Transcript Of The "Role Of Labor In Graduate Medical Education" April 5 Meeting

DOCTOR SUNDWALL: Thank you.

All right. I'd like to ask our panel of speakers to come forward.

It's my pleasure to introduce the first panel today, focusing on the role of labor and graduate medical education. We are first going to hear from Mark Levy, Jim Bentley, and Sarah Fox, and then we're going to have a break.

So, Doctor Foreman and Susan Adelman, you can sit on the sidelines if you want. You don't have to come up -- if you want, you can get a chair up here that's fine, but I -- okay. I'm sorry, I was told otherwise. You've all got to come forward.

Excuse me, Spike, I didn't mean to relegate you to the periphery. I'm just trying to see if there was enough space here, but there will be.

Mark Levy, our first speaker, is the Executive Director of the Committee of Interns and Residents. I was pleased to see from his resume that he was initially a teacher, taught in secondary level in New York City, and then served on the faculty of Queen's College, but he has worked with doctors and unions for 17 years, serving in various organizations, negotiating and administrating staff positions with the committee of interns and residents. He has been CIR's Executive Director since May of 1998.

I'm going to introduce our next two speakers and then have them proceed in the order they are in your program, as well.

Jim Bentley is a fixture in Washington. He probably doesn't like that because of his gray hair, and he's younger than me anyway, so I can say that. But he is a highly regarded health policy expert now with the American Hospital Association and you can read from his resume his responsibilities, but prior to that he was 15 years with the Association of American Medical Colleges, where I knew and respected and worked with him in various capacities. Most importantly, he used to be in the U.S. Navy Medical Corps, so you're very legitimately involved in all this health stuff. I think that's cool. Although he was doing something here in Bethesda, it still counts.

And also, we have Sarah Fox, who is a member of the NLRB, National Labor Relations Board, an independent agency established by Congress in 1935. She is a Presidential appointment and has served on that Council since 1996.

And Sarah, while I haven't met you, I want you to know we share a bond. I worked on the Labor and Human Resources Committee for five years and was the Health Staff Director there a long, long time ago, but have an affection for labor and I'll never learn to call it Help, it's not the Help Committee, it's the Labor Committee, right?

Okay. So first of all, please welcome Mr. Levy.

MR. LEVY: Is it easier for back there to --

DOCTOR SUNDWALL: I think it's better if you use the podium. Thank you.

MR. LEVY: I think this is the first meeting that I've been to in a long time where actually we're proceeding on schedule. I hope I don't change that. I'll try my best and I'm sure somebody will stop me if I go over my time limit.

Thank you for inviting me today. I'm actually very proud to work for CIR. I'm proud of our record for all the years that I've been there, for what we've done for residents. I'm proud that we've been

able to improve working conditions for residents and I'm proud that we've been able to give residents a vehicle to advocate around their patient care concerns.

I hope that my presence here in this topic of discussion is really the beginning of a dialogue and a continuation of conversations in a broader way. I'm actually not sure what this audience wants to hear. I have one set of things that I would love to say. I have another set of things that I need to say, partly because we know that this is being videotaped, so I have to read from the record. The other thing is that I flipped through the American Hospital Association's chart of what they're going to present, so it seems like we're going to relitigate the case today, tomorrow, and several times in the future.

With the dramatic changes that are going on in health care now, I think one of the things that we need to look at is that there are, in fact, many areas of things that we can work on together. One example, even though New York seems to be a little under represented in the Council, is the dramatic passage of what's called HCRA 2000 in New York State. It was a bill that brought a lot of money, particularly to teaching hospitals and it's a bill that passed and could only have passed in New York State by the cooperation of our parent union, SCLU, and it's largest affiliate, 1199, working in close cooperation with the greater New York Hospital Association.

I think these are the kinds of times where those kinds of activities become more and more important. I think these are also times when we can either have stacks of problems just sort of piling up in unresolved kinds of ways or where we can find labor management processes that help facilitate solving those problems. So I think that there really are many ways that we can work together.

I've been asked to give CIR's position on the NLRB decision, it's impact on Graduate Medical Education and when i was first asked to do this I said that would be a very short speech and I could almost stop now because my position is that there will be little or no adverse affect on education.

I appeared as an expert witness in at least three or four hearings so far, the Boston case, the Jackson Memorial case, the University of California case, and I believe there was a case here in Washington, D.C., where I appeared and said the same things.

In addition to my appearance, particularly in Boston, everyone of our collective bargaining agreements was subpoenaed by the attorney for management, they were submitted into the record. Our contracts, even though it seems not to be remembered or referenced, of all our contracts, there are a number of them, probably about 15 of them that are in the private sector. We had private sector agreements even without NLRB jurisdiction, as well as many public sector contracts. All of these were scrutinized.

After the testimony from both sides was scrutinized, after all these documents were scrutinized, the NLRB decision, I wish there were packs of it sitting back out there, said that, and I'm not going to do too much from the decision, said that "no party has pointed to any difficulty arising from this bargaining." That's the finding of the NLRB after looking at all the documents, the history, the facts.

They also said there is no indication that any of the negative problems, as predicted in the original Cedar Sinai case, have occurred or would occur. I think, to sort of back up and not retry the whole case, particularly for this audience, some common sense is probably useful.

CIO was founded in 1957. If you go back to 1957 with the turnover in house staff and you do a little arithmetic, probably somewhere between 100,000 and 200,000 residents went through training programs and have become dentists, physicians, and are practicing or working now, 100,000 to 200,000 residents.

In all of those hospitals and all of those programs and all of those experiences, it really cannot be argued or shown that the presence of a union adversely impacted or changed or in any way that was dramatic, affected the educational programs. It's common sense, 100,000 to 200,000 residents have already gone through experiences where they've been in that.

Another common sense thing that I think people need to remember is that there's no contract that we have that is not mutually agreed to. I've negotiated a number of first contracts. There's not one word that's in an agreement that hasn't been argued back and forth on both sides and when we're finished is signed off on by both sides. Management always sends very articulate and wise and thoughtful and aggressive negotiators to deal with us. So, I think that the contracts reflect the mutual discussion about the issues that we can cover and how to cover them.

I would say that the fundamental core of the decision has a common sense aspect to it that we agree to. And that is that somebody can be a student and an employee at the same time. That's what the decision said, and it says it a couple of times and I think that's really important to remember.

I get very frustrated when I reread some of the briefs and read some of the articles that appear in various places and statements in the New England Journal that really want to create this procrustean bed of student, student, student, and therefore you have no other aspects of your life. It just doesn't make sense. It's just not true.

I understand where those arguments come from. In looking at slides that were distributed back there from the Hospital Association, if you took out the work "house staff" and you used the same arguments, you could apply it to nurses, you could apply it to all health care workers, et cetera, et cetera.

Let's be honest. There's some people who don't want anybody to have a union and if you want to argue that, that to me is sort of a common sense argument and then you can go certain places. If you want to argue how it's going to impact on the educational programs, then I say let's not look at the hypothetical things that were put forth 25 years ago, lets look at the record since then and I think the record not only was so clear at that time, but I think that it's still clear now and it can be discussed and shown and in fact in negotiations, those issues are always brought up.

CIR entered into challenging the Cedar Sinai decision for two reasons. One, we think that residents work very hard and as they have some aspect of employees in their life, in their experience, in their work life, that they do have rights and should have those rights. The second thing that we thought is what I said before, was that the record of the real world since the Cedar Sinai decision in 1973 has shown that the arguments put forward then just didn't hold up.

I don't want to go into more details of the case. I would leave that to Sarah Fox. I would also hope that at some point we go into the very practical discussion of what it really means to be covered by NLRB procedures. There are some procedures that I wish I wasn't covered by or there's some procedures that I'm glad we're covered by and there's some procedures that -- most procedures, I think, work for all of us.

I think, even though I say it doesn't, the decision won't affect Graduate Medical Education. I certainly hope the presence of a union has some role in affecting how house staff are treated as employees. That is a fact and there will be some impact there. Hopefully, collective bargaining brings better conditions, or at least a say in those conditions.

The biggest thing that collective bargaining brings is really a right to sit at the table. It ends a traditional take it or leave it relationship, and I think that's really the biggest issue that we're dealing with.

I've been in situations both with groups of house staff or having reports from house staff where I've encouraged people, and I have, myself, experienced where you say, "Why?" And I've had medical directors just say, "Who are you to ask me why? I've made this decision." And I said, "What about thinking about it this way, or what about another way to handle it, or since you said, you answered why, let me deal with some of the reasons why."

There begins a dialogue, there begins negotiations. Once you can get past that feeling of it's take it or leave it or nothing, and can enter into a discussion, you've changed a relationship, and I've

found in all my negotiations, both renewals and first contracts, that once you get past that point, the other stuff is easy. We can agree on contract language on almost anything.

Take a set of numbers, whether they're for a book allowance or whether they're for salaries or whether they're for benefits, you can work that stuff out. The biggest question that seems continually to be debated is whether residents should have that right, and I would say that residents have employee aspects that they should have those rights on.

In talking about rights, we also need to be concrete. What are some of the things that make house staff angry that they turn to CIR for? One set of house staff said, "We haven't gotten a pay raise in five years and everybody else in the hospital, management, nurses, everybody else has gotten a raise." Do residents have a collective right to say something and do something about that? I think so.

Residents have said, "Management just took away our insurance benefits and now they've really changed things and they're making us do whatever, whatever. Do we have a right to say anything about that?" I say, I think so.

Meal tickets. I've seen management take away meal tickets. Meal tickets are terribly important. You can't talk to a resident without feeding her or him, it's just the nature of time pressure and all of that. Meal tickets are also -- meals and food and how that's treated is a mark of respect or disrespect very much in a residency situation, as many of you, I'm sure, know.

I've seen a hospital build a new building and not put in on-call rooms, and residents said, "What are we supposed to do?" Well, you're not supposed to sleep or you can find an empty bed, or sleep on a couch in a patient care area. In those negotiations I remember saying, "Well, what about having a folding couch in the Medical Director's office so that they could at least go in and sleep at night?" That was considered disrespectful.

Parking spaces, numbers of translators, maternity leave. I should say that I'm very pleased that in one of the largest and biggest complex of hospitals in a collective bargaining, New York City's Health and Hospital Corporation, we probably negotiated the first and the best whole procedure around maternity leave and what to do about that, how residents take off and how residents cover when other residents are on maternity leave. We were able to do that. It doesn't really exist, no hospitals were really volunteering that at the time we were able to negotiate it.

Probably the biggest issue that you hear out there over and over and over again is resident work hours. CIR has been in the lead in this issue for almost 30 years. Let's take a look at the real world for a second. What's happening with residents if you really want to put it out there?

There are shorter patient stays, sicker patients, higher patient turnover, more paperwork, more clinics and out patient duties added on top of inpatient work, there are fewer house staff, there are fewer fellows, so that third years are doing the consults that fellows used to do. There are dramatic reductions in many hospitals in nurses and ancillary staff. What does this all mean for house staff? It means they're working longer and longer hours. It just does. Short staffed and longer hours.

We say this and then we get into these debates about, well it's good in emergencies and all that kind of stuff. We're not talking about residents leaving in the middle of a procedure, we're talking about residents being scheduled for, regularly, longer and longer hours to fill in for other people.

