NYC HEALTH + HOSPITALS

New York City Council Hearing

Oversight:

Health + Hospitals Doctors Council Work Stoppage

Committee on Hospitals

Committee on Health

Committee on Civil Service and Labor

Mitchell Katz, MD

President & CEO

NYC Health + Hospitals

January 10, 2025

Good afternoon, Chairwoman Narcisse, Chairwoman Schulman, Chairwoman De La Rosa, members of the Committees on Hospitals, Health, and Civil Service and Labor, and members of the City Council. I am Dr. Mitch Katz, a practicing primary care physician and the President and CEO of NYC Health + Hospitals (Health + Hospitals). Thank you for holding this important hearing this afternoon.

I am here today to discuss the long-standing and vital partnerships between Health + Hospitals and its affiliated voluntary hospitals, and how these affiliations enhance our ability to deliver high-quality healthcare to New Yorkers and address the challenges we face. Most importantly, I am here to reinforce our commitment to our physicians.

As you may know, we employ the majority of our physicians through contracts with 4 major health care affiliates. Relatively few of our doctors are employed by Health + Hospitals directly. That does not change our commitment or responsibility to our physician colleagues, but it may be helpful for you to understand our system.

This is not a new structure: as early as 1961, the City established partnerships with private, not-for-profit hospitals – sometimes known as voluntary hospitals – to ensure that public hospitals maintained an adequate number of attending physicians.

The concept of utilizing private sector resources in public health is not unique to New York City. In cities like Los Angeles and San Francisco, public hospitals have successfully employed affiliate agreements with private voluntary hospitals. These partnerships have proven effective in addressing staffing shortages and improving

service delivery, demonstrating that collaboration can amplify the strengths of both sectors.

No matter who employs our doctors technically, Health + Hospitals is committed to supporting them. Physicians are integral to our mission and vision. We recognize the vital role our doctors play in delivering exceptional care, and we strive to provide a comprehensive suite of resources designed to foster their well-being.

Since I joined Health + Hospitals in 2018, we have taken a variety of steps to support our doctors emotionally, professionally, and in their day-to-day practice. We initiated a number of wellness programs when I joined the system. One of my first actions was to create Helping Healers Heal (or H3), a specialized program to directly address the challenge of work-related stress and secondary trauma. The need for H3 and other supports became even more important during and after the COVID-19 pandemic.

During that horrible time, we initiated a range of supports for our physicians and staff. We created a dedicated behavioral health hotline for our staff; developed wellness rounds to check on our physicians and other staff on the floors; offered necessary resources like meals, childcare, clean scrubs, transportation, hotels, groceries and other personal essentials; brought in external counselors to provide parenting coaching; offered transcendental meditation; and made trained peers available for staff "debriefs" to help our heroes process the burdens of their work without stigma. We also crated dedicated wellness rooms for decompression in our facilities, which we are now enhancing with generous private donations.

The COVID-19 pandemic tested our healthcare system in unimaginable ways, and at the heart of that response were the doctors who worked tirelessly to care for our patients. Their heroic efforts on the frontlines went far beyond the call of duty, and their commitment to patient care and unwavering service deserves our deepest gratitude. I would like to use this moment to again thank all of our doctors for their bravery and selflessness.

Following the profound toll the COVID-19 pandemic took on physicians and healthcare workforce, Health + Hospitals maintained and bolstered our comprehensive workforce wellness strategy, making it an even richer part of our general operations. Our system's Chief Wellness Officer and his team focus on increasing awareness of mental health issues, enhancing access to critical resources, encouraging help-seeking behavior, and improving overall satisfaction with both resources and working conditions. We also continue to offer our enhanced Helping Healers Heal (H3) program, which includes vital resources such as an anonymous internal support hotline and individualized and group peer support sessions. These initiatives are specifically designed to address the emotional, psychological, and social well-being of our healthcare providers.

To ensure broad accessibility, Health + Hospitals launched the House Staff Wellness website in 2021, offering comprehensive mental health resources and support hotlines to all staff, regardless of academic affiliation or pay line.

Additionally, Health + Hospitals expanded its commitment to mental health by incorporating behavioral health services into our Virtual ExpressCare platform, providing 24/7 access to mental health care through telehealth. This service is

available to all Health + Hospitals staff, ensuring that our workforce has immediate access to critical mental health support when they need it most. We also have an on demand 24/7 virtual clinic for urgent behavioral health needs for our team members who may need ongoing care.

On a day to day basis, we prioritize listening to our staff. We hold town halls both with our physicians and with our full teams, seeking open dialogue and collaboration. Through regular surveys and working groups, we actively solicit feedback from our physicians, which directly informs our operational strategies. This responsiveness has led to tangible, actionable changes that we continue to build and enhance.

Our commitment goes beyond wellness. We offer a robust array of professional development opportunities, including research fairs, AMA membership, cutting-edge educational content, and leadership training, all designed to empower our physicians at every stage of their career. In addition, we provide numerous channels for staff to raise concerns safely and constructively, through their supervisors, our physician councils, our systemwide patient safety program, or our compliance program

I recognize that our physicians are seeking compensation as well as supportive resources. It is no secret that safety net hospitals, like Health + Hospitals, often face challenges in competing with private hospitals and certainly with out-of-state for-profit hospitals in terms of healthcare workforce salaries due to our payer mix and limited reimbursement. Unlike many of our peer systems, we are not driven by

revenue and thus we do not compensate our physicians based on the money they make for us.

However, there have been substantial investments in physician salaries to remain competitive, and the current salary average is over $265,000. In addition, Health + Hospitals prioritizes offering a comprehensive range of additional benefits unique to public and non-profit health systems like ours.

We also leverage funding and programming to help our physicians with student debt. This includes our participation in initiatives such as the National Health Service Corps loan repayment program and the Doctors Across New York program. Within our System, we are proud to have launched the Behavioral Health Loan Repayment Program (BH4NYC), funded by generous private donations, and aimed at engaging highly talented and motivated behavioral health staff. This program offers psychiatrist up to $75,000 in debt relief in exchange for a three-year commitment to serve Health + Hospitals.

We are also always looking for opportunities to make more resources available to our physician and staff, including for our ongoing advocacy to increase Medicaid rates through State and Federal partnerships, seek more advantageous commercial contracts, and garner donations including from generous elected leaders like you.

Through these multifaceted efforts, Health + Hospitals remains resolute in its mission to support the mental, emotional, and psychological well-being of our healthcare providers, recognizing that their health is essential to the continued success of our organization and the quality of care we deliver to our communities. At Health + Hospitals, we are not only dedicated to the health of our patients, but equally committed to the health of those who care for them.

I am pleased that we were able to work together and reach agreement for the physicians directly employed by the city recently, and I am grateful for your support in that process. I am confident that we can work together to get the same kind of positive conclusion for our affiliate physicians. Thank you for your time and consideration and for your support for our physicians. I am happy to take any questions you have.

JUMAANE D. WILLIAMS

TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL COMMITTEES ON HEALTH, HOSPITALS, AND CIVIL SERVICE & LABOR

Good afternoon,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. I want to thank Chairs Narcisse, Schulman and De La Rosa, as well as the members of the Committees on Health, Hospitals and Civil Service and Labor for holding this important hearing.

New York City public hospitals are a vital safety net for our constituents. While I am gratified to hear that affiliates have come back to the negotiation table with a mediator, thereby extending the days before an effective strike, it would be remiss of this administration if it did not acknowledge how this situation could have been avoided. Since September 2023, the Doctors Council SEIU has been in negotiations with H+H and its affiliate employers: NYU, Mt. Sinai, and Physician Affiliate Group of NY (PAGNY).

Work stoppage is not a decision that doctors take lightly. Attending physicians in NYC public hospitals could be earning far more in the private sector, but day in and day out, they dedicate themselves to serving our communities. The failure of private affiliates like Mount Sinai and PAGNY to address the needs of doctors long plagued by burnout, understaffing and draining work conditions is unacceptable. Doctors are seeking improved pay and benefits in negotiations, as well as remedies for unilateral policy decisions like a directive by H+H to limit time with patients to twenty minutes — a measure meant to allow more patients to be seen as demand for care grows. But limiting the time per patient visit runs the risk of diminishing quality of patient care and further contributes to burnout amongst physicians.[1]

But instead of engaging in good faith with the union in negotiations, employer affiliates have refused to address key areas of compensation and further demanded a series of cuts/givebacks, such as a 20% reduction in sick time, that would make it even harder to recruit and keep doctors serving New Yorkers. The Adams administration further allowed this issue to fester by ignoring the Doctor Council's letters, petitions and requests to meet.

[1] gothamist.com/news/nyc-public-hospital-doctors-ordered-to-shorten-appointments-to-see-more-patients

JUMAANE D. WILLIAMS

If realized, this strike would be disastrous for our city at large and its most vulnerable. At a time when rates of COVID-19, flu and other respiratory illnesses are high, we need our doctors and physicians more than ever. The outer boroughs, which already face disproportionate health outcomes, would be gravely impacted by work stoppages at Queens Hospital Center in Jamaica, Jacobi Medical Center and North Central Bronx Hospital in the Bronx, and Coney Island's South Brooklyn Health.

We simply cannot fail to adequately serve our communities and instability brought about by pending hospital closures further strains our healthcare as a city.

City and state elected officials, as well as other relevant stakeholders who contract with our public healthcare system, must come together to address these issues and ensure that our hospitals and clinics are fully staffed and fully funded with dignity and care ensured for patients and healthcare workers alike. Thank you.

Committee on Health Jointly with the Committee on Hospitals
Oversight Hearing - Health and Hospitals Doctors Council Work Stoppage
Friday, January 10th, 2025

Testimony of Sonia Lawrence RN, BSN
NYSNA Director at Large
President, NYSNA NYC Health+Hospitals / Mayorals Executive Council

Good morning, members of the City Council. My name is Sonia Lawrence, I am a nurse at Lincoln Hospital in the Bronx and I am President of the New York State Nurses Association's Health and Hospitals Executive Committee representing nearly 10,000 nurses at NYC H+H. Today, I stand in solidarity with the Doctors Council as they continue to fight for a fair contract.

We are witnessing a crisis in recruitment and retention that is impacting not just our doctors but also the entire healthcare system, including nurses like myself. Over the past several months, I have seen firsthand the strain that the staffing crisis has placed on our H+H facilities. It often feels like we are just trying to keep our heads above water, and this crisis has real consequences for our patients. When we cannot recruit and retain qualified healthcare professionals, it becomes increasingly difficult to provide the high-quality care that our communities deserve.

The unilateral cuts to new patient appointment times implemented by H+H have further exacerbated this crisis. As a nurse, I witness the frustration and anxiety on our patients' faces when they cannot access timely care. This decision has forced doctors to see more patients in less time, reducing the opportunity for meaningful interaction and proper assessment. Comprehensive patient evaluations are critical for accurate diagnoses and the development of effective treatment plans. Rushing through assessments due to insufficient staffing and unrealistic time constraints increases the likelihood of misdiagnosis, improper treatment, and ultimately worse health outcomes jeopardizing the well-being of those we serve.

The Doctors Council's decision to plan a work stoppage is not just about the physicians; it is about all of us who are dedicated to the mission of providing healthcare for all who need it. Doctors are taking a stand for their patients. As we have seen with nurses, residents, and so many other front-line workers – collective action to demand safe staffing and better working conditions results in greater worker retention and better patient outcomes.

NYSNA's victory for nurse parity pay and real staffing improvements has shown that investments in our public health system are both possible and the path to stronger patient outcomes. The employers and H+H should follow that model to get the Doctors Council a fair deal.

NYSNA supports the Doctors Council's demands for fair pay and better working conditions. I urge the City Council and the members of this committee to recognize the critical nature of these negotiations and to advocate for fair treatment and adequate resources for all H+H healthcare workers. Our patients deserve a robust H+H healthcare system that prioritizes their needs and ensures that those who serve them can do so without fear of burnout or inadequate support. Together, we can create a healthier New York City for everyone.

Thank you for your time.

January 9th, 2025

To: New York City Council Committees on Hospitals, Health, Civil Service and Labor

From: A Cohort of Health and Hospitals Primary Care Doctors

Re: Oversight Hearing on Health and Hospitals Doctors Council Work Stoppage

Thank you for this opportunity for all of us, front line primary care physicians, to present our innumerable, urgent, and growing concerns about the state of Health and Hospitals.

We are a group of primary care clinicians who have multiple decades of collective experience working for a hospital within Health and Hospitals. Together, we have poured hundreds of thousands of hours into building safe, equitable, joyful spaces for providing care to our beautiful, diverse, unparalleled patient communities at Health and Hospitals. We have loved this beautiful work, though at times heartbreaking and challenging. It is work that we know to be worth every minute we have given.

With this in mind, we are urgently writing today regarding the new H+H policy that dramatically reduces visit times for primary care with new patients by half. This policy significantly risks the quality of the care we provide to our patients, potentially endangering their health and well-being. This rushed and unilateral policy change was a decision that did not, at any stage, involve our input and therefore, has deeply shaken our confidence in the leadership of our hospitals and raised serious concerns about our role within the H+H.

We have attempted to reason with the leadership of our hospitals through countless written testimonials from physicians across H+H, raising concerns in the leadership town halls, and even through public outreach via press support. Yet, the responses have been dismissive, unmoving repetitions of, “we believe you will adjust.” This lack of meaningful dialogue and refusal to reconsider the policy has left us questioning our value to the system and eroded the trust we once had in hospital leadership.

And so, we write. We write to you, as our political representatives, earnestly and with urgency, so that you will hear us. So that you will advocate with us and for us. We need you to hear us. We write so that you will see us as not just employees of the public hospital system, but as essential, invaluable members of this magnificent family that is Health and Hospitals Primary Care, dedicated to providing quality care to all New Yorkers no matter their financial state.

That you will understand your own role as our interpreter: hearing our concerns around ways to improve patient care, how to limit overburdening our ancillary staff, and translating them into positive institutional changes for our patient communities. And your role as our protector: protecting these sacred spaces we’ve tirelessly built and ensuring that our ability to provide skilled care is not infringed upon by malignant entities including, but not limited to, financial dominance and inconsequential data.

To understand the drastic harm that a policy like this can make requires understanding what working as a primary care physician entails, and furthermore, what it feels like. From the moment our

patients arrive in the exam room, the clock is always ticking. Moreover, at the heart of our practice is our foundational rule: “Do No Harm”.

Most of our patients require interpreters, which adds time and complexity to our visits. Setting up an interpreter line often involves technical issues, like unclear connections and dropped calls, which at times requires us to call an additional interpreter. For new patients specifically, it is crucial to have an updated medication list and ensure their current medications are both safe and effective. This often requires 20 minutes in itself as many of our patients do not know the names of their medications, and because they are in transit to or from work cannot lug their bag of medications to the visit. In addition to reconciling their medications, we also gather the patient’s medical and life history, which often isn’t accessible electronically, especially if patients had their medical care outside of our system (in a different country or in hospitals not in our chart system). To safely provide medical care requires knowledge of a patient’s medical and surgical history and this takes time. Furthermore, for any concerns that a patient has, we seek to do a thorough physical exam, gather details around each concern, and present treatments. Each treatment requires counseling, discussion of risks and benefits, answering questions a patient may have.

This summary of our work doesn’t even account for the time that we spend getting to know our patients, building relationships that are safe and welcoming. This summary does not account for the time needed to comfort our patients struggling with depression that enter the rooms tearful, or the care we provide for those actively suicidal.

Imagine trying to fit all of this into less than an hour. Imagine being asked to do this within 20 minutes. There is no other word than, impossible.

The creators of this policy will state that if the first visit is shorter, we can carry this work into our follow-up visits. In other words, everything doesn’t need to be done in the first visit. Respectfully, all our panels are booked for months in advance. The work we describe cannot be held off for multiple months at a time. With the system as it is, doing partial amounts of work in our visits and leaving the rest for months later would be completely in opposition to our policy of Do No Harm.

The creators of this policy will also state that we need to increase access to care for New York. We agree wholeheartedly. We believe that to increase access to care for New Yorkers, the only true, sustainable, quality solution is to increase capacity by hiring more physicians and staff rather than burdening the already overstretched team. We believe that building contracts with equitable pay and benefits for H+H healthcare workers would be the solution to draw more capacity to the public hospital system, helping us to maintain the quality of our care while also addressing access. Fitting more into existing resources is unsafe and, as mentioned above, decisively harmful to new patients and existing patients alike.

This is why this policy matters. This is why we as a physician cohort across this hospital system continue to push back on this.

We wholly recommend the elimination of this new policy halving of new patient visit times and we hope that you review all of the concerns from today with our H+H healthcare family, these sacred spaces, and our magnificent patients in mind.

For our patients, please choose differently. They deserve more, not less.

NYC HEALTH + HOSPITALS | Jacobi

Joseph Seldin, MD

[redacted]

Board-Certified Physical Medicine and Rehabilitation

We are in a crisis. New York City's healthcare system is a broken system that is not adequately caring for our patients. We cannot recruit enough quality physicians, and we cannot retain enough quality physicians. There are many specialties that are missing at our hospitals and without those specialties we are unable to provide adequate care in an academic center of excellence. We have to scrape by daily with what resources we have and try to give the best care possible to our patients, but this approach can only go so far.

I was quite frustrated and disheartened when I was consulted upon a young woman in her forties that had an autoimmune disease exacerbation (rheumatoid arthritis, a disease that attacks the joints). Due to difficulties finding access to a rheumatologist, she was unable to get medication that she needed desperately to treat her disease. She is a mother of eight and living in a shelter. Due to lack of access of care and medication, she became debilitated, causing terrible pain in her joints and an inability for her to perform basic ADLs (activities of daily living) which include standing up, getting dressed, and the ability to walk a few steps. Most importantly she could not care for her family. This was totally preventable, but the system let her down! Her condition worsened to the point that she had to be admitted and undergo weeks of intensive Inpatient rehabilitation. This was a preventable strain on the health care system and more importantly a huge burden on the patient.

