representation on our steering committees as well as at our site specific level. What we try to do is to cascade as much information as possible, so some of the Just in Time trainings that I had just have mentioned, were created collaboratively with the Office of Diversity, Equity, and Inclusion. Uh, also our Helping Healers Heal, and here in New Yorker training, uh, are pulling in concepts about cultural sensitively and humility, and to build, uh, and enhance competency.

Uhm, the most important thing about wellness, is that there's representation not only in the clinical space for patient care delivery services, but also in our Workforce Wellness programming. So, we want and need to diversify our Peer Support Champions, uh, so that there's choice, if you will, both in race,

ethnicity, gender identify, sexual orientation, religion, etc.

Uhm, what we tend to do is, we recreate one - pagers, infographics, uh, as well as share research and resource links to our Peer Support Champions, our H3 leads, uh, and the steering teams for, uh, global dissemination, uh, to support our Workforce Wellness programming as well.

And, this is something that is, again, of the utmost importance to us, uhm, to continuously approve over time.

I think you might be on mute, uh, Chairwoman Rivera.

CHAIRPERSON RIVERA: Thank you... Thank you. Thank you so much.

How do you provide additional support to individuals who are immigrants, who, uh, speak English as a second language? Or, for example, someone who is pregnant?

DR. FATTAL: I'm sorry... (Cross-Talk)

JEREMY SEGALL: That's a valid question... Oh, go for it, Omar.

DR. FATTAL: That... I'm sorry, the last part you mentioned, uh, someone who's... Uh, I didn't

hear the question. The second part of the question... (Cross-Talk)

CHAIRPERSON RIVERA: Someone who is pregnant.

DR. FATTAL: Yeah, and I think that, uh, for us, again, for us a system, and I think that, you know, in a way we... We... And, as an immigrant myself and a Formedic graduate, I think it's extremely important to, like you mentioned, highlight the unique attributes of certain of certain populations, but at the same time, make sure that we're integrating them in to our services so that we're not necessarily, uh... so... So, that we're providing our services... Or, that our services are provided in a way that anyone can benefit from them, regardless of their background -- exactly like our mission says.

And, that's something that we do for our patients. What does that look like? For example specifically, we provide interpreter services if needed, for example. But, to specifically mention, when it comes to our wellness resources, I'm gonna let Jeremy add more details on how does that translate from how we do this as a culture, as a

system, to everyone in to specifically our wellness activities.

JEREMY SEGALL: Thank you, Omar.

Uh, again, it has to be stated that all of our Workforce Wellness initiatives and programs are equally accessible to all staff members, uh, despite their background.

One thing that we do, uh, across with Health + Hospitals, is honor and respect diversity. Uhm, and what we are in the process of doing, as I mentioned those wellness events, any time that we have an opportunity to create an inclusion group, to honor or recognize, uh, Black History Month, uh, Pride Month, uhm, any other holidays that we believe that any of our workforce members might engage in, we try to create equal spaces at the site level, uh, for us to be able honor, highlight, and respect, uhm, the faith, uhm, the inclusion, uh, as well as the experiences of our workforce members.

CHAIRPERSON RIVERA: Alright, I... I... I understand. I think, uhm, just generally being culturally... Clearly there's ways that we can I think be more inclusive all year round of course. Of course I know you know that. And, I appreciate the

celebration, uhm, in uplifting Black stories and experiences. Uhm, but I... I do know that... I do feel like some of the issues that we have seen, you know, and I know this is systematic, and healthcare in this country is systematically racist. It's not created to serve of color, low income people, immigrants.

So, I would just, uhm, I thank you for your feedback, for, uh, your comments overall today. I would just... I noticed that the people who are... who have died, who feel historically disenfranchised, are the people who are most disproportionally effected even as workers.

So, I just wanted to, uhm, I understand this is difficult, it is incredibly difficult in terms of all your positions and all of the things that you have to fulfill and how you measure that success.

Uhm, ,you know, when you mention a person who might need a day off, uhm , someone who might need coverage, uhm, and then you mentioned they need to go to their chief resident, I wonder if that would perhaps deter them or even bake in some reluctancy to ask for those days.

So, I don't quite have the solution for you in how you improve a system that could inherently prevent someone for requesting what they truly need, but that is why, uhm, we're here. And, that is why we're really here to also hear from these doctors, these Interns, and these residents and all of these frontline workers.

So, I do encourage you to, uhm, stay and listen. Uhm, and I thank you for your time.

DR. FATTAL: Thank you so much for having us.

JEREMY SEGALL: Thank you.

COMMITTEE COUNSEL: Thank you, Chair.

I'm now gonna quickly ask if any other council members have questions for this panel?

Seeing no hands, I'd like to thank this panel for their testimony. We've concluded administration testimony, and we will now be turning to public testimony.

I'd like to remind everyone that, uhm, we will be calling on individuals one by one to testify, and each panelist will be given three minutes to speak.

For panelist, after I call your name, a member of our staff will unmute you. There may be a few

seconds of delay before you are unmuted, and we thank you in advance for your patience.

Please wait a brief moment for the Sergeant At Arms to announce that you may begin before starting your testimony,

Council members who have questions for a particular panelist, should use their Raise Hand function in Zoom, and I will call on you after the panel has completed their testimony, in the order in which you have raised your hand.

I would like to know welcome our first panelist to testify.

Our first panelist will be Tim Johnson. You may begin your testimony when you are ready.

SERGEANT AT ARMS: Time starts now.

TIM JOHNSON: Uh, thank you,

Uhm, and, uh, thank you, Chair Rivera and other council members for the opportunity to present to this committee on this very important topic.

I am a Senior Vice President at the Greater New York Hospital Association.

I think everybody on the committee knows that The Greater New York Hospital Association includes, uhm,

all the hospital in New York City, uh, both public and private.

I will note that H+H is a member of The Greater New York Hospital Association. And, the vast majority of our hospitals are teaching hospitals that are committed to training the next generation of physicians.

And, I really appreciate the fact that this, uhm, committee is looking at this issue. This is a very important topic. And, I will say that we take the issue of Resident wellness and clinician burnout very seriously.

And, I just want to focus my testimony on a couple of key issues.

And, I want to start with how the looking at the Resident wellness issues and Resident well-being has really evolved, uh, both nationally and within, uhm, the city and our membership.

Uh, Chair Rivera, you talked about the limitations on Resident work hours, which I think we all know have been place for 20 - 30 years. And, this is really an outgrowth of recognition that, uh, limitations on Resident work hours were important,

and our members are supportive of those limitations; however, they're not enough.

And, to really look at the issues of Resident well-being, we need to go beyond just looking at work hours and really look at some of the, uhm, issues that might get in the way of residents really being able to have, uh, do well within their clinical learning environment.

Uhm, I think Jeremy or, uhm, others talked about the, uh, ACGME process. Nationally, they have been the accreditation council for graduate medical education. Has really looked to, uhm, update their standards for really making sure that Residency Programs in teaching hospitals really focus on this issue, and that has been welcome by the GME community.

And, I will say within our own membership in New York City, the, uh, graduate medical education leadership have been very supportive of, uhm, the ACGME really looking at this and really, uh, paying special attention to it.

I appreciate, uh, Chair Rivera, you making mention of the fact that Greater New York Hospital Association, we did create a Clinician Well-being

Advisory Group, uh, within the last couple of years. And, we've been looking at many issues relating to... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

TIM JOHNSON: Oh, uhm, I just want to say that the... I'll just finish by saying that, uh, I really appreciate the fact that H+H is an active member of that group. And, Jeremy, is a very terrific member, and he brings a lot to, uhm, the other members, the voluntary hospitals, and we really appreciate all the work hat H+H is doing to really be a leader in this space, and really helping the other hospitals in the city really learn from their terrific experience.

I'll stop there, Chair Rivera.

CHAIRPERSON RIVERA: Well, thank you so much for being here. Uhm, and I know that you testified at the hearing that I mentioned in, uh, June, 2020. And, you talked a little bit about the Clinician Well-being Advisory Group, which focuses exclusively on the issues faced by frontline providers.

So, can you describe what this advisory group does and how it works with hospitals to address issues faced by interns, residents, and other workers inside the systems?

TIM JOHNSON: Uh, happy to. Uhm, thank you. And, uh, yes, Greater New York Hospital Association, we did, uh, testify, my colleague, Jenna Mandel-Ricci, who really, uhm, chairs that group, uh, was the person that testified.

And, what we've been doing with that group is really bringing the hospitals together to focus on, uh, learning from each other, how they're dealing with, uhm... And, how they're putting some hospital programming in place to really address, uhm, issues across the board like the, uhm, Helping Healers Heal Program, and, uhm, wellness committees and how they operationalize those programs.

And, also, we've had people come in as experts in certain... Uh, the field. And, I'm sorry to say that... I'm sorry to say that we actually identified somebody that is... specializes in physician suicide. I didn't even realize beforehand that there was somebody who specialized in this. And, it's unfortunate commentary that there is such a person out there. But, we have this person come in and really talk to our members of the committee and others about how to look for signs of, uhm, you know, uhm, physician depression, burnout, etc. And, how to

really make sure that, you know, things are being addressed preemptively, and to ensure that signs are being seen and whatnot.

And, uh, so programming like that and other programs, we really have our hospitals learn from each other on how these, uhm... how to address a lot of these issues.

CHAIRPERSON RIVERA: Well, you also testified last summer about partnering with the American Medical Association to offer, uh, New York City hospitals, the AMA's COVID-19 coping survey, which would, uh, assess concepts of stress, anxiety, and burnout. And, this was done in an effort to better understand the impact of COVID-19 response on hospitals workforces and to inform future interventions.

So, what was learned from this survey, and what did it reveal, and how are the survey responses being used to inform future interventions?

TIM JOHNSON: Uh, I don't have, uhm information on the survey responses immediately available, Chair Rivera, I'm happy to get that. And, I will supply that to you and the committee members as soon as I can.

CHAIRPERSON RIVERA: Also, included in the testimony last summer was launching the HERO-NY program, The Healing, Education, Resilience & Opportunity for New York's Frontline Workforce program.

It was a five part online series that adapts military expertise in addressing trauma, stress, resilience, and wellness for a civilian audience, to support the mental health and well-being of frontline workers effected by the pandemic.

How was the program received by hospital staff?