We're talking about discussions on medical errors that don't mention long hours for interns and residents, that don't mention short staffing in ancillary areas. I've read Doctor Leach's work for a number of years and I thought it was absolutely wonderful, but he never, until this year, put in a sentence about the long hours that residents work and include the idea that that may have some impact on increasing the opportunity for errors.

With more time we could talk more about hours. I think that that's a critical thing to put on the table and to think about why that really hasn't been changed and that any little change that has ever come, has come in response to things that CIR has done.

Do all these problems that I've mentioned, whether it's pay or hours or other things, have to be done in an antagonistic situation? I really don't think so. Sometimes you see the world as a zero sum world, sometimes it can be an expanding sum world. It takes two to tango whenever you bring a problem to somebody's attention, how you resolve that problem. So I don't think there's anything inherent in the kinds of issues we bring to the table that lead to antagonism other than the fact that now somebody has to listen and talk and discuss and they can't just say, "Take it or leave it."

I think that there are many things that we can imagine that our patients, the hospitals could be much better places if we worked together on, medical errors, hours. I would love to be engaged in problem solving around those issues.

I hope that COGME's discussion of medical errors does not lead to blaming the individual resident kinds of analysis, but understands the whole -- my excitement about the IOM report is that it talks about medical errors as systemic errors, the errors that the good doctors make. I think that you have to look at hours and staffing and all of that in the context, and I think that COGME can bring some of that to the debate.

In the press and elsewhere, I've seen all sorts of statements about CIR, what CIR is, what it isn't et cetera, et cetera, and I wish I had more time to go into that. Included in the envelopes or the notebooks the people got is a schematic thing about what CIR is. It's a national union. We were founded in 1957. We're governed by house staff, house staff officers, nationally, locally, we're chapter based, et cetera, et cetera. There's more information in that. But I promised to not take you off your schedule, so thank you for the time to sort of introduce some of the framework for the debate.

DOCTOR SUNDWALL: Thank you very much.

DOCTOR BENTLEY: As David said, I'm Jim Bentley with the American Hospital Association. What I was asked to share with you today is what are the concerns that hospitals have with the way in which the issues have been framed or the application of labor law to residency programs.

What I'd like to do is you have, those of you on the Council, I assume, have the slides in your packet. For the visitors, they're at the back or at least copies of them are.

I'd like to start out with where our members start out when they think about this issue, and that is, unlike the allegation Mark made, they readily recognize that this is an unusual program or an unusual set of people in their institution and that's because we're taking a look at education in a service setting. We're not looking at education in the archetypical educational setting of the university or school in a purely didactic program, we're looking at education in a service institution where that education is conducted by participation.

Hospitals have recognized since the earliest days that as a result of that and various and conflicting federal decisions or state decisions, residents have characteristics of educational students and characteristics of employment that, at least from our point of view, has never been contested. What has been contested is which perspective should dominate, recognizing that one needs to start and work from one of those perspectives, especially given the statute of the National Labor Relations Act.

Now, what I'd like to share with you today in going through those, is a series of concerns about -- that the hospitals have so that you can understand what the hospital perspective on house staff unionization has been, and where we see, at the Association, the issue moving and now that there's been a decision, or a change in the decision of the National Labor Relations Board.

Beginning with the first hospital concern, the hospitals are concerned that the National Labor Relation Act basically assumes that there are two parties, the employee -- sorry for the typo -- the employer and the employee. Contrary to that bipartite look at the world, the residency program has multiple parties in terms of generally one or more hospitals, and hospitals which may have different sponsorships. Hospitals that may be private institutions subject to the National Labor Relations Act, maybe public institutions subject to state labor law, maybe federal institutions not subject to state labor law, so you have multiple hospitals, often a medical school, faculty involved in the operation of the program, program directors, residents, the Accrediting Council for Graduate Medical Education establishing the general and specialty essentials, the residency review committees, and the specialty boards.

So one concern of hospitals has been as the National Labor Relations Act operates from the perspective of the employer and employee, and this program operates with multiple parties, how does that fit?

Secondly, from the hospital perspective, the National Labor Relations Act and the Board exist to administer what is a presumed adversarial relationship in those two parties, employer and employee. We recognize that education and patient care both assume a hierarchy. That is, you have the teacher and student or the medical professional and the patient. But it need not be an adversarial relationship and in the experience of people in hospitals, is not the most constructive relationship if it is forced or fit into a model that assumes an adversarial relationship and tries to administer that relationship.

The third concerns that hospitals have deal with the broad areas that are subject to negotiation under the National Labor Relations Act. That is, one has to negotiate over wages and hours and other conditions in terms of employment. But in that context, the hospital can only negotiate within the boundaries set by the Council on Graduate Medical Education, the RRCs and the specialty boards. So one has a situation where the residents in a union organization or a labor organization have the right, under the National Labor Relations Act to raise issues which the hospital does not feel that it can negotiate in good faith on and if unable to negotiate in good faith, then the hospital itself is in violation of the National Labor Relations Act. Not surprisingly, hospitals did not seek to have themselves placed in a position where they feel they may have to behave in a way that doesn't comport with the requirements of the Act.

The fourth area of hospital concerns does not address the decision of the National Labor Relations Board directly, but the implications for that decision for the way in which Graduate Medical Education is funded. Graduate Medical Education for most payers in this country is not funded as an explicit payment. Whether we have a private insurance company that's for profit, a not for profit company, an HMO, they, in general, do not make explicit funding for that.

Some Medicaid programs do provide explicit funding for Graduate Medical Education, others do not. As you've discussed at this Council, historically, the one payer that has expressly recognized Graduate Medical Education has been the Medicare program, and it has done so under a perspective that Graduate Medical Education is primarily education and it has funded that education as a funding of a public good.

Defining residents primarily as employees threatens to weaken that perspective. It weakens it in terms of the special funding from the government and unfortunately, the NLRB reconsidered and changed it's view right at the time that another federal advisory panel, MedPAC, has adopted a perspective that argues that residents should be seen as employees of the hospital and the special funding should not be provided for education. That one should only have service funding, not educational funding.

Secondly, if the perspective of employees goes forward, we're in a position where we strengthen the hand of private insurers who've never wanted to pay this cost to say, "Now it's a patient care cost, why should I pay the teaching hospital a cost differential when I can get the same or similar service from non-teaching hospitals for a lower price?"

Third, the rise of the perspective that the resident is an employee has led some to argue that the way one is going to have to fund Graduate Medical Education in the future is to move to a tuition model that fits both the perspective that MedPAC is moving forward and may fit what happens with public or social good funding if it is eliminated. However, one begins to have to ask the question, as one looks at residents, as one looks at their household budget, is that a reasonable model to move to, and hospitals have not wanted to move toward that model.

Lastly, there -- if one begins to look at residents, define them as employees, treat them as employees, and classify them within the institution, hospitals that are committed to Graduate Medical Education have a concern that one will begin to make, primarily, decisions in terms of immediate work force of the hospital rather than in terms of it's long range commitment or historic commitment to Graduate Medical Education, and we may thus see a decline in the number of positions that are offered.

The fifth concern of our members revolves around the implications of a labor or union organization. One of the concerns is resident continuity. As Mark has described, residents do have limited free time given the hours that they are involved and in some cases, additional moonlighting that they choose to do. Is it reasonable to have them expect to spend additional time in the labor organization, it's organization and management.

Secondly, residents are a transient group of hospital employees. The average residency period in this country is about four years, some longer, and a few shorter, so that one has a constant turn-over in the group that would constitute the bargaining unit.

Second concern is what happens in terms of the potential of strikes and the honoring of strikes which may be caused by others or called by others. Is unionization going to lead to another group in the hospital that seeks to use the strike as a weapon of economic leverage and disrupt the hospital? Or is that going to be in some ways bargained away into mandatory adjudication or arbitration and if arbitration becomes the coin of the realm to avoid the strike, who gets to make decisions then about the nature of the program that the resident is involved in, and whether or not that program fits the requirements of Graduate Medical Education as prescribed by the ACGME and the RRCs.

The sixth concern of the hospitals was not one that went into the debate about reconsideration by the National Labor Relations Board of whether or not residents were primarily students or primarily employees, but has evolved from the decision that was made by the board. The board, years ago, decided that there should only be eight bargaining units in hospitals, one of which should be professional employees.

In their decision, the National Labor Relations Board takes the position that residents and other physicians employed by the hospital should be in a single unit. A unit that will combine hospital paid faculty, hospital paid physicians who may not be faculty, and residents. A serious question from the human resource people in hospitals with labor experience is, "Is there a community of interest among those either two or three groups," depending on how one chooses to kind of, group the first two groups. Will they have a shared experience?

I spent a lot of my educational time in Michigan, and watched sometimes when bargaining units in automobile plants would find there really were two different groups within the plant, and it was very difficult for the union bargaining group to represent both groups simultaneously. There have been experiences like that, and hospitals are concerned that the decision that the National Labor Relations Board reached that combines these two while it preserves the eight traditional bargaining units leaves open this question.

So where are we, as hospitals look at the future, recognizing that the National Labor Relations Board has acted, has made a decision that in terms of the National Labor Relations Act residents shall be regarded in this dual status at least for purposes of the act as employees and hospitals shall be subject to working under the rules of labor and management in the National Labor Relations Act.

I think most hospitals are in three positions simultaneously. Number one, the interest in the union, whether it be a house staff union or any other union, often is understood as a symptom of weakness in the institution or a failure to communicate in the institution or a frustration with various employee groups within the union whether or not the individual saw union as a first step, a union became a way for the individual to address the issues that concerned them.

San of the one of things the hospitals have is to move to step two and begin to say, if house staff have an interest in a labor organization to represent them, what is it in the way the institution operates and the program operates that leaves them in a position where they feel the union is their only recourse to open a dialogue locally? Is there an alternative way to have a dialogue so that one does not get to the point of a labor management negotiation and structure in order to have dialogue between the residents, the training program, and the hospital.

Finally, the hospitals have worked hard with the other sponsors of the Accrediting Council for Graduate Medical Education to seek to have that group incorporated in it's own right. It may not be familiar or in the awareness of most of you, but the ACGME is an unincorporated creature of it's five parents. It does not have an incorporated right. It does not have a board of directors therefore that has a single, sole fiduciary responsibility to the role of the ACGME and to it's mission of strengthening Graduate Medical Education.

The five parents have been getting closer and closer to that. We hope in June there is a vote that will strengthen the ACGME by making it an individually incorporated organization sponsored still by the five parents, but with clear responsibility for it's own mission with a clear responsibility for it's board and with a clear responsibility not to have to respond to the positions of any particular parent, but to act in the best interest of Graduate Medical Education and residency training in this country.

We think they have demonstrated in the last several years under David Leach's leadership, a new look at Graduate Medical Education, a willingness to address a number of issues that have concerned residents historically, and have provided an opportunity to change the relationship between residents and hospitals. We look forward to their continuing involvement.

Let me stop there in the interest of time.

Ann, are you next?

Sarah, I'm sorry.

DOCTOR SUNDWALL: Let's hear from Sarah, then we'll have time for questions before we break and we're sticking to the schedule pretty well this morning.

MS. FOX: Thank you very much for having me this morning.