This is just one example in which the system has let down one of our patients. Across the board there are unfilled positions in departments throughout the hospital, from Primary Care, Internal Medicine to Neurosurgery and Ob/Gyn which leads to limited access to care. As physicians we are doing the best we can, and we are really good at making the most out of what resources we have, but we need help! I am here today to stand up for what is right and if that means that we must strike to have our voices heard

then I am willing to do so. We as physicians work hard daily to do the best we can to help the patients and the community of the Bronx, but with limited resources we cannot deliver the best care, and the patients deserve better.

Thank you for allowing this testimony to be given,

Sincerely,

Joseph Seldin, MD
Assistant Professor Albert Einstein School of Medicine
Physical Medicine and Rehabilitation
Jacobi Medical Center

Dear New York City Councilmembers,

I am writing to highlight an urgent and ongoing crisis within the Department of Medicine at NYC NYC H+H Jacobi/NCB regarding the recruitment and retention of hospitalist physicians. As someone who completed my residency at NYC H+H Jacobi/NCB and has served here as a hospitalist for the past 25 years, I have a deep understanding of the vital role our department plays in caring for our community.

Hospitalist physicians at our public hospital often provide acute, but also primary care-level services to hospitalized patients, many of whom are among the most vulnerable members of our society. For some of them a hospital admission would be the first physician encounter in the US. We are the backbone of the inpatient and teaching medical service, providing comprehensive care for patients admitted through the Emergency Department.

Despite the critical nature of our work, hospitalist attendings are severely underpaid compared to both local and national standards.Unlike our colleagues in primary care clinics, we have not received fair market salary adjustments or retention bonuses. In addition our productivity bonus has been recently eliminated. This has created a significant disparity and has resulted in several unfilled positions within our department. These vacancies are currently being staffed by locum tenens physicians, who are compensated at exponentially higher rates, placing an undue financial burden on the hospital.

Most of the new hires are recent graduates who often leave within a few years for better-paying positions elsewhere after gaining clinical experience and securing permanent residency or work authorization. This recurring pattern over the years has undermined the stability of our team and adversely affected the continuity of care for our patients.

I urge NYC H+H Jacobi/NCB to take immediate action to secure adequate funding for hospitalists attending salaries. Without competitive compensation, we cannot attract or retain experienced physicians, jeopardizing the quality of care we provide. As someone who has dedicated my entire career to this public institution, I do not want to see the hospital fail to meet its mission of serving the community.

A work stoppage is the last thing we want, as we deeply care for our patients and the communities we serve. However, the current conditions are unsustainable, and the hospital’s leadership must prioritize this issue to avoid further deterioration of the service.

I call upon the NYC H+H and PAGNY administration to take swift and decisive action to address this crisis so that we can continue providing uninterrupted, high-quality care to those who need it most.

Sincerely,
Andrey ILiev, MD
Attending Physician, Inpatient Medicine
NYC H+H Jacobi/NCB

City Council, Committee on Hospitals

My name is Anuj Rao and I am a primary care physician at Elmhurst Hospital. I was born and raised in Queens and am honored to serve vulnerable New Yorkers. I am proud to work for Health and Hospitals, an institution that values patients over profits.

We have a segregated healthcare system here in NYC – where those with commercial insurance generally attend one of the five major nonprofit academic medical systems (NY Presbyterian, Northwell, NYU, Mt. Sinai, Montefiore) and those with public insurance or no insurance attend other hospitals, predominantly Health and Hospitals. This has created a gulf in reimbursement and subsequently the quality of services available to patients at Health and Hospitals.

Health and Hospitals is unable to attract quality physicians because of the poor salaries offered. Without quality physicians, patients are not seen be competent providers in a timely manner. Patients wait months to see their primary care physician or a specialist for necessary care. This leads to poor outcomes, and consequently, costly emergency room visits and inpatient admissions.

Unable to hire more quality physicians, Health and Hospitals decided to cut patient visit times so primary care doctors like me must see more patients. On one hand, it does increase access, but at a cost. I am now asked to conduct a new patient visit, usually using an interpreter, to diagnose, manage, and explain one or several medical conditions to a patient who likely has never been seen by a doctor before in twenty minutes. There is no way to do this well, will lead to burn out, and prompt me and my colleagues to leave the system. The answer is not to cut visit times, but to hire more quality physicians.

The call for a strike is serious and not taken lightly. Folks ask me is it moral for a doctor to strike. I reply if it moral for a patient to wait more than 6 months to have an essential procedure? Is it moral to conduct a new patient visit for an individual who has never seen a doctor before in 20 minutes? Is it moral that patients at Health and Hospitals receive second class care because of their public insurance or uninsured status? What does that say about how we as New Yorkers treat our neighbors and our essential workers?

To the Committee on Hospitals,

My name is Avinash Viswanath, and I am an emergency medicine physician at Harlem Hospital. I began working at Harlem in October 2019, just months before the COVID-19 pandemic upended healthcare as we knew it. During those early days, I was proud to be part of a team and a facility that rose to meet the extraordinary challenges of the pandemic. I frequently spoke highly of NYC Health + Hospitals (HHC) and the Physician Affiliate Group of New York (PAGNY) for their dedication during that crisis.

However, my perspective has since changed. Over the years, I've come to understand the deeper challenges of being a PAGNY employee at an HHC facility. These challenges have now reached a point where I have made the difficult decision to tender my resignation this year. My reasons are primarily twofold and should serve as a wake-up call to the ongoing crisis in recruitment and retention of physicians.

1. Violence in the Emergency Department (ED):
Violence in the ED has reached untenable levels, and the response from both HHC and PAGNY has been woefully inadequate. While it is true that hospitals cannot control every incident that occurs within their walls, the lack of timely and effective measures to protect staff is deeply troubling. For example, following the tragic shooting at the Jacobi Medical Center ED, staff at Harlem Hospital requested metal detectors. Yet it took over a year for these to be installed—a delay that puts lives at unnecessary risk. Furthermore, there seems to be little accountability for individuals who verbally or physically threaten healthcare workers. Allowing assailants to walk out of the ED without severe consequences sends a dangerous message about the value of frontline workers.

2. Contract Negotiations and Physician Retention:
Contract negotiations with PAGNY have dragged on for over a year, revealing a stark disconnect between HHC/PAGNY leadership and the physicians who form the backbone of patient care. The unilaterally imposed salaries fall far below the national average, and cuts to benefits have rendered the overall compensation package unacceptable. This approach has driven many experienced providers to leave, resulting in severe staffing shortages. Departments that remain fully staffed often rely heavily on new graduates, depriving patients of the expertise and continuity of care that come with seasoned professionals. The recently ratified PAGNY contract appears to prioritize rapid physician turnover rather than investing in long-term retention, further exacerbating the crisis.

These two critical issues—rampant workplace violence and an unsustainable approach to physician compensation—are driving an exodus of dedicated healthcare providers. I am far from alone in my decision to leave the system this year, and without significant changes, this trend will only worsen.

The Committee must take urgent action to address these systemic problems. Without meaningful improvements, HHC facilities will continue to lose their most valuable asset: experienced and dedicated physicians who are committed to serving the community.
Thank you for your attention to this pressing matter.

Sincerely,
Avinash Viswanath, MD

1/13/25

From: Damien Archbold
To: Testimony
Subject: [EXTERNAL] Supplementary information for Fri Jan 10 hospital committee oversight hearing
Date: Thursday, January 9, 2025 11:26:30 AM
Attachments: Doctor response to Collective Bargaining Framework.docx

[redacted]

Dear City Councilmembers,

I'm so grateful for your attention to the underlying factors leading to the recent strike threat at city hospitals.

I've been a doctor at Elmhurst Hospital since 2019 and have been on the bargaining committee since our contract expired in Aug 2023.

I've been dismayed at the bad faith, uncoordinated bargaining that has resulted from the cynical "affiliate employment" arrangement.

It's important to understand: there is a distinction between the "academic affiliation" of a medical school with a public hospital. It benefits everyone to have medical students and resident doctors at public hospitals.

There are doctors at Bellevue and Kings County that are directly employed by H+H (so they are city employees) and have an academic affiliation with NYU or SUNY Downstate (respectively).

The "affiliate employment" arrangement is seperate, and is a corporate tool to disenfranchise doctors from city benefits, while reducing accountability for employment practices, also fragmenting the workforce and making the system less resilient.

NYC H+H is a public benefit corporation and it's vision for itself is "a fully integrated health system" but this convoluted arrangement works against cross-credentialling and prevents doctors from moving from one site to another in the event of surges in demand. It is disappointing that this arrangement has persisted despite the harms it caused during the COVID-19 pandemic.

This arrangement funnels taxpayer dollars to pass-through organizations that take a "cut" - not only does the arrangement make our city less resilient, it is wasteful and misallocates resources, enriching administrators and middle managers.

Here is a set of initial proposals from doctors when our joint employer NYC H+H and Mount Sinai, PAGNY and NYU - which were repeatedly ignored.

We want to work together to build a more commonsense framework for employing city hospital doctors.

I am unable to attend the hearing but will submit further written testimony.

Kind regards,
Dr Damien Archbold
Elmhurst Hospital

[redacted]

Response to the H+H Coordinated Bargaining Framework proposal:

H+H doctors welcome greater coordination in the recruitment and retention of safety net hospital doctors across our nation's largest municipal health and hospital system. As frontline doctors we are deeply invested in the wellbeing of our system and community. We look forward to collectively bargaining a fair contract with our joint employer that respects and values doctors as critical partners in the H+H mission.

We share a vision of NYC H+H as an employer of choice for mission-driven doctors who fearlessly advocate for the wellbeing of our marginalized community, building a health system that all New Yorkers can be proud of.

Chronic understaffing at H+H disproportionately harmed our patients and community when our hospitals were overwhelmed in March 2020.

Doctors are seeking a more resilient, less fragmented and more fiscally responsible approach to the employment of safety net hospital doctors at H+H, that will ensure a more adequate response to future surges in demand. Adequately staffing our hospitals is a public health imperative.

Our collective bargaining framework centers racial and social equity in the H+H medical workforce. Structural factors drive the starkly segregated and unequal care we bear witness to. Our patients and community deserve doctors that they know and trust.

We request greater oversight of Affiliate HR practices. Despite the H+H board publicly opposing systemic racism, Affiliate HR practices perpetuate race and gender based wage disparities. Opaque discretionary payments, forced overtime, lack of flexible work options, degrading benefit cuts and high doctor turnover make our workplaces less diverse, inclusive and equitable.

Doctors look forward to working together with our joint H+H-Affiliate employer to make our system an employer of choice for mission-driven, well supported doctors who provide the highest quality care for our community.

1. **Redress chronic understaffing**

    a. Fair market value with yearly inflation-based COLA, transparent base salary and sessional pay reflecting hours worked, overtime burden, on-call responsibilities, leadership, administrative and educational roles for each department, rewarding experience and promoting parity with PGY- and specialty-based pay scales

    b. End the reactive practice of individual "market rate adjustments" in response to staffing crises, which result in patient harm.

c. Transparent PTO policies (including 12 weeks paid parental leave) with options for flexible and part-time work that promote an equitable and inclusive workforce, exceeding NYS minimum requirements

d. Generous CME and protected time for interdisciplinary education, quality/safety, journal club, M+M, simulation and other professional development activities to build better care processes and systems, redressing years of disinvestment in professional development.

e. Employer pays for all required courses and training outside of CME funding

f. Protected non-clinical time for all doctors, minimum 4 hours per week

g. H+H leaders to adopt AMIA 25x5 aiming to leverage our medical workforce, increasing time spent with patients

h. High quality health benefits with a wide network and zero premium, deductible, co-pay, co-insurance or any other "cost sharing"

i. Option to "buy back" to NYCERS or similar pension to start date of employment

j. Post-retirement lifetime health benefits

k. Long-service leave or sabbatical after 7 years to reward longevity

2. Re-establish trust between doctors and Affiliates

a. End all discretionary "bonus" payments that do not contribute to retirement and disability benefit calculation, replaced by fair base salary

b. No "pay for performance" in our safety net hospital system without involvement of doctors in metric development and monitoring, avoiding perverse incentives

c. Doctors Council members comprise half of Joint Oversight Committee membership or similar hospital staffing body with a 2 year term

3. A more resilient H+H

a. A single master contract for all doctors across H+H to promote transparency, parity and pay equity

b. Voluntary "float pool" of doctors credentialled across H+H to better respond to surges in demand

c. Good-faith re-assessment of recruitment and retention measures (including fair market value compensation) every 3 years using mutually agreed on physician compensation benchmarks driven by comprehensive market data research

From: Damien Archbold
To: Testimony
Subject: [EXTERNAL] Testimony for Jan 10 city council hearing re: Doctors Council
Date: Monday, January 13, 2025 12:26:28 PM

[redacted]

Dear City Councilmembers,

The following is testimony for the oversight hearing on the Doctors Council strike vote:

I have been an attending anesthesiologist at Elmhurst Hospital since 2019, and was on the frontline of what the New York Times and Dr Mitch Katz called “apocalyptic” conditions for members of my community, with nearly 200 patients on ventilators - an absurd number for our 550 bed safety net hospital. Scores of patients suffered and died alone due to suboptimal suboptimal intensive care.

I was a member of the airway and resuscitation team, intubating COVID19 patients and putting them on ventilators. In March/April 2020, almost all of these patients died, not because their disease was so severe, but because of chronic understaffing and “just in time”, “lean” systems devised by a ballooning class of middle-managers in the H+H system, asking frontline healthcare professionals to do more with less. These middle managers are H+H employees, therefore they have city benefits and a pension, unlike doctors at Elmhurst.

At the end of March 2020, I worked a 90 hour week when many of my colleagues were isolating at home with COVID19 cases they had contracted on the job. Mount Sinai Services paid me for a 40 hour week, telling me that I was a “salaried worker”. At the same time, Mount Sinai received hundreds of millions of dollars via the CARES Act, FEMA and CMS, some being earmarked as “employee retention credits”. At this moment, Mount Sinai CEO Dr Kenneth Davis was reported to be golfing in Florida, while earning an annual salary of $5.3m (he earned over $67m over his tenure at the helm of the tax-exempt ‘charity hospital’, which receives taxpayer money via the H+H board to full staff doctors at Elmhurst and Queens Hospitals).

When we escalated what seemed like wage theft, members of our department were told “it’s not in your contract” by then CEO Israel Rocha, and also that “I’m not your employer - talk to Mount Sinai”.

The day after this meeting I was diagnosed with acute leukemia as an otherwise healthy 36 year old.

The following 7 months of treatment I was frustrated to learn what many of my colleagues have since confirmed: there is no employee handbook that outlines our entitlements, we don't have an intelligible employment contract and accessing health insurance and disability benefits through Mount Sinai Services is a labyrinthine, exasperating process.

Mount Sinai has a "self-funded" insurance arrangement, so they hire third-party benefit administrators such as United HealthGroup and the Hartford to add friction to the claims-making process, deny care and benefits whenever possible, in order to protect Mount Sinai's funds being used by employees for their health needs. After a 1 week stay as an inpatient at Mount Sinai, I moved to Memorial Sloane Kettering and had excellent care. Ultimately my (expensive) care was mostly paid for by Mount Sinai, although having cancer was very financially toxic to my family and I.

Although I encountered many excellent and caring frontline professionals at Mount Sinai Hospital, the billing process was nightmarish and convoluted - I had debt collectors from Mount Sinai harassing me while I was receiving infusions of chemotherapy drugs.

Having debt collectors call my phone repeatedly and demand my credit card number did help me understand what it must be like for less privileged people (like the patients I care for every day at Elmhurst) going through the same process, but having limited English proficiency, being precarious due to immigration status, and having less insight into the health industry.

Prior to working at Elmhurst Hospital, I was a fellow in regional anesthesia and acute pain medicine at the Hospital for Special Surgery. I also work for Doctors Without Border, and have worked in numerous countries. Moving from a private, non-profit (but very highly resourced) hospital on the Upper East Side of Manhattan to Elmhurst was a crash course in NYC-style "medical apartheid" referred to by a Jacobi nurse who testified at the hearing.

Here is a positive vision that is achievable: doctors from across the US and the world are drawn to NYCH+H as a refuge from a profiteering sickness reimbursement industry that have hijacked most of American healthcare. Doctors are valued partners in an integrated, resilient system that values all staff working as a team to achieve the IHIs "quintuple aim". An integrated contract for doctors across the system would be the first step towards that. So would passing the New York Health Act.

Councilmember and Hospital Committee Chair Mercedes Narcisse:

I was concerned that the H+H CEO Dr Mitch Katz was given a nearly 2 hour platform during this hearing, but the president of my union Dr Frances Quee, a black immigrant

woman and practicing pediatrician in the South Bronx, was cut off after 2 minutes when testifying.

Don't the city councilors want to hear from the leader of our union, who represents doctors who just held an unprecedented strike vote? What specifically are doctors asking for?

The impression for the public was that Dr Katz' voice is much more important than hers, and the 2800 attending physicians she represents who work on the front line of a grossly understaffed safety net hospital system.

I respect Dr Katz, but I agree with the Jacobi nurse who commented that "Dr Katz is presenting a far-too-rosy picture". There are common-sense methods to recruit and retain workers in any workplace, but especially for mission-driven professionals: listen to them. Ask what they need. Make sure they are paid close to the market rate. Make sure they have flexible working conditions and have excellent benefits, and have input and transparency around their working conditions. Make sure they have adequate support staff. Make sure they feel safe in their job, so they can be effective advocates for their often voiceless patients.