TIM JOHNSON: Oh, hospital staff, uh, received that program very well. And, uh, you know, so much of what we were dealing with during the COVID, uhm, and continue to deal with during the COVID, uhm, situation and the surge, is very similar to what the military go through -- these very incredibly stressful situations. And, we were happy to bring that to the hospital members. And, uh, I think really, it really shed a light on how to think about this situation that we're dealing with right now in a very different way. And, uh, by really looking at how the military has dealt with a lot of these issues -- dealing with trauma and whatnot. And, I will say

that some of these concerns that are out there about trauma, we are particularly concerned about the effect that it has on residents, and... Which is why as part of that clinical advisory group, we've actually focused a lot on the residents and seeing about doing special programming for them to deal with some of the issues that you mentioned earlier -- having to do with stigma, and not being concerned about not coming forward and whatnot. And, we've got some strategies that, uh, we're looking to launch very soon about how to address that for them also.

CHAIRPERSON RIVERA: Uh, it... So, aside from some of those... From the programs aimed to address Resident mental health, what other supports of programs does Greater New York have in place specifically focused on Resident wellness and/residency programs in general? For example, and specifically, do hospitals discuss, uh, how to structure, restructure, change/improve, their residency programs? Do hospitals seek information about how to run their residency programs? And, how much of that information that you do seek, how to best run their programs, come from the actual frontline workers themselves?

TIM JOHNSON: Absolutely, and, uh, I think Dr. Bell commented on this earlier. The role of the GME committee, uhm, every hospital has a Graduate Medical Education Committee, and included within that committee are residents. And, the leadership of the, uhm, the, uh, GME committees and the hospital leadership are always looking for input from residents on concerns that they have about the structure of the program and concerns about the scheduling and whatnot to ensure that they have the best possible experience, uhm, and they don't feel stressed our more than they do to really make a good learning experience for them.

And, I will say that's also the focus of, again, the ACGME, is really looking at the clinical learning environment to ensure that what's going on in the hospitals for the residents is really a learning environment for them. There is an element of patient care here, but, uh, of course, and that's how they learn. But, this is supposed to be a learning environment, and our hospitals are very cognizant to make sure that that is the case.

And, again, I would just say that H+H has been a real leader for us, uhm, with the Helping Healers

Heal and other programs to really help, uh, the voluntary hospitals really learn from their great work that they've put in to place.

CHAIRPERSON RIVERA: Thank you, and just one last question, because I have doctors who have been waiting to testify. And, I... And, I am very much looking forward to hearing from them.

Do you think oversight by the ACGME should be more regular? Meaning, should they do site visits more frequently? Do residents think the oversight is enough?

TIM JOHNSON: Uhm, I think that the, uhm, you know, the ACGME has worked very hard to put a survey process in place that works directly with the residents themselves that's confidential. So, the surveys are administered and required to be administered by the hospitals. But, the ACGME gets that information directly from the residents in a confidential manner. And, any concerns that are brought to the ACGME about their experience, the program, the hospital, etc., is shared with the hospital themselves. And, uhm, I think that, if it's something that is concerning to those that collect that information... And, I will say the people, the

hospital, uh, there's an intervention that's there. And, I think there's... There are, uhm, numerous mechanisms that have been put in place. It's not enough, clearly, and we always want residents to feel comfortable bringing more concerns to leadership of the hospital or the ACGME. But, I think the fact that it's confidential and anonymous is really a very important mechanism that's in place and very helpful.

CHAIRPERSON RIVERA: It... Yeah, absolutely and, I didn't mean to speak in acronyms. Uh, but, I do think that oversight is important.

I just... My... I think our overall concern is, we just want to make sure that the mechanisms and polices that are in place for trainees, for everyone, to give feedback, uhm, if not solely performative. Right?

And, I think you've kind of dove in to a little bit about what you could do. Uhm, I think the oversight is important, because we have to make sure that hospitals are incentivized to make change. And, residents sometimes feel like they don't have a way to truly give feedback. Or, they don't have a way out -- that they can't quit. They can't stop what they're doing.

So, I just want to thank you for your testimony. I want to thank you for your, uhm, the information that you provided. I realize there is a lot more work to do. And, I encourage you as well to please stay and listen to the professionals who will be joining us and sharing very, very honest and open testimony about what... you know, the challenges and what we can change. So, thank you... (Cross-Talk)

TIM JOHNSON: Thank you, Chair... Thank you, Chair Rivera.

CHAIRPERSON RIVERA: Thank you very much.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome our next panel to testify. Uhm, in order, I will be calling on Dr. Oluyemi Omotoso, followed by Dr. Olga Kobolva , followed by Dr. Yannick Kofi Ralph Jones, Dr. Zadoo Bendega.

Uhm, Dr. Oluyemi Omotoso, you may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. OMOTOSO: Thank you.

My name is Dr. Oluyemi Omotoso; I go by Yemi. I'm an Emergency Medicine Resident at Lincoln Hospital.

And, the current National Secretary Treasurer of the Committee on Interns and Residents.

First, I would like to sincerely thank this committee for holding this hearing on the wellness of the City Resident Physicians.

Interns, residents, and fellows, make up a vital part of our healthcare system; and are on the frontlines, often being some of the very first people that patients see when seeking care at hospitals.

However, with the recent spate of deaths of residents at New York City Hospitals this year, it's clear that this vital part of our healthcare workforce is facing an ongoing crisis that has only worsened with, but existed long before COVID.

This is breaking down our doctors and effecting the care that our communities are able to receive.

Resident physicians and medical school graduates, who have entered in to a residency training program, they deliver care under the supervision of attending physicians, while further expanding their knowledge and training in to their chosen specialty. As they use to reside in hospitals, they are offered referred to as "house staff."

Residents are matched in to programs in an algorithmic process, but because there's a congressionally imposed cap, there are not enough resident's spots for all the applicants.

There are 2,800 house staff in New York City's Health + Hospitals, and we are all proud to serve our city's most vulnerable communities, and do everything in our power to provide the quality of care that these patients deserve.

However, residency is an extremely difficult time with brutal working conditions that are disrespectful, dangerous, and unfair. And, they disregard evidence on the results and bad outcomes in both patients and residents.

As a result, residents are facing a crisis of poor well-being, burnout, and suicide. About 50% of residents physicians developed burnout during training, and 25% developed clinical depression -- a rate that is three to four times higher than other workers.

Suicide is the leading cause of death for male residents and the second leading cause of death for female residents as we've heard today of various times.

Major drivers of burnout and stress have been identified as long work hours, out of title work, and bullying exacerbated by student debt and lack of mental health services.

These issues are significantly worse at institutions plagued with chronic under staffing and under resourcing like in New York City's Health + Hospitals system.

Attempts made to address resident well-being have historically placed the onus on us at the individual level, and charged residents themselves with building resilience to cope with stress and burnout -- instead of fundamentally addressing what produced those feelings... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. OMOTOSO: in the first place.

I have some other Lincoln resident stories to tell, and I can just share it quickly if time permits. But, otherwise, I can come back to it.

CHAIRPERSON RIVERA: Is it alright if I call you Dr. Yemi? Is that okay?

DR. OMOTOSO: Yemi's perfect, that's what everyone calls me.

CHAIRPERSON RIVERA: Okay.

Uhm, if you can go, you know, speak a little bit to kind of maybe there's on particular thing you wanted to highlight in your testimony, and I would just also ask the question, uhm, how can residency programs better support the mental health of residents and interns?

DR. OMOTOSO: Can I... I'm just going read what my, uh, one of my co-residents put (INAUDIBLE 01:33:33) just to answer that question.

CHAIRPERSON RIVERA: Okay.

DR. OMOTOSO: Uh, and she said, "I have raised my voice at patients, because they are taking too long to answer. And, all I can think of is the to-do list I have -- medications to give patients; transporting patients to imaging; drawing labs of patients; the notes I have to write, these charges I have to print out; finding the patient a taxi to go home, and so forth. This is not me. I don't like shouting at patients, but my hospital is changing me because of how exhausted I am. I want to be the amazing doctor I came here to become, but I am overworked, oversaturated, and I'm not becoming who I want to be."

That is just her own appeal -- uh, what she just said in her anonymous letter to the council. Basically residents are being overworked, exhausted, and they seem themselves just, you know, not being emphatic the way they thought they were gonna be. They do a lot of out of title work that, at the end of the day, takes them away from actual patient care. And, basically, they have to take a step back sometimes and realize that, look it's not the patient's fault, it's not my fault, it's just the conditions I'm working in. And, this is clearly what leads to resident burnout and, you know, effects wellness.

CHAIRPERSON RIVERA: Thank you very much.

I do believe that leading with empathy is probably the most important thing an individual can do, and it's hard to when you feel physically, mentally broken in many respects.

So, please tell your colleague, I want her to be the most amazing doctor, too. So, we are gonna try our best to, you know, hold our systems accountable and really try to work on improving what sound like really terrible conditions.

So, thank you for your testimony.

DR. OMOTOSO: I just... Thank you, uh, Councilwoman Rivera, for convening this hearing.

Uhm, I am just proud of the many members of (INAUDIBLE 01:35:36) and the alumni who have sent their personal stories. There's so much, and I hope you can get to receive the stories.

And, if I can just say one last thing, first the issues me and my colleagues face at Lincoln are not unique. In my own hospital, at Lincoln Hospital, residents across the H+H programs all experience the same challenges. And, it's actually time to address it, like you said, as a hospital system, and I know H+H can actually do it.

Secondly, the overwhelming majority residents wanted to be anonymous out of credible fear of retaliation. Residents shouldn't be afraid to speak about their work conditions and their health and well-being.

If you Google Reddit right now you can see numerous stories about this, where residents are actually afraid to speak up. We must address this cultural that perpetrates this.

And, finally, when asked what effects their well-being, our members to the opportunity to, yes,

advocate for themselves, but mostly for their patients. They would rather spend hours doing all of the things that we've mentioned, just to make sure their patients get the optimal care.

So, we received story after story pleading for change for, overwhelming not for us, but for the sake of our patients.

Thank you.

CHAIRPERSON RIVERA: Thank you so much... (Cross-Talk)

COMMITTEE COUNSEL: Thank you for your testimony.

I'd like to just remind everyone that you are welcome to submit written testimony if you are unable to testify today at, uh, testimony@council.nyc.gov. And, you are welcome to submit anonymously as well.

Uhm, I'd like to now welcome Dr. Olga Kobolva to testify. You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. KOBOLVA: Hello, everyone. I'm Olga Kobolva, a third year psychiatry resident at Harlem Hospital.