Obviously there's been a lot of talk. The premise of this panel, I guess is the consequences of the National Labor Relations Board's decision last November in the Boston Medical Center case that dealt with the employee status of house staff, interns and residents. So I thought I would talk to you a little bit about that decision and a little bit of the history of the Board's treatment of house staff prior to this decision.

Just to start with, the National Labor Relations Board is, as was alluded to in the beginning, is created under the National Labor Relations Act to administer the statute, which is the primary statute private sector employees in the United States. The Board consists of five members who are appointed by the President and confirmed by the Senate, subject to confirmation by the Senate.

The Board has two primary functions. One is to adjudicate cases involving allegations that one or the other party has created what is defined under the statute as an unfair labor practice. The Board's

other main function is to oversee the process by which employees decide whether or not they want to be represented by labor unions.

In this particular case, Boston Medical Center, arose -- it is the second category of cases. It is one of what was called "representation cases" by the Board, and the issue arose because there had been a consolidation of the Boston City Hospital, formerly a public hospital, and Boston University Medical Center Hospital, resulting in the creation of a new entity.

Interns and residents at Boston City Hospital had, for many years, been represented by the Committee on Interns and Residents as part of the legislative framework by which this merger came about. You can maybe correct me if I miss any of the background on this incorrectly, but I do believe that the Boston City Council had made a condition of the deal on some level that there be at least continuing voluntary recognition of this union. But the union wanted full certification recognition by the board as the certified bargaining representative of the employees and therefore filed a petition for an election with the board, at which point the question was put as to "Are these employees under the Act, and therefore, are they entitled to use the Board's processes, and again, can there be certification of the union as their representative?"

The extant precedent stems back to 1976, which was the first time that the National Labor Relations Board ever considered specifically the question of whether interns and residents were employees under the Act. In that decision, the Board appeared to say that it did not regard interns and residents as employees, period. That they did not fit the statutory definition of an employee, and therefore, there was no coverage for them.

Well the next development after that was that since they were not covered by the National Labor Relations Act and under the statutory scheme, if the federal government is not regulating than the states are free to regulate. The next thing that happened was that New York State asserted jurisdiction over these interns and residents. There was a particular dispute going on in New York, and said all right, well they're not covered by the National Labor Relations Act but they are covered by our state collective bargaining law and therefore we will proceed to deal with this dispute under our state law.

At which point the National Labor Relations Board did something quite unprecedented, which is that they kind of announced that they were going to revise to a certain extent, the rationale for their earlier decision. That they, in essence said, "Well, we may have created some confusion here."

What they said in their next decision, which again is not all together clear, seemed to be that "We're not really saying that these are not employees. In fact, we're very clearly saying that these are people who are covered by the National Labor Relations Act, but we're going to make a policy judgement that even though the Act says that employees under the Act have a set of rights that there are rights relating to collective bargaining that we think it is not appropriate to grant to these people, even though we are not saying that they're not covered by the Act."

That was, again, a hotly contested position. There was an effort made through the D.C. Circuit Court of Appeals to have that decision declared beyond the Board's confidence, outside the clear meaning of the Act. It was successful with the panel of the D.C. Court of Appeals and then it went to an en banc decision in the full court and the court upheld the Board, but with a very strong dissent by four people. The Board's original decision also had a very strong dissent by then member Fannon.

So at every level that this decision was made, it provoked a lot of controversy and there were a lot of strongly felt views that were expressed on either side.

That's kind of where things have sat in intervening years. There was, at one point in 1978 I believe, an effort to legislatively overturn the decision. That kind of went somewhere in the House of Representatives, nowhere in the Senate, and that was the end of that.

From the Board's perspective, I would -- before I get into talking about what the Board has just done, I want to make clear that what the Board's job is in deciding cases like these is to interpret and apply the National Labor Relations Act. We are bound to look at that statute and try as best we can to follow that statute. If we disagree with that statute, it's not for us to rule differently than we believe that the statute requires. If we think that the policies that are reflected in the statute are unwise, that's really beyond our purview.

So let me just say that when the Board has made this decision, the question before it has not been, is it a good idea for interns and residents to be able to engage in collective bargaining, because that's not really a question that was left open to us. The question before us is, did Congress, when it enacted the statute and over the years as it's amended the statute, cover these people, and is it fair to say that congressional intent, as evidenced through the statute in the legislative history, was that people in this category should be employees under the Act and have the rights of employees under the Act.

In our November decision, a majority of the Board, it was a four to one decision, reversed the Cedar Sinai decision and said that, "On reconsidering this issue, looking at the plain language of the statute, looking at the legislative history, and looking at the arguments that had been made by the majority, we were unable to sustain that earlier decision and that in our view that decision was wrong and that, in fact, the statute plainly covered interns and residents."

Again, I stress that this was a decision about what we think the statute requires and to the extent that people think that that's a wrong -- they're sort of two separate questions. Did the Board correctly decide the statute? But there's a separate question about if so, is the statute a good thing? And all I can say is those arguments really are arguments that have to be addressed to Congress.

So with that caveat, let me tell you about the Board's reasoning here as to what the National Labor Relations Act says about this.

The Board started with fact that the statute has a very, very broad definition of employee, and the Supreme Court has repeatedly stressed just how broad that definition is, most recently in cases dealing with the fact that illegal aliens can be employees. It's a very expansive decision. In order to find -- and it's one that the Supreme Court has instructed us to broadly construe so that in order to find that someone, that a group that appeared to have the incidence of employees were non-employees, you'd have to have some pretty clear cut evidence to the contrary.

So we started with that and we went through various indicia of what it is that residents and interns do. And in many regards, and I think it was conceded here, that in many regards what they do is consistent with the definition of an employee. They perform services for the hospital or whoever is the employing entity, under the direction of that hospital. They perform services that are part of the business of that employer. They can be -- they receive a salary for that.

We went through, under the common law definition and how the Board has interpreted that definition in other contexts, and went through many incidents of that relationship which are consistent with an employee relationship.

We also looked at the legislative history of the statute, and in particular, two parts. One is the specific statutory definition of what constitutes a professional employee. In 1947, the National Labor Relations Act was itself enacted in 1975 -- 1935. In 1947, in the Taft-Hartley amendments, Congress amended the statute and specifically wrote into the statute a provision that professional employees should be treated as employees under the statute.

They defined a professional employee as follows. "Any employee engaged in work, among other things, requiring knowledge of an advanced type in field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital." That's a definition that would clearly cover a doctor, for instance. And then, "or any employee who has completed the courses of specialized intellectual instruction and study described in

that clause. And two, is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph A."

In the Board's decision, we cited some legislative history statements by members of Congress that indicated that they specifically had in mind interns when that definition was written, and we believe that that definition precisely fits the definition of an intern or resident.

So again, that was something that we relied on the majority in having to look at the statute and the legislative history to try to discern what we felt Congress intended. That was another thing that we cited as evidence that we did not think that Congress meant to exclude these people.

We also cited certain things that occurred during the 1974 period when Congress was debating the 1974 amendments which extended the coverage -- me?

DOCTOR SUNDWALL: Wrap it up.

MS. FOX: Oh, yes. Extended the coverage to health care members.

So in effect, we looked at all of the legislative history and concluded that this supported a finding that Congress intended to cover the interns and residents.

We also, at the end, talked about the fact that we addressed arguments that this was a bad decision because of the adverse consequences that it would have, and we noted in that connection, as was said before, that no evidence had been presented of actual adverse consequences that had occurred even though there is a long history in nine states of collective bargaining by interns and residents in public employee settings.

But again, I stress, I would say that is a secondary argument because that was more of a policy argument as to whether it was a good thing than a legal argument as to whether the statute in fact covered the employees.

I'll stop there and I'm happy to answer any questions.

DOCTOR SUNDWALL: Thank you very much to all three of our speakers. I think they've set the stage for a very vigorous discussion.

Thank you, Sarah, for your comments. It was great.

I see we have scheduled discussion after our next two speakers who will present after our break, but I just want to ask, are there any questions you want to pose right now before you lose the thought or the moment?

MR. DAVIDSON: Just a technical question. I guess this is from the AMA News. It says this was a three to two decision and you said it was --

MS. FOX: Yes. It's a three to two decision. There was a board member who felt particularly strongly about it who expressed his views at length. But you're right, it was a three to two decision. I have it right here.

MR. DAVIDSON: Oh, okay. Not a four to one decision?

DOCTOR SUNDWALL: Well, I just want you all to understand the impact of house staff, or residents and students, because it was William Ching that got this ball rolling.

We thank you for that because I think it is a timely and important discussion.

We're going to have a break. We're going to stick to it.

By the way, welcome, Doctor Nicole Lurie. We're glad to have you here. Do you want to do a check-in and report what you're doing today?

DOCTOR LURIE: No, I'll just listen for now. Thank you.

DOCTOR SUNDWALL: Well, she's here representing Doctor Satcher.

We're delighted to have you here.

Let's have a break. Stick to schedule. Let's try to be back in our seats at 10:35, no later than that because we're going to get started right then.

(Whereupon, at 10:20 a.m., off the record until 10:39 a.m.)

DOCTOR SUNDWALL: Welcome to the second session of our discussion on labor issues and house staff and GME. We're very pleased to have Doctor Spencer Foreman and Doctor Susan Adelman to be our final presenters and then we've allotted time for discussion with the Council.

Remember, I don't know if it's clear here on the agenda, but we wanted to have public comment also at the end of this morning's session. No, that's later, 2:15 p.m. But I still think if there are sage comments on this, we'll see if we can accommodate public --

Anyway, Doctor Foreman admits to 30 years, my goodness, as the head of a hospital health system, the chief executive for 30 years. He's now the President of Montefiore Medical Center. He's a professor at the Albert Einstein College of Medicine. He's the former head of the AAMC, or chairman of the AAMC. Very impressive credentials. Certainly been involved in Medical Education for all of his adult life.

I chaired a panel with him before the bipartisan commission on the future of Medicare, where we were kind of on opposite sides of the fence on IMGs. But he was a friendly debater and so I'm assuming from that performance that he would also be a good negotiator.

So, Doctor Foreman, we're happy to have you here.

And I'm also going to introduce, before you begin, Doctor Susan Hirshberg Adelman, M.D., a pediatric surgeon from Detroit, Michigan. She was elected to the AMA Board of Trustees in 1991, I believe?

DOCTOR ADELMAN: '98.

DOCTOR SUNDWALL: Well, you've been a delegate, I guess, an AMA delegate since '91, a Board of Trustees since '98. I was telling her she's a true pioneer because she's the first president, last year, of the Physicians for Responsible Negotiations, a labor organization created by the AMA. So clearly, as I say, pioneering at this level of organized medicine and how do we deal with negotiations and collective bargaining, and making sure the interests of physicians are met in this new economic environment.

So we're very pleased to have such qualified people to discuss labor issues. First Doctor Foreman and then Doctor Adelman.

DOCTOR FOREMAN: Thank you very much, David.

I must say, I feel more at home in this room than I anticipated I would. I haven't seen so many Public Health Service uniforms since I was director of the Public Health Service Hospital 30 years ago in Baltimore.

