

No. 09-837

---

---

In the Supreme Court of the United States

MAYO FOUNDATION FOR MEDICAL EDUCATION AND  
RESEARCH, ET AL.,

*Petitioners,*

v.

UNITED STATES,

*Respondent.*

---

ON WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

---

**BRIEF OF BJC HEALTHCARE, CAPITAL AREA  
HEALTH CONSORTIUM, INC., HENRY FORD  
HEALTH SYSTEM, MEMORIAL SLOAN-  
KETTERING CANCER CENTER, AND OREGON  
HEALTH & SCIENCE UNIVERSITY AS  
*AMICI CURIAE* SUPPORTING PETITIONERS**

---

Mark H. Churchill  
Paul M. Thompson  
*Counsel of Record*  
Robin L. Greenhouse  
Jeffrey W. Mikoni  
MCDERMOTT WILL & EMERY LLP  
600 Thirteenth St., NW  
Washington, DC 20005  
(202) 756-8000  
pthompson@mwe.com

*Attorneys for BJC HealthCare, Capital Area Health  
Consortium, Inc., Henry Ford Health System, Memorial  
Sloan-Kettering Cancer Center, and Oregon Health &  
Science University*

August 2010

---

---

## TABLE OF CONTENTS

	<b>Page</b>
INTEREST OF AMICI CURIAE.....	1
SUMMARY OF ARGUMENT .....	5
ARGUMENT .....	8
I. Residencies Are A Central Part Of The Medical Education Process.....	8
A. Aspiring Physicians Must Complete A Residency Before They Can Inde- pendently Practice Medicine.....	8
B. Residency Programs Teach Residents How To Care For Actual Patients.....	11
II. Within The Residency System, Attending Physicians Serve As Teachers, With Resi- dents As Their Students.....	15
A. Medical Residencies Establish A Teacher/Student Relationship Be- tween Attending Physicians And Their Residents. ....	15
B. The Residency Systems Creates An Academic Culture In Which All In- volved View Residents As Students.....	22
III. As Both The Statutory And Common- Sense Definitions Of “Student” Include Medical Residents, The 2004 Treasury Regulation Is Invalid. ....	23
CONCLUSION .....	26

**TABLE OF AUTHORITIES**

**Cases**

*Chevron U.S.A., Inc. v. Natural Resources  
Defense Council, Inc.*, 467 U.S. 837 (1984) .....28

*United States v. Detroit Med. Ctr.*, 557 F.3d  
412 (6th Cir. 2009).....29

*United States v. Mem’l Sloan-Kettering  
Cancer Ctr.*, 563 F.3d 19 (2d Cir. 2009).....3, 14, 29

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, 486 F.3d 1248 (11th Cir. 2007).....5, 29

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, No. 02-cv-22715, 2008 U.S. Dist.  
LEXIS 57808 (S.D. Fla. July 28, 2008).....*passim*

*Univ. of Chicago Hosps. v. United States*, 545  
F.3d 564 (7th Cir. 2008) .....29

**Statutes**

26 U.S.C. § 3121(B)(10) ..... 5

**Regulations**

Treas. Reg. § 31.3121(B)..... 6

**Other Authorities**

*United States v. Memorial Sloan-Kettering  
Cancer Center*, No. 06-cv-0026 (S.D.N.Y),  
Dkt. 27 (“Dougherty Decl.”).....*passim*

*United States v. Memorial Sloan-Kettering  
Cancer Center*, No. 06-cv-0026 (S.D.N.Y.),  
Dkt. 28 (“Massie Decl.”) .....*passim*

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, No. 02-cv-22715 (S.D. Fla.), Dkt.  
188 (“Katz Test.”).....*passim*

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, No. 02-cv-22715 (S.D. Fla.), Dkt.  
188 (“Mesko Test.”).....*passim*

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, No. 02-cv-22715 (S.D. Fla.), Dkt.  
190 (“Weinberg Test.”).....*passim*

*United States v. Mount Sinai Medical Ctr. of  
Fla., Inc.*, No. 02-cv-22715 (S.D. Fla.), Dkt.  
191 (“Lang Test.”)..... 13, 17, 19, 24

**INTEREST OF *AMICI CURIAE***

Pursuant to Supreme Court Rule 37, BJC HealthCare, Capital Area Health Consortium, Inc., Henry Ford Health System, Memorial Sloan-Kettering Cancer Center, and Oregon Health & Science University submit this *amici curiae* brief in support of Petitioners Mayo Foundation for Medical Education and Research, *et al.*<sup>1</sup> *Amici* are each sponsors of graduate medical education programs and, thus, are keenly interested in supporting and safeguarding one of the educational missions of teaching hospitals in this country—the completion of the formal education of medical residents and fellows.