I spoke with multiple residents in my department asking what they think is essential for their well-being.

Let me briefly summarize my thoughts and their thoughts.

We all strive for happiness, which can only be possible when seven spheres of life are balanced. They are: Self-development, career and finances, human relations, environment, house atmosphere, health and sports, recreation and entertainment, and spiritual development.

In residency, life is centered around career and educational development with an inevitable component of human relations.

Speaking of financial life, it is (INAUDIBLE 01:38:06) in expectancy of future gain, but in the present, we are in the mode of survival.

Educational development gets compromised by almost an immediate job responsibilities.

Human relations is the sphere where disconnect often happens.

Residents are in a vulnerable position to speak up if they get unfairly treated for their attendings, because the risk of loss of their career is great.

Often there is not enough time and resources for team building, so residents don’t get support from their peers.

Also, time commitment of three to four years, without flexibility of change in the residency program if things become too stressful, create a situation of learned helplessness -- hopelessness.

Concerning the other four areas of life, they're usually neglected in the favor of the first three.

I want to bring your attention to our essential need to have filtered water in every station where residents works.

So, to summarize, residents need more balance in their life, more support from peers and attendings.

Here we are asking to promote team building activities, which require financial support.

Attendings need to be committed to supporting residents.

We need what seem like small changes, like access to drinking water at resident stations, so we can stay hydrated, maintaining the basics of our physical health.

And, we need big structural changes like a decrease in non-physician work, and protections for speaking up.

We need to agent a system to adopt a system wide approach to improving residency. And, we need to get

legislators and all levels of government to support us in every way you can.

If we act to improve the well-being of the residents, we will be also improving well-being of patients and our community.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Yannick Kofi Ralph Jones.

SERGEANT AT ARMS: Time starts now.

DR. JONES: Hi Gooday, I am hoping everyone is having a great day.

My name is Yannick Jones; I am an FMG, and I am here to give a short testimony on the things that can affect residents currently.

I am in Internal Medicine resident and Harlem Hospital. And, I would like to use this testimony to discuss several challenges that H+H resident feel. This includes (BACKGROUND NOISE) (INAUDIBLE 01:49:39) work hours and an intense level of financial strain. Along with some of the specific difficulties facing residents who are foreigner medical graduates.

Dr. Yemi, for example, hit the nail on the head for many issues that I will discuss now.

In leading up to this hearing my colleagues and I heard from residents across H+H who regularly work 80 plus hours. And, these include some 18-hour days. They are saddled with so much work that they can barely find time to eat or use the bathroom. And, they are constantly, consistently exhausted and sleep deprived at their job.

At Lincoln, for example, we heard from a resident who said that he's working 24 hours consistently, without having 15 minutes to even have a bite to eat.

While there are limits on number of hours residents can technically work, there reality that is that we are forced to do work outside of what we are officially logging -- like Dr. Yemi discussed -- Uhm, lab draws, transporting patients, discussing transport, for example.

Another anonymous resident also told us that, "Although, we are all humans, we need our rest to be able to function." He says, Goodnight and Good morning to the same person, because he's working constantly 24 hours without being able to sleep.

Uhm, this happens particularly with the third year residents at my own hospital, but also the first and second year residents experience this also.

Uhm, for those who familiar with residency, uh, we hear about long hours that are not unique to H+H residents.

As residents we get both Saturday and Sunday off, this is called... what we call a "golden weekend", uh, which is coveted and rare. For example, personally, me, I've only had one of these weekends where I get both Saturday and Sunday off, uhm, since I've started, and that's three months now with only one full weekend off.

Uhm, in response to this we are told that the ACGME rules that are too often... Uh, we have to abide by the ACGME rules, which is 80 plus hours per week, uhm, just because we have to make residents work so long, we shouldn't have to continue doing so. Change needs to happen.

Uhm, in additional to the stress, and the facts relative to the number of hours we work, a lot of experience medical debt. And, residents are grossly underpaid like we discussed before.

Uh, for example, we have a resident who's a US resident at Harlem Hospital, uhm, she said her car is towed and she's ticketed way too many times, because there is not enough space for garages and for her to budget to pay for garages. Uhm, for example she said she had her cable and internet shut off, and she is was danger of losing her electricity.

Uhm, H+H residents have a reportedly been (INAUDIBLE 01:43:11) to pay basic necessities like their own prescription medications and sometimes even food.

An anonymous (INAUDIBLE 01:43:17) resident told us to that he's budget... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. JONES: for first year was very tight, (BACKGROUND NOISE) more than half of his monthly salary was going to pay for his rent, as we can do. He lived in subsidized housing for most of the year. He would buy... He would have to ration food -- like dumplings in Chinatown. And, this would cause him intense anxiety when he had to pay rent.

Uhm, in conclusion, we believe it's obvious that fostering a hospital environments where the doctors on the frontlines are seriously overworked and are

worried about paying rent, for example. (INAUDIBLE 01:43:48) are doctors serving the communities, uh, that need the most help here, we will suffer on to society itself.

Uhm, thankfully, it is in the H+H powers to correct many of the difficulties mentioned. To start, that the administration was reform our working hours; they must increase resident salaries; and they must provide housing assistance.

Uhm, it is difficult to live in New York as anyone knows, and we shouldn't have to be rationing food for example.

In doing this, residents will be able to better focus on assigned tasks, duties, and our medical education. And, this will help to improve quality of care for our patients.

Thank you for allowing me to speak and give my testimonial.

COMMITTEE COUNSEL: Thank you so much for your testimony.

Next I'd like to call on Dr. Zadoo Bendega.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. BENDEGA: Good morning, my name is Dr. Zadoo Bendega; I'm an Infectious Disease Fellow at Harlem Hospital.

This morning, I want to talk to you about the struggles I face as an international medical graduate and that many others face.

When I got in to a fellowship at Harlem, I was happy. But, starting residency was quite stressful. Even though I am American, my family is from Nigeria. So, when I moved here, I was alone. When I moved back here I was alone. And, I had to pay an exorbitant amount of money to rent an Airbnb for a month.

This I was only able to do, because prior to this, I'd lived in the UK for four years. I had to use my savings.

When I applied for an apartment to stay, the landlord's requirement was that my income be four times the rent as I'm sure most of you know.

Uhm, even though I'm a fellow, I am being paid a year one resident's salary -- it's a different story. So, this was quite steep for me. Uh, and this is what most (INAUDIBLE 01:45:28) do go through.

Because, I wasn't making four times the salary, I was asked to bring a guarantor. But, the thing is, the guarantor had to make at least eight times the rent. And, please, remember, I have no family in the country. So, I had to ask my best friend, because that was my only option, to be this guarantor. And, this was extremely uncomfortable, because I had to ask for her tax returns, her personal documents, which is very invasive. I was really uncomfortable. She wanted to help me, but her husband didn't want her to be my guarantor. So, I was putting a strain on that marriage; I was putting a strain on our friendship.

Luckily, I did find an apartment in the end, uhm, which was rented to me because of my job. But, I never should have had to go through this.

My hospital and H+H should have provided support to me to find an apartment when I moved here.

With my income, I'm still struggling to pay the rent, because it's more than my paycheck, as I think Yannick said, it's more than half my paycheck. So. I'm really struggling on less than... On living on less than a paycheck.

Uh, H+H has many residents who are international medical graduates and foreign medical graduates. We work hard to provide excellent care to our patients.

It is not a secret that it's harder for us to secure housing when we start our residency. The least H+H can do, is provide us with the support with need to secure housing, so we don't have to beg friends to be our guarantors or sleep on people's couches.

Uh, I just want to note that item 7 of our contract states that we do get housing support. This was not the case at all -- because, I was told that this was in a contract that was written in the 90's, which is unacceptable.

Thank you very much for listening to my testimony.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Maham Rehman to testify.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

COMMITTEE COUNSEL: Dr. Rehman, are you on?

SERGEANT AT ARMS: I believe he's in attendees.

COMMITTEE COUNSEL: Okay, I think we're maybe having some technical difficulties. So, we will circle back to you.

Uhm, I'd like to thank this panel for their testimony, and I'll turn it to Chair Rivera for any questions and comments.

CHAIRPERSON RIVERA: I just, uh, I guess just generally in terms of the after what happened at Lincoln Hospital, uhm, your experience and the system's response to those deaths. Uhm, if anyone just wants to add any feedback or any insight in to that, I would appreciate it.

(BACKGROUND NOISE) I think Yemi wants to add something.

DR. OMOTOSO: Okay, can you hear me? Oh, perfect, I was trying to unmute myself but I couldn't.

Uhm, so, thank you for, uhm, for that.

Uh, I know the... Dr. Omar and Jeremy, uhm, mentioned something about following the, uhm, ACGME clinician suicide toolkit. And, I do want to acknowledge that, uh, they did to an extent. But, just from memory, I recall that after, uh, the first, uhm, one of our first colleague died by suicide in August 2020, uhm, I recall it was a shock to

everybody, not just within the Internal Medicine Department area, but outside of the Internal Medicine Department. And, while I appreciate the ideas that have been proposed today by the, uhm, H3 and the Helping Healers Healing team, but sometimes it doesn't necessarily translate to reality. And, you forget that people outside of the Internal Medicine Department are actually being... Uhm, in shock.

So, all of the departments are in shock. So, all the things that were done, were not necessarily carried out for all the departments. Like, there was a meeting with the residents of the Internal Medicine Department, but you have seven different programs and two fellowships in Lincoln. None of them really had that same thing that they had as well.

Uhm, we had another resident die by suicide April 2021. And, I maybe a 100% wrong, but I do not think a memorial service was heard for that person.

And, yes, Jeremy did come to Lincoln hospital. Yes, he... Yes, he came; he spoke to residents, and I appreciated everything that he did. But, uhm, you know, after the first death... And, I may be wrong, but if it happened in the second and third, what I remember very vividly, after Adhiraj died by suicide,

the Internal Medicine residents had a meeting, they spoke to them, they offered mental health services, they did everything, but they still went back to work. You know? And, some of them were asking my attending's like, "How am I gonna go back to work? I'm in shock right now." And, I really don't know what happened in the second and third case. I'll be honest with you, I cannot remember. Uhm, but it... Just to reiterate again, I'm a Chief Resident of my department right now, so, all of the things that have been talked about, I do happening, but sometimes it just doesn't translate to reality, because if it's just one program, there other programs as well that are actually affected, and that whole thing doesn't necessarily carry over to them as well.