I must say, in those days, the only PHS officers who got to wear uniforms were those in what were called uniform stations. They were inevitably somewhere outside of Washington. There were no PHS officers in uniform inside the beltway then. Since they closed the Public Health Service hospitals, I assume they had to do something to recycle the uniforms and now I know they're all here.

The second thing I want to say is that you really did get second choice today. Jordy Cohen, the President of the AAMC, really wanted to be here himself, but unfortunately was committed elsewhere and called me to see whether I would stand in for him, which I was happy to do. But obviously, I'm presenting the AAMC's position for Jordan and the Association, and not for Montefiore, although we obviously have our own views on the subject.

The Association of American Medical Colleges is strongly opposed to unionization of resident physicians, and our position derives from two principles. The first is that resident physicians are, above all else, students. The second is that they are members of the medical profession and must adhere to the tenants of medical professionalism.

The Association believes that unionization has the potential to undermine the roles of residents both as learners and as professionals. Most alarmingly, by the threat of withholding patient care during a strike.

The Association recognizes that the NLRB has recently reclassified resident physicians as employees. In so doing, the Board reversed the position that it had held for more than two decades, that residents were students -- protections afforded by the National Labor Relations Act, as you've just so ably heard.

Despite this ruling, the Association wishes to make clear that it continues to believe that resident physicians are primarily students and it will adhere to this position as it works to ensure that residents -- that the legitimate concerns of residents about the educational environments in which they work are addressed.

There can be little dispute that resident physicians enroll in graduate medical education programs primarily to acquire the knowledge, skills, attitudes and behaviors that are required for the independent practice of medicine in the specialty of their choice. It's true, they provide patient care services throughout the course of their residency, but that is not their primary purpose in enrolling in Graduate Medical Education programs, they are there primarily to learn and not to serve.

Furthermore, their relationship with the hospital or other entity or entities, as Jim Bentley ably pointed out, that provides their stipends and benefits is not typical of an employee/employer relationship. They are not even hired, in the conventional sense, by that entity. Rather, they have a contractual relationship with it by virtue of having been matched to one of its graduate medical education programs.

Resident physicians are enrolled in programs of graduate medical education to learn. Once enrolled, they must embrace their status as learners and be committed to it throughout the course of their residency. Any activities that divert their attention from that goal, and thereby undermine their role as learners, may adversely affect their preparation for independent medical practice. For these reasons, the Association continues to believe, despite the NLRB's recent ruling, that residents are primarily students, and not employees.

Residency training is not just an apprenticeship. It is a process of education and acculturation through which neophyte physicians become independently practicing professionals with the character, judgment, knowledge, and skills to take full responsibility for the care of human life.

Physicians are among the few licensed professionals with virtually complete autonomy within boundaries defined largely by the profession itself. It's essential that their training prepare them to

exercise their authority within that autonomy responsibly in the best interest of their patients and, as importantly, the larger society.

Unionization of resident physicians, we believe, may interfere with that goal. At a crucial stage of their development, it encourages residents to think and act collectively on behalf of their own group's self interest rather than in service to others, which is medicine's highest calling.

Resident physicians are medical professionals and should not accept the right to strike. To do so poses the threat that they would, under certain circumstances, withhold treatment or abandon patients under their care. Such a threat is clearly contrary to the tenants of the profession and physicians in training should not be encouraged to develop the attitude that it is legitimate to withhold care from patients in order to advance their personal goals.

No responsible professional organization, including everyone represented in this room today, advocates -- no responsible professional organization or any of the advocates for unionization argues that resident physicians should actually strike as a means of achieving their goals in a collective bargaining situation.

Indeed, almost everyone engaged in the debate has disavowed the use of the strike by residents. But the no strike pledge in the name of professionalism is clearly belied by experience.

Unions representing other professionals, such as nurses and teachers, do not refrain from striking. If one looks back to the 1970s and early 1980s, there were plenty of examples of physician strikes as well. In 1981 there was a rash of them, including an 11 day strike at Montefiore Medical Center. Those strikes were the vestiges of an era that preceded the 1976 Cedar Sinai Ruling that residents were primarily students.

Although strikes continued to occur for several years following that ruling, they eventually subsided. But the recent past offers no assurances for the future because the majority of resident unions during the past 20 years have involved public employees who by and large have been prohibited from striking by law.

The new reality is that the NLRB's most recent ruling confers a legally protected right to strike. Assertions that labor organizations representing residents would never ask them to exercise their right defy experience. The right to strike is an essential element of the collective bargaining process as envisioned by the National Labor Relations Act. Any pledge to restrain from exercising it limits the effectiveness of unions in achieving their objectives.

Similarly, the Association takes no comfort in the assertions that labor organizations representing resident physicians would not become involved in the collective bargaining on academic issues. There are a number of aspects of graduate medical education we view as educational in nature, but could be seen by others as primarily work related. It's inevitable that efforts to resolve those differences of opinion will become imbedded in the collective bargaining process. There would be no way to avoid this. Matters such as resident scheduling and renewal of contracts are among the legally mandated subjects of bargaining that will encroach on academic prerogatives.

No one would argue that the decision of and institution of higher learning to advance a student to the next year of study or to grant a degree should be the subject of collective bargaining. But that's exactly the sort of decision by a program director that could be subject to collective bargaining if house staff become unionized.

Third party intervention would substitute for the direct student/teacher interaction that is at the core of medical education, and residents' futures would be put in the hands of what we regard as outsiders who are strangers to the profession.

The Association acknowledges that there are some aspects of resident life that are clearly work related, and that these may, on occasion, adversely affect the creation of an optimal learning environment. When that is the case, administrators an directors of graduate medical education programs have a responsibility to address the issues in ways that are responsive to the legitimate concerns expressed by the residents. A number of recent actions have provided a framework for ensuring that they do so.

In July 1998, the Accreditation Council for Graduate Medical Education implemented new institutional requirements which set forth in detail the actions that institutions must take to address work related concerns of residents. Institutions that fail to comply with these requirements face the possibility that all, I repeat, all of their graduate medical education programs will lose accreditation, even if the programs themselves are in full compliance with the special requirements established by the ACGME's Residency Review Committees. Claims that there are not mechanisms in place to protect the interest of resident physicians with regard to the work environment reflect, we believe, a lack of familiarity with either the new institutional requirements or the ways these requirements are being implemented in institutions across the country.

The Association is working with its member institutions and its organization of resident representatives to develop resource materials and other services that can assist institutions in their efforts to comply with these requirements.

The Association is committed to continuous improvement of the accreditation process, to make certain that the sponsors of GME programs are addressing issues of concerns to residents. To support this effort, this past summer the Association's Council of Deans and its Council of Teaching Hospitals established a joint task force to examine institutional accountability for GME programs. The Association believes that the work of this task force, which includes resident representation, will result in recommendations for improving the scholarly environments in which residents carry out their responsibility.

These initiatives provide a framework for addressing residents' concerns without introducing the harmful consequences of unionization. We believe that recent interest in the house staff unions has grown in very large part from the assault by market forces on hospitals and health care institutions that reduced reimbursement, demanded increased productivity and have transformed all of health care.

But unionization is an ineffective response to these external pressures. It adds nothing to the resources of a medical center. It merely organizes residents as an interest group competing for existing resources. By fostering inter-institutional competition and conflict, it divides the medical profession against itself and diverts physician's attention from the real problems in the external environment.

At a time when physicians most need to be aligned with one another and with the institutions in which they work and learn, unionization is a wedge that splinters the profession and weakens already stressed academic medical centers. We believe it would undermine the ability of these institutions to respond effectively to change, and to sustain their fundamental obligations to resident physicians and to others.

To conclude, the AAMC believes that the risks of unionization greatly exceed any benefits that resident physicians might gain from it. But we are committed to improving the education of resident physicians in ways that are consistent with their roles as learners and medical professionals. We believe strongly that resident unionization is incompatible with that goal.

Thank you very much.

DOCTOR ADELMAN: Thank you very much for the opportunity to address COGME on behalf of Physicians for Responsible Negotiation. I'm also a member of the Board of Trustees of the AMA, but I'm speaking today on behalf of PRN.

Let me tell you a little bit about PRN. PRN was founded at the behest of the AMA. In June of 1999, the AMA House of Delegates passed a resolution asking the AMA to do several things. It said first that "all activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism consistent with the principles of medical ethics and the current opinions of the Council on Ethical and Judicial Affairs."

The House then asked the AMA to immediately implement a national labor organization under the NLRB to "support the development and operation of local negotiating units as an option for employed physicians." In other words, we did not suddenly say that that's the only way to solve problems. We simply said that after all other ways of attempting to solve problems have been tried, if collective negotiation is necessary, we need to provide the mechanism for that to happen.

It further asked for this also to be an option for "resident and fellow physicians who are authorized under state laws to collectively bargain, and for the AMA to be prepared to implement a national labor organization to support such units as an option for all resident and fellow physicians at such time as the NLRB determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act."
This was before the decision, obviously, of November of 1999. So that's in, part, what the resolution read.

In response to that, the AMA established PRN. We announced that we were fully formed in November. We are located in Chicago in the AMA building and we're initially funded with a loan, which has to be repaid, from the AMA.

The Board of Trustees started out with two members of the -- the Board of Directors started out with two members of the Board of Trustees of the AMA, two senior staff, and from there we picked the additional members of the Board, one of whom is a fellow just completing his fellowship.

Our bylaws, and I'm going to quote, spell out, "Physicians for Responsible Negotiations shall strictly adhere to the American Medical Association's principles of medical ethics which prohibit this organization or any of its members from engaging in any strike by the withholding of essential medical services from patients." This is absolutely clear. A strike is prohibited by our bylaws.

We have a prototype contract that we're working with right now in Detroit, and it says, in quotes, "To ensure that patients' rights and patient care are never impaired, the parties agree in perpetuity that they will not engage in any strike, work stoppage, slow down, or lock out." This should be clear and we mean what we say.

Just to expand on that subject, is that a bad thing? Actually, and I live in Detroit and I see articles all the time on labor issues. The UAW and other unions across the country are saying that the strike is becoming less and less effective. In the heyday of strikes there were several hundred strikes a year. Now there are maybe 20 or fewer a year in the whole country. Strikes are recognized as hurting the employee, they're recognized as alienating the public, and they're recognized as not very effective. They also are not a very good thing in the health care field for obvious reasons.

There are other things that can be done. If you want to start with the highest ideal, probably the highest ideal is mutual gains negotiation or mutual interest negotiation in which both sides put their interests and concerns on the table, together they prioritize them and they start working toward resolution of these interests on both sides in a prioritized fashion. This is not contentious,it is not adversarial. It is win/win, and it is professional.

This is exactly the way the University of Michigan house staff -- Resident Union currently functions with administration. It's been doing so since about '91, and is doing very well. I've spoken to the Dean of University of Michigan, Alan Lichter, and he tells me he sees no problem with resident unions based on his experience.

I've had the same experience in the past when I was a resident at Henry Ford Hospital and was involved in setting up a house staff association and negotiating on behalf of it. This also was a process that worked well, and I have to say, can't be too contentious because Henry Ford Hospital has supported me through every single thing I've every run for, given me every award that it's able to award me, and named me Vice President of their House Alumni Association, and so forth. So apparently we remained friends.