BJC HealthCare (“BJC”) is a Missouri not-for-profit corporation comprised of thirteen member hospitals in and around St. Louis, Missouri. Barnes-Jewish Hospital (“BJH”) and St. Louis Children’s Hospital (“SLCH”) are BJC’s academic hospitals, affiliated with Washington University School of Medicine. BJH is consistently ranked on the US News and World Report Honor Roll and SLCH is one of the top five Children’s Hospitals in the country. The Siteman Cancer Center at Barnes-Jewish Hospital has been designated a National Cancer Institute

---

<sup>1</sup> *Amici* confirm that (i) no person other than *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief, (ii) no counsel for any party authored any part of this brief, and (iii) no party or counsel contributed money intended to fund the preparation or submission of this brief. Petitioners have filed a blanket waiver consenting to the filing of *amicus* briefs, and *amici* secured specific written consent from the respondent.

comprehensive cancer center. BJH and SLCH together sponsor 95 programs, 80 of which are accredited by the American Council on Graduate Medical Education. These programs cover a broad spectrum of medical and surgical specialties and subspecialties educating more than 1100 residents and fellows annually. All BJH and SLCH Medical Staff Members and teaching physicians have faculty appointments at Washington University School of Medicine.

The Capital Area Health Consortium (“CAHC”) is a voluntary association of several Connecticut hospitals: the Connecticut Children’s Medical Center, Hartford Hospital, the Hospital For Special Care, the Hospital of Central Connecticut, St. Francis Hospital & Medical Center, the John Dempsey Hospital/UConn Health Center – School of Medicine, and the VA Connecticut Healthcare System. Through the University of Connecticut School of Medicine, CAHC supports 50 fully accredited residency and fellowship programs, educating nearly 600 residents and fellows each year. Teaching faculty all hold appointments at the University of Connecticut School of Medicine.

Henry Ford Health System (“HFHS”) is a Michigan not-for-profit corporation and one of the premier integrated health care delivery systems in the country. Through its member hospitals and 30 ambulatory centers, located in and around Detroit, Michigan, HFHS honors its educational mission through the offering of nearly 50 fully accredited residency and fellowship programs, educating almost 600 residents and fellows each academic year. Teaching faculty are employed by the Henry Ford Medical

group—founded in 1915 after consultations with physicians at Johns Hopkins Hospital and the Mayo Clinic.

Memorial Sloan-Kettering Cancer Center (“MSKCC”) is a New York not-for-profit corporation comprised of three entities: Memorial Hospital for Cancer and Allied Diseases, Sloan-Kettering Institute for Cancer Research, and Memorial Sloan-Kettering Cancer Center. Collectively, these entities comprise the nation’s leading cancer center. In fulfilling its commitment to medical education, MSKCC sponsors world-renowned residency and fellowship programs in most of the recognized specialties and subspecialties of cancer medicine. MSKCC is a major teaching affiliate of Weill Medical College of Cornell University, and all of its staff physicians are on the Weill Medical College’s faculty. In 2009, the United States Court of Appeals for the Second Circuit ruled, in MSKCC’s favor, that FICA’s Student Exception unambiguously does not exclude medical residents from coverage. *See United States v. Mem’l Sloan-Kettering Cancer Ctr.*, 563 F.3d 19 (2d Cir. 2009).

Oregon Health & Science University (“OHSU”) is the state of Oregon’s only academic health and research university. OHSU brings together patient care, research, education of the next generation of health care providers, and scientists and community service to improve the health and well-being of all Oregonians. The university continually assesses healthcare shortages in every region of the state. Based on those assessments, OHSU develops curricula and policies designed to improve the geographic

distribution of healthcare professionals in Oregon. OHSU's graduate medical education programs, in particular, educate nearly 700 residents and fellows each year across 71 programs accredited by the Accreditation Council for Graduate Medical Education. Graduate medical education teaching faculty all hold appointments with the university.