I have never taken part in a "focus group". There are no "exit interviews" when my colleagues quit in exasperation, or because of the heavy burden of mandatory overtime, or the inflexibility and frankly hostile HR practices by our "affiliate employers". Each year Mount Sinai Services has cut health benefits for Elmhurst and Queens doctors without negotiating with our union, increasing "cost sharing". For a self-funded plan by a health system, this is simply a technique to cut employee pay, while also discouraging employees from seeking health care due to rising deductibles and out-of-pocket costs.

Doctors (unlike nurses, physician assistants, administrative staff - nearly all of our colleagues) do not have a pension - Dr Katz seems unfamiliar with our poor and deteriorating benefits from the Affiliates.

Why weren't CEOs Drs. Robert L. Grossman (NYU), Brendan Carr (Mount Sinai), or Ed Chew (PAGNY) accountable to the city council and present for questioning, and to hear from doctors? I encourage you to learn how much these CEOs pay themselves, and how their salaries have exceeded inflation since 2020.

Please follow-up with Dr Mitch Katz with this question: how much are these Affiliate employers costing taxpayers as "pass-throughs", and why doesn't H+H directly employ physicians, living up to its stated corporate mission of "a more integrated health system"?

Councilmember Carmen de la Rosa:

I am an elected Doctors Council SEIU delegate and bargaining committee member.

In 2020, when doctors at my hospital were understandably distracted, our employer pressured a “city pattern” memorandum of agreement on doctors across the system, ignoring our bargaining proposals, with the understanding that the pandemic had created great uncertainty and “we will make it up to you”. Since then, inflation (CPI-W) has been 21%.

I receive unsolicited text messages, phone calls and emails daily from physician recruiters (even from other safety net hospital systems in NYC like Maimonides and Montefiore), where I could be paid 30% to work in a more supportive and well resourced setting. Dr Mitch Katz is perhaps unfamiliar with the current regional and national job market for physicians (his pay has increased by about 30% since 2020). Physicians outside New York City are paid considerably higher paradoxically, despite the very high cost-of-living and worse working conditions in NYC, as noted by CM Zhuang. In part our sub-market wages are explained by labor practices described here.

Affiliate-employed doctors are not city employees, and do not have a pension or other city benefits, yet we are paid like city workers, with pay below market benchmarks.

Dr Katz may not be aware: there is an industry of “physician compensation consultants” who provide reports to health systems (including H+H) to prove to CMS that they aren’t overpaying doctors, to comply with the Stark law and Anti-Kickback Statutes. We have requested these reports and have been ignored. Benchmarks to ascertain Fair Market Value for doctors doing the work we do are readily available.

The academic affiliations (which Dr Mitch Katz conflated in his testimony) are distinct - this is important.

Doctors, patients and the system benefit from training residents and medical students with affiliated medical schools - I love teaching residents and medical students, although Mount Sinai affords me no protected time for education (one of our ignored contract proposals).

There are doctors who are employed by H+H (and are city employees) but are academically affiliated with medical schools at Bellevue and Kings County (NYU and SUNY Downstate, respectively).

The “employment affiliation” arrangement seems to have been devised when Mayor Giuliani tried and failed to privatize several H+H hospitals including Elmhurst Hospital - he failed due to community opposition, but succeeded in privatizing the employment of city hospital physicians, disenfranchising them from city benefits.

I am very concerned by the conduct of our employer(s), and would appreciate your ongoing fact-finding from the Affiliate employers (PAGNY, NYU and Mount Sinai Services) who are

awarded large sums of taxpayer money from the H+H board (nominated mostly by Eric Adams) to fully staff our safety net hospital system. The leadership of these Affiliates were conspicuously absent from the Jan 10 2025 oversight hearing.

Mount Sinai has cut pay (by ending or decreasing various discretionary, opaque "bonuses"), degraded health benefits yearly, and unilaterally altered our working conditions (you heard from many testifying about the halving of time for PCPs - this is one of the worst examples). Each of these is an unfair labor practice that has the effect of unfairly gaining an advantage over doctors (NYU and Mount Sinai are multibillion dollar corporations) during bargaining.

You heard what Dr Mitch Katz told my former colleague and former bargaining committee member Dr Roona Ray, who was laid off by Mount Sinai Services while pregnant: "you are not my employee".

She bravely explained in her testimony how her "position was eliminated" while she was 37w pregnant, which appeared retaliatory and had a chilling effect on some doctors' participation in union negotiations. The same job was swapped from "Mount Sinai Services" to "PAGNY", minus benefits - a common practice in modern corporate healthcare promoting the "uberization" of the medical workforce. She has applied for the job and been ignored.

Unfortunately, our union legal representative (Pryor Cashman) failed to file a timely unfair labor practice charge for this reprehensible act by Mount Sinai Services/H+H/PAGNY.

Dr Roona Ray's case helps illustrate the shell game of the Affiliate employment arrangement: H+H avoids accountability for unsavory employment practices, which keep down labor costs by keeping doctors disorganized and frequently turning over. The most underserved New Yorkers lose out from this cynical arrangement.

This practice recently gained notoriety when the NLRB decided in 2024 that Amazon's similar arrangement with pass-through "delivery service providers" (who wear Amazon uniforms and deliver Amazon packages in Amazon trucks) was a tool to avoid bargaining, and named Amazon and the DSPs as "joint employers". It also led to the Dec 2024 ULP strike by Amazon drivers.

In the affiliation agreements, safety net hospital doctors are referred to as "contract service providers".

Doctors at each hospital will recognize the confusing and deceptive arrangement (I work at an H+H hospital - I am not credentialed at Mount Sinai Hospital and have never worked there) as a way to waste our time, commit piecemeal and surface bargaining, which are unfair labor practices designed to gain an unfair advantage, wearing down and confusing doctors. Since our contract expired in Aug 2023, I have never witnessed any good faith

bargaining by the Affiliate employers or H+H.

Both Amazon and H+H (via PAGNY, using taxpayer funds) pay Seyfarth Shaw, a notorious union-busting law firm that fought Cesar Chavez' United Farmworkers:

https://www.work-bites.com/view-all/with-doctors-contract-talks-dragging-city-hospitals-hire-union-busting-law-firms

Finally, there appears to be a campaign to spread fear among doctors who hold H1B visas and rely on our Affiliate employers to renew their visas. Many doctors are reluctant to engage in collective action (or stand up for their patients) due to fear of retaliation due to visa status. One of our bargaining committee members at Elmhurst is currently out of the country because Mount Sinai Services failed to renew his visa - leading to patients having even less access to care. Was this incompetence or retaliation? The same fear and rumor campaign was experienced by Mount Sinai employed residents at Elmhurst (many are also visa holders) during their strike in 2023.

The structure of our employment is an anti-union tool that wastes taxpayer money, diminishes voice and job security for frontline physicians, and exposes the most vulnerable and marginalized New Yorkers to a rotating door of frontline physicians. Our patients need more time (not less) to establish trust with their doctors, often having good reason to avoid and mistrust health systems and the medical establishment.

If doctors were all directly employed by H+H, we would be subject to the Taylor Law and this hearing would not have been necessary.

I took an oath to put my patient's best interest above the bottom line of my employer. The Affiliate-employment arrangement discourages doctors from fulfilling that oath.

Councilmember Lynn Schulman:

I'm grateful for your decades of healthcare advocacy, and for your team highlighting hospital closures in Queens (10 hospitals closing over 20 years), and the questioning of H+H officials in the October 2024 oversight hearing on hospital closures (watched closely by many of my colleagues, given the obvious impact on Bellevue's ER).

I am personally offended that my nominal employer Mount Sinai intends to close Mount Sinai Beth Israel (my sister is a patient) apparently planning to flip it for luxury real estate, highlighted in the hearing by testimony from Arthur Schwartz. As a doctor that cared for patients at the "epicenter of the epicenter" of the devastating first wave of the COVID19 pandemic, I am disturbed to see my employer degrade NYC's capacity to better respond to predictable future surges in demand for hospital capacity, especially one that cares for a mostly underserved community.

The understaffing and high turnover of physicians at Elmhurst and Queens Hospitals by Mount Sinai and H+H is a public health crisis.

Here is a report by colleagues at the DOHMH highlighting the disturbing association between racial segregation, ICU strain and mortality during the COVID19 pandemic in New York City. The hospitals aren't named, but it is clear that Elmhurst and Queens patients both care for high proportions of non-white patients and were uniquely underprepared given chronic understaffing and lack of capacity. Understaffing, and promoting a revolving door approach to physician staffing, is overt structural racism.

As the chair of the health committee, please hold Dr Brendan Carr (CEO) and the Mount Sinai Health System board (along with Eric Adams and his H+H board) accountable for employment practices at Elmhurst and Queens Hospitals, that not only devalue and disrespect frontline safety net hospital physicians but also their patients.

Kind regards,

Dr Damien Archbold
[redacted]
Elmhurst Hospital

Written Testimony for NYC City Council Committee on Hospitals
Daniel Neghassi, M.D. **January 10, 2025**

Re: NYC Health + Hospitals Physician Staffing Crisis

Dear Members of the City Council:

I write as a family physician practicing at both an academic medical center and a community clinic in New York City. While I do not work for NYC Health + Hospitals (H+H), I regularly refer patients to H+H facilities and have firsthand experience with how physician staffing challenges affect patient care across our city's healthcare system.

Through my practice, I care for many uninsured and underinsured patients who rely on H+H for specialty care. The current staffing crisis directly impacts these vulnerable patients' ability to access timely specialty care. As a physician, it is devastating to watch my patients struggle with deteriorating health conditions while waiting months for specialist appointments. When referrals to specialists face extended delays or are unavailable, patients' conditions often worsen, leading to more severe health outcomes and higher costs to our healthcare system.

H+H must attract and retain a strong physician workforce to provide high quality care for our city's residents. When physicians leave, we lose their deep institutional knowledge and relationships with patients. The gaps in coverage while recruiting replacements and the time needed for new physicians to become fully integrated into H+H's systems create additional barriers to care. Most importantly, breaks in continuity of care can lead to missed diagnoses, delayed treatments, and poorer health outcomes.

These challenges are magnified because H+H serves as the safety net for New York City's most marginalized populations. As an academic center physician, I regularly refer uninsured patients to H+H facilities because they are often the only option for comprehensive care. This dynamic creates an unsustainable burden on H+H physicians and facilities.

To address these systemic issues, I urge the City Council to not only support fair contract negotiations for H+H physicians but to also advocate strongly for the NY Health Act. This legislation would ensure health coverage for all New York residents, allowing patients to access care at any hospital while ensuring all facilities receive proper reimbursement. This would create a more equitable distribution of patient care across all of New York City's hospitals.

The current crisis requires immediate action to prevent the loss of dedicated H+H physicians and protect patient care. I urge the Council to support our public hospital physicians in their fight for fair working conditions and adequate resources to serve our communities.

Thank you for your consideration of this testimony.

Daniel Neghassi, M.D.
Family Physician
Columbia University Vagelos College of Physician & Surgeons

Hello and thank you for accepting my testimony.

I will keep this brief.

I am a fellowship trained Canadian urologist who has been serving the Queens community at Elmhurst and Queens hospital since 2021. When I was hired, we had 3 full time urologists serving both hospitals. We are now down to 1.6 full time urologists, all while both hospitals are trying to increase productivity and demand more from their physicians. Both urologists I started with left because of decreasing bonuses and income and worsening benefits. We have been trying to hire and are unable to because of the low salary that we offer – we've had about 5 people reject positions. The employer offers 40% below the median salary for a urologist and what they offer at their other sites, based on MGMA. As a result, our vulnerable and marginalized patients with kidney stones and other urologic issues are often being booked out 3-4 months to get surgery.

Furthermore, I am part of the bargaining committee but am currently unable to attend this hearing. I was forced to leave the USA as Mount Sinai delayed my visa and green card application in fall 2024, leading to a lag in employment for myself and a further delay in care for the people of Queens as they manage with less than 1 full time urologist for 2 hospitals. They knew this process would take a significant amount of time and they delayed processing until just 1 month ago amid negotiations. This is a major error on their part which leaves me without income and leaves the community further underserved for potentially months.

I hope that the city can help us improve working conditions so that we can recruit and retain doctors at HHC hospitals – this is the only way to ensure our patients get the respectable health care they deserve.

Thank you

New York City Council Committee on Hospitals Hearing 1/10/25

I am Dr. Deborah Shapiro. I am the chief of rheumatology at Lincoln Medical Center in the Bronx. I have come today to testify about the crisis in rheumatology care in the Bronx since the closure of the rheumatology clinics at Jacobi Hospital at the end of 2023. My rheumatology service at Lincoln has been directly impacted by the departure of four rheumatologists who all left Jacobi over a three month period because of arbitrary and disrespectful treatment by their hospital administration. The Division of Rheumatology at Jacobi was an active, thriving division with over two thousand patients receiving excellent medical care from four highly trained, capable, and dedicated physicians. The rheumatologists knew that their salaries were uncompetitive even compared to other Health and Hospitals facilities, but their chief's efforts to ask for raises were unsuccessful. However, salary was not the reason for the closure of the division.

In about September 2023, one of the Jacobi rheumatologists gave notice, I believe for personal reasons. Of the remaining three, two had school age children and one had a new baby. Two of these rheumatologists requested flexible work schedules so that they could care for their children. The administration refused to allow them to change their schedules in any way and told them that they would have to resign unless they worked 8 hours a day, 5 days a week. One asked if she could work 10 hours a day 4 days a week for a total of 40 hours weekly but this request was refused. Both of these doctors then submitted their resignations. The one remaining doctor was the chief of rheumatology, Dr. Beverly Johnson, who told the administration that the situation was untenable and requested a meeting with the CEO. However, the CEO refused to meet with her. Human resources told her that her request for a meeting with the CEO was insubordinate. Both the chief of medicine and the chief of ambulatory care tried to reason with the administration but failed, so Dr. Johnson also submitted her resignation at the end of December 2023. The Jacobi administration did nothing to plan for the continuing care of the thousands of clinic patients who were about to lose their doctors, and chaos predictably ensued. The lack of concern for patient care shown by the administration is incomprehensible and disgraceful.

I was aware of everything that was taking place at Jacobi since I know Dr. Johnson well and I offered to take as many of their rheumatology patients as my new colleague at Lincoln and I could handle. I had multiple

discussions with the chiefs of medicine and ambulatory care at both Jacobi and Lincoln as well. I had multiple discussions with the chiefs of rheumatology at all of the other H&H hospitals. We had no support in our planning from anyone in the administration at Jacobi. I applied for and received admitting privileges at Jacobi so that I could do electronic consults, known as e-consults, to communicate with the primary care and other doctors at Jacobi. After Dr. Johnson left at the end of 2023, I spent at least two hours every weekday evening after my normal work day writing e-consults and approving referrals to Lincoln. I did e-consults for about three months and was paid by the hour for this work by Jacobi, but then the Jacobi administration decided to stop paying for e-consults. I decided not to continue working for Jacobi without compensation.

At Lincoln we have been seeing the Medicaid and uninsured Jacobi patients for a year now and they make up a substantial number of the patients we see every day. Many have very complex medical problems and require infusion therapy at Lincoln. Some patients have not been seen by a rheumatologist in a year and ran out of all of their medications long ago. One of Dr. Johnson's lupus patients lost her access to rheumatology care and ran out of her medications before finally being admitted to Bellevue, where she died.

The four rheumatologists who left Jacobi, all with outstanding training and resumes, quickly found new positions at private hospitals in Manhattan where they are all treated with respect. On the other hand, for the past year Jacobi has been unable to recruit new rheumatologists to replace them. It should be obvious that any prospective recruit will contact the previous rheumatologists, ask why they left and why the division closed, and not even consider working at Jacobi once they hear the truth. How does Jacobi plan to recruit rheumatologists when it might as well post a notice saying that parents of young children need not apply? How does Jacobi plan to retain any rheumatologist who might need a job badly enough to work there when the salary is substantially lower than at other hospitals in the city? Why are physicians with world class educations not valued? We should understand that the problems are not limited to binary issues between the union and employers. The third party is New York City Health and Hospitals, which funds the employers and which hires administrators. When unreasonable and arbitrary actions by these

administrators cause catastrophic loss of patient access to specialty care, the culture needs to change.

Since my colleague and I are on the front lines of rheumatology care for working class and poor people in the Bronx, we want the City Council Committee on Hospitals, Committee on Health, and Committee on Civil Service and Labor to know the real reason for the crisis in physician recruitment and retention in the borough we serve. The names and contact information of the previous Jacobi rheumatologists are available and they will corroborate the background information I have provided if necessary. This crisis was manufactured and was entirely preventable. The end of it is not in sight.

Deborah L. Shapiro, M.D.
shapirod1@nychhc.org

My name is Debra Bergen and I live in Manhattan. I am here in support of the members of the Doctors Council, the attending physicians employed at the HHC hospitals throughout the city. I was once on the staff at the Doctors Council as a contract administrator from 1987-1991 under the leadership of Dr. Barry Liebowitz. While at the Council I represented the physicians at some of the very same hospitals now under siege and I was the lead organizer for the doctors at Coney Island Hospital. I am currently retired after over 30 years as a labor organizer, educator and negotiator.

Having represented the attending physicians, I know, first hand, the dedication to public service and the level of expertise that members of Doctors Council bring to their patients everyday. They face rising living costs, long work hours, and increasing stress and burnout due to chronic understaffing. It is therefore essential that the city hospitals recruit, retain and pay these doctors fairly.

In closing, I must state, knowing that one of the city negotiators here actually represented the members of the Doctors Council at one time, if the city truly cared about providing quality care to some of the most vulnerable New Yorkers it would start negotiating in good faith and do all it can to ensure that H&H and its affiliates invest in a fair contract for these physicians.