In November of 1999, you just heard the NLRB ruled that residents are employees for purposes of the labor laws. They, however, said -- and this is very important. They, however, said that residents are still students. It is not an either/or. It is both. So when we wish to go to Congress and talk about funding for graduate medical educations, residents are students. The fact that they can bargain as employees for certain issues does not make them any less students. They still do the same thing that they did before the NLRB ruled.

The AMA has been active for many years in helping residents maximize their learning opportunity during their residency years to minimize the amount of scut work they have to do that interferes with their educational experience, and to try to standardize their work hours in the interest of greater patient safety and to minimize resident errors. The AMA is a parent of the ACGME and it's been instrumental in achieving those changes in the ACGME institutional requirements that you've just heard about.

However, it needs to be recognized that the ACGME has a limited range of tools available to it in enforcing these requirements. It can withhold accreditation, give provisional accreditation, give full accreditation, put a program on -- give probationary accreditation, withdraw accreditation, give a warning, or defer accreditation. The sub-specialty programs also have similar opportunities, a little bit of a different line up, but it's all very similar, give accreditation, hold it, give a warning, or withdraw it.

Those that are accredited through institutional review committees, institutional review committees can issue a favorable report, an unfavorable report, a proposed unfavorable report, second successive unfavorable report, warning, third successive with withdraw of the program.

These are blunt instruments. This is actually a weakness of the ACGME. This means that if you have problem, you dump the program. There is no place within this mechanism, the ability or mechanism for residents to sit down with their residency directors and discuss problem issues with protection from retribution. There isn't any mechanism for addressing specific problems within a residency, such as having to spend the night transporting patients and drawing blood until the resident is too exhausted to learn or to give safe patient care the next day.

These ACGME sanctions don't address issues at that level of detail. They don't offer protections from retaliation if a hapless resident complains to the ACGME and then his residency program loses accreditation. The resident actually has an incentive to conceal problems from the accreditors, not only because of fear of personal consequences, but also for fear of losing the whole program.

Now, in contrast, the NLRA provides specific protections for the resident, as it does any employee, from punitive actions on the part of the employer for joining other residents and getting together to talk with the program in order to try to make things better and to improve conditions so everyone can learn under optimal circumstances. That's what the NLRA is for.

Doctor Cohen, in his article in the New England Journal of Medicine from AAMC said, and he recognized that one of things program directors really have to concentrate on now is improving the educational experience of the residents, decreasing the amount of scut work, increasing the way the residencies listen to the residents and making sure that the programs comply with the ACGME. It looks like we're already getting really positive results from the NLRB decision.

It kind of makes people think a little bit. If the result were that all the residencies miraculously started to do all those things and did them very well, and all the residents were happy and we never had

to go in and organize a resident group, that would be an absolute win/win and that would be ideal. Maybe a little idealistic.

Let me point out the business of residents needing to learn to be autonomous professionals. Obviously, that's true. But in today's world, a lot of things have changed. Doctors need to learn to work together. More and more, medicine is practiced in teams.

In managed care we're being taught to balance the needs of our individual patients with those of communities of patients. We have to work with multiple other categories of health care workers. Forty-six percent of all physicians under age 40 are employees. Our young physicians, our residents, have to learn to function as good employees and as good members of a team. If our profession, the medical profession, is even going to survive in this new environment, doctors will have to learn how to work in teams, and I believe will have to learn how to seize the leadership of these teams, otherwise, of course, the nurses are certainly learning how to do it in their education and they'll simply lead the teams, which is fine. But from the point of view of the medical profession, I think it would be nice for doctors also to learn some leadership skills on the teams.

Now are resident organizations going to negotiate over academic issues? First of all, we need considerably more dialogue on what is and what is not an academic issue. More interestingly again, at the University of Michigan it's not been a problem and the resident union has been there for over 20 years.

Hurley Hospital in Flint has a resident union. It sits down with the program directors weekly, goes over problems, they decide what they need to address, they head off issues before the start to fester. They've worked with each other for years, they know from experience what they can talk about, and probably the essence of it all is they trust each other. They trust each other to choose the subjects of negotiation intelligently.

If the negotiating agent for a resident group is PRN in a contract negotiation, obviously you know that we're all physicians, we know what's necessary in order to learn, we know what's necessary in order to teach, we've all gone through this process.

Let me talk a little about professionalism. Physicians, whether or not in unions, are professionals. There are multiple definitions of a professional. Elliott Friedson, a professor of sociology, describes as the central principle of professionalism, "the condition that members of a specialized occupation control their own work."

A very excellent book came out quite recently, I recommend you to, The American Medical Ethics Revolution, was edited by Baker, Kaplan, Emmanuel, and Latham, and in this, Elliott Friedson has a very nice article. He says that "unlike professionals, technicians have little voice in choosing the goals of their work, selecting the actual tasks they're to perform or establishing the criteria by which their work is evaluated."

In contrast, he says a profession, and I quote, "must use every means possible to require working conditions that provide its members with the resources necessary for both competent and beneficent service." This implies that it's important for a physician, during the course of her training, to learn how to insist on suitable working conditions to facilitate the best possible care of patients.

This is a learned skill, just like surgery, I'm a surgeon, and it, too, should be learned during residency. This requires learning to insist on one's professional needs, to do it in an effective way, to minimize the degree to which this is confrontational, to learn to pick and prioritize issues, and to learn to argue them effectively. This needs to be learned.

In the same book, Doctor Friedson suggests they are losing control over the allocation of resources that allow them to do good work. That, more than anything else, is why groups of employed physicians have come to PRN. They want a voice in allocation of scarce resources.

Today we're experiencing cut backs throughout the health care system. We're finding that employers are deciding such matters as when the laboratory, the Radiology Department, and the pharmacy should be staffed and when they shouldn't be staffed. Yet the decisions they're making are having an impact on the patients, they're having an impact on the doctors' ability to take care of the patients. The doctors are there on the front lines. They know what's needed. They know what hours of staffing is necessary, they know what the decision should be.

They know -- for instance, we're finding in one negotiating effort that we're involved in right now, that an urgent care was set up but administration made the decision that there would be no laboratory and no x-ray staffed at the time of the hours of the urgent care, and the pharmacy would be closed. So they saw the patients and then they sent them to a local emergency room. This is being done in terms of cost containment?

The doctors are saying, "This is crazy. It's penny wise and pound foolish. Ask us. We're on the front lines, we're taking care of the patients. Please give us the opportunity to weigh in and help you. We probably can save you money." But doctors need to be able to bring their expertise, whether it's asked or not, and they need to be able to do so without fear of retaliation.

Doctor Friedson goes so far as to say that it's part of the ethical obligation of physicians to be able to negotiate with their employers about the resources they need for the benefit of their patients. And in fact, he says that "as part of its primary ethical obligation to serve the good of its patients, the profession should fight for revision in American labor law that would grant its employed members the right to negotiate collectively."

I'm not sure we need changes of law but I do really believe that learning the skills of collegial negotiation is a good thing. I do not believe that experience has shown that these negotiations so far have impacted on academic issues. I believe that as mature adults, residents and residency directors can work together, can develop an atmosphere of trust through working together and talking across the table, and I think this is very healthy. I recommend that you look favorably upon this.

Thank you.

DOCTOR SUNDWALL: Thank you very much. I'd like all of our panelists up here. Do we have them all? And I think we've set the stage for a good discussion. For a change, we have ample time and I have a number of questions but I'm not going to seize the first opportunity and now open it up to Council members to pose questions to our presenters.

Ann? Ann Kempski, our Labor Representative on the Council.

MS. KEMPSKI: Doctor Sundwall, I know you're shocked I have the first comment and question.

DOCTOR SUNDWALL: You're normally so demure.

MS. KEMPSKI: I have a comment and a question. The comment is that as a patient, as a consumer, if 40 percent of the physicians in a state don't participate in the Medicaid program, is that withholding care? If I walk into my intern's office and there's a sign on the wall that says, "I'm no longer participating in CIGNA," and I carry the CIGNA card, is that withholding care?

Taking that a step further, every week in every local newspaper around this country, there are headlines about "Children's Hospital of Philadelphia in Showdown with Blue Cross Over Reimbursements," and the whole city is worried. People who belong to Blue Cross are wondering if they're going to be able to go to Children's Hospital of Philadelphia.

Meanwhile, in New York City, we have hospitals merging with one another. All over the country we have hospitals merging with one another expressly to gain bargaining power with insurance plans.

So, forgive me if I detect a little bit of hypocrisy in what is considered withholding care. That's my comment.

Then my question is to Sarah Fox, because I think, Sarah, that not everybody understands the specific procedures in health care around -- when disputes, when impasse is reached in a bargaining situation there are specific notices that have to be done. There's a great deal of procedures built into the bargaining process to minimize the likelihood of a labor stoppage. So that's my question.

MS. FOX: I won't say much more than you have said, but there are, as part of the 1974 health care amendment, specific special requirements which, as you say, are supposed to minimize the potential for disruption in the health care industry by such things as longer notice requirements than exist in other industries, and provisions for mediation and -- with the Federal Mediation Service, et cetera, to try to maximize the potential for resolution of disputes without resort to the use of economic weapons.

DOCTOR SUNDWALL: Regina first, and then Doug.

DOCTOR BENJAMIN: Sorry, I just want to respond to your analogy. I have to. I don't think that someone saying they don't take Medicaid or they don't take your particular insurance card has anything to do with the access. They didn't say they wouldn't treat you. They just said they wouldn't take those cards. It's just like going to Macy's and they say, "we no longer take American Express." They didn't say they wouldn't serve you. They just won't take your means of payment. That is totally different.

When you walk in my office, we will see you no matter what. We just happen to take whatever you have. Some of the insurance cards won't take me. So what's the difference?

DOCTOR SUNDWALL: You mean, based on your profile they won't consider you as a provider?

DOCTOR BENJAMIN: Or based on my patients. The fact that they don't have any money. They can't buy insurance. They can't even get it.

DOCTOR SUNDWALL: Doctor Wood?

DOCTOR WOOD: I have a couple of questions, primarily addressed to Mr. Levy, and I'd like to ask you, number one, about the strike issue and number two, about the future. It probably is important to give you some information on my background because I may have some biases.

Number one, I was a member of a union for about six years. Not a physicians union, a musician's union.

So that's something about my past you didn't know, David.

DOCTOR SUNDWALL: I'd heard rumors.

DOCTOR WOOD: Did you? Well I'm not a union member any more, so you can have that rumor.

I would contend that in that particular union, and also having lived most of my life in Michigan, that in unions there is a group think, which is very bothersome to me when we start thinking about physicians. It seemed that everyone in the union thought the same, and if they didn't, then there were pressures put on you to think the same.

Now, the other thing that I've experienced as a physician, in the mid '80s I was the director of a dialysis unit in a hospital in Michigan. We had about 110 patients at that time. The nurses in that facility

were unionized, however, when that contract was negotiated, there was like a swear on the Bible agreement that nurses in the Intensive Care Units and nurses in the Dialysis Unit would not go on strike.

Well, guess what happened. They went on strike for about six weeks and that was a very, very difficult time trying to perform dialysis on patients. So my questions, Mr. Levy, are two. My presumption is in the agreements that you negotiate that the strike issue is not there. It's not part of the agreements.