## SUMMARY OF ARGUMENT

Graduation from an undergraduate medical school, though sufficient to confer an M.D. or parallel degree, does not allow aspiring physicians to practice medicine. Instead, they must continue their education through a teaching hospital's residency program, in which they are supervised by a faculty of fully-trained, Board-certified, attending physicians who serve as the residents' teachers.

Given the educational nature of residency programs, several circuit courts have correctly recognized that medical residents and their employers are not required to pay FICA taxes. Since 1939, FICA has included a Student Exception that—like the other exceptions listed under Internal Revenue Code § 3121(b)—supersedes the normal rule that payments for services rendered are subject to FICA. Specifically, under the Student Exception, payments for “service[s] performed in the employ of a school, college, or university” are not subject to FICA taxes if they are paid to any “student who is enrolled and regularly attending classes at such school, college, or university.” *See* 26 U.S.C. § 3121(b)(10). As the Eleventh Circuit explained, this unambiguous statute is broad enough to encompass the services rendered by medical residents, because it “does not limit the types of services that qualify for the exemption.” *United States v. Mount Sinai Medical Ctr. of Fla., Inc.*, 486 F.3d 1248, 1251–1256 (11th Cir. 2007). Such holdings reflect the reality of the residency system—residents are students, learning how to prac-

tice medicine from their teachers, the attending physicians.<sup>2</sup>

In 2004, the Treasury Department set out to defy both this law and common sense. Through promulgation of a new regulation, an amendment of Treasury Regulation § 31.3121(b), the Department asserted that services performed by a “full-time employee” should no longer be protected by the statutory Student Exception, notwithstanding any “educational, instructional, or training aspect[s]” of such work—a change that serves to exclude medical residents from the scope of the exception. But this new regulation cannot change the plain text of the statute, nor does its promulgation somehow alter the factual realities of modern medical education. As courts have analyzed and applied the Student Exception in recent years, they have been guided by their factual understanding of graduate medical education<sup>3</sup>—what

---

<sup>2</sup> As has been the convention in these cases, this brief uses the term “resident” to refer generally to all students in graduate medical education programs, including “interns” (a term used in years past, but with less frequency today, to refer to residents in their first year of a residency program) and “fellows” (in some medical specialties, a resident who has completed several years of residency but is pursuing additional education in order to practice in a subspecialty). *See, e.g., United States v. Mount Sinai Medical Ctr. of Fla., Inc.*, No. 02-cv-22715, 2008 U.S. Dist. LEXIS 57808, at \*2 n.1 (S.D. Fla. July 28, 2008).

<sup>3</sup> “Graduate medical education” is the accepted term for the phase of formal education that commences upon the completion of undergraduate medical school (and the conferral of a degree, such as M.D., D.O., or D.D.S.). Residency and fellowship training programs are overseen generally by a “GME” office or committee, including a faculty attending physician serving as direc-

it is, why it matters, and how it works in practice. This background remains just as relevant under the new regulation. Neither graduate medical education nor the statutory Student Exception has changed since these cases were decided. As a result, it is important for this Court to understand graduate medical education in detail.

Through this brief, *amici* aspire to share with this Court the benefit of that understanding. Any serious investigation of residency programs establishes that they are fundamentally educational in nature. In these programs, attending physicians serve as teachers, training future generations of physicians in the art of patient care. Thus, both systemically and culturally, medical residents are “students” in any relevant sense of the word—a fact recognized by every circuit court to consider the question prior to the decision now before this Court.

The Eighth Circuit’s decision below therefore cannot stand. The 2004 Treasury Regulation contradicts not only the statutory text of FICA’s Student Exception, but also the common-sense understanding of anyone involved in the residency process—demonstrating the fundamental disconnect between the government’s claims and the realities of the modern medical education system. As a result, the new regulation is not entitled to *Chevron* deference, and must be invalidated.

---

tor or dean. See *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*2 n.1, 10, 37–38.