In its heyday when fully staffed, the Queens Cancer Center used to have two surgical oncologists, four medical oncologists, one gynecologist/oncologist, a breast surgeon, and one urologic oncologist.

Last year we had no surgical oncologists to perform any cancer surgeries at Queens Hospital, and patients were referred for surgical oncology care to Elmhurst Hospital. Many patients did not want to travel so far. It took 13 months to fill the surgical oncologist/Chief of Cancer Center position, and the new Chief will be arriving at the end of January 2025. The second surgical oncology position remains open after 15 months. Most recently, we lost the sole urologic oncologist and one medical oncologist.

The Medical oncology department always works best with 4 medical oncologists. In recent years, we have had difficulty filling that fourth position. Once a medical oncologist leaves, it is very hard to attract a new physician predominantly due to low compensation, even new graduates have not been interested in the position. At one point after Covid, we were down to two medical oncologists for 3 months. This was a dangerously low level and as a result, the Cancer Center could not accept any new patients during that time. The hematology clinic wait time lengthened, and currently has a new patient wait time of at least one year.

When we do have less than four medical oncologists, we must cover more patients in clinic, chemotherapy infusion center, inpatient, and overnight and weekend on call. This gives us less time to prepare for our own patients. In addition to our own workload, we must cover more patients, most of whom are new to us and often very complex. This compromises patient safety and care and leads to physician burnout. In the past, we had asked administration for temporary coverage during times of low staffing. Due to high locum tenens salaries which are more than 3 times that of a full-time H+H physician, the administration typically constrains the length of hours and duties that the temporary physician could perform. As a result, we have difficulty finding a locum's candidate. Even with the locum help, the full-time medical oncologists still have extra duties and responsibilities, including more weekend call, more evening call, more inpatient/outpatient work and this all adversely affects physician well-being and efficiency.

The remaining providers at the Cancer Center do not get compensated for the extra work. It is simply expected that we perform more duties, as a part of professionalism. What we really want is a colleague that will stay for the long term, in essence, to recruit and retain with respect.

This cycle of staff shortage repeats itself. How many times does one have to endure this before just quietly moving on to a different place of employment? Many leave and some stay. We are committed to the patients of the City of New York and are committed to staying and working to make H and H better.

Respectfully submitted,

Debra Ferman, M.D.
Cancer Center, Dept. of Medicine

January 10th 2025

Dear Committee on Hospitals;

The Emergency Department (ED) plays a critical role in providing acute care to patients, often under intense and challenging conditions. However, the increasing incidents of violence within the ED, coupled with an unfair contract structure, have significantly impacted both recruitment and retention of healthcare professionals.

Violence in the Emergency Department
Over the past year, there has been a noticeable rise in violent incidents at the Emergency Department of Harlem Hospital, involving both patients and visitors. In the past 10 months alone, there have been at least one staff assault each month, with 14 reported physical assaults (that I know of) resulting in injuries and significant disruption to the team. These incidents have not only posed direct risks to staff safety but have also fostered an environment of heightened stress and fear. For example, in April, I faced repeated threats and verbal abuse from a patient, leading me to implement a self-imposed personal safety plan due to the ineffectiveness of the existing monitoring and hospital procedures. This incident, and the persistent lack of adequate safety measures, ultimately led to my decision to resign, as it became clear that my well-being and ability to provide quality care were being compromised.

Contractual Challenges
In addition to safety concerns, the existing contract structure contributes to the difficulties in recruitment and retention. An unfair contract, which may involve inadequate compensation and excessive workloads, further discourages potential recruits and drives current staff to seek opportunities elsewhere. The combination of workplace violence and an inequitable contract creates a professional environment that feels unsustainable and undervalued.

Impact on Recruitment and Retention
The persistent threat of violence and subpar contract are both significant deterrents to both current and prospective staff. Healthcare professionals are less inclined to join or remain in an environment where their safety is routinely compromised. The normalization of daily verbal abuse and the prevalence of physical assaults create a hostile work environment, eroding morale and job satisfaction. This not only hinders the ability to retain experienced staff but also makes it challenging to attract new talent, exacerbating staffing shortages and affecting patient care delivery.

By addressing these critical issues, the organization can create a safer, more supportive environment that fosters both the well-being of staff and the delivery of high-quality patient care. Improving recruitment and retention is essential to sustaining a resilient and effective Emergency Department.

Sincerely,

Destiny Judkins, MPH, MD

JACOBI MEDICAL CENTER
Affiliated with the Albert Einstein College of Medicine

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January 6, 2025

Matt Siliciano
Lead Contract Organizer
Doctor's Council

Dear Sir,

I am writing to present my views on the issues surrounding the PAGNY doctor's contract negotiation. It is crucial that New York City understands the reason why the doctors are willing to strike for higher wages at this time. It is not simply that we want more money. We have been underpaid compared to both local and our national colleagues for decades. However, the situation has become dire over the past few years, with a decreased ability to recruit and retain physicians, especially recent graduates of training programs.

Our local and H+H experience illustrates the problem. At Jacobi and NCB, we lost our whole Division of Rheumatology with the major reason being low salaries. Our Oncology Division also has been decimated as several attending physicians have left for better paying jobs. The reasons are not hard to understand, especially for recent graduates of training programs, whose expenses related to educational loans, housing costs and care for young children have risen considerably over the past decades. For clinicians currently in practice, there is little incentive to accept a lower paying job. In addition, most are not comfortable or qualified to mentor trainees, who currently provide a substantial amount of the caregiving at H+H hospitals.

The experience of H+H Gastrointestinal Divisions is similar. The Divisions at Lincoln Hospital, Metropolitan Hospital and Kings County Hospital all have suffered major losses of faculty which have affected their ability to provide timely care to patients, especially in the area of cancer prevention. They have had great difficulties in attracting new hires. The toll on the remaining clinicians has been great. As a result, the remaining GI Divisions have been asked to step up and assist, but there is little room to increase our productivity. Even more ominous, the loss of key clinical faculty adversely affects the ability to maintain fellowship and even residency training programs. Many faculty members have been willing to accept lower salaries in order to play active roles in training

programs. It is very likely that faculty losses will continue and even increase in the absence of trainees, leading to increased reliance on and expense of hiring *locums* doctors, and likely to a medical staff less committed to the health of our institutions.

Time is limited to repair the damage done to our hospitals' attending staffs. However, if the problems are not addressed, the losses of attending physicians will continue and we will lose both training programs and our reputations as high-quality hospitals. It is difficult to see how our public hospital system can be maintained and even more difficult to see how the city's private hospital system will manage the health care needs of the city's poor and disadvantaged citizens.

Sincerely

Donald P. Kotler, MD

I resigned from 0.9 FTE position in Obstetrics/Gynecology (OB/GYN) at Harlem Hospital in September 2024. At the time, there was a physician shortage in the OB/GYN department, and over five hiring lines were frozen by the New York City Health + Hospitals (H+H) administration. Additionally, in the final fiscal quarter of 2024, agency nurses, which often had more experience than their new graduate counterparts, and which could identify and better manage the physical needs of the laboring patients, did not have their contracts renewed as a result of new H+H policies.

The long term staffing plan that was discussed with the OB/GYN team included decreasing coverage from two physicians to one physician for both obstetrics and gynecology services. Thus, a single OB/GYN physician would be responsible for patients in the labor and delivery unit, the postpartum unit, on the gynecology floor, OB/GYN patients in the Emergency Room, and for patient recovering from OB/GYN procedures and surgeries. Additionally, there would be a physician on back-up call—someone that can reach the hospital within 20 minutes in case of an emergency. According to the proposed plan, midlevel providers would assist the single OB/GYN physician covering the hospital.

That the OB/GYN patients at Harlem Hospital are often high-risk, where almost every patient has multiple co-morbidities that adversely affect health outcomes, is amongst the many reasons that the present state of understaffing and the proposed model are detrimental for any OB/GYN department. In true obstetric or gynecological emergencies, immediate patient care and management of complications usually takes place in the operating room, and an "all hands on deck" approach is necessary. As a result, a minimum of two physicians, are needed to manage the obstetrics and gynecology services at any given moment. Moreover, midlevel providers often have limitations in their scope of practice and they require supervision by the physician. This is especially relevant given the high acuity patients that present at Harlem Hospital. Hence, there is a greater workload for the covering physician, and it places already sick patients at an even greater risk for poor outcomes.

The current state of staffing and the long term staffing model that was proposed, cut costs in order to boost hospital profit. Directly, this has resulted in physicians that are often overworked and underpaid, while their medical licenses are placed at risk due to the likelihood of near misses and adverse patients events. In addition to their duties, H+H physicians also can be found assuming some of the work of nursing, transport services, and even that of lab technicians. This type of work environment has led to physician burnout, as demonstrated by the number of physicians that have left working at H+H or have assumed administrative positions in medicine.

I do not know if H+H is seeking higher reimbursements from insurance companies for providing care, or if it is engaging in efforts to combat large numbers of wrongly denied patient claims by insurances, much like private physicians are doing. I also do not know if H+H is aiding in efforts to address yearly increasing medical malpractice insurance rates. H+H, however, is paying lower salaries to physicians while costs of living are on the rise, decreasing physician health benefits and physician continuing medical educations (CME) time, and perpetuating pay disparity amongst physicians in the same specialties across H+H in order to maintain a base level of functionality.

After working for multiple hospitals in New York City, some of these practices are not unique to H+H. These practices, however, are unsustainable for good patient care, and they are making it increasingly difficult for decent physicians to continue working.

Testimony for City Council Hearing on Hospitals 1/10/2024

Retention and Recruitment of Primary Care Doctors at Jacobi Medical Center

Thank you for the opportunity to express myself about something I care about deeply. I am a general internist and geriatrician and have been practicing at Jacobi Medical Center for most of my career, since 1994. I love my work with patients, medical students, residents and colleagues at Jacobi. It has been rewarding and wonderful in so many aspects. I have patients that I have cared for for more than 25 years. Part of my work was also to provide home - based primary care to homebound patients. I did this for about 20 years, with 2 of my colleagues. I know the value of excellent, high quality primary care and I know what it takes to achieve this type of care. When patients do well, avoid complications of their chronic conditions, avoid unnecessary ED visits and hospitalizations, much of this is due to high quality primary care with continuity of care with the same physician and access to the provider and the health care team.

I have been proud to work at Jacobi – I think that we do amazing work for a very complex and diverse patient population. Many patients present to us with advanced disease already with complications. We do our best, with limited resources, to get the patient what they need. This can be difficult work especially in these times when so many New Yorkers are struggling with social determinants of health that impact so greatly on their ability to care for themselves and address their health needs.

I am getting towards the end of my career and I am so very concerned about the future of the primary care workforce in NYC especially in our safety net health system, here at H+H. We know it is difficult for all to arrange for the type of high-quality primary care that I am writing about, even those who have excellent coverage and ample resources. Many providers are retiring and the current group of medical students are not choosing this path. There is a shortage in many areas around the country and a crisis looms for the future.

We have had vacancies in our primary care section at Jacobi for years. We have also been trying to recruit a geriatrician for several years - -but have been unable to do so. Primary care doctors and geriatricians are in high demand. We need to have a better package to offer the few applicants that may come our way. Base salaries need to be competitive with other positions around the NYC area. With the high cost of living in this area, and most young physicians starting off with large debt from undergraduate and medical schools, we can understand why it would be a difficult choice to come to a system where salary and benefits are not on par. Even for those who would wish to work with an underserved population such as the one we serve at H+H – these facts make it a difficult choice. Additionally, knowing that resources in our system are tight and that we have staff shortages that make the work more challenging has an impact on whether physicians will choose to work with us. To not address this gap is to be penny-wise and pound foolish.

Clearly, we are at a breaking point. I hope we can come to a fair resolution – for the patients and for the community we serve.

Eleanor Weinstein, MD

Attending Physician, Jacobi Medical Center

From: Francois Merle
To: Narcisse, Mercedes; Testimony
Subject: [EXTERNAL] Follow-up hearing Jan 10, 2025
Date: Sunday, January 12, 2025 10:29:39 AM

[redacted]

Dear Councilmember Narcisse,

Thank you for having a hearing last Friday regarding the H+H crisis.

During his testimony, Mitch Katz painted a different picture than the true situation that is affecting H+H. He purposefully minimized the impact of a failed contract negotiation. He gave you politically correct answers and only focussed on the positive rather than the reasons that pushed the doctors to want to strike.

Our doctors only have one goal in mind: to recruit and retain. But H+H/PAGNY came to the negotiation table with non-starters to fund the new contract. They eliminated our PI bonus and decreased our benefits (less vacation days, less sick days, less CME days, etc...). In fact, according to the H+H Budget that you are familiar with, H+H has decreased our Affiliations budget (between 2025 and 2026) rather than increasing it.

Whereas Mitch Katz promotes the concept of a mission, the reality is that most doctors are regular people who respond to changes in the job market. The fact that H+H is having tremendous difficulty hiring and retaining its doctors is proof of his failed vision. H+H must do better than just endorsing an imaginative mission.

Since the hearing, a fifth hospital voted to authorize a strike. It is likely that more will join in. A strike can easily be prevented if the Council follows these three recommendations:

1) Reinstate our PI bonus and benefits;
2) Raise the base salary of the 67% doctors in the system who are grossly underpaid to the 80% MGMA (i.e. 25th percentile of market value);
3) Increase the base salaries of all of the doctors by a percentage that is commensurate with the inflation.

I thank you in advance for doing your best to convince Mitch Katz and Mayor Adams to increase the Affiliations budget by a sufficient amount that will help with recruitment and retention.

Yours truly,
Dr. Francois Merle

“I don’t want a higher salary - I want more colleagues.”

My name is Gray Ballinger, and I am a primary care physician at Queens Hospital Center. As a member of the primary care department, I was at the forefront of the push for strike action. I now sit on the Strike Committee for our center.

Allow me to introduce to you our patients: hardworking, intelligent, and compassionate New Yorkers who face incredible barriers to care. I am often the first doctor my patient has ever seen. A doctor did not attend their birth; they did not get childhood vaccines.

I collected the following data based on a random sequential sample of 40 weekday patients. 35% of my visits occur using a formal translator. 65% of my patients are functionally illiterate in English at an 8th grade level; 60% of my patients are functionally illiterate at an 8th grade level in their native language.

These patients cannot read their clinic discharge paperwork or prescription bottles; they cannot read that letter notifying them of a mammogram or Pap smear showing evidence of cancer. They need my time and my attention in order to learn about their conditions, their treatments, and sometimes simply how to call a pharmacy and request a refill.

The inciting factor that led to our strike action was a change in primary care visit time for new patients. The administration cut the visit from 40 minutes to 20 minutes, resulting in unanimous outcry from the clinic staff. Facing challenges of their own, our colleagues across the hospital joined us.

Our vote to authorize strike action passed with a 97% supermajority. A colleague joked that “97% of doctors probably don’t even agree you should brush your teeth.”

My patients deserve my time and attention. I cannot do justice to their needs in 20 minutes—not with their incredible socioeconomic barriers to care, and certainly not when a patient who had a stroke the day before, now has a 9 month wait to see a neurologist.

I have worked at Queens since early 2022. Since that time, I have seen increasing wait times for specialist visits. A specialist quits or retires, and we cannot fill their spot. In two particularly poignant cases, colleagues of ours who were themselves in poor health chose not to retire, knowing it was unlikely they could be replaced due to the recruitment crisis. They are mourned by their patients, colleagues and families. Their seats remain empty.

Currently, the departments with the most favorable wait times are those like Cardiology and Pulmonology, where I can expect a wait time of 3-4 months. Others, like Neurology and Rheumatology, have been so impacted by physician shortages that the time to a new appointment is 8-9 months.

To restate this plainly: at our hospital, a patient with a new diagnosis of heart failure has to wait 3 months to be seen by a heart doctor. They spend that time unable to sleep because they wake up 20 times a night, gasping in an effort to clear the fluid from their lungs. A patient with a new diagnosis of rheumatoid arthritis has to wait 9 months to see the doctor who can stop the damage to their eyes, lungs, and joints. They spend that time in excruciating pain, unable to work and support their families.

By the time these patients see the specialist they need, their condition may have progressed from treatable to permanently disabling—and some patients never make it to that specialist appointment at all.

A fair contract—one with reasonable salaries and reasonable benefits—is necessary so we can address this crisis of physician recruitment and provide the healthcare that our patients so desperately need. We aren't asking to be treated like rockstars; we're just asking for the bare minimum changes to physician pay structure and benefits that are needed to begin to reverse the care shortages at our city hospitals.

I don't want a higher salary—I want more colleagues.

Thank you for giving me the opportunity to address all those assembled.

January 9, 2025

NYC Council,

We currently have a healthcare crisis in NYC. There is a shortage of doctors in our city hospitals because these hospitals are unable to recruit and retain quality doctors. The city doctors are requesting a fair contract to address this crisis. However, our employer, PAGNY, has not bargained in good faith and has unilaterally implemented an unfair contract that does not address the recruitment and retention problem. In addition, Mayor Adams has not allocated the necessary funds needed to fund a fair contract.

Some of the consequences of this doctor shortage include a reduction in the amount of time doctors spend with patients in order to accommodate more patients. Longer wait times to see a doctor and have tests and procedures performed, and a lack of some specialists. Our patients deserve better than this.

The city hospitals are a safety net treating the most marginalized and vulnerable individuals in our communities. The city hospital doctors are committed to providing high quality and compassionate healthcare to our patients. We the doctors are prepared to strike for our patients to ensure that they receive the healthcare services that they deserve.

We are asking for Mayor Adams to do the right thing and allocate the necessary funds and for PAGNY to bargain in good faith in order to address this crisis.