My second question is, I'd like to have you hypothesize about the future, if you would. If we presume that over X number of years that most of the residents in this country are unionized, and my thought then is, what happens then to the physicians in this country once they come out of residency programs? Will most physicians in this country think that the way to act, either through their county society or through a state association, through a specialty society, is the best way to act, then, to be unionized, and what the affect be on health care in this country? Do we then end up with a Canadian type system where the physicians go on strike?

MR. LEVY: I'm shocked that this discussion has all of a sudden focused on strikes. I did not expect it at all today. I'm sorry.

It has to do with the ability to sort of shift the dialogue. Let me respond to one thing. I actually take some degree of offense at the concept of group think among union members.

The American Hospital Association speaks with one voice. The AAMC speaks with one voice. The AMA, after it's debate, speaks with a voice. All of us, each of us in various ways belong to all sorts of organizations and our organizations act collectively. Nobody at the AAMC, nobody at the American Hospital Association asked my position as a citizen and a tax payer, whether public money should be used out of their general funds to pay for their membership in their organizations. And their organizations work as a group, think as a group, speak as a group. So I think there's a sort of misstatement of that kind of thing.

The working class people I know don't think as a group in any kind of directed way and God help me, working with residents for 17 years, residents don't think as a group. Not even are they not a group, but then you've got the psychiatrists an you've got the surgeons, and the surgeons say the psychiatrists aren't doctors and then everybody says, well who are those folks in family practice, they're just sort of dallying around. Where does some of this stuff end?

I think it's really an unfair characterization. I think the strike issue is another one of those, sort of, straw men issues. Let's be very clear. Students legally can strike, anytime, any place, anywhere in the world. We always read about student strikes. So what is it about getting the right to have analog B protections that makes residents more likely to strike?

In fact, I would argue the opposite is true. Under analog B procedures, I forget all the details because I haven't worked under those procedures for a long time, but there's a 60 day notice when the contract is going to be expiring, then even before you can have a rally outside or hand out a leaflet you have to give a ten day notice and they send a mediator and you have federal mediation.

If there are complaints about unfair labor practices instead of sort of rolling up your sleeves and squaring out outside, you pay your folks to go to the NLRB and you hope you'll get an impartial decision. So I think, in fact, there's a decrease in strikes, or the likelihood of strikes under analog B procedures.

In the 17 years that I've worked at CIR there have been two strikes. They're a matter of public record, anybody could research the newspapers and find them. Both those strikes were around recognition issues, how staff wanted to organize. They approached the employer, the employer, in one case, said, "No, we won't let you organize." In the other situation there was a union in the middle of negotiations, the employer just said I no longer recognize. It was the house staff, themselves, that demanded to use that option because there really weren't other options.

But there's something about the strike issue that I really want to describe for people in this room because I'm not advocating strikes and I'm terribly afraid that the camera can video clips of my explaining this and it be used in other kinds of ways. But for those people in this room who've never been in a health care situation, whether it's service and maintenance employees, whether it's nurses, whether it's physicians. When you give notice to the employer, 30 days, 60 days, 10 days ahead of time, where does the responsibility shift for the patients? At what point is the employer keeping patients in the hospital not for patient care purposes, but as hostages in a dispute?

EMS can divert. There are lots of hospitals in the neighborhood. Most patients don't stay in hospitals 60 days, 30 days, 10 days, where you've had notice about either changing appointments, moving people, transferring people, sending them other places. In my experience, working for another union in health care, the employers knew that there was a dispute going on, as well as anybody else. The employees took every action possible to say "Let's settle it, A, and B, if it doesn't get settled and there's going to be a strike, please, please make alternate patient care arrangements for the patients." Those alternate arrangements are there and possible.

Not one patient is transferred, EMS is not notified, et cetera, et cetera. The hospital goes ahead full speed, I would say at a certain point, they're being kept hostages.

Now this is just to describe to you what goes on because shifting the whole moral burden to the side of the hard working doctors, residents, nurses, or other people, I think is a little bit unrealistic given the realities of the world, of how negotiations go on.

Does this mean I'm advocating strikes? Of course not. I'm really not. Does this mean that I think strikes are fun or easy or anything like that? Of course not. But I'm saying that there's a reality there that's not being put on the table.

Your other question was about looking into the future in terms of what happens to doctors if they're in resident unions, might they be in unions in later parts of their career? Well, it really depends on what happens to their work and the world.

Twenty years ago, doctors weren't really thinking about being in any union except the AMA, which I would argue even at that time was union. But the conditions, the market forces, the changed nature of the relationships is really what's driving those people's decisions about how they feel that they can have some sort of influence. So it's not like some blank slate or weak mind is going to be molded in their residency that's going to then twist them and send them directly to being a union doctor. I think that that's not the correct thing.

I think what's going on is there are forces in this society that is taking medical care, health care away from people who make health care decisions and into the hands that make economic decisions and the world has changed and people have to figure out how to respond to it.

I hope I answered your question.

DOCTOR SUNDWALL: Let me just give some order to our comments, now. I'd like to have Doctor Foreman respond and hear from Doctor Nicole Lurie, then Doctor Adelman. So if you want to make a statement, I'll try and keep track.

DOCTOR FOREMAN: Because the question of labor unions tends to be one of those polar things in our society like whether you're a Democrat or a Republican or Pro-Lifer or Pro-Choicer, that as people come to the debate with a lot o preconceived, not only preconceived, but a lot of beliefs and views, I think it's important that we sharpen the focus on the discussion about what's being proposed today.

The National Labor Relations Act protects physicians and nurses employed by medical care organizations if they want to form union. There's no question that physicians are protected by the Act and

there's no question that nurses are protected by the Act. The question is whether house staff should be protected by the Act and whether house staff are in fact workers or are they learners? That's the central focus of today's decision.

I suspect that long before you were -- you were probably in grade school when I was an intern at Henry Ford, and in those days, I received a stipend of $170.00 a month, and Henry Ford was paying the highest salary for house officers in the United States. In most places, salaries ranged between $50.00 and $100.00 a month and were not dignified by calling them salaries. Five years earlier it was quite common for house staff to be engaged in training programs in which no stipendiary support was provided. At most it was laundry and meals.

Setting aside the questions of the 14th Amendment and whether servitude is permissible under the Constitution, I ask you the question, would we have this debate today if house officers still were not receiving a stipend?

My own concerns here, which is that the health care industry, as it was, deliberately and cognitively decided that you, in dealing with the house staff, graduate physicians, mature people with families, that you could not expect them to work without stipendiary support. But I don't think they're are any more or less students with or without a stipend and my belief is were we not paying house staff now, there wouldn't be anybody who'd say they qualified as employees. I'm not recommending that, I'm simply observing it.

DOCTOR LURIE: As I'm listening to this debate and thinking about roles as educators, I continue to think about our need to prepare physicians to the future, I'm reminded of a prior COGME document that I'm familiar with that outlined competencies for physicians going into the future, and one of those sets of competencies included teaching people leadership, teamwork skills, and how to promote and create responsible organizational change. As I listen to this debate I ask myself whether or not one model versus the other gets us to that goal any better.

It seems to me that historically we've done a pretty crumby job teaching physicians particularly in residency, but in general, often to think about issues that are outside of themselves and their immediate self interest. It's pretty hard for them to think about, in a concerted way, improving quality of care in their institutions or improving quality of care in their communities.

So I'm curious about the take of the panelists. Are people likely to learn these sort of leadership skills and how to promote organizational change better in one model versus another? If we stick with the current model, what else do we have to do to get these skills to function more effectively when they're in practice in whatever setting.

If we go to a situation in which most house staff are unionized, do we need to do anything different? Do they learn those skills by virtue of the fact that they're now in a union? Do we need to teach anything different about leadership and organizational change and team work? Do we need to teach anything different about professionalism and what assurances and accountability are there for residency programs and others to assure that these skills are mastered in one format versus another?

DOCTOR SUNDWALL: I think that the most likely next respondent is Doctor Adelman, to talk about that. Then I'm going to call on Lucy and then Susan and then our student representative, William.

DOCTOR ADELMAN: Fortunately I've been making notes. I can comment on several of the points that were raised.

The first one, the group think one, probably everybody in the room has heard people talk about trying to get doctors together and organize them is like herding cats and it's really true, so I think that group think is hardly the most likely thing in a room full of doctors, who usually if there are five, there are 20 opinions. Also, joining a union, doing and organizing campaign, doing the vote and so forth, is an exercise in hanging together and persistence and leadership and teamwork. It's very hard to do. It's not

an easy undertaking. It takes a lot of time and commitment if there is opposition. If there isn't and it's voluntary it may not take so much.

But I think that that's a partial response to the question, "Are most doctors going to unionize?" Certainly if residents have been in unions and they've had a positive experience with it, they will look more favorably upon unionization as a solution to problems when they emerge from residency.

If the problems aren't there, they won't want to do it. It's too much effort and they really won't want to. So I think that there may be an increased probability that the young doctors will move from residencies into that kind of activity, but not necessarily if their work environment is going well.

I want to emphasize again on the NLRB decision, it was not a question of either/or, either student or employee, but both. Please, and it's very important to remember that, it wasn't my decision, but as we're lobbying and all of us lobbying in Congress, we have to emphasize it is both. Residents continue to be students.

I just want to make one comment on the no stipend discussion, of course you could pay residents no stipend and get out of the whole situation, but one of the goals that we have in the medical profession is to increase the diversity of our profession. We want to have people who come from backgrounds where they will get medical training and hopefully go and serve the under served, hopefully people who look a little bit different from the standard issue doctor and who have different experiences and backgrounds. These people likely are not going to come in rich and if you deny them the opportunity to train by saying only the rich can train because the rich don't have to be paid you're going to get exactly what you're paying for or not paying for. You're going to get a bunch of kids from rich families in the suburbs and they're going to be the medical profession of the future. You will not have diversity, so that clearly is not something we want.

In terms of whether or not you learn leadership skills through this activity, I can only say that I came up through the house staff association at Henry Ford Hospital.

Jay Harness started the University of Michigan Resident's Union and he popped up in our AMA delegation.

Rex Green started the one at L.A. and he's been in the AMA delegation of California ever since and we've all gone through the chairs of our respective medical societies.

Ron McComela at Hurley Hospital also started the House Staff Association there and is now in a variety of respected positions in the AMA.

Yes, that has been a route for people to move on to leadership. They have learned the skills. We have learned the skills. There are many other possible routes, but this is yet one more route to learn the skills and to learn what needs to be done and how to be effective.

CHAIRMAN SUNDWALL: Lucy?

DOCTOR MONTALVO-HICKS: I think I should probably explain a little bit of my personal background to say some of the things I'm going to say.

First of all, I'm from Chile, so there's my accent. I trained in Canada, so I have that background too. And I work for the State of California, so I am a salaried doctor, so I'm not the typical doctor in private practice.

When I first started working for the State of California, I found out that some money was taken monthly from my salary to pay the union dues, whether I was a union member or not, and several of my colleagues in the same situation had that, I must recognize, fear of the unknown.

When you're a physician, physicians are not unionized, and I didn't understand too much what this was all about, but as the years have gone by and I'm with the state nine years now, the UAPD, which is the union that we belong to, the Union of American Physicians and Dentists, has done a terrific job bargaining for us, have gotten very good contracts for us that the previous governor opposed tremendously for years, and good pay raises. So I like it.