## ARGUMENT

### I. Residencies Are A Central Part Of The Medical Education Process.

#### A. Aspiring Physicians Must Complete A Residency Before They Can Independently Practice Medicine.

In the modern world of medicine, physicians may not effectively practice in their chosen specialties without first crossing two critical thresholds: they must be certified by a medical board in their intended areas of practice, and they must secure access to privileges at a hospital. *See, e.g., United States v. Mount Sinai Medical Ctr. of Fla., Inc.*, No. 02-cv-22715, 2008 U.S. Dist. LEXIS 57808, at \*10–12 (S.D. Fla. July 28, 2008).

The first of these benchmarks—board certification—denotes a physician’s substantive qualifications as a medical practitioner. A number of medical organizations, united by a common goal of ensuring the professional competency of practicing physicians, are responsible for establishing the standards for certification in a wide array of medical specialties and subspecialties. *Id.* at 11.<sup>4</sup> These standards form the basis of board examinations administered by each organization, through which physicians demon-

---

<sup>4</sup> For example, the American Board of Internal Medicine, the certifying body for internal medicine, establishes both the standards for certification as an internist and the standards for certification in all internal medicine subspecialties, such as cardiology or hematology. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*11–12.

strate their qualification to practice. Just as lawyers must pass the bar before practicing law, physicians cannot practice medicine in a specialty or subspecialty without first receiving board certification in that specialty or subspecialty. *See id.* at \*11–12.

The second benchmark—access to “privileges” at a hospital—controls a physician’s practical ability to provide patient care. Without hospital privileges, a physician may not admit patients to a given hospital for medical or surgical care. As a result, possession of hospital privileges—or absence thereof—dictates the scope of care that a physician can provide, and complete care is not possible without hospital access. *See id.* at \*11.

These two criteria, the basis of modern medical practice, can *only* be achieved by first completing a licensed residency program at a teaching hospital. *Id.* at \*10. Undergraduate medical education grants an aspiring physician an M.D. or equivalent terminal medical degree, but no more. *Id.* at \*2 n.1. Completion of a residency is a mandatory prerequisite to be eligible to sit for a medical board. Indeed, even a board-certified physician must complete additional “fellowship” residency training before being eligible to sit for a subspecialty board. *Id.* at \*10–11. Likewise, a physician cannot secure hospital privileges without first completing a residency and becoming board-certified. The most physicians can do prior to completing a residency is obtain their state licensure—a necessary step for them to continue their residency education, in most cases, but beyond that one that “does not enable them to practice medicine in the specialty for which they are training and,

therefore, is of no real significance.” *Id.* at \*12–13 n.6. And even this limited license can only be secured after completion of at least the first year of a post-graduate residency. *Id.*

The centrality of this residency requirement may appear to conflict with the historic concept of recent medical school graduates serving as “general practitioners”—an image of medical education that many may still retain, in error. It is certainly true that, in the early twentieth century, many doctors completed only a one-year internship after graduating medical school and then began a generalized practice of medicine. But the general practitioner model is dead and has been since the 1970s. *Id.* As medicine has grown more complex over time, so too has the training and certification necessary to practice it safely. Today, the term lives on only as a misnomer wrongly applied to practitioners of family medicine—a specialty like any other medical specialty, and one that requires a residency in order to practice. *Id.*

In sum, the residency requirement has developed, over time, into the cornerstone of the medical educational process. Even though a physician’s residency follows his or her receipt of an undergraduate medical degree, completion of the graduate medical education curriculum for a residency program nevertheless is a necessary precondition before a physician can effectively and independently practice medicine.

**B. Residency Programs Teach Residents How To Care For Actual Patients.**

1. As the Southern District of Florida aptly observed, “[a] residency program is an extension of a medical resident’s formal education.” *Id.* at \*15–16. At every stage, the residency program is structured like traditional medical education and designed to advance pedagogical goals.

At the onset, medical school graduates apply for residency programs based upon their academic records and career goals, evaluating potential residencies the same way rising undergraduates evaluate colleges. *Id.* at \*19. Aspiring residents submit their applications to a national “matching” system that pairs hospitals with compatible students. *Id.* at \*18–19. Thus, the application process closely mirrors traditional collegiate applications. *Id.* at \*20.