So, while the things are happening, there's a still a lot more work to be done if I... And, I hope that answers your question.

CHAIRPERSON RIVERA: It does, thank you. And, I know we have individuals here who are listening and taking this feedback.

So, thank you all for your testimony. Thank you very, very much.

COMMITTEE COUNSEL: Thank you all for your testimony.

I'd like to now welcome our next panel to testify.

We'd like to circle back for Dr. Maham Rehman.

You may begin your testimony when you are ready.

SERGEANT AT ARMS: Time starts now.

(***NOTE TO EDITOR: Technical difficulties throughout this testimony)**

DR. REHMAN: Okay.

My name is Meham, I one of the medicine residents. I'm in third year now. I am a foreign medical graduate who came here as an immigrant through California. And, then I struggled to (INAUDIBLE 01:52:33) debt and do my (INAUDIBLE 01:52:36) exams, but luckily my family was a great (INAUDIBLE 01:52:38) through all the residency. But, then I did some observation, and (INAUDIBLE 01:52:40) I was financially dependent on my family.

I got many interviews, and I got (INAUDIBLE 01:52:45) but, by the time I started my residency, I was four months pregnant. I struggled to find an apartment. I couldn't even walk from one place to another place to find an apartment for a place to

live. My (INAUDIBLE 01:53:04) was with me, but I had no prior credit history as I was away from my family and never rented before. My husband was applying from Pakistan from Bronx, so he got a (INAUDIBLE 01:53:08) and he was (INAUDIBLE 01:53:11) over there. He commuted everyday (INAUDIBLE 01:53:12) while I was pregnant. (INAUDIBLE 01:53:14) found an apartment finally. I had to show them $11,000 in my account I got from my brothers, uh, to just show that I had the enough rent to pay. And, then I just owed them those amount, but I started a job (INAUDIBLE 01:53:29) bad from being pregnant and being financially this difficulty. And, then my husband came, and it was very hard. My schedule during residency was really hard. There was no (INAUDIBLE 01:53:39) pregnant. I had no OBGYN appointment until my insurance was active. Uh, and without medical (INAUDIBLE 01:53:52) until I was six months pregnant, I had no checkup (INAUDIBLE 01:53:55) my OB followup for (INAUDIBLE 01:53:56) months between time I migrated from Pakistan between the time I was in New York. So, finally because of all that I went in to premature delivery, and I had to stay in the hospital for two weeks. And, then my baby (BACKGROUND NOISE) stays

five months in NICU, and finally we got home. And, I had a C-section, I had no insurance at that time. I wanted to take time off, because I had a C-section. I could not do work normally (INAUDIBLE 01:54:26) for like four weeks at least. But, my (INAUDIBLE 01:54:29) told me that my (INAUDIBLE 01:54:31) recuperate I couldn't take time off, because it would also affect my insurance, and my baby was using my insurance for (INAUDIBLE 01:54:37) And, we didn't know how to apply for short term disability. And, then I ended up (INAUDIBLE 01:54:46) COVID hit, and I had to work a lot, and went in to... I suffered depression because of after that I couldn't do anything. (INAUDIBLE 01:54:56) I couldn't get anything. And, to the point where I was having an episode of (INAUDIBLE 01:55:01) so, I just, uhm, and I searched for (INAUDIBLE 01:55:07) I'm not a person I am not... I was not the person I am now. I was not a person like that. I was a very bright student all of my medical life. I was (INAUDIBLE 01:55:15) person who had medical (INAUDIBLE 01:55:18) since I was second in school student. And, then, it also affected my family life... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. REHMAN: (INAUDIBLE 1:55:23) married life.

So, uhm, (INAUDIBLE 1:55:28) because I didn't have my family. My family was back in California. (INAUDIBLE 1:55:38) a weekend off, and be with my family for a weekend, and it helps I think. (INAUDIBLE 1:55:46) and having financial security.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Kaushal Khambhati to testify. After, uhm, we will be calling on Dr. Michael Zingman, followed by Dr. Lindsay Juarez.

Dr. Kaushal Khambhati, you may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. KHAMBHATI: And, uh, thank you Councilwoman Rivera for having us and taking the time to listen to us. We appreciate it.

Uh, I'm Dr. Kaushal Khambhati. I'm a Senior Emergency Medicine Resident over at Jacobi Medical Center, and a member leader of my union, The Committee of Interns and Residents.

Uhm, working in one of the hardest hit hospitals during the pandemic for the last year and a half was

nothing short of harrowing for both me and every single co-resident I worked with.

Uhm, to say the least, I think we've been through a complex and nuanced set of emotions.

Uh, that said, I started residency in 2018, which is well before the pandemic ever began. Uh, and the crisis of residents being forced to spend hours performing non physician duties and the culture of not feeling truly supported has sort of been hallmarks of residency at H+H long before COVID ever kind of came on the scene, uhm, sure.

But, over the last year and a half, you know, it was terrifying to code people, pronounce them, uh, have difficult conversations with their family members in the same place where COVID was running rampant. Uhm, you know, we received emails of reassurance from some of our administrators, uh, simple things like, if you need help get it or reach out if you need help. Uhm, but the truth is most residents don't really feel comfortable doing that. We don't know if our jobs will be at stake if we do that. Uhm, so, it's not necessarily the easiest thing for someone to come out and say, "I feel depressed", or, "I feel anxious." We don't have the

reassurances we need for those things to even take place.

Uhm, you know, we were offered dimly lit rooms, we were offered wellness events with snacks, the hotline or an email, but it's not... There's nothing infrastructural to say, "This is how we're gonna get you better, and how we're gonna get you working."

Uhm that said, the last year was, like I said, harrowing. We do a lot of non-physician focused tasks. I think the most important thing that I can sort of impart, is that, you know, none of us really complain about doing the work. I think the reason we do it, because we understand that our patients need it, and that's the thing that will get them the things that they need the quickest.

Uhm, you know, believing that the hospital, despite all of your work and dedication, doesn't sort of like care about your well-being and allowing you to do your job the most efficient, is really what weighs on us.

Uhm, you know, we've been publicly hailed as heroes, uh, for our work, but on the other hand, sort of, our administration makes us fight for PPE, makes us continue to do things like transport patients to

radiology, or draw our own bloods, or we're grossly understaffed. And, those are the things they need to fix for us to feel better.

Uhm, so, CIR asked our members about they wanted you to know about what they wanted you to know about what impacts their well-being overwhelming. And, uh, many people from across our hospitals, you know, shared stories.

So, I know I'm a little short on time, but I'm gonna try to share as many as these as I can, because they're important.

Uh, Dr. Shane Solger from Kings County Hospital: "In the main ED, my routine duties, in addition to seeing patients, documenting the encounter, and creating a treatment plan, might involve phlebotomy... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. KHAMBHATI: IV placements, starting fluids, getting sandwiches, getting blankets, coordinating with family members to pick up their loved ones, and filling out discharge forms. The alternative would be to wait for a phlebotomist or a nurse to get around to for the task, which may occur one to hours later -- which pushes discharges further and further away

from the moment the patient entered the ED. It's a no win situation."

Dr. Sarah Leventer from Kings County: "Many of our patient's health issues are inextricably linked with the socioeconomic context of their lives. As a resident, I care about helping my patients, and so I end up doing the work that should be done by a social worker, case manager, or patient navigator. Creating more of these positions in the hospitals would increase the volume of patients that residents could care for by decreasing the amount of extra work residents are doing for each patient. For example, in order to get a breast pump for a new mother, I had to call her insurance company three separate times. I also spoke with the patient twice regarding the issue. These phone calls could have been made by a social worker. And, I would have been able to see more patients during that time."

Alright, then, one last one, if you'll humor me. I know I'm over.

Uh, from a resident at Jacobi: "Every single sheet change, bed clean, 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's to say how many patients I could have seen and helped with my full medical training? 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 two nurses for 30 patients; this is not safe, and it can't be tolerated. And, frankly, New Yorkers just deserve better."

Uhm, those are the three stories I had. Uh, I think they pretty much resonate with I think with what a lot of us feel -- is that, we could do so much better for our patients if we had the support we needed from our hospitals.

Thanks.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Michael Zingman to testify. You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. ZINGMAN: Good afternoon, my name is Dr. Michael Zingman, I'm a PGY2 in Psychiatry at Bellevue

and NYU, as well as a CIR New York Regional Vice President.

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.

As a resident on a split-payroll with NYU and New York State, I also recently experienced multiple rapid changes to my health insurance and uncertainty about my enrolment, as well as a one month delay in my payment leading to financial strain.

When we asked CIR members to share their stories about what impacted their health and wellness as a resident at H+H, our members overwhelming told us it was the excessive time spent doing non-physician duties.

In talking about out of title work, one member told us. "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."

Another member told us, "I entered residency to get a good education and become a well-rounded doctor. I feel the system has greatly underserved me. And, I'm worried about my own well-being and ability to provide excellent patient care."

When our education is neglected by our programs or not respected, it impacts our well-being. It disconnects us from why we became doctors and why we chose our specialties. Many physicians 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. When our programs lack this experiential learning aspect, it provides additional stress on residents. The work CIR has done to meet this gap in experiential

learning is another example of how are union is stepping up to meet the needs of residents.

One fantastic example that I'd like to mention, is that Lincoln Hospital, uhm, through their Emergency Medicine Program, they have a community walking tour organized by CIR leaders for incoming interns to fill a gap in their training. Made possible with union resources, this is an experience meant to educate its new care providers on the history and reality of the community, and highlight the advocacy work already being done by community members.

CIR's efforts to connect residents with the community is longstanding as exemplified by The Family Health Challenge, which is a program in which doctors go to local.... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. ZINGMAN: elementary schools to educate students on health habits. So far, we have engaged over 750 CIR doctors and over 2,500 New York City school children.

These types of initiatives have added much value and a renewed sense of purpose to our members, making

them more connected to their communities and improving the care their able to provide.

We need more investment from H+H and experimental learning like this.

As you can see, I'm incredibly proud of the work my union's doing to meet the needs of residents, but we need H+H to be as invested in improving residency as we are.

I want to end by talking about a recent win CIR members have fought hard for at Woodhull Hospital.

In October of 2020, residents at Woodhull began to push the hospital to address the excessive out of title work they have been doing and the impact on their ability to complete their physician assigned tasks on time as well as the resulting duty hour violations and increased workloads.