Sincerely,

Ignacio Medina, MD

Attending Psychiatrist

Jacobi Medical Center, Bronx NY

Jennyfer Almanzar
City Council Testimony for Friday, January 10 2025 @ 1 PM
Committee on Hospitals (Jointly with Committee on Health and the Committee of Civil Service and Labor

Good afternoon, my name is Jennyfer Almanzar, and I am here to testify on behalf of CIR/SEIU. As someone who grew up on Medicaid in New York City and received care at public hospitals like the ones we are discussing today, I have seen firsthand how vital these institutions are to our communities. They were a lifeline for my family and for so many others who rely on them not just for healthcare, but for hope and dignity.

Today, the crisis we face is deeply personal, because it directly affects the quality of care for families like mine. Doctors are leaving the public system because of understaffing, burnout, and a lack of fair contracts that respect their critical work. The decision by H+H to slash new patient appointment times, from 40 minutes to 20, is not just short-sighted—it's dangerous. It means that doctors, already stretched thin, are being asked to do more with less, and patients suffer as a result.

As someone who has benefited from the attention and expertise of NYC's public hospital doctors, I know the importance of a thorough patient-doctor relationship. But today, many families don't get that. Shorter appointment times and critical staffing shortages mean that doctors cannot properly address their patients' needs. This disproportionately affects vulnerable populations—those who have no other options.

What we need now is for PAGNY, Mt. Sinai, and H+H to come to the table in good faith. Doctors don't want to strike—they are being forced to by an untenable system. A system that prioritizes budgets over lives and cuts corners at the expense of care. The solutions are clear: respect the work these doctors do, invest in them, and let them do their jobs without fear of burnout or neglecting their patients.

I ask this Council to remember that the people served by our public hospitals are not just patients. They are mothers, fathers, children, and neighbors. They are people like my family, who depended on the care of compassionate doctors in these very hospitals. Let's honor their work and the patients they serve by building a system that prioritizes health, fairness, and humanity.

Good Afternoon to the members of the Committee on Health, Committee on Civil Service and Labor, and Committee on Hospitals.

My name is Joaquin Morante and I am a pulmonary and critical care physician at Jacobi Medical Center and a member of Doctors Council. I completed my Internal Medicine residency at Woodhull Medical Center in 2016 and began my career as an Attending Physician at Jacobi Medical Center in 2019. As a child growing up in East Harlem my hospital was Metropolitan. I have family members and lifelong friends who currently obtain their care at Woodhull, Lincoln, North Central Bronx, and Jacobi.

I believe that one of the key characteristics of a humane society is its dedication to ensuring that all members of that society have access to quality health care. The public hospital system of New York has always cared for some of the most marginalized in our communities. On a daily basis its health professionals execute Its mission to provide care, regardless of one's ability to pay and to treat people with respect no matter their race, gender, country of origin, or immigration status.

As a witness to the care that we provide at Jacobi I can attest that since the pandemic our public hospital system has continued to be in crisis. It is in crisis because one of its most important resources, physicians, are now stretched so thin that our patients are suffering. We are in a crisis that prevents us from recruiting and retaining the necessary physicians to deal effectively with the swell of community members living with chronic disease that was only exacerbated by the pandemic. This has led to a greater demand for appointments for primary care and specialty clinics. The solution has been to cut visit times to accommodate the growing need for people to see a doctor. Unfortunately, the answer has not been to address the physician shortage by improving recruitment and retention throughout the system and improving staffing ratios. This is evidenced by the lack of a negotiated physician contract by the affiliates over the last 15 months.

As a result of insufficient physician staffing, especially in the sub-specialties, we have been forced to start to transfer the care of our patients to other facilities. As a personal example, I treat people with complicated lung disease that often requires that doctors of different specialties collaborate on the care of one patient. At Jacobi, as a consequence of the lack of competitive salaries, we have been without a rheumatology division over the last year. This has led us to have to have to send our patients to Lincoln and Metropolitan, further straining their own patient panels. This is not a proactive solution. This is a crisis management solution.

As a pulmonologist, I am often asked to perform procedures to aid in the diagnosis of various lung diseases, one of those being lung cancer. The biopsies that we obtain are then examined by Pathologists whose expertise is to discern whether a person may have a malignancy or something that is benign. Currently at Jacobi, because of the lack of pathologists, it takes approximately two weeks to have biopsy specimens examined. Our Pathologists are responsible for examining not only specimens obtained at Jacobi, but also several other H+H facilities. In order to ensure that the specimens are

examined in a timely manner, the solution has been to outsource the work to a private company. And why is it that it takes so long to be able to provide someone the diagnosis of cancer? It's because the Department of Pathology and H+H non-competitive salaries have been unable to recruit and hire adequate staff to serve the needs of the community.

But to make matters worse, the department of Oncology is also woefully understaffed. After a diagnosis of lung cancer has been made, patients may have to wait anywhere between three to six weeks before seeing an Oncologist at Jacobi. To make this concrete, a Bronx resident whom I perform a bronchoscopy on today, January 10th, 2025, and who is diagnosed with lung cancer will likely not see an oncologist who can begin a treatment plan for this disease until late February or early March. Of course, it is the physicians that often deal with this problem by overbooking and seeing more patients than can possibly be seen in one day. Working hard to provide patients with the space to ask questions and come to terms with a life-changing diagnosis, all while simultaneously facing the pressures of having to ensure that the patients in the waiting room get equal time to do the same.

This inequity is a direct result of the lack of Recruitment and Retention of physicians to address this massive need. Instead of providing a proactive plan we have decided to address this crisis with short term crisis management solutions. Paying high hourly wage private contractor doctors to fill in the gaps instead.

Full-time salaried and per-diem physicians, a group of physicians that make up twenty percent of Doctors Council membership, see themselves as part of the solution to helping our communities get healthier. We are not the problem. I am compelled to speak out when I see a system that is letting down those that it is supposed to care for. It is up to all of us to make sure that we do not accept less than the very best for our patients. And they should be able to have access to a physician who has enough bandwidth to treat them with the dignity and respect that they deserve.

Therefore, I am asking that we come together to focus on recruitment and retention of physicians at H+H facilities by increasing salaries so that they are competitive with local hospitals and not allowing for the erosion of benefits as proposed by the current affiliate contract. Our communities very much need the services that our public hospital system provides, and our public hospital system very much needs physicians to provide those services. We are in this together. Thank you for your time.

I am an Primary Care Physician at Jacobi Medical center and a member of Doctor's council and I am providing written testimony in support of a fair contract (now a Tentative agreement as of 1230 AM this morning). I am also providing written testimony regarding the reduction of the "NEW PATIENT VISIT TIME" changing the original time from 40 minutes down to 20 min.

Regarding our contract and our tentative agreement. We call our campaign, "RECRUIT, RETAIN and RESPECT". From a financial perspective I, personally, have nothing to complain about. I am getting a salary that is competitive for my specialty. There are few holes to plug in my department because it is a competitive salary and the benefits are fair-- albeit they have been reduced from our baseline in this round of bargaining (not RESPECTFUL!). But there are other doctors who are grossly under market salary rates and other departments where there are large vacancies, putting doctors at risk for burnout and demoralization and putting patients at risk for safe patient care. We also have a heterogeneous group of doctors who commit their time to jacobi-- for example some are "per diems", doctors who come in not so regularly but we need them due to their specialized fields, ie a retinal specialist. We plug holes with doctors working sessional hours to both make ends meet and to plug holes for the services for which they work. While, we were able to negotiate competitive salaries for some there are many others who do not make a competitive wage. That may be the fallout from any negotiation but really what we did not achieve in our Tentative agreement is, what to me, is the most important tenet of our campaign and often not quantifiable. This is the element of "RESPECT".

The reason we are not being respected, is because there is no sense of parity across the system with doctors in one specialty at one hospital with a salary differences by as much as 100 K less for doctors doing the same work at one location to another. The creates division across our system and competition where we should be working together for one goal, in the interest of our patients. An initiative by HHC was recently adopted to exploit this-- if we have one specialty at one hospital with a lot of doctors and we are lacking in that specialty for another hospital, one solution is to say to our patients to go to that respective hospital where the service is thriving and exists. In theory, this is a nice idea, but what this means is patients having to travel from one borough to another for their care. This is not easy for many of our patients. If they require transportation services, they cannot use the transportation unless there is a special approval (special form) for them to travel outside the borough. If they require public transportation, then some are simply not comfortable, and they definitely do not have the money to spend on a car service both ways. Some of my patients have never used the subway, or even travelled to another borough. I spent 15 minutes of a 20-minute visit explaining to one of my patients (via translator) how to get to Bellevue for a sleep specialty appointment (a service we do not have at Jacobi) for someone who likely has undiagnosed sleep apnea. She never went to that appointment (wasting a slot) . About a year later, she still has not seen a sleep specialist or gotten a definitive sleep study. How does this tie back to respect? This cycle and downstream effect of ineffective care coordination is time consuming and demoralizing. I do not feel respected, my time is not respected, nor are my fruitless efforts.

Regarding the decrease in the NEW VISIT time to 20 minutes from 40 minutes. In my 12 years of being an Attending in Primary care at Jacobi I have seen the panel size of a morning or a afternoon session balloon from 6-7 patients to now 10. We always had one 40 minute slot devoted to a NEW patient. This change has indirectly ballooned our sessions to include another

20 min revist-- this is a double whammy-- not only is the NEW visit time shorter, but there is an additional REVISIT patient added to the panel. My most recent panel had 11 patients starting at 840AM and the last patient was scheduled for 1200. I finished with my patients at 115pm -- my lunch hour is supposed to run from 1230-130. At 130 I have another engagement to precept residents for the afternoon session. This gives me 15 min to scarf down my lunch. These are 15 minutes that I am being bombarded by EPIC Chats, and because this is not protected time, I theoretically could have been scheduled to cover as a preceptor over the lunch hour of 1230 to 130, and would not have arrived on time, potentially creating an undue burden on a colleagues.

The aforementioned panel had 4 of 11 pts requiring an interpreter. One of the four patients refused to use an interpreter-- which is even more challenging than with an interpreter! One of the patients was autistic and their mother was deaf-- so the challenge becomes communicating to the patient's mother with a sign language interpreter and then she in turn communicates to the patient. How are we supposed to do this in 20 minutes? This particular patient requires a level of coordinated care that will require me to write an email to a specialist at a different facility and find out what they need for their end. I will need to bring them back to my office, when it becomes clear if there is any additional needs. How are we supposed to do this in 20 minutes? If I run behind, or if a patient is late, I am 100% certain to work thru my lunch hour-- which I do 99% of the time. The only time I get a lunch break is if a patient doesn't show up or if a patient cancels-- and usually I still work thru my lunch hour.

What is being asked of us and our patients is a "Drive thru" approach to medicine. If that is what patient care is turning into, then we need the throughput infrastructure to make that happen. The question is, do we want Drive Thru medicine? If we do, then we need meaningful support . So far, that has not happened and knowing how slow resources at HHC materialize that could take over a year.

Dear Honorable members of the City Council,

Workers in education and healthcare keep this city running and sacrificed heavily during the COVID19 pandemic. Now is the time to finally sign a fair contract with city safety net hospital doctors and stop busting their union. Every New Yorker benefits from having a stable, valued attending physician workforce. H+H needs to stop cutting time patients have with their doctors, and instead employ enough frontline doctors and other healthcare workers to rise to the growing demand and be better prepared for the next predictable surge in demand.

Thank you,

Katherine Connors

Friday, January 10, 2025

To the Members of the New York City Council,

I am a public health nurse and born and bred New Yorker, writing in support the public doctors at four NYC hospitals and the SEIU Doctors Council who are demanding higher wages and better benefits.

It is hard to overstate the vital importance of this workforce to our city's immediate safety and quality of life. Let's pay them the wages they deserve, and make sure their benefits are up to par. There is a bigger picture here even than fair pay for labor. Increasing funding to city hospitals is one way we can begin to address the racial segregation in our healthcare system.

This is New York City. Our public hospitals must be materially supportive of their workers, or we will run these doctors ragged and burn them out, until they throw up their hands and move to the suburbs or go take a job on a yacht and only come back to visit in the summer. We don't want that.

Protect New Yorkers, keep our doctors able to keep us healthy. I support the SEIU Doctors Council and their authorization to strike. Their demands must be addressed, their wages raised, and their benefits improved.

These doctors need a single, fair contract across the city. The best path forward is to eliminate sub contractors, so-called "affiliates" NYU, Mount Sinai, and PagNY, due not only to their history of unfair labor practices, which NY tax payers should not support, but due to the lack of value they add to the public hospital system.

Thank you for your time.

Regards from Brooklyn,
Kim Kaiser, LPN

Statement in Support of my Former Colleagues at Elmhurst Hospital

I trained at Mount Sinai Hospital as a Pulmonary and Critical Care fellow from 2013-2016, and spent a quarter of my 2 years of clinical training at Elmhurst Hospital, which is THE major teaching hospital for Mount Sinai. After working in an underserved area in Maine to satisfy a visa requirement, I returned to Elmhurst as Assistant Professor in September 2020 and soon became Associate Program Director for the Pulmonary and Critical Care Fellowship Program there. I love Elmhurst's patients, staff and trainees - they are a unique combination even by NYC standards. All three come from all over the world, and the patients often have barely had medical care before they come to Elmhurst. It is remarkable how well this impossible, Babylonian place works despite the challenges that start with a notoriously crowded ED and don't end with finding the right interpreter for a specific Fukienese dialect.

However, this is not some self-sustaining miracle. It only works because a lot of people care enough to overcome the barriers and the bureaucracy, and these people need to be recognized and valued. We were never in it for the money, or none of us would have ever chosen Elmhurst. But we are not fools or saints either, and we owe it to our families to not let our employers take advantage of us.

That is why I left Elmhurst in July 2024 with a heavy heart - I did not have the admirable patience of my colleagues, who are still negotiating in good faith with an entity that has neglected them for years. One should question why a private hospital (that is paying some of its celebrity cardiologists over 10 times of what their colleagues at Elmhurst earn) should be in charge of a safety net hospital. There is a role for public-private partnerships in healthcare, but this requires close oversight of public funds and accountability on both sides. The City Council should embrace the efforts by my former colleagues and treat them as allies in a quest to save public healthcare in NYC from being hollowed out by corporate “non-profits”.

Klaus T. Meinhof, MD
Former Associate Program Director
Pulmonary and Critical Care Fellowship Program
Mount Sinai/NYC H&H Elmhurst

To The Honorable NYC Councilmembers,

My name is Lana Irons and I am a Doctor and Psychiatrist who is employed by Physician Affiliate Group of New York and works at Health + Hospitals. I am also a member of the Doctors Council Union. I underwent my residency training at Kings County Hospital and decided to stay on as an attending physician. In these two positions I have worked a total of 5 ½ years in the public hospital system here in NYC. Throughout my career working with some of the most vulnerable New Yorkers, I have repeatedly been faced with the chronic levels of short staffing, burned out physicians, and high levels of patientcare burden that our public hospital system has historically accepted as a normal part of doing business. Many of my colleagues continue working for Health + Hospitals because we are passionate about providing good quality healthcare regardless of a patient's economic, immigration, or diagnoses status. Altruism alone, however, cannot itself fix the problems of recruitment and retention of physicians or ensuring ready access to healthcare for the patients we serve. The solutions so far proposed by PAGNY and Health + Hospitals to put more and more patients into physicians' schedules is unsustainable regarding patient safety and deleterious to the well-being of the physicians who themselves suffer from Burnout and moral injury from our current system. In central Brooklyn, where I currently work, many community hospitals over the years have closed, continuing to place an even greater burden at the H + H facilities located here. With this decreased access comes the responsibility of the city to step up to ensure the continuation of healthcare access in this community. Please, I urge you to support the Doctors Council and the physicians at Health + Hospitals, by urging PAGNY and H + H to continue their negotiations with our union to come up with an agreement that will provide the pay and benefits that we need to fully staff the NYC public hospital system so that we can continue to provide safe and good quality care for New Yorkers now and in the future.

Thank you for your time,

Lana Irons MD

Dear Members of the New York City Council,

My name is Leyla Doss, and I submit this testimony as the spouse of an NYC public hospital worker and as a deeply concerned citizen of New York City. I write in unwavering support of the physicians who have authorized strikes at four NYC public hospitals due to stalled wages, benefits, and unsafe working conditions.

Our public hospitals are in crisis. I've witnessed this crisis unfold through my husband's experiences at Kings County Hospital Center, one of New York City's vital safety net hospitals. During the COVID-19 pandemic, he and his colleagues faced what can only be described as a war zone. But even before the pandemic, the situation was dire. My husband would often be the only doctor for an entire ER section, working grueling 12-hour shifts without a moment to eat, drink, or even use the bathroom. This isn't just exhausting – it's dangerous for both healthcare workers and patients.

Imagine being a patient in excruciating pain, waiting 16 hours or more in an emergency room because there simply aren't enough doctors or nurses to see you. Picture hallways overflowing with sick and injured people, rooms packed beyond capacity. This isn't a dystopian fiction – it's the reality in our public hospitals right now. And when patients, justifiably frustrated, lash out at healthcare workers, it's because the system has failed them both.

The pandemic laid bare the consequences of this chronic understaffing and underfunding. Nearly 50,000 New Yorkers lost their lives while our healthcare workers fought on the frontlines without adequate protection. They were told to microwave their masks to disinfect them because there weren't enough to go around. This is the shameful reality of how we treat those who save our lives.

We're told there isn't enough funding, but that's an unacceptable excuse. While the NYPD receives a staggering $109.4 billion from the city budget, healthcare gets a mere $53.8 billion. How can we justify this disparity when our hospitals are in crisis? Meanwhile, H+H executives receive exorbitant salaries – the CEO pockets over $875,787 annually – while frontline workers struggle to make ends meet in one of the most expensive cities in the world.