Once accepted, the residents develop through programs designed to continue their educational growth by teaching them how to translate academic knowledge into practical expertise. This process actually begins during medical school, where third- and fourth-year undergraduate students begin interacting with actual patients during hospital “rounds.” Indeed, the line between residency and undergraduate education is initially almost nonexistent, as undergraduate students regularly “round” with residents and fellows, under the supervision of a common attending physician. *Mount Sinai*, No. 02-civ-

22715 (S.D. Fla), Dkt. 188 (“Katz Test.”) at 184.<sup>5</sup> Over time, residents continue through a “quite analogous” pattern of patient exposure, through which the residents progressively gain additional responsibilities and experiences. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*17. For residents, “the bedside [is] the predominant classroom.” *Id.* at \*73.

But residents do not solely learn their future trade by assisting with patient care. As part of their education, residents are required to engage in a number of more stereotypically “academic” tasks. *Id.* at \*28. They are assigned textbook reading, and quizzed upon it. They are required to attend scholarly conferences and lectures. Weinberg Test. at 128; *United States v. Memorial Sloan-Kettering Cancer Center*, No. 06-cv-0026 (S.D.N.Y.), Dkt. 28 (“Massie Decl.”) at ¶17.<sup>6</sup> And they are tested after

---

<sup>5</sup> Dr. Paul Katz, Mount Sinai Medical Center’s former vice-president for academic and research affairs, testified in the *Mount Sinai* trial regarding the nature of residency programs. Also testifying were Dr. Gloria Weinberg, chairman of the Department of Medicine at Mount Sinai (Dkt. 190, “Weinberg Test”); Dr. Thomas Mesko, an attending physician at Mount Sinai (Dkt. 188, “Mesko Test.”); and Dr. David Lang, Mount Sinai’s chief of emergency medicine (Dkt. 191, “Lang Test.”). Their testimony was repeatedly credited by the trial court. See generally 2008 U.S. Dist. LEXIS 57808.

<sup>6</sup> Dr. Mary Jane Massie practices at Memorial Sloan-Kettering Cancer Center, where she is both an attending physician and the Chairman of Memorial’s Graduate Medical Education Committee. She submitted a sworn declaration to the Southern District of New York in the case in which the Second Circuit ultimately held that the FICA Student Exception unambiguously does not exclude medical residents. See 563 F.3d 19, 27 (2d Cir. 2009).

each rotation, with these tests forming the basis of a yearly determination of whether the resident should advance to the next educational year. Katz Test. at 47.

This educational content is not left to the discretion of the teaching hospitals. Rather, organizations like the Accreditation Council for Graduate Medical Education (“ACGME”), an association of several constituent medical organizations, dictate requirements governing both residency programs themselves and the institutions that sponsor them. *See generally Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*23–32; Katz Test. at 14–15. The ACGME then regularly monitors institutional compliance with these requirements, to ensure that residents receive a consistent level of education. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*23–32.

These accreditation standards require that “the educational goals of the residency program and learning objectives of the residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations.” *Id.* at \*28–29. As a result, throughout the residency process, the program’s focus is on educating the residents, not merely on providing patient care. *Id.* at \*84 (quoting testimony of Dr. Katz). The rotation model ensures that residents are directed towards the educational opportunities that they need to develop their skills, rather than merely towards whatever medical needs are present in the hospital at a given time. *Id.* at 31–32; *United States v. Memorial Sloan-Kettering Cancer Center*, No. 06-cv-0026 (S.D.N.Y), Dkt. 27

(“Dougherty Decl.”) at ¶22.<sup>7</sup> Likewise, non-educational ancillary procedures are performed by non-residents, to ensure that residents maintain their educational focus. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*48–49. Education, not patient service, remains the touchstone.

The accreditation process also dictates the nature of the wages paid to residents by their employer hospitals. The ACGME requires sponsoring institutions to provide all residents with appropriate financial support to cover living expenses—but these payments are not a competitive wage or bargained-for compensation. *See id.* at \*8, \*34. As with all other elements of the residency program, the focus is upon providing for the education of the students, not upon compensating them for the services they provide to patients.

In the end, hospitals must be able to establish and certify that their residents are capable of the independent practice of medicine. *Katz Test.* at 51. Over the span of a several-year residency program, medical students are given the opportunity to learn how to take the academic knowledge they developed as undergraduates and apply it to the actual care of patients. The nature, structure, and purpose of residency programs prove that they are inescapably educational.