It was an eight-month-long campaign where residents banded together to hold meetings with hospital administrators, collect data, organize petitions, and more.

These efforts finally paid off when the hospital issued a memo eliminating resident responsibility for phlebotomy, and arranged for additional training of ancillary staff to meet these needs.

As a result, residents can now focus on learning and providing their patients with holistic care.

Though this was a fantastic win, the effort needed to achieve it was immense. It does not serve residents or H+H to continue to make residents fight program by program, and hospital by hospital to address what is a system wide issue.

While we acknowledge the exact solutions to realizing a reduction in blood draws being performed by residents at each hospital may differ, we call upon H+H to step up and require all programs issued directives, such as the ones from Woodhull, to remove these duties from the residents, and work with CIR to identify the hospital specific solutions.

H+H can and should take this system wide approach to out of title work if they truly value, and want to support residents, and improve our well-being.

Truly addressing the crisis of out of title work residents perform will require funding for additional nursing and ancillary staff. This is something the city must commit to providing.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Lindsay Juarez to testify. After Dr. Juarez, we'll be hearing from Dr. Dina Jaber.

Uhm, Dr. Lindsay Juarez, you may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. JUAREZ: Uh, good morning, my name is Dr. Lindsay Juarez; I'm a third year Anesthesia Resident from Metropolitan Hospital.

Uhm, I wanted to talk to today about how are health and wellness is negatively impacted when some of our very basic needs are routinely not met by our programs, and additional financial strains are put on us.

Uhm, as part of our residency program, we do mandatory outside rotations at other sites. Uh, one of these is Montefiore Medical Center where we are to arrive at 5:00 a. m. and finish around 7:00 p. m., though that routinely, uh, extends to eight or 9:00 p. m. at night.

Uh, this means we're at the subway at 3:30 in the morning. Uh, and issues were raised with our programs leadership about safety.

In response to these safety concerns that were raised, uh, one of our residents was simply told "to take an Uber." Uh, it should be noted that an Uber is $60.00 to $80.00 each way to Montefiore.

Uh, after more concerns were voiced, uh, both via phone calls, meetings, and emails, we received a written letter from program leadership, uh, stating that we were made aware during interviews, uh, that we would be rotating to these sites, and that it's our own responsibility to get to our rotation on our own on time.

Uh, it's not just this issue that affects our well-being, but the consistent act of having to fight, have meeting after meeting, send email after email, uhm, this in itself is really exhausting, uh, especially when it's over the most basic of needs.

Uh, another issue that really, uh, is impacted us at Metropolitan Hospital, since the end of summer 2020, uh, surgical and anesthesiology residents, uh, at my hospital, have been plagued by constant interference with their ability to obtain hospital issued scrubs from the scrub machine.

Uh, institutional policy requires all OR staff to wear these scrubs. Uh, at this time, I.D. badge

access to the machine is to the machine is frequently revoked and scrub credits disappear without any notification. When someone is unable to obtain scrubs from the machine, the only alternative is to wear disposable paper scrubs.

Uh, I don't know if any of you have worn disposable paper scrubs, but they're very uncomfortable. They're bulky, they have loose elastic waists and they have a high tendency to tear, uh, often just from sitting down. I can't tell you the number of times I've had to wear them, and the crotch or the armpit, uh, simply tear from moving or sitting down.

Uh, it may seem to be a funny picture, but it's definitely not a dignified way to work.

Uh, paper scrubs are designed to be worn over one's street clothes and they're made available in the operating room ,uh, for visitors like surgical device representatives or shadowing students, uh, who are to wear them over their clothes so they can enter the operating room. Uh; however, they're clearly not appropriate at all for all-day use by hospital staff working in such a high-acuity environment as the operating room.

Over the last 12 months, repeated inquires have made to the one, single person in charge of scrub access via telephone, email, and personal visits. Uh, and we are repeatedly met with the same response. He says, "I'll have to look into it" or "I'm busy right now", "I haven't had time yet"... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. JUAREZ: Uh, he says, "You'll have to come back later." Uh, after weeks or months of followup, no resolution is ever reached.

Uh, struggling to get the absolute basics is not unique to my hospital, and I'm sure that every H+H resident has at least one example like mine.

I'd like to share a statement that Dr. Hoffman from Bellevue shared, uh, in regards to, "ongoing and often failed hunt for sheets to sleep on," he said, "It makes me feel like no one cares about the residents. Like I don't even belong in this hospital."

Uh, forgive me, I know I'm out of time, uh, but I just wanted to bring up these two issues, which really are exhausting and demoralizing to us. Uhm, and they representation kind of the hospital's in

ability to provide us with the very basics that we need to work.

Uh, so, thank you for listening to my testimony.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Dina Jaber to testify.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. JABER: Hello everyone, my name is Dr. Dina Jaber. I am a PDY2 in Internal Medicine at Kings County Hospital, where I've actually been since I was a third year medical student.

I just want to talk about the burden of non-physician duties that we've carrying as residents at H+H, and that it's real and often overwhelming. But, it is a product of years of under sourcing and under investment and must change.

Uh, duties that have been historically vague became the tasks of physicians even if it isn't. It's often presented as quote, "Oh, well, the docs usually do that" or nurses will say, "I have to take care of x, y, and z, I'll get to that if I can." And, so, the physicians will often do tasks, and it

becomes something that the nurses see us doing consistently, and understandably come to think that that is the duty of the resident and not a nurse.

I'd like to give you guys an example that I went through at Kings County.

I was often told by the nurses that calling LiveOn, the organ donation hotline, that we call when a patient passes away, was a task that I had to do, because, quote, "The physician does it." And, I didn't know any different. So, in addition to pronouncing a patient, calling their family, filling out my paperwork, I was also making sure that I called LiveOn in a timely fashion.

One day, while working across the street at Downstate, I had a patient pass away, and it was my first time doing the process at Downstate. So, I went to the nurse asking if he could provide me with the rest of the papers needed for me. He told me he had already completed it and I could focus on the rest of my work. I initially thought he was joking, and I was confused, because I do it all the time at County, so I must have to do it here, too. He laughed, and he said, "No" but also then asked me, like, "What else do you do at County? Because it

seems like you have a lot of extra tasks on your hands."

I feel like there's a lack of communication on what nurses are trained to do, and not all the nurses are trained to have the same capabilities. It leads to far too much time spent going back and forth determining what is the task to be done by the residents versus the nurses and other ancillary staff. And, so, it doesn't create a good culture between the nurses and the residents, which is a further stressor for us, for the nurses, and clearly is not good for our patients.

Right now, I'm actually rotating Memorial Sloan Kettering, and nurses do blood cultures as it is the same, exact process of any other blood draw. But, at Kings County, the nurses don't do blood cultures, and as they say, quote, "are not allowed to".

But, the reason behind it is vague, and it means that the doctors now have come in and do blood draws. So, this is extra time that we are spending coming in to do lab work that could have been done at the same time in the morning.

This also means that we're now sticking the patients twice. And, I'm sure anyone who's gotten

their blood drawn, doesn't want to get stuck twice by needles. It's bad enough we have to stick them once, to come in again, and say, "Hey, sorry, the nurse couldn't do this, so I have to do it now," means that we have to stick patients twice.

I feel like the nurses and the techs are totally understaffed. One evening I was covering, various patients needed blood draws; however, the nurse taking... that was taking care of these patients, was dealing with urgent transfusion. So, I stepped in, drew blood on four different patients that hour, and stayed past my sign out by almost two hours.

I'm not the only one who sees and feels this, as another resident from Kings County told us, quote...

(Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. JABER: "The nursing culture at Kings 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."

When any group of workers is stretched too thin, it affects all of us. A resident from Lincoln put it best when he said, "When everyone is burned out, overworked, and unhappy, it further creates an unhealthy environment for everybody."

I'd like to close it off as finally saying, I want to make it clear that it is possible to improve the health and well-being of residents at H+H.

Things don't have to stay the way they are, and now is the time for that to change. We don't want to be here telling you story after story of how we had to spend 80 hours in the hospital doing non-physician work, and that we are exhausted and burnt out.

I believe that we can invest in the staff -- invest in the nurses -- invest in their training, and you'll also be investing in us and our patients.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

Uhm, this concludes testimony for this panel.

I'd like to just ask if there are any council member questions at this time. As a reminder, if there are, you may use the Zoom Raise Hand function.

CHAIRPERSON RIVERA: I do want to recognize that we've been joined by Council Member Eugene.

And, I want to thank this panel, of course, for bringing up experiences, and how important it is to visit places and do this work intersectionally.

Again, uh, to people who are new mothers or pregnant, the work that we have to do for them is incredibly important.

So, thank you all for your testimony.

COMMITTEE COUNSEL: Thank you, Chair.

Uhm, I'd like to thank this panel for their testimony, and will be now moving on to our next panel.

In order, I'll be calling on Dr. Keriann Shalvoy, followed by Dr. Leo Eisenstein, followed by Dr. Hannah Marshall, followed by Dr. Michael Del Valle, followed by Dr. Pramma Elayaperumal, followed by Dr. I. Michael Leitman

Dr. Keriann Shalvoy, you may begin your testimony when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. SHALVOY: Uhm, good afternoon. Uhm, thank you for the time today, uhm, Chairwoman Rivera. I especially want to thank you for convening this

hearing, and for your advocacy for interns, residents, and fellows like myself.

Uh, my name is Dr. Keriann Shalvoy, I'm an Addiction Psychiatry Fellow at Bellevue Hospital.

I knew becoming a doctor would be hard. My mother is a nurse, so from a young age I knew the toll that comes with working in healthcare helping people during the hardest moments of their lives.

But, along with that toll, comes the reward of knowing that perfect strangers put their trust in you to be there for them when they're at their most vulnerable.

I knew that I wanted to dedicate my profession to earning that trust and studying medicine to live up to that privilege to the best of my ability.

I worked at a competitive undergrad school and medical school with hopes of realizing this dream. I accrued over $400,000 in student debt, and by the time I started my intern year, I was already starting to feel burned out.

As the months went on, I was performing more and more non-physician work. I was only sleeping a few hours a night, didn't see my family and friends, and

was doing much more administrative work than practicing medicine.

One day a friend asked me to talk to their younger sibling who wanted to become a doctor, and I told them it wasn't a good idea, because I had completely forgotten why I spent the last decade fighting tooth-and-nail for the privilege to be allowed in to this profession.

