Thank you for inviting me here this morning.

My name is Mark Levy.

I think I am the one on this panel who has the most traditional union experience.

I am happy to talk from that perspective.

I serve as the Executive Director of the Committee of Interns and Residents – known as "CIR." It is a national union of interns and residents. CIR does chapter-based, collective bargaining for 12,000 private- and public-sector interns and residents. There are about 3,000 additional interns and residents who are members of other unions. Some of those others are in independent local unions; a few are in discrete AFL-CIO resident-only units; and several groups are included in broad, multi-title professional or public-sector units.

That would mean that about 15,000 out of ~100,000 interns and residents are currently covered by collective bargaining contracts.

(Just in case there is any one not familiar with these terms, let me give a few definitions. "Interns and residents" have finished medical school and have completed their M.D. or D.O. degrees. They are addressed as "doctor." They are in apprenticeship-like training for specialty and sub-specialty

certification. I use the term “attending” to describe those licensed doctors who practice outside of residency in a range of clinical (mainly in hospital-connected) situations. For the most part, attending physicians are board-eligible or board-certified in a specialty.)

CIR is a national affiliate of Service Employees International Union (SEIU, AFL-CIO). SEIU the largest healthcare union in the U.S.

We work closely with Doctors Council, our sister doctors local in SEIU. Doctors Council represents post-residency salaried-attendings.

CIR and Doctors Council were both originally founded back in the late 1950’s. We have been around for quite a while. Each of us has been growing the past number of years. Both of us regularly receive calls from frustrated and upset doctors who want to join a union.

I have been at CIR for over 20 years and have seen many healthcare changes dramatically and adversely impact on both residents and attendings.

Let me start by saying that world is full of “doomsayers.”

Every time I have been involved in an organizing campaign, I have heard the employers say: “Oh my, if the doctors unionize, it will shut this hospital.”

When the NLRB said a few years ago that residents had rights as “employees,” hospitals opposed that decision and said that it would end medicine as we knew it.

When residents and medical students went to OSHA and Congress last year to seek legislation for rational work hour limits, we said that regularly working 80, 100, 120 hours was “bad medicine.” The doomsayers again predicted catastrophe if hours limits with governmental enforcement would become law.

None of those predictions came to be.

I know of nowhere that doctor collective bargaining – either by residents or attendings – closed a hospital.

Residency programs did not collapse when residents achieved collective bargaining rights under the NLRB.

State hours regulations in New York State did not lead to any of the predicted catastrophes.

But the doomsayers who opposed the changes we sought, in fact, went right ahead and instituted all sorts of their own kinds of changes.

Managed care and other industry changes have led to dramatic “speed up” -- to borrow a term from industry.

There are more admissions and discharges for each doctor to handle as the length of stay in hospitals decreases. There is dramatically more paperwork to fill out as insurance forms and regulations proliferate. Acuity is greater and treatment is more complicated as the growing number of uninsured delay their

coming for care. Work is more intense for doctors every second a patient is in a hospital these days -- as new technology and new treatment options expand.

Salaried-attendings work under productivity schemes that force them to cut corners. They shorten their time with each patient. Surveys of our members also indicate that attendings are spending less time with residents. Residents are made to work on their own much more.

As nurses, transporters, translators and other staff are laid-off (or otherwise in short supply like RN's), someone has to do their work. It gets passed down to the already harassed and overworked interns and residents.

Compassion and creativity are often squeezed -- and seldom rewarded -- in the current system.

Let me use some data I found from a large teaching hospital in New York. The numbers are three years old, but they still paint a vivid picture:

The CEO proudly said in 2000: "... we have driven our outpatient activity from 875,000 visits in 1993 to 1.7 million in 2000. [*That's an increase of 100% or a doubling of outpatient visits*] Our hospital admissions have gone from just under 40,000 in 1990 to more than 50,000 in 2000. [*That's an increase of 25%]* This enormous growth in inpatient activity was made possible by a concomitant reduction in our inpatient length of stay ... During

this period when overall clinical activity increased ... , the work force declined by 4.5%."