The consequences of this mismanagement are stark. According to the New York State Comptroller's report, our hospitals are hemorrhaging staff. Woodhull Hospital lost 24.1% of its nurses. Harlem Hospital saw a 22% decrease. Lincoln Hospital faced a 14.5% reduction. Each percentage point represents not just a lost healthcare worker, but potentially lives at risk in our most vulnerable communities.

This isn't just about fair pay for doctors and nurses – though they certainly deserve it. This is about the very survival of our public healthcare system. It's about ensuring that every New Yorker, regardless of their income or zip code, has access to quality healthcare. It's about serving the underserved, protecting our Black, Brown, and immigrant communities who rely on these hospitals as their primary source of care.

Striking isn't a decision our doctors have made lightly. They've reached this point because the situation is beyond dire. They're fighting not just for themselves, but for every patient who walks through those hospital doors.

New York City prides itself on being a leader, a trendsetter, a city that others look to for inspiration. So I ask you: if we can lead the nation in finance, in culture, in innovation, why can't we lead in healthcare? Why can't we be the city that says, "Everyone deserves top-quality medical care, and we're going to make it happen"?

I urge this council to take immediate action. Support our doctors' demands for fair contracts and safe working conditions. Reallocate our budget to prioritize healthcare. Implement stringent oversight to ensure every dollar spent on healthcare is used efficiently. Work with H+H to develop a comprehensive, long-term strategy for retaining and recruiting healthcare workers.

The health of our city – of our friends, families, and neighbors – depends on the health of our public hospital system. Let's make New York City a shining example of what public healthcare can and should be. We have the resources. We have the talent. All we need now is the will to act.

Thank you for your time and consideration. The lives of countless New Yorkers depend on your decision.

Respectfully submitted,

Leyla Doss
Concerned Citizen and Healthcare Advocate

My name is Liza Romero, and I stand with the physicians of Doctors Council SEIU as they fight for fair contracts, better staffing, and respect for their vital role in New York City's public healthcare system.

NYC Health + Hospitals is at a critical crossroads. Doctors at Jacobi, North Central Bronx, Queens Hospital, and South Brooklyn Health are voting to strike because after more than a year of stalled negotiations, this impasse reflects a deeper crisis in our public health system—chronic understaffing, substandard pay, and the erosion of patient care standards.

Recruitment, Retention, and Staffing Shortages

New York City's public hospitals face a dire shortage of doctors, with a massive population relying on their care. Emergency departments are plagued by "revolving door" staffing, with locum doctors filling critical gaps at significantly higher costs than permanent staff. Entire departments, like rheumatology, have disappeared due to the inability to retain skilled physicians. These challenges jeopardize patient outcomes and put immense strain on existing staff.

Pay offers from PAGNY and Mount Sinai are below market rates, fail to keep pace with inflation, and even propose reductions in time off and health benefits—moves that further discourage recruitment and retention. If this trend continues, it's unlikely the system could handle another public health crisis like COVID-19.

The Cost of Compromised Care

The recent reduction of new patient visit times from 40 minutes to 20 minutes is a stark example of misplaced priorities. Many patients, especially immigrants, require translators, additional care for undiagnosed conditions, and more time to navigate complex health issues. Slashing appointment times undermines comprehensive care and leads to worse long-term outcomes, such as preventable strokes or hospitalizations, which ultimately cost the system more.

A Call to Action

This is a turning point for NYC's public health system. The Adams administration must decide whether to invest in a sustainable future or allow the system to deteriorate further. We urge NYC H+H and its affiliates to:

1. **Invest in recruitment and retention** to address chronic staffing shortages.
2. **Reinstate adequate patient appointment times** to ensure the quality of care patients deserve.
3. **Prioritize frontline physicians in decision-making processes** to align policies with the realities of patient care.

Healthcare is a human right, and New York's public hospitals are a lifeline for millions. To remain viable, they must invest in their most essential resource—the doctors who dedicate their lives to serving our communities. To achieve the mission of providing high-quality, equitable

healthcare to all New Yorkers, we must first invest in the doctors who dedicate their lives to this cause. Let us stand together to build a public healthcare system that values patients and providers alike.

Thank you.

Dear Council Members,

I am writing to you to regarding the potential upcoming physician strike at several NYC H+H facilities. As an OB/Gyn physician at Jacobi/North Central Bronx I have felt first-hand the effect that an inadequate contract has had largely due to our inability to recruit and retain adequate staff. This has resulted in an unsustainable and unsafe increase in workload for our physicians. We often have months long waits for gyn patients which has resulted in several instances of delayed care and patient requiring multiple ED visits and admissions for blood transfusions. In order to try and care for these patients we are often double or triple booked during clinic days. This requires us to either spend approximately ten minutes with each patient or to stay many hours beyond the end of the clinic day. Being centrally located within the Bronx our hospitals service communities which already have some of the poorest health outcomes in the city, including maternal and infant mortality. Rates of diabetes, hypertension, obesity, asthma are higher making many of our Obstetric patients incredibly high risk. Due to inability to recruit/retain both generalist and maternal-fetal medicine specialists our patients are often unable to get what is widely considered by ACOG to be the standard of care. Patients have to go longer between appointments and cannot access the antenatal testing (ultrasounds, etc.) that they need. It often feels like we are just barely hanging on each day as we struggle to find ways to care for our patients, often covering multiple services as the same time. We are simply asking PAGNY to provide a fair contract which will allow us to retain the staff we have and to be able to be competitive in our recruitment of new staff. Without this, I am certain that health outcomes will continue to suffer despite our best efforts.

Sincerely,
Dr. Margaret Seybolt, MD FACOG

Testimony before the Committee on Hospitals, jointly with the Committee on Health and the Committee on Civil Service and Labor

To the Committees:

I am out of town or I would have attended the hearing and testified in person. I testify as a Professor of Public Health at SUNY Old Westbury, where I teach healthcare policy and ethics and the social determinants of health, and as a longtime activist in the struggle for healthcare access for all in the United States.

In a healthcare system devoted not to patient care but corporate profit, all but wealthy shareholders lose. Healthcare needs to be a right, not a privilege; all in the United States, whatever their status, need to be able to access the best of care, period.

Our H&H hospitals, which provide a safety net for many who have nowhere else to turn for care, have been underfunded for many years, and the staff of these institutions have been heroic in their efforts to care for too many patients with too few resources. We clapped for them at the outbreak of Covid; numerous H&H providers lost their lives in that battle.

But we seem to have a short memory; that was less than five years ago. H&H doctors do not want to strike; they are simply, and rightly, asking for the bare minimum they need to provide good care to their patients. Period. Let’s stand with them and demand adequate resources for all of our patients.

Martha Livingston, Ph.D.
Professor, Public Health
SUNY Old Westbury
January 10, 2025

Written Testimony of
Nicole DeNuccio, MSN, CNM, LM
Midwife at NYC Health + Hospitals / Woodhull
Before the NYC Council Committee on Hospitals
Jointly with the Committee on Health and Committee on Civil Service and Labor
Hearing T2025-2912 on Health and Hospitals Doctors Council Work Stoppage
January 10, 2025

Honorable NYC Council Committee Chairs Narcisse, Shulman and De La Rosa, thank you for calling this hearing, and listening to our testimonies today.

My name is Nicole DeNuccio. I am a midwife at NYC Health + Hospitals / Woodhull. I am here to testify that the failure of H+H and its subcontractor employers to offer fair and competitive contracts to its physicians, is not only a labor issue, but also a patient safety issue, and an issue of systemic racism and medical apartheid.

At Woodhull Hospital we continue to grapple with an increasing and devastating series of perinatal deaths in our care in recent years, all of which can be linked in part to issues of chronic understaffing and overburdening of staff, as well as physician staffing shortages from the crisis of recruitment and retention, a dire situation that clinicians in our OB/GYN Service have sounded the alarms about to our Hospital Administration over a period of years, each time with no actionable response until it was too late for the human lives lost.

The crisis has been deepened by a corporate-style takeover of our current OB/GYN Leadership in 2023, using an autocratic and punitive leadership style that has seeks to weed out staff who are not loyal to them by making it a hostile environment for them to work, blaming and punishing individual clinicians and scapegoating midwifery care for adverse outcomes that are truly rooted in underfunding and other systemic issues, and thus failing to address the real root causes of preventable death and iatrogenic harm to the people we are supposed to serve. This has caused an increasing number of physicians to resign from our service, further deepening the crisis.

I will speak very briefly to the most egregious and unforgivable harm caused by this crisis, the preventable deaths in recent years of three Black mothers, one of them Afro-Latina, as well as the intrapartum deaths of a Black baby and a Latino baby. However, the numbers of people that have suffered preventable iatrogenic morbidity due to delayed care, missed details and medical errors as a result of this crisis are far more numerous and also warrant further attention and investigation.

At Woodhull Hospital during the COVID-19 pandemic, my OB/GYN physician colleagues took it upon themselves to take more call shifts beyond their contract obligations, because they

recognized the level of acuity of the OB/GYN inpatient units required more physician coverage to assure patient safety.

Simultaneously, Woodhull's Anesthesiology Department allowed a dangerous Anesthesiologist to remain in practice, despite multiple reported safety concerns raised by clinicians in the OB/GYN Service, amidst a crisis of recruitment and retention due to severely noncompetitive Anesthesiology pay. In 2020 Black mother Sha-Asia Semple was killed by a fatal error by this Anesthesiologist, characteristic of his unsafe practice. He went on to lose his license because he was deemed unsafe to practice. Since that time the Anesthesia Department at Woodhull has been overhauled, and Anesthesiologist pay increased to competitive levels in order to staff the Service safely, but this action came too late for the life of Ms. Semple.

As chronic burnout in the OB/GYN Service deepened, physicians' ability to sustain taking additional call shifts diminished, and some physicians resigned, in March 2023 Woodhull OB/GYN physicians issued a collective plea for help to the Woodhull Hospital, H+H, and NYU Langone Affiliate Administrations, flagging the dire level of OB/GYN physician shortages and levels of chronic burnout in the Service. In their letter, they demanded active physician recruitment, competitive pay to make recruitment efforts viable, and the temporary hiring of locum tenens physicians to fill coverage gaps and prevent more physicians from leaving or reaching dangerous levels of burnout. These demands were not acted upon by the Administration.

Physicians were also forced to work shifts that they did not feel were safe for them to work, because it was outside of their skill set, beyond their capacity, or they felt unable to use sick time, as insufficient options for sick coverage meant placing additional burden on their already burnt out colleagues. An OB physician in his 70s who faced health complications, requested not to be scheduled on the night shift, because he did not feel it was safe for him to practice at night. Though this accommodation was initially honored, as coverage gaps became increasingly dire in 2023, he was again routinely scheduled to work night shifts at least twice monthly, initially only for 12 hour shifts, but starting in July 2023 also for 24 hour shifts.

In September 2023, issues with unsafe staffing ratios and unit cultural norms formed in the setting of chronic understaffing and burnout, contributed to the substandard monitoring and care that a Black mother in labor received leading up to the death of her baby that day. In October 2023, a Latina mother lost her baby and uterus in labor to a uterine rupture. An OB physician worked sick with a packed surgical schedule that day and handed off the floor that night to the same physician who did not feel it was safe for him to work at night. Delays in this mother's necessary cesarean birth resulted in the death of her baby and loss of her uterus. The following morning this physician again expressed his dismay that his safety concern was not honored. Two weeks later, he remained scheduled for a night shift, and that night he made a fatal surgical error and post-operative management decisions that resulted in the death of Black mother Christine Fields.

Some of the demands in the physicians March 2023 letter have now been implemented by the Hospital and OB/GYN Administration, but again, far too late, and only in response to these catastrophic losses of life.

In 2024, again, the OB/GYN Administration's prioritization of their bottom line, over the lives of Black people came with deadly consequences, when a locum tenens physician that had been reported for concerns about her clinical incompetence, lack of ethics and professionalism, and history of not upholding her duties as the OB Attending on call, remained on the OB schedule months later to use up the remaining funds in her contract. In September 2024, this physician's mismanagement of Afro-Latina mother Bevorlin Garcia Barrios' care led to substandard monitoring and delays in her necessary cesarean birth, during which she died later that day.

OB/GYN physician shortages at Woodhull have continued to deepen, with physicians resigning en masse, and in late November 2024, the OB/GYN Department staff was informed that there was insufficient physician coverage to maintain our level of care, with more than 20 physician call shifts left uncovered in the month of December. Rather than suddenly turning away patients that had planned to give birth at Woodhull, our already chronically overworked physicians continued to extend themselves beyond their limits to cover these shifts. Amidst this physician recruitment and retention crisis, the Department has had to resort to relying more extensively on locum tenens agencies for necessary staffing, which represents wasted administrative costs paid to these predatory agencies in an order far greater than would have been required if they had heeded physician's warning and plea for help in 2023. Relying extensively on locum tenens physicians is not safe for the staffing makeup of Woodhull's Labor and Birthing Unit. With only one OB physician staffed on the Unit at a time, these locum tenens physicians don't have the institutional knowledge to keep patients safe in acute and emergent situations, nor are they invested in our Hospital and serving our community.

As H+H serves predominantly Black and Brown communities, the crux of the issues highlighted here is the systemic devaluation of Black and Brown people's lives, through funding decisions made at the City level. Though I have spoken specifically to physician overworking and noncompetitive contracts, as it is the focus of this hearing, I would be remiss not to mention that the themes highlighted here extend to other professions in the H+H system, including H+H midwives and nurses, who face the same undervaluing of their labor rooted in racism, but also an undervaluing of their labor rooted in patriarchy, as nursing and midwifery are majority women workforces, and midwifery care is centered on women and womb bearing people.

The most recent example of this at H+H is the case of the Jacobi Midwives, who have been without a contract for more than a year and remain significantly underpaid compared to not only their private, but even their other H+H counterparts. Woodhull Midwives on the H+H staffing lines also receive significantly less pay than those on the NYU Langone Affiliate staffing lines. H+H midwives are all significantly underpaid compared to their H+H nurse practitioner counterparts, though they have the same level of education and training, and midwives are often

more frequently managing acute and emergent clinical situations, not to mention when providing perinatal care, that they are caring for two human lives at each clinical encounter.

Midwives do not have the bargaining power in numbers and are not unionized to the extent that our physician or nurse counterparts are, but H+H must nevertheless ensure fair compensation for midwives and expand access to midwives and full-scope midwifery care at all H+H Hospitals. Research shows that when midwifery care plays a central and integrated role in perinatal care, outcomes are improved by numerous measures, patient satisfaction increases, costs decrease, and health disparities and issues with clinician workforce shortages may be alleviated.[1] The Black maternal mortality and morbidity crisis in our city will not be addressed without the correction of these disparities in funding and the elimination of barriers to full midwifery care utilization and integration.

Our City finds the funds to increasingly expand and militarize our police force, that disproportionately imprisons, brutalizes and kills Black people, as well as surveils, brutalizes and arrests concerned citizens, including healthcare workers, who unite in peaceful protest against this and other forms of systemic racism, such as the US-backed genocide in Palestine. Yet it doesn't allocate sufficient funds to adequately compensate healthcare providers and fund the services necessary to maintain healthcare safety and quality in the institutions that serve Black and Brown communities. The consequences of this misallocation of funds, combined with H+H mismanagement, are grave.

The case study of Woodhull's OB/GYN Service is a warning to you in this moment. I stand with the H+H physicians whose strike notice is an appropriate measure given severity of the physician recruitment and retention crisis and what is at stake—that is, the lives and wellbeing of the predominantly Black, Brown, immigrant and working class people served by H+H, as well as the healthcare workers that care for them. I urge you to do everything in your power to address these funding deficiencies. Thank you for your time, attention, public service, and commitment to act.

[1] Niles, P.M. & Zephyrin, L.C. (2023, May 5). *How expanding the role of midwives in U.S. health care could help address the maternal health crisis*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

Dear City Council,

My name is Noah Berland, MD, I've given testimony in the past with regards caring for undomiciled individuals. Though on first blush it might appear that I'm testifying selfishly on behalf of myself and my colleagues for better pay, petter benefits, and better working conditions, at the end of the day I truly believe that without advocating for our pay, I will be doing my patients a disservice. Whether for good reasons or not, there are far too few physicians in this world, and some specialties are even more critically lacking an adequate number of physicians. Everyone who work's at a NYC H+H hospital is working there out of a passion and dedication to care for the most vulnerable of New Yorkers. However, this dedication only goes so far when our salaries are far from keeping up with the both inflation and the increasing market rate. The physicians at NYC H+H including myself, treated the patients most critically impacted by COVID-19 and we never got hazard pay, or even raises to keep up with inflation. We will continue to lose more and more physicians to the private and for all intents and purposes for profit hospitals. And what does this mean for our patients? Longer waits for the simplest of things, from seeing a primary care physician (cutting time for appointments will only further hurt patients), longer waits for getting necessary cancer care, and even longer waits to see a physician in the emergency department because it is the only place to turn when you can't get an appointment. I already see too many patients in the emergency department who are not able to get adequate screening or care who show up because there is no other way to see a physician. I can only imagine when there are fewer physicians in the emergency department and fewer physicians in our clinics and on the floor of our hospitals will hurt more and more patients and force more and more physicians to leave the NYC H+H system for work that does not cause so much harm to ourselves. In all of our asks, we are not even asking to make parity, but we are asking for our pay to be 80% of the market rate, and to not lose our benefits, and for a few other small things. It is intolerable to imagine that PAGNY and NYC H+H have completely ignored us. If you want NYC to continue to have the best public safety net hospital system in the country, then please ensure adequate funding for the physicians that are the corner stone of that system. However, if what you want is for our amazing public system to collapse and be replaced by charity care by the likes of the privates, than don't do anything.