Then toward the end of my intern year, a co-resident in my program died by suicide. I will never know why she ended her life, and it would be unfair for me to make any assumptions about the unique pain she was experiencing that led her to that point. Of course, we're left to wonder whether some of these residency experiences that you've heard about today may have contributed.

It's hard to talk about suicide; it scares us, and none of us, not even myself as a psychiatrist will ever fully understand it.

But, we know, and we have known for a long time, that physician suicide is a major issue in our field that goes too often unspoken.

As doctors, it can feel like a betrayal to make an assumption about why one of our friends and colleagues ended their own life.

However, on a larger systemic scale here's what we know: Doctors are under enormous pressure to be infallible, to work nonstop, and to make up for the gaping holes in our healthcare system.

We also know that doctors are dying too soon from suicide at rates disproportionate to their non-doctor peers.

Although, I cannot say why my colleague ended her life, what I can say is that it made me and the entire community I work in look closely at the affect our residency was having on our lives and our mental health. It made me realize how burnt out I was, and scared that others were also suffering in silence.

Uhm, I want to speak for a moment as well about The Patient Care Trust Fund, which really significantly improved my well-being after that time -- as well as getting more involved in CIR, uhm, advocating for changes in my program that were really realized over the next year.

Uhm, The Patient Care Trust Fund is... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. SHALVOY: uh... Uh, I'm just gonna explain a little bit about what it is. Uhm, it's a great example about, uh, how giving power to residents can make real change in our hospital. Uhm, it's a grant program, and that it provides, uh, holiday grants, uh, research funds, and equipment funds to residents. And, I served as the chair of this fund last year along with other representatives from Health + Hospitals. Uhm, we're all residents who determining the grant distributions to residents.

Uhm, and if you have some time, I'd like to speak a little bit more about it, uh, if possible?

COMMITTEE COUNSEL: Thank you so much for your testimony, I'd like to now welcome Dr. Leo Eisenstein to testify.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. EISENSTEIN: Hello, my name is Leo Eisenstein, and I am a third year Internal Medicine Resident at Bellevue Hospital Center.

In our residency, we work both at Bellevue and at the private NYU Langone just a few blocks away.

I can tell you that it is daily distress toggling between these hospitals, seeing and participating firsthand in our city's segregated healthcare system. I'm proud to train New York City's public hospital system, which cares predominantly for the city's poor patients and its people of color, as well as the many undocumented patients with only emergency Medicaid or no health insurance at all.

Working at Bellevue, which is why most of chose this residency. We provide high quality care to patients regardless of ability to pay or documentation status. And, we pride ourselves in the possibility that by providing excellent care to historically marginalized groups, we can maybe help a little to chip away at the rightful, longstanding distrust of the healthcare system by Black people and other people of color.

But, there is no denying that the experience of training at Bellevue is a constant uphill battle. Because of the profound resource limitations, like shortages of nursing and phlebotomy, we as residents have to fight tooth-and-nail to advance our patients' care.

As residents we draw labs, take vital signs, transport patients, not because the nurses and phlebotomist and PCA's are bad at their jobs -- far from it -- they are terrific. But, they're stretched thin just like us.

Residents are left to try and fill in these holes. We do it to make sure our patients get the quality care they need and have a right to. But, we only accomplish that by bending over backwards -- staying late -- it is exhausting and demoralizing -- a recipe for burnout.

Meanwhile, just up the street at NYU Langone, our experience as residents could not be more different. Resources abound and the city's wealthy and privately insured patients get expedited, streamlined care. And, 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.

For residents of color, the impact is only compounded. As one resident who wished to remain anonymous said, when talking about practicing in a segregated healthcare system, quote, "Seeing this

unequal treatment in care contributes to my burnout as a Black resident," end quote.

This is from an anonymous resident at Jacobi, quote, "I regret to see that understaffing and out of title work here leaves you with no opportunity to learn, and the only thing you bring home every day is the fatigue and sense of burnout. It's sad to see my patients are not satisfied with the care they receive, and that their concerns are valid," end quote.

So, our direct appeal to you is this, allocate more resources to H+H; insure safe nursing ratios at H+H; and more transport and phlebotomy staff. Because, when the city government distributes more resources to H+H, and when H+H can adequately staff its hospitals... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. EISENSTEIN: this intervention will have a direct, appreciable effect on our well-being as residents. It will mean that we can focus on doing our jobs and focus less on plugging the holes on a currently under resourced system.

Finally, the issue we're describing about training at H+H isn't just about our wellness as

residents now. It also raises recruitment concerns for the city's public hospitals.

Residents come specifically to H+H hoping to fight systemic racial and economic inequities in healthcare. But, if residents here experience burnout from the lack of resources, that represents a very serious risk to recruitment and retention -- as residents are inclined to accept jobs elsewhere, further draining talent from our city's public hospitals.

H+H patients deserve and need doctors who train here and then stay after residency to continue serving these patients.

If you want to support resident wellness and retain the H+H trainees for their future careers, than H+H needs more resources and better staff to patient ratios; because mission driven healthcare should not come with the moral injury we experience regularly at H+H.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Hannah Marshall to testify.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. MARSHALL: Hi, Good morning.

Good morning, everyone, thank you for having this panel. My name is Hannah Marshall. I'm a third year OBGYN resident at Kings County Hospital.

Uhm, I'm speaking as a member of CIR. I'm our department representative as well.

Uhm, I wanted to highlight another aspect of how training at public hospitals affects resident wellness and well-being.

Uhm, healthcare funding and resource allocation is a big topic to address at a complex based systems level. But, working in a public healthcare system, we as residents have front row seats to how service cuts and lack of resources can be catastrophic for our already vulnerable patient population -- and have resonating implications for our learning and training and wellness.

Uhm, as residents we're here to learn, but we all chose to train at these public hospitals. We chose, as Leo said, to train at H+H, because we are committed to and passionate about getting our patients the care that they deserve. It's one of the

things I love most about my residency and my co-residents.

Uhm, as a safety net hospital, Kings County is one of the only public hospitals treating women without insurance or who are undocumented in Brooklyn. We serve an 85% Black population who is already facing the worth health disparities in New York City.

Speaking to our personal experience then, in July of 2020, gynecologic oncology services were cut from Kings County Hospital with no real plan in place.

Gynecologic oncology is doctors that specialize in treating cancer of the female reproductive tract. Uhm, the loss of this service affected us and our patients at every level.

Importantly, we worried that this loss would have huge implications for our patients in terms of worsening health disparities and worsening rates of Black maternal mortality.

For example, a Gyn/Onc surgeon is surgical back up for high risk pregnancies for fibroids, for placenta accrete. And, there's a clear difference between health outcomes for Black women and women of any other race. Uhm, for all cause of ovarian

cancer, mortality rates are 1.3 times higher in Black woman than white, and endometrial and cervical cancer mortality rates are twice as high.

Uhm, limiting access to essential services, like surgery, chemotherapy, and followups simply compounds those baseline disparities.

For years, we've been discussing healthcare disparities, and yet we continue allowing changes that disproportionally impact our already vulnerable populations.

Uhm, so how does this affect us as residents and our training and our wellness?

Uh, for better or for worse, a huge part of our collective energies has turned to patient advocacy. Uhm, uh, for, in many ways I'm thankful. Uh, with the help of CIR, local community organizations, our patients, and our faculty we circulated a petition; we organized a rally; we've held many meetings with H+H leadership over the past year regarding the return of gynecologic oncology service to Brooklyn. And, we're happy to report that Kings County is currently interviewing candidates for new Gyn/Onc position.

We genuinely appreciate the efforts that H+H leadership has made to bring back this service. But, I can say with certain... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. MARSHALL: We have spent hours and hours figuring out care coordination -- how we consult and follow up these patients -- instead of reading, studying, or discussing direct patient care. And, these out of title measures, these phone calls to the financial office, these are not unique to GYN or this situation. We all know this.

We've seen numerous cases of patients signing out against medical advice from Bellevue -- this referral center -- an hour and a half away by public transportation -- only to present the next day at Kings County with the same complaints, because we their home hospital. We are accessible. We're here.

Every day, and even more over the past year, we see women in our community miss treatments, forgo care entirely, or present with advance disease due to barriers of care. And, we see their outcomes suffer.

We see these tragedies and feel like we're part of the system -- Should we have advocated more for that patient? Could we have done more for her?

Having to deal with that constant fight for more resources for our patients for better and just care leads to a moral injury that eventually compounds these feelings of burnout -- that we can't do anything more.

Moral injury defined is when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs. Over time these moral injustices we see add up.

Uh, as we all noted, many H+H residents also rotate at private hospitals, and we see how the distribution of resources is so glaringly unequal.

Why does my patient here in central Brooklyn deserve anything less?

The worst outcomes we see in poor communities in Black and Brown patients, seem almost premeditated as the resource allocation is so starkly unequal.

We all chose these programs because we care about our patient population. H+H is one of the most initiative public healthcare systems in the world. We come here with the intention of making the world a better place. But, we are constantly fighting for our patients against this avalanche of failure, and it leads to this general disillusionment that

compounds the burnout. It's not just a failure of H+H, it's a failure of the American healthcare system in general.

We fight this system every day, tooth-and-nail, to provide for our patients but often, at the expense of our learning and clinical training and at the expense of our mental well-being.

In conclusion, the things that improve patient care also improve resident wellness. They're inextricably linked.

Treat everyone with respect, give us the resources for us to do our jobs to the best of our ability.

Allocate more funding to Health + Hospitals -- *allocate more funding to Health + Hospitals.* Prioritize the lives and health and of your most marginalized communities, and with that, you will uplift and protect the resident physicians who have dedicated their time to this city.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Michael Del Valle to testify.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. DEL VALLE: Hello, so, my name is Dr. Michael Del Valle, I am a fourth year Emergency Medicine Resident and I work at Jacobi Medical Center in the Bronx. I'm also the Regional VP of the union, uhm, of the New Yorker area, of the Committee of Interns and Residents.

So, just to begin, we're not the hired powered independent physicians with six digit salaries the general public thinks we are.

Thousands of residents struggle to manage the high cost of living, and work extreme hours while maintaining the well-being of themselves and their families.

Just to get in to the numbers, the average base pay of resident physician in New York City, is approximately $63,000 a year. We work 60 to 80 hours per week.

Current medical graduates -- that's just out of medical school -- starting residency sit in an average debt of $250,000. And, we accrue $13,000 in interest every year on average.