This is the trend in hospitals these days. Fewer people are now having to do much more work.

On top of this industrial-like "speed-up," many hospitals are also lessening employee benefits and introducing all other sorts of cost cutting schemes.

In a factory you would expect workers on a sped-up assembly line to react under similar conditions. They would be objecting to the wear and tear on their bodies, dangerous conditions, and to the degradation of their product.

CIR and Doctors Council are unions of highly-skilled, professional employees. We negotiate on wages, benefits, due process, and all the other traditional issues generally concerning U.S. workers. We also advocate around quality concerns related to patient care, staffing, and professional development issues.

The union provides a structured format for dialog and problem solving.

The professional union setting is something I know and am comfortable with. I used to be a teacher on both secondary and college levels. I know – both as a member then and a staff person for a doctors' union now -- that professionalism and union membership are synergistic.

It never ceases to shock me how the attacks on doctors' rights to be a union member, to have representation, and to

collectively bargain – wherever he or she is in the healthcare system – never end:

If you work as an *intern or resident*, employers want to classify you as a "*student*" and deny you union membership and the right of collective bargaining.

If you later work as a *salaried-attending*, employers want to classify you as a "*supervisor*" or "*manager*" and deny you union membership and the right of collective bargaining.

If you work *fee-for-service* (or in some other form of group practice), you are classified as an "*independent contractor*" and denied union membership and the right of collective bargaining.

If doctors want to change the conditions they work under, they are told to go join their medical or professional society.

But in those organizations, doctor-workers and doctor-CEO's are lumped together. Those organizations are thus prevented from doing for collective bargaining.

All these legal fictions produce crazy result.

Somebody out there in the real world is doing doctor work, taking care of sick people. To avoid collective bargaining with doctors – our legal system labels most "docs" as "student," "manager," "supervisor," or "independent contractor."

It makes you want to ask: Will the "real doctor" please stand up!

On a related issue, to use another term from industry, not only is the "uneven playing field" dramatically tilted to favor

employers and insurance companies, one side isn't even allowed to form a team – if all those definitions are applied.

In your invitation to me you asked me to comment on the idea of "non-employee" physicians having the right to join unions.

Let me extend a historical metaphor often used in talking about doctors:

Doctors no longer provide care within the old constructs of some ancient or imagined cottage industry that once was medicine. Like the craft workers after the middle ages, doctors have been gathered together in buildings they don't own. They use expensive tools and equipment they don't' own. They work in conditions they have less and less control over and no longer set the prices for their products (or services). Times and conditions have changed. Crafts became industries. Guilds became unions. The old "non-employees" are really now "*new* employees."

In the real world of the 21st century, hospital systems, insurance companies, group purchasing companies, pharmaceutical corporations, academic medical centers, government programs, and all the rest so dominate the working conditions of doctors, that it is both unfair and unreasonable to not allow hard-working doctors to move toward a better balanced playing field through collective bargaining.

From trying to get a pension or a parking space, doctors without unions have to fight the system alone

You ask about the effects of unionization on the cost, quality, and availability of health care to consumers? The short answer is: Doctors care about their patients in hands-on kinds of ways. Insurance companies care about their bottom-lines in corporate kinds of ways.

The decision to open or close a specialty clinic or to recruit a certain patient population is driven by a hospital's or insurance company's marketing strategy – not on the patient care needs of a community.

I know two things from sitting at the table with employers:

a) That intern and resident -- and salaried–attending -- pay and benefits are relatively small factors in the overall budget of the institution which also includes big items like advertising, capital construction, debt interest, administration, and executive compensation;

b) Whatever is eventually settled on is a product of discussion and compromise ... and must be mutually agreed upon by both sides.

Finally, you asked if collective negotiations focus on enhanced quality, or on just on compensation, or on both?

The answer from my experience -- quite simply and accurately -- is both ... and each is a struggle.

Employers want to give less pay and fewer benefits. Employees want better pay and improved benefits. Nothing is new or unusual here.