CHAIRMAN SUNDWALL: Thank you. That's a refreshing perspective. Ann, you're not alone on this panel.

MS. KEMPSKI: She's a member of my union.

CHAIRMAN SUNDWALL: That's great.

Susan?

DOCTOR SCHOOLEY: I was a steward in the International Brotherhood of Electrical Workers 30 years ago.

CHAIRMAN SUNDWALL: Really? As long as we're coming out of the closet, I was at a union card working two summers as a laborer at Kennecott Copper when I was a young man. It was a green colored card. I was very proud of it.

DOCTOR FOREMAN: Try this. I do my own TV and radio ads in New York and I can't work without a card. So, I'm a member of the union.

CHAIRMAN SUNDWALL: That's great.

DOCTOR SCHOOLEY: One of the benefits of that job for me was that they took me to upper level management negotiations because they thought the presence of a girl in the room would keep management from swearing and throw them off their game.

I also operationally manage two unionized primary care ambulatory care centers currently. I am very supportive of the initiatives for the continued improvement of conditions that produce better physicians and better patient care. So, any comments I make I want to preface that way.

I have a concern, however, which comes from the fact that my observations of the day to day work both in my own work as a union steward and in my management role in relation to unions on a daily basis, this is not an initiative that often works toward a high performance culture. The day to day work is frequently set about the business of defining the floor of performance and defending individual rights in relation to the floor of performance. Our mandate as medical educators can't accept operating at the floor of performance. We have a higher calling than that. I am very concerned about deteriorating in that direction. The regression toward the mean, if you will.

I think the ACGME has done a wonderful job in establishing a process by which conditions of work and residents' rights are protected. I want to remind the Council that not only do they work in that way through accreditation, both institutionally and with individual programs, but that they receive and address individual resident grievances and they do so in a very expeditious and firm manner. As a member of an RRC, among other items on our agenda are individual grievances of residents.

CHAIRMAN SUNDWALL: Very good.

William?

MR. CHING: I'd actually like to address some of the comments that were made earlier. As the medical student resident physician representative, we kind of have a vested interest in this issue. There are a couple of points that were brought up that I would like to address.

First off, we wouldn't be here if medical students, as future residents and residents, did not feel powerless. I think this is absolutely key to the debate that we're having and the issues that we're raising here, to one point.

Regarding the role of the ACGME in dealing with standards of work conditions and educational conditions, as mentioned earlier by Doctor Adelman, the sanctions pretty much center around accreditation which, as far as the residents are concerned, is a pretty blunt and counterproductive instrument. The effective loss of accreditation affects the resident far more than it will ever affect the hospital.

As you mentioned, for a resident to point out deficiencies in work conditions, educational conditions is tantamount to say, "Hey, pull the accreditation from my program or at least threaten it and make my life miserable," because of the lack of protections offered to that resident. So, in that case, we feel that, as it stands now, the sanctions that are offered simply do not work and we feel that binding legal, contractual arrangements are the way to go with that.

For example, examples in which this hasn't quite worked. First off is the issue of resident hours. In New York State, you may be aware that we are pretty much the only state in the nation that regulates hours in a statutory basis. These were established by the Bell Commission and have been amended afterwards and were made in response to the Libby Zion case quite a few years back in which pretty much an overworked, over tired resident made mistakes which ultimately led to a series of incidents that led to a very unfortunate outcome.

So, these resident hour regulations have been on the books for years. In a recent audit last year, virtually every single hospital audited failed. Virtually every single one of them. Either program directors misreported or under reported hours that they were scheduled as opposed to the hours actually worked. There were a number of issues that were not in compliance with statute and the hospitals were fined. Granted, at a thousand dollars an incident it's not much more than a slap on the wrist, but it concerns us deeply that if it's in statute and it's currently being ignored, that accreditation sanctions will have even less effect.

Second issue regarding the role of contract is the New York Eye & Ear incident which took place last year in New York. As a background to this, the Board of Trustees of New York Eye & Ear decided to sell the hospital, dissolve the residency programs and pretty much disperse the assets of the organization into a series of programs that they thought would "more adequately serve the purpose of the foundation." The residents were left hanging high and dry. ACGME sanctions would have done absolutely nothing because the hospital would have ceased to exist. These residents were left scrambling to find places to go within the space of weeks. This is clearly not an acceptable situation and existing protections clearly were inadequate to address this.

So, that's one response to that.

Second one is regarding the comment about group think and kind of how residents would approach negotiations. I would also take a bit of offense at that and would address earlier comments by saying herding residents is like herding cats. I challenge you to find a group of medical professionals who can agree on anything. We're not going to have that.

I also would like the group and the Council as a whole to recognize that we have a vested interest in remaining professional. We are in this as physicians to serve our patients. Any implication that we would somehow undermine that in the name of dealing with our working conditions I think is a slap in our face. Give us credit for being professionals.

Another issue regarding dual status. Yes, we're students. Yes, we also work. In college, I will also confess, we work, we're unionized. It is not incompatible with our student status. We simply leave

the two separate. Our educational process is left separate from our working environment and I think that's the way it should proceed and I think that's the way it will proceed.

Finally, regarding leadership. Coming through organized medicine, it has been an incredible opportunity to build leadership and has been an incredible process for building leadership, building consensus for debate, for hearing new points of view, for addressing them and for coming to some kind of position that we can all if not wholeheartedly agree with, at least can live with.

The process of negotiation within a collective bargaining environment absolutely is perfect for this. We cannot at the same time say, as physicians we need collective bargaining ability, as evidenced through the Campbell Bill to deal with managed care organizations, and at the same time say, residents should not organize to deal with the situation in which they are equally powerless. Maybe not as powerless as some around the room think, but nevertheless a very weak negotiating position.

So, I challenge you. Let's be consistent. If you wish physicians to be able to negotiate for better conditions, for higher quality care, we should be able to do this at all levels, not just in private practice, not just as employed physicians, but as interns and residents as well.

Thank you all for coming and I hope these comments --

CHAIRMAN SUNDWALL: Thank you, William. They are very welcome and they provoke some responses from our speakers. So, first of all, Mr. Levy and then Doctor Foreman.

MR. LEVY: I'd like to respond to Mr. Lurie's serious question. I understand that people have concerns, but out of the 40 odd years, 43 years experience of CIR, my own 17 years at CIR, I can tell you that CIR does not lower the standards of residents, their desire to learn, their desire and ability to provide real quality patient care. It would sell yourselves short as physicians to say that if residents were in a union they would sort of work to the lowest standard. It's not my experience.

First of all, the standards really for that kind of work are set by ACGME are not covered by the contracts. So, those standards exist outside the contract for that level of work.

The second thing is what really happens, if I can be specific rather than hypothetical, is that the residents use their union, as Doctor Adelman was saying, as somewhat of a protective situation to be advocates for improvement of quality care. When a program director or a chair is in a budget squeeze about how many nurses they can have, how many transporters they can have and residents are running around doing more service, more scut work if you will, and having less time to learn when their attendings, in fact, are being given more time to do service work and having less time to teach, when residents are told very directly, "If you have a choice between filling out your charts, doing your records, seeing your patients or coming to any sort of a didactic requirements, you better take care of those other things and let the didactic go."

You go to some of these meetings during the course of the day, maybe a third of the house staff or a quarter of the house staff are there because the rest have to be on the floors. The residents use the union to be able to say, "We need more staff. We need more attendings to be teaching. We need time to get to our didactics," et cetera, et cetera.

But the union has been, in concrete experience, my experience 17 years at CIR, I've never seen it operate to dumb down the standards of anything. It's been a pain in the ass, thorn in management's side demanding better quality. When the hospital is busy trying to do other stuff and meeting its budget, we have a bunch of residents who are saying, "Help us learn more. Help us have more time to take some courses. Let us not have to work on call the night before I take my exam." Right? We had a resident die last year in a car accident because he was required to work before he went off to his exam. How much time do you give your residents to rest before they take their tests?

Our residents are demanding access to quality care that they want to provide, demanding access to quality training and better learning situations, and it's so hard, so hard for a resident to be able to say to their program director or anybody else, "Listen, I've got a little problem and we're all having this problem. Could you deal with it?" because we know what it's like in residency programs and how program directors and chairs and other people tend to respond. It's scary. The AMA News has been filled with articles recently about residents who are terrified to complain about the hours that they're working. They know it's bad, they know in New York State it's illegal, but they're terrified to report it. These are active, courageous people and the union gives them a vehicle to say, "This isn't right. Let's do something about it."

So, from my experience rather than concern on a hypothetical, is that, in fact, what happens, standards really are increased.

I guess the last thing that I want to just sort of close on with that statement is that if you list all your concerns, there could be two reasons for listing those concerns. One can kill an argument by listing concerns because you can always raise more questions than anything and then you can kill what's going to happen. Or if those are concerns that you want to work on, then say, "Let's sit down and deal with some of those concerns. We can meet some of those."

One concern the AHA said was it's a problem having residents and attendings possibly be in the same unit based on this particular decision. Well, do you want to use that as an argument or should the AHA and the resident union sit down and talk about how you address those issues? Is it a debating point or is it something that we can work on together?

There are a whole list of these other concerns that I think we can work on if the intention is to solve problems. If it's just to raise issues, then it's just to raise issues.

CHAIRMAN SUNDWALL: Go ahead.

DOCTOR FOREMAN: I'd like to respond to a couple of points that Doctor Ching made because I think they're very important points.

The first is that the history of resident hours does not derive from the union movement in this country. In fact, the resident hours revolution took place after the tragic death of Libby Zion in New York Hospital in 1985 when the Commissioner of Health of New York, David Axelrod, convened a commission headed by Bert Bell that did the first comprehensive study and report of the problems created by working hours. That became ultimately the law in New York and adopted by the ACGME as its own framework for accreditation. Long overdue, many of us thought, exactly the right thing to do and couldn't imagine why it took so long, but it wasn't brought about by collective bargaining.

The second thing. At least in New York, there are qui tam protections for house staff. That is, whistle-blower protections. If a house officer feels that the program in which he or she is enrolled is abusing or not following the rules, they can call the State Department of Health and with total anonymity get people to look at it.

In fact, the site visits that occurred that you referred to earlier grew out of whistle-blowing complaints. What was fascinating was that there really was no difference between where the problems were, whether the hospitals were unionized or non-unionized and I think it's very important to recognize that as important as that issue, there were abuses in hospitals that were unionized and abuses in hospitals that were not unionized and vice versa.

The last point I'd like to make is to respond to your point about Manhattan Eye & Ear. We were appalled, absolutely appalled that a hospital could choose to enter into a transaction to sell and simply pull the rip cord on their residency programs and tell everybody to find their own way. It was an appalling situation. What's not clear to me is how that house staff could have done anything had they been unionized. That is, what could have happened as a result of a labor union that didn't happen. If the place

wants to close its doors, it didn't obviously, for lots of reasons. That story played out a number of interesting ways. But at the moment that that occurred, it appeared that the place could just close the doors and say, "Good bye, so long, see you later," and I can't imagine what a labor organization of anybody could have done to protect that.