Add to this, the extreme physical and emotional toll of working in our overwhelmed healthcare system, during a historic global crisis that was sitting right on top of us. And, it's pretty to understand why New York City residents feel unsupported, unseen and hopeless.

Residents are reluctant to take any action that may endanger their place in their programs. When we do find our voices, we are completely dismissed.

Uhm, as one of my colleagues, Dr. Malika (INAUDIBLE 02:31:39) from Jacobi as well, uh, said, quote, "When we speak about issues we face as residents, we are told that, "back in the day, it was much worse" or, "you guys have it easier now." Our concerns are perceived as unnecessary complaining. This mentality is pervasive among medicine, and promotes the idea that we should not try to improve of change the system. Caring about ability to provide adequate patient care, and its effects on our mental and physical health, means we are somehow weaker as physicians." end quote.

It is difficult for a resident to access mental health services, because licensing bodies and

employers look in to what mental health treatments a physician has sought.

These training environments can even turn abusive. One resident, who feared retaliation, anonymously shared the following: Quote, "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, it's unprofessional. They tell us we don't do 24 hours, but many of us have actually been told to stay the nightshift after a dayshift and we complied. And, if you bring this up to the program directors, telling them you're exhausted, because you just worked 24 hours, they'll say "that's impossible". You tell them well the 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."" End quote.

I wish this story was an outlier, but it's not. In the lead up to the this hearing, we had countless members reach out to tell us they were bullied, dismissed, gas lit, and retaliated against for

speaking out. There's a reason so many of our testimonies are sent in anonymously.

As unions, we have won protections for our members against losing their jobs. We can't stop an attending from withholding a recommendation a resident needs to get in to the cutthroat, highly competitive fellowships they need to or to practice as an attending.

We need H+H to have system wide oversight. Union protections are crucial, and one of the main reasons why I feel comfortable speaking to you today, as well as being a senior... (Cross-Talk)

SERGEANT AT ARMS: Time.

DR. DEL VALLE: on my (INAUDIBLE 02:33:30) but, many residents across New York City do not have these protections, and many of them are providing care in non H+H hospitals.

As one resident explained, quote "In my hospital, one of which half of the residents are unionized, and the other in which half are not, I get to see what happens when residents decide they should have a say. As an intern, you're stuck with the crappier private hospital contract, and once you become a senior, then you graduate to the better unionized contract. Being

on the union contract means you work less hours, get better pay, get more benefits, have an option for sick and parental leave, and ultimately an ability to stand as a united resident front." end quote.

When we were split payroll programs, and half the program is nonunionized, it directly affects us. Recent actions in the split NYU/Bellevue EM program are a clear example. NYU administrators reviewed the EM Department, which serves both NYU and Bellevue, and they perceived the program as social justice oriented, which was characterized as a negative quality.

Interns are no longer allowed to learn in practice in the Bellevue ED. Interns are being trained in a private healthcare environment that serves a predominately white, English speaking, socioeconomically advantage patient population in contrast to the city hospital system, of which Bellevue is a part, and which aims to serve all New Yorkers.

Additionally, residents who have already completed their intern year, are now covering intern year shifts. This means they're working longer

shifts, they're not given the graduated responsibility that is so essential to learning.

As the resident in a (INAUDIBLE 02:34:56) situation explains, "The fact that admin views social justice has an undesirable goal was harmful to resident wellness. Furthermore, reports that faculty members have lost their jobs after speaking up on behalf of residents, has created a culture in which residents fear very real retribution. No doctor should fear for their career because they advocated for their patients and their communities. When we struggle, our patients suffer. We are the biggest public healthcare system in the country, and we have the opportunity to stand as leaders on these issues. We cannot continue to manage medical residency as various compartmentalized institutions. We need a system wide approach. We're here now, we're asking for help, please listen. Help us take action."

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Pramma Elayaperumal.

You may begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. ELAYAPERUMAL: Okay, good afternoon everybody. Thank you for hearing from me.

So, listen, my name is Pramma Elayaperumal. After med school, I did three years of internal medicine residency at Woodhull Hospital, and I'm currently doing my fellowship in Pulmonary and Critical Care Medicine, which has me rotating through Kings County and Coney Island Hospitals.

As the speakers before me have said, H+H hospitals lean very heavily on resident physicians. Uhm, the system simply would not be able to care the volume of patients that we care for at the level of quality approaching the standard of care, without the diligence of residents.

Yet, speaking quite frankly, residents are abused in the course of being asked to perform their duty for patients. And, the strain that, quotation, "... The residents have suffered through was on exacerbated by the COVID-19 pandemic. On top of existing stress, we were hit with more death than ever seen before in our careers, the upheaval of schedules, educational time, vacations and whatnot."

On August 27th, uh, CIR had a resident wellness activity over Zoom, and I spoke face to face with HHC

CEO Dr. Mitchell Katz. And, uh, I mentioned that there were conditions within our work environment, and specifically being antagonized, condescended to, berated by hospital administration, that was leading to harm in morale.

Now, three days after my conversation, on August 30th, uh, Dr. Adhiraj Satija from India, uh, a Lincoln resident, died by suicide.

Ten days later, on September 10th, a resident physician, uh, in my class attempted suicide, and, uhm, that required an eight day hospital stay. And, this resident, in particular, did site the toxic environment at work as a contributing factor, and described being yelled at by, uh, HR staff that very afternoon, uh, the night of the suicide attempt.

And, the following April, of course Dr. Waleed Saleh Abuhishmeh of Jordan took his life.

Uh, even in the face of these tragedies, I don't feel like HHC leadership has taken meaningful action. In their opening remarks, they just talked about wellness rooms at Lincoln Hospital. These rooms were actually staffed, run, and financially supported by psychiatry residents themselves.

HHC talked about, uhm, the Helping Healers Heal program and peer support groups. The truth is, residents are very good at supporting one another. We go through this together. We have such impressive, comprehensiveness, cooperation, among residents.

The problem is what is being done to us. Right? And, what we need, and what there is no substitute for, is improving the working conditions for us, for our communities, for our patients, uh, and to be... to have us treated with the dignity and respect due a doctor working in a difficult job. Right? No amount of chair yoga or protein shakes in the break rooms can make up for the fact that we lack robust support for these issues.

And, residents do seek help. They are turned away. They are sometimes punished.

The resident who incurred an eight day hospital stay after a suicide attempt at my program, was told that they would have to make up for those days or would be graduating late, thus jeopardizing starting a career, starting fellowship or other things.

Another resident on mental health leave at Woodhull, sent a message to her colleagues explaining

her absence, saying things like, "I left work, because I was gonna jump from a train after a long week of work... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. ELAYAPERUMAL: and, thank you everybody for showing your support during this time I'm going through."

That message was forwarded by the Chief of Medicine at Woodhull to Woodhull leadership, saying, and I quote, "This is the kind of the instability I was concerned about." So, that's the kind of response that people who put out honest, genuine cries for help get in response.

Uh, a former Bellevue resident says, "HHC leaves their trainees and staff with the impression that they are indifferent to whether we live or die on the job."

And, real quick, too, I think it's important people understand, uhm, The Accreditation Council For Graduate Medical Education is the governing body of residency programs, but what they can do is limited. They can cite a program. They can put a program on probation, and then can withdraw accreditation. But, those are not... They can't fine, they can't force

personnel changes. So, Woodhull was placed on probationary accreditation in January of this year.

And, the yearly surveys, might make administration try to change some things, because if they get bad reviews on the surveys, they can lose accreditation. But, the residents know that if the hospital loses accreditation, they're out of jobs and then they'd have a hard time getting a new job. So, there's trepidation in honestly reporting whether or not, uh, things improved.

So, in closing, I just wanted to say, this is like a recipe for disaster. Right? Uhm, personally, I've been extremely disappointed with Dr. Katz's, the CEO's, uh, response to everything that's happened this past year. I've engaged him multiple times directly and through email.

And, HHC is the largest public health system in the nation. We care for so many people, from so many communities with pride and compassion under very difficult circumstances.

So, if I've moved you here today, I urge the members of the city council and the mayor's office to take up the cause of improving things for resident physicians within the HHC system, because I believe

only strong, external pressures from your offices could do so.

Thank you guys very much for your time.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. I. Michael Leitman, followed by Dr. Ernesto Blanco.

Dr. Leitman, you begin when you are ready.

SERGEANT AT ARMS: Time starts now.

DR. LEITMAN: Thank you.

Thank you, good afternoon Chair Rivera, and members of the committee.

My name's Michael Leitman. I'm a general surgeon, and I've been practicing in New York City Hospitals for more than 36 years.

I'm currently the Dean for Graduate Medical Education at Mount Sinai. And, I have the privilege of being responsible for the largest GME program in the United States with more than 2,600 residents, interns, and fellows learning and working at eight Mount Sinai health system hospitals and two campuses at H+H.

The testimony that we've heard today is very compelling. Five years ago, I learned of the death,

by suicide, of a Mount Sinai resident. She was beautiful, intelligent, well liked, and well regarded. And, her death had major impact on me and on Mount Sinai. She was not the first New York City resident that died by suicide, nor the last.

Until six years ago, we were focused on resident duty hours, supervision, patient safety, and education.

At this very moment, there are 14,000 interns, residents, and fellows on duty, as Dr. Omotoso described, on the frontlines at our New York City hospitals.

The negative impact of burnout is that it not only effects the physician, it may also result and impact the patient, coworkers, family members, close friends, and our healthcare organizations.

Burnout and depression are not the result of working excessive duty hours, rather they are the result of the intensity of the work that residents do, the need to study and pass examinations; and, as you've heard, the moral injury that one experiences when they spend a lifetime preparing to practice medicine, only to learn that there are limits on the

ability of treatments for certain diseases, and for patients with limited resources.

Working conditions are better than they were generations ago when people like me worked excessive hours as a resident. 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, often very ill, hospitalized patients in even more complex healthcare environments does take its toll on intern and resident wellness and their health.

Six years ago, we began to measure burnout and depression utilizing well accepted scientifically validated survey tools. The majority of our residents completed survey, and we found that 57% of our residents screened positive for burnout, and 40% of our residents screen positive depression.

In some programs, depression was high as 80% of residents, and burnout was measured to be as high as 92%.

We also found other factors that increased well-being, such as having departmental well-being champions and promoting team building support for

families of international medical graduates, investing in food pantries, and group meetings to learn techniques for building resilience were important. We invested in well-being screening tools that the America's Foundation for Prevention of Suicide has enabled us to give our residents self-screening tools. We've invested in mental health services, and supporting interns and residents with physician assistants and... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. LEITMAN: nurse practitioners where possible.