Thank you.

Cheers
Noah Berland, MD, MS
Kings County Hospital
Associate Director Division of Medical Toxicology
Department of Emergency Medicine

NYC HEALTH+ HOSPITALS | Jacobi

EINSTEIN
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RE: New York City Council Written Testimony 1/10/2025, Committee on Hospitals

As one of two Pediatric Hospitalists at NYC Health+Hospitals/Jacobi I am charged with caring for children who are admitted to our Pediatrics inpatient service in the Bronx. I am the supervising physician working closely with Pediatrics residents in training and I evaluate and examine patients alongside them and help to directly deliver clinical care. I am on clinical service one week at a time and am in person in the hospital for 8-10 hours a day depending on patient acuity, and I am on telephone call from home 14-16h a day from home to triage phone calls and review patient charts from home and continue to help direct management while at home. Me and my other colleague are on in person and telephone call 24h/day x 7d a week, one week at a time. We are only compensated financially for 8 hours of in person time per day regardless of how much time we spend in the hospital and are not compensated at all for being on telephone call and fielding/triaging patient issues and coming back into the hospital for emergencies.

There are times where I will work 70 in person hospital hours/week and only be paid for 40 hours. I will work 98-112 hours of at home on call telephone call where I review charts, document, and direct patient management in coordination with the pediatrics residents and I am not compensated for any of that time. The summary for my total compensation per week is that I typically work 70 in person clinical hours per week, 98 at home on call hours, and am only compensated for 40 in person clinical hours per week.

The Pediatrics Inpatient Service at NYC Health+Hospitals/Jacobi is a 24 bed pediatrics inpatient unit and the only certified pediatric trauma center in the Bronx. Our pediatrics inpatient service is the largest pediatrics inpatient service in the NYC Health + Hospitals system, and yet it is only staffed by 2 full time Supervising Pediatrics Hospitalist Physicians. The average full-time supervising Pediatrics Hospitalist Physicians on inpatient services of a similar size is 6-8 physicians nationally, and here I am one of two. It has been well documented that understaffing results in poor patient outcomes, medical errors, and contributes significantly to physician burnout which results in an inability to retain physicians and can also result in deleterious effects on physician mental health and heightens the risk of physician suicides nationally.

I am striking for my patients because I am working under unsafe working conditions with poor staffing which could compromise my own ability to care for the sick children of the Bronx. I am working within an unsustainable system of constantly feeling like I am at work 24h/day for 7 full days one week at a time, and compromising my own mental health and well-being in exchange for my dedication to patient care. I care deeply for my patients, and I hope for a fairer contract to effectively recruit and retain physicians dedicated to the care of our patient population. The Bronx children I care for are in the borough of New York City with the highest proportion of children living below the federal poverty level, and these disadvantaged children deserve to be cared for by competent, dedicated, and well supported physicians working within a sustainable system dedicated to positive patient clinical outcomes.

From: Preeti Kishore
To: Testimony
Subject: [EXTERNAL] Testimony for Health and Hospitals City Council Hearing
Date: Sunday, January 12, 2025 8:47:28 AM

[redacted]

Respected Council Members,

The physicians at H+H work in chronically understaffed and under-resourced conditions. I am chief of endocrinology at H+H/Jacobi-NCB. It took over 1.5 years to hire an endocrinologists at NCB due to the low salary offered about $40,000 below market rate. What that meant was there was no one to take care of patients with diabetes, thyroid, pituitary, bone and adrenal disease at this hospital for almost 2 years. The sole endocrinologist at Jacobi, was expected to absorb all these additional patients with no additional assistance. Currently at NCB, the wait time to be seen by the only endocrinologist is over 4 months even for emergencies such as severe hyperthyroidism and patients who were admitted to the hospital with diabetes emergencies such as Diabetic ketoacidosis. At Jacobi, the wait time to be seen in weight management clinic is 5-6 months. We have to pick and chose which patients with diabetes can be seen by us. If we wish to refer a patient who we are concerned about loss of vision or losing a foot due to diabetes complications they have to wait to see a doctor for 6-12 months because we do not have enough ophthalmologists or vascular surgeons. We do not have the ability to see patients admitted with diabetes emergency such as diabetic ketoacidosis in the hospital because we do not have the staff to do it. The limited staff we do have our busy taking care of patients in the clinic. We do not get paid for overtime work eg, I routinely work 10-12 hours every week over the scheduled 32 hours and have done so for the last 7 years but am not entitled to sessional pay. It is unfair to expect anyone to work without wages. This does not happen in any other profession. We the doctors are routinely taken advantage of because we believe in the oath we have taken to serve the community and simply cannot say “my time to care for you, the patient is up and you must wait for your issues to be addressed until I come back tomorrow for my scheduled shift”. Therefore, we continue to do unpaid work. PAGNY has unilaterally decided to cut our benefits, which we depend on. Our work needs to be valued by PAGNY and H+H and we are asking to be treated fairly so that we can recruit and retain physicians who are willing to work in difficult circumstances to take care of the most vulnerable amongst us. We need the budget allocation for H+H increased and not decreased as the numbers of patients we care for each year goes up and exponentially.

Respectfully submitted,
Preeti Kishore, MD
Chief of Endocrinology
Professor of Medicine

From: Quratulain Z. Syedain
To: Testimony
Subject: [EXTERNAL] Testimony for over-sight hearing of hospital committee for 01/10/2025
Date: Thursday, January 9, 2025 6:14:47 PM

[redacted]

I am a Primary Care Physician at New York City Health + Hospitals/Elmhurst. Writing to convey deep sense of frustration ,dismay and disapppintment at H+H leadership's unilateral , unconsulted and authoritarian decision to cut New patients time slot from 40 to 20 minutes. Resulting in decline in quality of health care and longer waiting time for patients in clinic

Our patient population is unique in the sense that it comprises > 90 % of immigrants with language barrier to communication often requiring interpretor service which takes triple time Vast majority of them are uninsured with complex medical problem coming to see Primary care Physician first time in their Adult life . They need more time and not less.

Qurat-Ul-Ain Syedain, MD

Outlook

I have been a NYC H+H doctor since nearly 30 years. The last thing I want to d

From Sameer Misra [redacted]
Date Fri 1/10/2025 9:53 AM
To Sameer Misra [redacted]

1 attachment (26 KB)
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I have been a NYC H+H doctor since nearly 30 years. The last thing I want to do is go on a strike. I want to go to work, taking care of my large panel of patients, some of whom will not see anyone else if I am not there, almost all of whom have myriads of complex problems, multiple medications, several needs and a lot of whom have no other place to go to.

So why has it come to this that we have announced a strike. I shall put down the reasons

1. We need support to take care of our patients. I am a primary care physician. Due to the inadequate staffing at H +H hospitals , the waiting times for my patients for things like specialist appointments, mammograms and colonoscopies has stretched to several months now.

2. The inadequate staffing is due to H+ H not able to recruit and retain physicians . This is in turn because they do not pay even close to market value when it comes to hiring.

3. We, our union Doctors Council , have been trying to negotiate over such things for the last two years. Our voices are truly falling on deaf ears of H+H and their affiliates. Hence we have been pushed to this job action.

4. Recently it came to light that post Covid H+H hospitals have a huge backlog of patients, waiting for appointments to get into the system. Normally a system would hire more doctors and try to clear this backlog. Not for H+H- they came up with the ingenious idea that we shall halve the time spent with new patients from 40 to 20 minutes. This without asking for or taking our opinion at all. This went into effect September 16, 2024. Numerous supports were promised at that time, like additional nurses, nurse practitioners and physician assistants- at my hospital , we have seen none to date. I have seen many new patients after this went into effect. Not even the simplest of such patients has taken less than 40 minutes.

5. As I have written earlier- we need better support and help from H+H to take care of often the most vulnerable of patients under difficult situations. Physician burnout is at an all time high. The future of H+H hospitals depends on all stakeholders being listened to, not in people sitting in offices making arbitrary decisions.

Thank You.

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Shailly Prasad
OBGYN Generalist Attending Physician
Elmhurst Hospital Center

Testimony for NYC Council

·What does the crisis of recruitment and retention look like in your facility/department?

In recent years we have had several attendings leave to higher paying jobs in the area which have resulted in a several open salary lines (Drs. Bohn (generalist), Carroll-Bennett (generalist), Tsatsas (Gyn Onc), Ghafar (UroGyn), several MFM doctors, Ditchik, Gerber/Goldman (Family Planning), and several others) which only a few have been backfilled. We have a chronically understaffed department which results in our staff double covering clinical assignments and insufficient supervision of residents. For example, Attendings are often assigned in clinic or the labor floor while also covering GYN consults, which on other services maybe not be a big deal as many consults are not emergencies, however we often have consults that are emergent and require surgical intervention (ruptured ectopics, ovarian torsions) and then it is a problem for that attending to cover both the surgery and their clinical assignment. Furthermore, in the clinics where we have residents, per ACGME guidelines the supervising attending should solely be focused on supervising the resident see patients, but usually because of an overwhelming number of patients with inadequate number of providers, attendings are also seeing patients with resident and do not have the ability to always adequately supervise residents. Ideally, we would have some attendings see only patients with an extra attending to fully supervise all residents in clinic.

Although we are actively recruiting, in the last 3 years that I've been here, we have only been able to hire 2 attendings who intimately understand and enjoy working with underserved populations, while likely ~8 or 9 candidates who we have given offers to have declined and selected higher paying jobs in the area. Our base salary is approximately 42% lower than the average obgyn salary in the NYC area. Speaking personally, while I enjoy working with the patients at Elmhurst and my colleagues, this is not a long-term sustainable option for me and my family financially, and likely in next few years without a pay raise, I will likely leave to look for a job with better compensation.

·How has the crisis of recruitment and retention impacted you and your patients?

As mentioned above, because of the shortage of attendings, clinical coverage is strained, resulting in longer wait times and delays in patient care. If we were able to recruit and retain more attendings, we would be able to spend more time with patients and teaching our residents better care for patients. Residents would have improved supervision, which would result in more thorough care for patients. Right now, the wait time for new gynecology patient is more than 3-4 months. With more staffing, we could see more patients, reducing appointment wait times.

The doctors that stay at Elmhurst innately have compassion for the underserved so they work very hard to provide the best care that they can for their patients. Over time however, the chronic understaffing leads to burnout, and despite that compassion, doctors leave to better paying and less stressful jobs. This will leave Elmhurst without high quality doctors for with the patients and the community of Queens will suffer.

NYC HEALTH+ HOSPITALS | Jacobi

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1400 Pelham Parkway South
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Tel. (718) 918-4318 Fax (718) 918-4317

9/4/2024

To: Robert Faillace MD, FACP, Chairman of Medicine, NYCH+H/Jacobi-NCB
Michael Zinaman MD, Chief Medical Officer, NYCH+H/Jacobi-NCB
Christopher Mastromano, Chief Executive Officer, NYHCH+H/Jacobi-NCB
Hospital Administration, North Central Bronx Hospital

Subject: Critical Physician Shortage in Oncology and Hematology, Patient Safety Concerns, and Degree of Coverage possible in the immediate future

Dear Mr. Mastromano,

We are writing to inform you that our division will not be able to provide physician coverage of any kind at North Central Bronx beyond 9/30/24, including remote or e-consults. At that time, critical staffing level shortages will impact our ability to maintain safe and effective care at both North Central Bronx and Jacobi.

As you are aware, about one year ago we had 7 attending physicians (representing a 6.4 FTE status). As of October 2024, we will be down to just a 3.2 clinical FTE level. In addition to providing hematology/oncology services at both institutions, servicing inpatient, outpatient and emergency services, we also achieved and maintained:

- American College of Surgeons (ACOS) Cancer Center accreditation
- Breast Cancer Center of Excellence designation
- ACGME accredited Hematology and Oncology Fellowship

Achieving all three of these accomplishments has been unique in the HHC system and has been a visible demonstration of success for our institution. This has allowed us to provide a remarkable level of care in these disciplines for the patients that we serve. All of these are now in severe jeopardy with our markedly diminished staffing levels.

One must recognize that our Division serves two disciplines in the Department of Medicine, and we are now reduced to just 1.3 FTE in Hematology and 1.9 FTE in Oncology. Given the current pressures in oncology and hematology in the US, we have been unable to recruit even one additional attending physician in over one year of maximal efforts. Most notably, there was recently the opportunity to retain a superb attending physician at our institution, who requested parity with the typical salary structure of our area, but this was declined. We have now lost three attending physicians in less than one year, with no replacement, and no sign of replacement, reducing us to a critical staffing level.

NYC HEALTH+ HOSPITALS | Jacobi

Division of Hematology / Oncology
1400 Pelham Parkway South
Building 1 - 6 South
Bronx, New York 10461
Tel. (718) 918-4318 Fax (718) 918-4317

To continue to deliver the highest standard of care, the current circumstances dictate that we focus our energy and resources on Jacobi. It is not feasible to continue coverage at North Central Bronx. This was a unanimous decision within our group.

Respectfully,

Tarek Elrafei DO
Hematology-Oncology Division Chief, NYCH+H/Jacobi-NCB
Associate Professor of Medicine, Albert Einstein College of Medicine

Richard Gralla MD FACP FRCP Edin
Professor of Medicine, Albert Einstein College of Medicine
Attending Physician, NYCHHC/Jacobi-NCB

Lewis Steinberg MD MS
Fellowship Director Hematology-Oncology
Assistant Professor of Medicine, Albert Einstein College of Medicine
Attending Physician, NYCHHC/Jacobi-NCB

Lewis Steinberg MD

Julia Mandelblat MD
Assistant Professor of Medicine, Albert Einstein College of Medicine
Attending Physician, NYCHHC/Jacobi-NCB

Dear Councilmembers,

Maternal mortality is a sensitive topic for any physician who has witnessed it or tried their best to prevent it. It is a gut-wrenching encounter that no family member should have to experience.

Nevertheless, pregnancy is a major medical event in a woman's life, and we take it for granted. Their bodies go through dramatic physiological changes that most people do not comprehend. Not uncommonly, a pregnancy can place a women's life at risk. According to the CDC, there were **241 maternal deaths from 2018-2022 in New York State** during pregnancy or within 42 days after pregnancy.

Disappointingly, this statistic disproportionately affects Black women and women of low socioeconomic status. Therefore, the patients of New York's public hospital system (Health & Hospitals - H&H) contribute the most to this abhorrent statistic.

Two major contributors to maternal mortality include health system failures and social determinants of health. It is a failure of H&H that Ob-Gyn departments are not safely staffed with experienced and trained physicians, midwives, nurses.

I share with you the current circumstances at Harlem Hospital. Harlem Hospital has undergone a mass exodus of providers. The Chair and Associate Chair of the department have resigned. There is **only** 1 Maternal Fetal Medicine (MFM) subspecialist for the entire department. Furthermore, there is no full-time surgical subspecialist working at Harlem Hospital.

The H&H system has succumbed to maternal mortality events in the past 4 years. **Do not be surprised if the next maternal mortality event occurs at Harlem Hospital**. Sadly, the situation at Harlem is similarly shared at other H&H Ob/Gyn departments.

H&H supposedly prides itself on racial equity. H&H is not supporting the Black and Hispanic women of Harlem. With our patient population, the inadequate staffing at Harlem Hospital is **hypocrisy of the highest order**.

We ask you to directly question H&H Leadership and their objectionable management of staffing, recruitment, and retention of experienced physicians across the H&H system. **Consequently, what is H&H doing to prevent maternal mortality events system-wide? Not enough**.

Respectfully,

Dr. Vijay Palvia

Ob/Gyn

I support doctors and believe in their right to stand up for themselves and by extension, their patients. I believe that a more resilient and fully staffed city hospital system benefits all New Yorkers. Providing doctors with fair pay and generous health benefits is the absolute very least we can do.

I was born and raised in Jamaica, NY and graduated from Jamaica High School. I am a product of this city. Queens Hospital is the center of care for many of my family members and community. This was my inspiration to become a physician and work at this facility. I made my dream come true through many hurdles and completing my residency training during the COVID pandemic. During that time, I saw a need for primary care physicians and more-so a need in my community. I was overjoyed when I was offered a job as a primary care attending at Queens Hospital, the same hospital I visited sick family members, only seeing this as a dream as a teenager. When I started working as an attending, I loved my job and embraced every day I walked through those doors. Making a difference and seeing that difference in the faces of my patients during each follow up has been the most rewarding aspect. When I am in that exam room one on one with my patient, I am elated knowing I will make a difference in their lives before we both walk out that door at the end of the visit. I take pride in my job. Ultimately, medical school did not prepare me for the harshness of the healthcare system and how brutal it is, not only to its patients but its doctors as well. From high demand patients with needs outside of their medical care and my involvement outside of that exam room. I felt overwhelmed at times yet pushed through each day. Some days were long and tiring. Losing sleep thinking about the work I had done, the work I had left to do. With every passing day, I started noticing colleagues leaving because they could not sustain the stress and their expenses could not be sustained on the salary here. I saw my workload increasing and myself becoming more overworked and burnt out. Then, Health and Hospitals imploded a cut to our new patient time and I crumbled. Imagine, seeing 4 new patients back to back undocumented with high risk diseases, many needs, 3 of those 4 patients needing translation services and only having 20 minutes with each, yet each visit lasting at least 40 minutes. And still having 4 other new patients and 14 revisits totaling 22 patients for the day for a 9-5 shift. My "lunch break" is non-existent and has been since I started. I am lucky some days to have time to run to the bathroom to empty my bladder between patients. Some days I made my 1.5 hour commute home in a daze due to hunger and exhaustion. And yet, I have to go home to my most important duty, a mom of 2, a 5-year-old son and 8-year-old daughter with homework assignments, reading time, organizing book bags/papers, getting dinner ready. Then going to sleep to do it all over again the next day. All for an underpaid job that has overworked me. 8 years of education and 3 grueling years of residency didn't prepare me for this. Alas, life goes on, mortgages have to be paid, school loans are still present and inflation is rising. When I was a teenager, I thought I would work to live but now, I feel as though I am living to work. Since this cut in new patient times, I feel like a robot. My rapport with patients has been cut because I have to see more patients and spend little time with them. More patients mean more labs to look over, more calls to make, more paperwork to fill out. I no longer find gratification in the difference I make only that I was able to get through the day and get my work done. We have lost the true value of this industry because hospital revenue has become the priority rather than the impact we make on lives. I am not the physician I was in the beginning and this is just the start of my career. I have joined many colleagues in searching for better paying jobs with better schedules. I do not want to leave this place but Health and Hospitals is forcing my hand

here. We are suffering. We need relief now. We need a fair contract NOW! We need more physicians. We need more time with our patients not more patients at a time.