When we try to negotiate about the quality of care, administration screams “management rights” and wants to avoid such discussions. But then we push beyond that first reaction and try to find real solutions to real problems.

I have a long list of examples of patient care issues we have fought for over the years – many of which we’ve won:

e.g., funding for safety-net hospitals, access to care for indigent and uninsured patients, more nurse and other support staff, better access to patient information, and better equipment – even including allocating part of negotiated pay raises to the purchase of patient care equipment.

The longest, bitterest, and most important resident fight to improve quality care has been the struggle for shorter hours.

Every (!) advance in reducing resident hours that has come since the 1970’s has followed after some CIR (i.e., union) initiative.

The recently identified “medical errors” epidemic – along with hospital infections – has been cited as the leading cause of death in the U.S. Those studies of medical errors do not even count the “near misses” – errors actually made but caught by someone else before they cause harm.

Exhaustion is a major cause of error – and our union has been the leading -- and often only – voice to limit resident work hours.

On the public policy level, I find it absurd, unfair, and illogical – and not even good policy -- that ten or a hundred 'docs' who ask for a collective voice on improving quality of care and their compensation are open to anti-trust action while huge, billion-dollar, insurance companies, hospital chains, academic medical centers (and their "associations") can change the face of healthcare and the way they treat their professional and non-professional employees without hardly any checks and balances.

Not only do the companies fight unionization, they also fight "transparency" and openness of information to the public. Insurance companies and hospitals really want to exist in the market place both without checks and balances from their doctors and without the public knowing about staff-patient ratios, the number of hours doctors are working, the status of residency programs, settled and pending malpractice suits, etc. It is not a true and informed market place if one side holds all the information.

All this leads to a situation where we have too many doctors and nurses who are getting more and more cynical and burned out.

Many are dropping out of the healthcare system. Many others who stay are moving away from clinical into non-provider roles.

We need professional caregivers who stay in the system and fight for a vision of a compassionate and high quality system. They need collective bargaining as a tool to advocate for change.

The healthcare system is out of balance.

Doctors work hard. Their expertise provides critical services. Doctors are the skilled “tool and die” makers of the healthcare industry and should be seen as the skilled workers of that industry with no fewer rights than other skilled workers in other fields.

To me, it makes good sense from a healthcare policy perspective to have an organized and independent countervailing voice of health professionals to balance the bottom line drive of insurance companies and hospital chains.

I would urge these two Agencies to review existing policies so that the definition of “employee” is broadened, rather than narrowed. Those (truly non-supervisory) resident and post-residency doctors who provide clinical care in a range of situations should not be denied the democratic right of collective bargaining because they are called “doctors.”

In closing, I want to ask: “What are the fears? The objections?”

Some say that doctors make too much money so they shouldn't be allowed to have a union. Airline pilots and many professional athletes earn more than most doctors -- and they can form unions.

Some say that doctors provide essential services and shouldn't be allowed to have a union. Police and firefighters provide essential services -- and they are allowed to join unions.

Some say resident physicians are "students" and thus shouldn't be allowed into unions. "Apprentices" of all kinds are allowed to join unions ... and besides who do you think is the doctor giving you care at 4:00 AM in the morning.

Some say that doctors are independent contractors and shouldn't be allowed to join unions. A range of others from musicians and movie stars ... to electricians and carpenters have independent contracts -- but they can join unions.

Some academics say that doctors shouldn't be allowed to join unions because the doctors can't prove that doctor unions would guarantee the improvement of quality. Nurses, teachers, and autoworkers are not held to that standard -- and they are still allowed to join unions.

Some worry that doctors would be too powerful if they could join unions. But you have to look at the power on the other side of the hospital systems and chains, insurance companies, and academic medical centers. The business organizations are the really powerful ones.

Working “docs” have families to support, have concerns about their own health insurance, benefits, and pay. They want to work in a safe workplace. They want due process and fair treatment.

They want an effective voice and protection to speak (and negotiate) without fear of retaliation about quality issues.

This is what traditional unions generally do.

In my experience, this is what doctors’ unions do too.

Thank you.