We carefully monitor all of our residents for signs of stress. And, each year, the majority of our residents complete wellness surveys. And, we've done much research in terms of how to mitigate the effect of training on young physicians.

Here are a few examples of what we provide at Mount Sinai: We hold support sessions led by social workers and psychologist, we have a 24/7 helpline that provides trained counselors to answer phone calls to help and create connections to emotional care, we have regular town halls for our residents, and we provide safe transportation for our residents

off hours. We've been providing wellness days for our residents and fellows since 2016.

In summary, New York City's interns and residents play an important frontline provider role as they undergo necessary training to develop the skills required for independent practice.

But, there is still 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, as you've heard today, are necessary to understand how to meditate this problem, and invest in healthier physician workforce for a healthier New Yorker.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

I'd like to now welcome Dr. Ernesto Blanco to testify.

You may begin when you are ready.

SERGEANT SADOWSKY: Time starts now.

DR. BLANCO: Thank you very much. Uh, my name is as I said is Dr. Ernesto Blanco. Uh, I was an

Internal Medicine Resident at Coney Island Hospital from 2017 through 2020.

And, I want to say myself is very compelled by the stories I've been listening to. And, I feel like it really highlights how we from different hospital lived a similar... similar realities, and it is definitely a shared experience.

Uh, you have heard many stories about how the hours and the immense amount of out of title work will wear a resident down. It will cause burnout. And, this was definitely true and my experience in Coney Island. And, as the previous speaker mentioned, it is consistent with their statistics. Burnout tends to be less of a rarity and more the norm.

Uhm, I do want to be clear, the only reason I feel like I'm here today and to be able to say any of this, is because I am no longer employed at Coney Island. And, I'm an attending physician in another state. And, if this was happening perhaps when I was a resident, I think I might have hesitated to speak. Because, sometimes it does seem to exist a culture of retaliation, and that's targeted by higher ups. Uh,

or at least just made to feel that this environment exist through where residents cannot speak out.

Uh, the culture at Coney was not a one that valued and championed resident's physical or mental health, or at least it felt like the opposite to us. We felt like every year a new responsibility, a new out of title task was being added to us. And, there wasn't much of a choice from the resident standpoint. There wasn't a negotiation, it was just "we inform you".

Uh, as an international medical graduate, I particularly had a very tough situation. I am from Venezuela, and in 2019, uh, because of many different, uh, political problems in my country, uh, my country had no way to be contacted for over a week. There was no internet. There was no electricity. Obviously, this affected me extremely emotionally and mentally. And, I figured I needed some time off. It was negotiated that I would have four days off. But, I guess, again, because of this culture of how mental health is looked at, I was within the second day called back, that this was not the way of dealing with things, that I needed to be at the hospital, that I should be able to deal with

this better -- and not really understanding what that meant.

I told this story, I remember, as we tried to get wellness days during a CIR negotiations, and I remember the sharp looks and the uncomfortable ambiance that it created. And, but at the time that, I feel like it's insufficient that we're trying to accomplish these two wellness days. It really speaks to that whole situation that residents are on. And, we're fighting to see if we can get two, uncontested wellness days for residents a year, where they can just focus on their mental health.

Uhm, outside of the CIR delegate at Coney, I really felt that we did have... (Cross-Talk)

SERGEANT AT ARMS: Time expired.

DR. BLANCO: (INAUDIBLE 02:48:23) with these issues that we were facing. But, we weren't really listened to. It was actually impressive that the one thing we were supported on was a one-commitment to do kind of a wellness day party. And, well, you know what, while this was a nice gesture, it did feel insufficient, because it was not addressing the long-term issues that perhaps many of us have spoken of

today, causing the severe the amount of burnout in our residents.

Uhm, I think I've stressed that one of the reasons I feel like I speak out freely today is because I no longer work at Coney Island. And, perhaps, my future was not something that I would feel was compromised if I put myself out there as I had before to try to speak up for other residents. Because, I am in a position now, I feel like I... I felt like I must speak as I was the (BACKGROUND NOISE) (INAUDIBLE 02:49:18) for CIR, and it was always in my interest to advocate for other residents.

Uhm, obviously, just we want to be there to help our communities, but our mental health and physical health should be also be priority, because we would not be able to do the best that we can if we are not taking care of health and wellness as well.

So, the conditions that I experienced, takes undue burdens on me and my training and my fellows training.

And, I do hope that we shed light on the struggles that we face, and that we get your support, and the support for CIR to move forward, and for

international support for residents and physicians for system wide oversight, so that programs are held accountable and for change.

I think only then can we change the culture and raise the standards both at Coney and at across all H+H residency programs.

Thank you very much.

COMMITTEE COUNSEL: Thank you so much for your testimony.

Uhm, I'd like to now turn it to Chair Rivera for any questions.

CHAIRPERSON RIVERA: I wanted to ask Dr. Shalvoy, uh, Keriann, I'm not sure if you're still with us, I wanted to ask you, I know you had... I feel like you had a little bit more to say. And, I wanted to ask whether there was something additional, another story you wanted to share with us?

DR. SHALVOY: Uh, yes, uh, thank you, uh, Chairwoman Rivera.

Uhm, I wanted to say a bit more, uhm, about The Patient Care Trust Fund, but first we received a very moving anonymous story from a resident about sort of how... What the day to day is like. I think we've heard some very poignant examples, but I think that

this resident spoke very eloquently about it's like on a daily basis.

And, so, I quote, "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 hours as scheduled. Over several years as a resident, I have worked many 100+ hour weeks and 30+ hour shifts, but no extra pay, rarely any sleep on 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 program 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 to the care they need, that 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', for example, slowing clinic by trying to help a cognitively impaired patient, recently admitted with

a life threatening blood clot, to navigate hospital'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. 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.

I feel utterly hopeless sometimes in the face of this all. But my colleagues and I keep showing up with whatever we have."

So, I think with that testimony from that resident, I think, uh, really captures the experience

on the day to day. And, you can understand why the depression rates are so high -- as we recently heard.

I think something related, that I wanted to just, uh, speak a bit more about is The Patient Care Trust Fund, which has been a really helpful outlet amid all of this, uh, it works for the residents in the H+H system.

Uhm, so, The Patient Care Trust Fund, uh, provides Health + Hospitals health staff with critical funding to reduce health disparities, strengthen medical education, and meet the complex health needs of our patients and communities through annual equipment, and holiday grants, and bi-annual research grants.

Uhm, reviewing Patient Care Trust Fund applications, was one of the most rewarding experiences of my residency and my life. And, I was really honored to serve as the chair of that board last year.

Equipment and resource shortages, make it harder and slower to treat our patients, and it all results in longer and longer hours for us, and more and more frustration as we've mentioned -- how these ideas tie in to each other between resources and well-being.

When we lack the resources we need to treat our patients, we stop practicing medicine on what is the best treatment plan, and instead, based on what's achievable.

It takes creativity, time, and huge and emotional cost to provide the best quality care under those conditions. But, that's what we put in each day.

Our, patients deserve better, and this is a moral injury.

I just want to share a brief example of the impact that the Patient Care Trust Fund grants have on our patients and communities as well as our well-being as residents, on not only for those of us who are on the board of residents, who approve these grants, uhm, but for the residents who receive them.

For years Coney Island Hospital lacked a proper sonogram in its Labor and Delivery Wing. OBGYN residents were forced to use a 10-year-old, malfunctioning sonogram to care for the estimated 1,800 patients served by their department each year.

Shocked by these conditions, a resident leader stepped up, and was sent to the PTCF by the hospital because administration said it didn't have the money for a new machine despite, the high patient need and

the fact that residents much complete 60 bedside sonograms in order to graduate. And, the resident's application may narrate a truly painful and sadly very common scene. "One time our external fetal monitor was longer able to differentiate fetal from maternal heart rate, and there was concern for prolonged fetal bradycardia, a dangerously low heart rate. We weren't able to confirm our suspicions due to lack of a functioning sonogram, and the patient was taken to the OR for a STAT cesarean section, an operation which could have been avoided if we simply had a sonogram that worked."

Uhm, so I just, you know, I appreciate having the opportunity to take this time to also highlight some of the programs like the Patient Care Trust Fund that we have that really make a difference for our well-being and for patients. And, that we only wish we could approve more of the applications that we receive to make differences for us and for all New Yorkers.

Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony.

Uhm, I'd like to... At this point, we've concluded our public testimony.

And, I'd like to just ask if we had inadvertently missed anyone that is registered to testify today, and has yet to be called, please use the Zoom Raise Hand function now, and you will be called on in the order in which you have raised your hand.

Okay, seeing no hands, uhm, I'm gonna turn it back to Chair Rivera for closing remarks.

CHAIRPERSON RIVERA: I just want to say thank you to you all.

I... Accessing wellness days and days off are incredibly important, and I know something was mentioned on -- in terms of a wellness activity over Zoom, and again, I know that our institutions are trying to do the right thing, and I appreciate that they are still here listening to you all. So, just you know, they are still in this meeting listening.

So, I want to thank everyone for being here, for sharing your story. I realize the pressure to be infallible, to work nonstop, is not fair. It's not sustainable. And, it's not realistic.

Many of you continue to suffer in silence, and as much empowerment as you may be given, as is... is

really just perception, is what it feels like. And, it's clear that improved working conditions, more staff, more resources that is the intervention needed to have a more profound effect, so that way workers are not feeling like they're alone with their finger in the dam.

Think moral injury will compound the problems if we do not act now. Health + Hospitals, The Greater New York Hospital Association, they can do something system wide so that our interns, our residents, our workers can lead with empathy, and they can become the amazing and appreciated individuals and doctors that they have always strived to be.

We don't want to lose to talent, and we cannot lose another life.

I'm looking forward to working with every single one of you to implement immediate changes. I know we're capable of it. I know we can do something system wide.

And, I want to thank all of you for being here. Of course, I want to thank the entire council team, The Committee on Interns and Residents, Health + Hospitals, The Greater New York, uh, thank you so, so much.

Uhm, again, I will not stop until we see some changes. And, I want to just thank you for taking what is actually brave, bold action to be here and speak frankly, and honestly, and authentically to your experiences.

So, with that, uhm, we will adjourn the hearing.

And, thanks again to everyone for being here.

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date October 24, 2021