I work as a hospitalist in the department of medicine at an HHC facility, and as part of my duties I also have a leadership position in our residency program to help train new physicians.

Last year, our hospitalist program had openings for attending physicians. During this time I often took extra shifts to provide team coverage, but this extra work became very tiring and draining. Furthermore, to fill the open positions our medicine department attempted to recruit three of our graduating residents, and while these newly-trained physicians showed interest in the positions, they all took other jobs and stated that financial considerations impacted their decisions. At that time, our graduating residents were accepting hospitalist jobs that paid $300,000 per year with $50,000 signing bonuses (along with further incentives to add to their base salaries) compared to the $193,000 per year base salary offered at our hospital. In short, we can not offer salaries adequate enough to recruit *our very own residents that we have worked so hard to develop*.

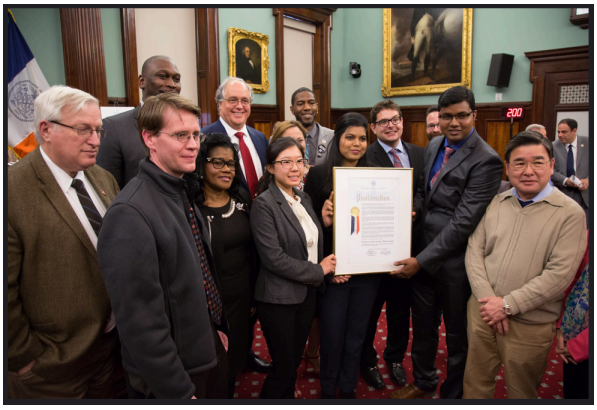
So, why do physicians choose to work at HHC? In my case, I am fortunate to work at HHC to fulfill a scholarship commitment through the CityDoctors scholarship program. (Interestingly, this program was recognized by a CIty Council proclamation in 2017, below.) I very much enjoy taking care of New Yorkers in a city hospital and love training new physicians. However, I still owe $200,000 in student loans. When my scholarship obligation ends in ten months, I may need to seek a higher paying position elsewhere to pay back my loans, even though I prefer to continue my work in HHC. I am not trying to get rich, I simply wish to get out of debt and build my life. If I leave, I anticipate it will be difficult to fill the open position, especially since the disparity from HHC base salaries and those offered at other hospitals has continued to grow.

A work stoppage, as proposed by the Doctor's Council, would provide an unfortunate shock to the HHC system, but the slow strain caused by physicians leaving, the overworked conditions for the physicians that remain, along with challenges of hiring replacements likely represents an even worse and more profound threat to the care of New Yorkers, especially those who rely on the safety-net system provided by HHC.

I strongly encourage the NY City Council to support the HHC system and its doctors to strengthen the current system and help prevent worsening work conditions.

“More Than $1.5 Million in “CityDoctors” Scholarships Awarded to Students Committed to Practicing Primary Care at NYC Health + Hospitals”
https://www.nychealthandhospitals.org/report-to-the-board-of-directors-apr-2017/

City Council Proclamation recognizing the CityDoctors scholarship program, April, 2017



https://www.flickr.com/photos/sguedu/38574406375/in/photostream/

I am just a member of the public supporting a more resilient safety net hospital system that values it's full-time doctors and upset at Eric Adams defunding frontline clinicians and inflicting false austerity on the most marginalized NYers.

I want H+H to stop cutting the time that patients have with their doctors and stop paying union-busting law firms instead of hiring enough frontline clinicians.

I am a hospitalist at Elmhurst in Queens. As a hospitalist, I deal with patients in the inpatient/hospital setting. I started practicing since 2020 during the peak of the covid pandemic which Elmhurst was the epicenter. I have watched my colleagues work long hours, every day desperately trying to save as many lives as we could. We hardly took any breaks with low resources but the community needed us and we did not hesitate to help. Many people quit during the pandemic or retired early. I hoped as the amount of covid cases started to drop, we would finally get a break because we were so burnt out, we did not.

The volume of patients did not decrease and those who stayed were overwhelmed by the volume. This is severe with the specialties which include endocrinology, rheumatology, infectious disease, psychiatry, hematology and oncology. Because of an uncompetitive salary among the subspecialties, many have left leaving unfilled vacancies. I had one colleague who loved working at Elmhurst leave because he was working overtime almost every day. He had a newborn at home and left because he had to help support his family. The sub-specialties work in the hospital and clinic, splitting their time between the two. The lack of staff is so severe that some departments are left with one physician and when that physician takes a much-needed break/vacation, we don't have that service available.

This impacts my work and my patient's care directly. At times consults are delayed because they are so overwhelmed by the volume of patients they see in the clinic. Because the clinic is overwhelmed, patients are waiting months to see their provider. Those with severe chronic illnesses can't wait that long and end up in the hospital. Something simple that could have been managed outside the hospital ends up in the ER because the patient is in severe pain or in acute crises impacting their daily function. A clinic visit is a couple hundreds of dollars compared to thousands of dollars for a hospital admission. It is frustrating to watch this because we end up paying more for healthcare with poor outcomes. Surgeries, biopsies, cancer screenings are also delayed due to inadequate staff. It breaks my heart to diagnose a patient with stage 4 metastatic cancer just because they were not able to get screenings or care in time. Instead of consulting oncology, now I have to consult palliative care. Who is also understaffed.

Recruit, retain, respect is what we want. We need to recruit more physicians to fill the vacancies, we need to retain the hardworking and dedicated staff that we already have and we want respect by good faith bargaining and a fair contract. I urge the city council to work with us, to help us achieve this. This is a public health crisis that will have ripple effects among all social services and care.

I am a primary care attending at Jacobi Medical Center for over 31 years. My patients and I feel the impact of the recruitment and retention crisis every day. Jacobi lost their entire department of Rheumatology and the patients have been the ones to suffer from this. I have had patients on infusion therapies fall through the cracks despite the best effort of our per diem coverage by physicians and our clerical staff and present with flares in their disease process which could've been avoided. Inpatients can only get a video visit from a rheumatologist at another site. There is no rheumatologist on site to do a physical exam or directly treat these patients.

Our current wait time now for a colonoscopy is > year! It is very difficult to tell a new patient who happens to be 45 and requesting a screening colonoscopy that they will have to wait until they are 46 or older to get their screening tests. On our established patients, we often request the study a year in advance to keep them on the appropriate screening schedule and I have convinced patients to do FIT testing in the interim so if that is positive I can try to uptriage their colonoscopy. We have been told by administration to try and convince more patients to do home FIT testing or Cologuard to bring down the wait time instead of addressing the real issue that we do not have sufficient staffing to continue the gold standard for colon cancer screening.

I often feel like I am the gate keeper for my patients, trying to make sure they are able to see subspecialists in a timely fashion when needed, but often wait times for subspecialty clinics can be about 6 months. You end up spending endless time on the phone, or sending chats, in order to reach a doctor in the other services to help out, and many times, there is simply no availability because there is not enough doctors to care for the patients.

Finally, we now have 20 minutes, instead of 40 minutes to see new patients to the clinic. PAGNY and H & H have lost sight of that vision. It has become increasingly apparent that the bottom line is financial and not always what is best for our patients. The complexity of our patient population both with regards to their medical co-morbidities and to their social and economic circumstances has increased dramatically, as our resources have dwindled. Decreasing the visit time for new patients who may not speak English and have all these issues that have not been addressed to 20 minutes is doing a disservice to the doctor and the patient. What we need to allow better access for primary care is more doctors that want to stay in the system, not less time to address this vulnerable community.

As a public school teacher who's mission is to support the general public, I stand fully behind our doctors at public hospitals. I support doctors standing up for themselves. They should be allowed to better advocate for needs addressing their profession and protect their patients. Their time per patient allowance has been slashed due to monied interests, not the interest of their patients who would benefit fromt a more resilient and fully staffed city hospital system.
We used to bang pots and pans each evening in support of our frontline workers. We must renew this support.

I write to support the doctors who work at the Health and Hospitals Corporation of the City of New York in their struggle to properly serve the people of the City and to be accorded the respect which they are due.

Their treatment at the hands of their employers, putatively us, the people of the City of New York, has been so egregious that it is difficult to know where to begin, but I will start with why these doctors are important to me.

First, I write as a citizen of the City of New York, one who has, along with many others, received excellent and thoughtful care from these doctors. That those who take care of us in our neediest moments should themselves be mistreated is appalling.

Second, I write as one who lives in a part of the City where the Health and Hospitals Corporation provides most of the medical services to the residents. My neighbors and I need those who take care of us to be in excellent condition, not overworked. Further, we need their knowledge and training to be respected.

Third, I write as a retiree of the City, one who worked many years for low pay, because I wanted to participate in strengthening the people of the City and the City itself, much as these doctors have participated in the life of the City, especially in its difficult moments, as during the worst of Covid-19 pandemic.

Fourth, I write as a worker. I have only recently learned that the doctors employed by Health and Hospitals do not even work for the City, but are subcontracted, their wages and working conditions determined by private hospital corporations such as Mt. Sinai. Not only do they have neither job security nor benefits, but they are notably underpaid for their level of knowledge and by comparison with other doctors, some of whom officially work for these same hospital corporations. Further, they are forced to provide services under conditions which would seem to be designed to make them fail. To employ one doctor where four are needed, or to have one, and only one specialist on call 24 hours a day seven days a week, presumably with no relief in sight is obscene. No one should be working under these conditions and the people of the City of New

York should not have doctors who are subjected to these work conditions. This is impermissible.

How can we expect these doctors to take care of us when we treat them with such deplorable disdain? Or, perhaps, this is what the Health and Hospitals Corporation and the City of New York are trying to say: That those who take care of us do not matter precisely because we citizens do not matter.

Whether or not that is the intent of the Health and Hospitals Corporation, I write in support of those who chose helping others as their life's work, who have been scandalously, mistreated, and who should be receiving not only raises, proper scheduling, and proper support, but awards for their dedication. We must treat them like the heroes they are.

I am an OBGYN provider at North Central Bronx. We are having a crisis of recruitment and retention in our department. We have been working hard to be able to recruit a new vice chair as well as other attendings to ensure that we have adequate coverage to take care of our high risk population of patients, both in OB and GYN. Due to our inability to adequately recruit, those of us in the department are stretched thin ensuring adequate coverage. Our providers do the best to double book our high risk OB patients to ensure that they get adequate care, but this is not a sustainable system. Our patients deserve better as they are some of the most high risk in New York at an extremely vulnerable time in their lives – a pregnancy.

I wore my Blue Patagonia, the free one that says Elmhurst Hospital that we got during Covid, to the Trader Joes in Commack, Long Island post call. I wear it proudly now. Many people recognize it. To me it means doing work I love near the neighborhood I grew up in. It reminds me of the outpouring of support, support that I did not knew I'd need, until memories of simultaneous intubations and facetime calls to families and sadness, that I have not processed 3 years later even though I invited the resilience psychologist to give us grand rounds, get intermixed with the one time in 2020 that I went for a Spring walk in Jackson Heights at 7pm and people opened up their apartment windows and applauded. I didn't know they were doing that.

The Trader Joes employee checking my groceries out eyes me with glee. Oh my god, he says, you work at Elmhurst? Thank you so much for all you did during Covid.

Thank YOU for all YOU do I reply sheepishly with a strong sense of imposter syndrome.

But this is what I was also so embarrassed to say.

That I worked trauma call overnight and am really tired. Overnight trauma call means resuscitating sick trauma patients at any hour overnight while teaching and supervising Mount Sinai residents. It means staggering emergency cases with non-emergency cases even though data shows I shouldn't. And no one thinks of it's impact because we don't have enough staff during the day and try to fit these cases in at night.

It means that it took me 7 years of working 24 hour shifts for free on the weekends and on Holidays to know that it violated my official job description. That a mysterious contract between the city and Mount Sinai and my payslip said one thing but that my Director was allowed to do another because there is little oversight.

It means that there is a Faculty Practice collection that we kind of have a share in and is part of our salary but we aren't sure how it works or why there is so much skimming off the top and why we are shown charts of how well our hospital is doing but this practice payment has been going down for 16 years.

It means that yes, I am well paid compared to the rest of America and I often feel guilty about that but shouldn't I and all my HHC physician colleagues also be fairly paid not too too far from that of our colleagues at Mount Sinai in the private sector because we too went to great schools and work hard.

It also means that I feel committed to serving people like me, immigrant kids like I was. But even with my status change, I still feel disenfranchised. It is nebulous about who my Employer is. Is it Mount Sinai Hospital? Is it the NYC/Health and Hospitals Corporation?

Should I be entitled to a pension and retirement health benefits as a city worker? Or am I entitled to opportunities (and monies and time) for academic advancement like my former co-residents at my affiliate hospital, Mount Sinai.

Are we a community hospital or a tertiary care center? Am I doing what is right for those patients who might get better care elsewhere because we have inconsistent resources here?

It also means that I am part of a cadre of sophisticated, smart and caring physicians who are committed to working in safety net hospitals. But I think they too are having an identity crisis embedded in burnour. And many are meeting every week for about 16 months to spearhead a campaign to get the respect and transparency and just simply a fair contract that we all deserve. But there is just stonewalling or we can't help you or we don't understand the problem or your job has no production pressure and you get a lunch hour which is weird. We have no one to trust.

So I want to say, we might as well take off the Covid swag because sometimes it feels like a one off. Because whoever it is who should be giving us this fair contract apparently has a short memory and no money.

I am a Pediatric Rehabilitation Medicine specialist, a physician who treats children with disabilities like spina bífida, cerebral palsy, complex genetic syndromes, premature infants and pediatric concussions. I work in an outpatient clinic at the Child Developmental Center at Morrisania/Gotham in the Bronx.

Like the whole H+H system we are having issues with recruitment and retention of providers. Our Clinic has been without a Developmental Pediatrician for over 18 months and recently lost its Speech Pathologist.

This crisis is much more acute in the public sector than in the private one due to low wages and decreasing benefits. This creates a great disparity, if not downright institutionalized segregation, in the care of the most vulnerable of New Yorkers.

Patients are faced with long waiting times for appointments (I am the only pediatric physiatrist in the system to my knowledge) and having to travel to other facilities most times located in distant boroughs to see a specialty physicians.

This crisis is also compounded by an increase in patients seeking care in the public healthcare sector. H+H management because of their inability to hire more physicians decreases the time of initial primary care visits over burdening physicians who remain in the system even more.

This is not equal and equitable healthcare the city is providing for the most vulnerable newyorkers.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/10/2025

(PLEASE PRINT)

Name: Nicole DeNuccio, CNM

Address: [redacted] Brooklyn, NY 11233

I represent: Myself, midwife at NYC H+H/Woodhull

Address: 760 Broadway, Brooklyn, NY 11206

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: NOZOMI IKUTA

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Elizabeth K. Jenny Antal

Address: [redacted] NYNY

I represent: Myself MD a Doctor at

Address: 1400 Pelham Pkwy Jacobi Bronx NY 5

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr Mitchell Katz

Address: President and Chief Executive Officer

I represent: NYC Health + Hospitals

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DEBORAH SHAPIRO MD

Address: _____

I represent: LINCOLN HOSPITAL

Address: BRONX

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rich Sinett

Address: Kings County H.C.

I represent: [redacted]

Address: [redacted]

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr Maxine Orris

Address: [redacted]

I represent: Self.

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Sonia Lawrence, RN

Address: 131 W 35rd St NY NY 10001

I represent: NY State Nurses Assn (NYSNA)

Address: same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rooma Roy

Address:

I represent:

Address:

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: EARL KNIGHT

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ADEDAYO ADEDEJI

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: _____

Address: _____

I represent: _____

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/10/2025

(PLEASE PRINT)

Name: SINDHU VANGETI

Address: [redacted] ELMHURST NY. 11373

I represent: DOCTOR'S COUNCIL

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Roberta Tikser

Address: [redacted] 191 st St

I represent: myself

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Marylouise Patterson, MD

Address: 8

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Adam Hill

Address: [redacted] Brooklyn, NY 11222

I represent: Self

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: _____

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Frances Quee

Address: 50 Broadway, #1101 NY

I represent: Doctors Council SEIU

Address: Same address

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ~~Sandy Cohen~~

Address: _____

I represent: ~~The most vulnerable in my District~~

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: _____

Address: _____

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Arthur Schwartz.

Address: _____

I represent: Community Coalition to Save Beth Israel

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________________

(PLEASE PRINT)

Name: LORI LEMBERG

Address: 80 REED AVE.

I represent: Pilgrim / Diaper's Circle

Address: Jacobi 1400 Pelham Pkwy S

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________________

(PLEASE PRINT)

Name: [illegible]

Address: [redacted]

I represent: ________________

Address: ________________

Please complete this card and return to the Sergeant-at-Arms