DOCTOR ADELMAN: Thank you. On the lowest common denominator concern, that would apply where your population of persons, professionals, residents, employees, whatever, have a desire to do less. One of the reasons why it's very hard to enforce resident work hours is usually it's the residents themselves that subvert the hours, particularly surgery residents who really want to do more. They want to have more experience, they want to do more cases, they want to see more patients. They don't want to lose hold of their patient that they just operated on and turn them over to somebody else.

So, the motivation of the resident is to do more. I think that would very effectively counter the kind of concerns that we see if we see perhaps less motivated employees who want to do less.

Something that needs to be recognized by anybody, any of you who may not have gone through residency, is to a greater or lesser extent residencies are organized like a military hierarchy. Maybe not quite so much today, but certainly when I went through surgery residency at Henry Ford Hospital. That was the absolute prototype of a military hierarchy. When you were told to do something, the answer was yes, sir. Nobody had the slightest interest in whether you were tired or whether you had 14 other things you were supposed to do at the same time. That was the most irrelevant consideration there is on earth.

Now, let me tell you what I as a resident learned. When I was asked to do something, the answer is yes, sir, and that plagued me for the first several years of my life after I got out of there until I discovered that the whole world didn't function that way. That plagued me in my fellowship. I never believed that I was empowered to say, "Well, you know, I don't know how I can do this because I'm already obligated to do that and I've got somebody sick in the ICU and I'm not sure that I can follow you around on rounds and hold your clipboard for you because I just don't think that that fits into the priorities."

That was not an acceptable answer, so I never gave that answer. So, I tried at all times to do everything that everybody wanted me to do simultaneously, day or night. That's a formula for exhaustion, burnout, fear and very, very bad professional work habits. That is not what we want to teach our residents.

What we want is to be able to empower our residents to say, "Now, here's some problems that we have and I don't think that I can do these three things precisely at the same time between the hour of 3:00 and 4:00. I don't think it can happen." Now, that is the kind of thing that residents can learn if they see these things negotiated or if they participate in the process of negotiating. This leads to maturity. This does not lead to people feeling that no matter what happens, they always have to say, "Yes, sir."

Now, there are obviously lots of other ways to deal with -- there are sanctions, there are the Libby Zion laws, there are a lot of AMA policies that are on the books. There are a lot of ACGME policies that are there that are on the books. But that doesn't mean that everything is going to happen just because the laws are on the books or because there's a body of policy at the AMA. This has to be operationalized and it has to be operationalized in a mature, adult way. You have to sit down and figure out how to make it happen.

One way to do it is to sit down at a bargaining table. It's not the only way. You can sit down in a room and talk. You can sit down like the residents do at Hurley Hospital and talk with their directors and look at what the issues are. You don't want to go and do a qui tam. The qui tam is very, very gross. You do that about equivalent to reporting a violation to your congressman or going to the local police department or something and saying the conditions are unsafe or there are mice in the operating room. You only do that if things are really, real dire to get into that. And talk about time consuming. Now you have really bought it.

What could have been done in the Manhattan Eye & Ear? Well, if there were a contract that had something in it indicating how the hospital would assist the residents, what the procedures would be, if it ran into the type of financial problems that would cause it to have to collapse its program, at least that would have been anticipated. There would have been some structure. There would have been a pathway that would have been pre-thought out so that it doesn't suddenly become a crisis, "Oh, my, the program is gone. What happens?"

So, yes, these things can be put in a contract and that is one of the ways that you can implement good policies and good laws that just need some way to make them happen.

CHAIRMAN SUNDWALL: Okay. Ms. Green and then Sarah.

MS. GREEN: Calling on some personal experience, I happened to be, for many years, with an organization, a health care organization that dealt with, at one point, three different unions. This was an organization that was known throughout the nation as having a very good relationship with all of its various unions. I was in a management role.

One of the things that concerns me about what we're talking about here today was that there was in the situation work place, there were times where there was disagreement between the collective bargaining units and management as to what is a legitimate area for conversations, what is a legitimate area for a collective bargaining arrangement to have input. Quite often, management would set aside its own ideas about this because the benefit of prevailing did not in any way match up with the cost of dispute.

One of the areas though where I'm concerned is that performance in the work place was considered to be a legitimate area by both parties for discussions with collective bargaining organizations. When you have the situation where you have an employee who is a learner, how do you address the issue of performance in the work place being a legitimate issue for dispute between a third party and the other two? That is not a rhetorical question, that is a question I'd like to hear addressed by the panelists.

CHAIRMAN SUNDWALL: Do you want to go first?

MR. LEVY: Let Ms. Fox go first.

MS. FOX: I just was going to respond just briefly to the issue of what might have occurred in the Massachusetts Eye & Ear -- Manhattan, excuse me. Just to say something about the law. It may be that the employer would not even have been required to bargain over that decision to close. It would depend on the circumstances. But under the law, an employer in that circumstance is required to bargain over the effects of a decision to close. So, I just wanted to say that about the law, if there is a recognized union.

CHAIRMAN SUNDWALL: I want the panel to be able to respond to Kyle's question. Do you want to just posit the specific question again? The problem is it's work performance --

MS. GREEN: Yes. In a situation where you have both a learner and an employee, how do you handle the issue of work place performance and having a third party, a collective bargaining unit, a union, be actively involved in that along with the other two parties.

CHAIRMAN SUNDWALL: They couldn't be a judge of that kind of performance.

MS. GREEN: Exactly. Exactly.

CHAIRMAN SUNDWALL: Okay. Mr. Levy?

MR. LEVY: For 43 years we've been dealing with it. This is not a newly discovered problem. Just about the New York Eye & Ear. Let me just throw out one other word. Flushing Hospital started to

close and 1199 saved it and we were there and part of that, et cetera. So, there are other situations where the union did make a difference.

But in our collective bargaining agreements, all of which were subpoenaed, all of which were turned over to the Board, we set up a dichotomy between administrative actions and learning situations. The union does not get engaged in making decisions about evaluations. There's nothing in any of our contracts that mandates a program director to send a certificate to the Board, or if not the program director the chairman.

Really, again, a reality check is sometimes useful in these situations. How do you get to be board certified? You've got to take a lot of tests. Right? You've got to get together all your letters and there's nothing in a contract that contravenes that.

Some of our contracts clearly say that in some of those situations a resident made an error in the performance of her or his work. What happens? Well, the program director deals with it. If it's fair, it generally stops there. I had a resident at a hospital in Queens who was removed from clinical privileges. The program director said it was a clinical judgment. It was an ophthalmology program. The woman said, "My chief showed up at my door last night and asked to come in and wanted to spend time with me and I said no and I showed up in the hospital the next day and I was removed from clinical privileges."

What do you do in that situation? Is that purely an academic thing? Do you leave the chair to be in a position where his determination is never looked at by somebody higher?

In most of our contracts, what we have is where -- and this is included in a lot of professional standards, where something is appealable outside of the department. If a personality thing is getting in the way, it goes to another panel and a higher panel and it's a situation where people, when they make decisions, need to know that their actions are reviewable by somebody else.

What we do in our contract negotiations, and I've been through this a number of times, particularly with first contracts, is you sit down and you discuss which track is appropriate to review certain kinds of those decisions. Somebody who is performing, are they entitled to have a representative with them to hold their hand? When was the last time a resident ever walked into a room and sitting in that room unexpectedly there were a whole slew of attendings, the chair and the program director, and the resident was said, "Okay. Go ahead, tell me what happened." Residents are trained to be fairly articulate, but that's a tough situation.

Is there something inherently bad with saying, "Before I walk into that room with those odds, that I want to have counsel. I want to have some advice. I want to bring somebody with me." Does that make that situation adversarial? Well, when there's a panel of seven people at the top of that military hierarchy in one person, it seems to me that somebody else has set up an adversarial situation.

CHAIRMAN SUNDWALL: Speaking of military, I'm known as running things like the military and I'm going to ask if you have another point or, Dr. Adelman, do you want to make a comment on this?

MR. LEVY: I just had one really quick point.

CHAIRMAN SUNDWALL: Okay. These two and then Ezra gets the last word, as usual.

MR. LEVY: The New York State hours regulations did not come into effect solely because Libby Zion died or because her father, Sid Zion, was an important journalist. Why in New York State and not any other state? One, it was the vision of Doctor Axelrod, who was one tough bird, and wanted to do that. The other thing was that he had the support of the hospital association who, according to Doctor Axelrod, looked at what was happening in the match and that residents were not coming to New York State because of those conditions.

Third, organized labor in New York State has the highest degree of health care organizations, SCIU, AFSCME and the other health care unions all testified and all pushed not only for hours regulations, but for ancillary staff and more money, et cetera, et cetera, et cetera.

So, to rewrite history and to use what became a symbol at that time as an explanation of what really happened, I think sort of leads us into some false conclusions. Labor in New York, in coalition with hospitals, really made the difference in New York to get those regulations passed.

CHAIRMAN SUNDWALL: Thank you.

Susan?

DOCTOR ADELMAN: I don't really think that academic performance in the work place is something that certainly we would be terribly comfortable with getting into. This certainly sounds like academic matters to us. We would be very reluctant to get into that subject at all and don't feel that that's very high in the list of items that we believe should be subject to collective bargaining. We really believe that the conditions of employment, wages and conditions of employment, as it says in the labor act, are the real issues. Patient care issues are the ones that interest us the most. We're not in a big hurry to get into the subject of performance reviews. We feel those are academic matters and are best left with the residency chairs and the residency directors.

CHAIRMAN SUNDWALL: Doctor Davidson?

DOCTOR DAVIDSON: Just a brief comment. It stems from the fact that I chaired a large academic department for 25 years. I'm in Los Angeles where there's a long history of organized house staff activity. My comment does not relate to this, but I've also lived through a very debilitating, disruptive house staff strike. It's one of the worst things that can happen between faculty and residents and patients and administration.

But I think the key is to recognize that we are dealing with students and employees. In our circumstance, the academic decisions that allows an individual to remain an employee is entirely separate. I've had reason to test that all the way to the Superior Court of California to uphold an academic termination of such an employee. I just think that these things, though it is complex, there's a history of keeping them separate that I think makes it livable.

CHAIRMAN SUNDWALL: Well, I want to thank all of you.

Is there any last council member that wants to comment at this time?

If not, let me tell you that it's been suggested that one mechanism we might use to facilitate more debate and comment on this is that -- and I'm saying I may suggest, not that we necessarily can do it, but that we could potentially publish the proceedings of this morning's panel in print on the web, which will give it much broader distribution. But I think we've touched on some issues which are clearly important, of great interest and likely to be more so.

One comment sticks in my mind that Doctor Foreman made when he said, "This attempt to unionize is just a reaction to the vigorous marketplace forces on hospitals." That may be true, but I don't think you'd have to do a lot of historical research to find out that that's always been the force for unionization, is stimulus in the marketplace where people were feeling, as William said, powerless. And, by the way, join the club. Us real doctors already are feeling the very same way.

So, anyway, we're witnessing here another manifestation of the very rapid changes in health care delivery and education. I will counsel, I will just say publicly at this point, we'll take under consideration this as a topic for further review, analysis, and possibly publishing a report of some kind.

So, thank you for your attention this morning. You're on your own for lunch and I will reconvene at 1:15.

(Whereupon, at 12:12 p.m., the meeting was adjourned, to reconvene this same day.)