---

<sup>7</sup> Dr. James B. Dougherty, formerly Deputy Physician-in-Chief at Memorial Sloan-Kettering Cancer Center, also submitted a sworn declaration to the Southern District of New York in the *Memorial Sloan-Kettering* case.

## **II. Within The Residency System, Attending Physicians Serve As Teachers, With Residents As Their Students.**

With the educational nature of residency programs established, it becomes easier to understand the role residents play within that framework. The point is clearest through contrast: the many ways that attending physicians serve as teachers, and the resulting culture that shows that residents are their students—not their fellow employees.

### **A. Medical Residencies Establish A Teacher/Student Relationship Between Attending Physicians And Their Residents.**

1. At every stage in the process, the residency system prioritizes the attending physicians' role as teachers, as well as caregivers.

First, hospitals recruiting attending physicians specifically focus upon their educational qualifications, in addition to their professional skills. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*14–15; *Mesko Test.* at 202 (scholarly activities of potential attending physicians are reviewed as part of the hiring process). Conversely, many attending physicians are drawn to working in teaching hospitals due to their interest in being involved in the educational process. *Id.* at \*54–55; *Lang Test.* at 66 (“Number one, we enjoy the teaching, we enjoy the education, and we think it’s important.”). Indeed, in many cases, this results in attending physicians’ employment overlapping with a faculty appointment at a university affiliated with the hiring hospital. *Massie*

Decl. at ¶¶4, 7; Dougherty Decl. at ¶12; Katz Test. at 139.

This focus remains central throughout an attending physician's employment—even strong practitioners cannot remain attending physicians if their educational work is not equally solid. As Dr. Weinberg, Mount Sinai's chairman of the Department of Medicine, explained to the Southern District of Florida, "the quality of education is largely dependent on the quality of the teaching. So, if there is an attending who may be an excellent attending medically, but is just not a good teacher, that person is not appropriate." Weinberg Test. at 141. Meanwhile, attending physicians are expected to remain active in medical scholarship during their tenure at a teaching hospital—they cannot merely practice medicine. Katz Test. at 110–111; Weinberg Test. at 135.

Attending physicians view their commitment to teaching as a primary aspect of their professional goals and their missions are physician/educators. Massie Decl. at ¶15. The residency framework is built upon this commitment. As a result, attending physicians are responsible for a vast array of traditionally "academic" or "educational" tasks:

- As part of the accreditation process for ACGME programs, faculty attending physicians are responsible for creating a complex program information form, or "PIF." The PIF serves as a blend of curriculum and lesson plan, analogous to academic plans ordinarily created by teachers. Katz Test. at 28. Creation of a PIF is a mammoth undertaking, but it is an essential part of the academic process, as it demonstrates to the accredit-

ing agency both the substance of the residency program and the manner in which the program will ensure that residents are taught that content. Lang Test. at 65–66.

- The PIF in turn forms the basis of resident education, as program directors work to ensure that residents’ rotations accord with the ACGME’s requirements and the PIF. For example, as Dr. Weinberg explained, “for each experience that a resident has, we have to make sure that there is a written curriculum and that written curriculum is essentially put together by me with the person, if applicable, who is responsible for that subspecialty and has a syllabus as well. And it is looking to make sure that we are updating this frequently so we’re teaching residents up-to-date material, and it is ensuring that both the faculty and the residents participate in the creation and updating of the curriculum on a regular basis.” Weinberg Test. at 114.
- The core of this educational process is the rounds, in which attending physicians teach groups of residents how to care for patients. Rounds take many forms, ranging from “more academic . . . classroom like” lectures—where attending physicians teach residents about the physiology of medicine, as well as immersing them in patient care—to more-accelerated “management” rounds, where residents shadow attending physicians during their reviews of their patients. Weinberg Test. at 119–120. In each, attending physicians take time to teach their residents by explaining to them how to interpret and respond to the pa-

tient's medical issues, over time entrusting the residents with more and more responsibility over the patient's care. Weinberg Test. at 119.

- In addition to conventional rounds, attending physicians also oversee series of educational conferences and journal clubs, in which residents are required to learn by discussing assigned readings or other educational materials. Mesko Test. at 210–211. Again, these classes form a required part of a resident's academic curriculum, and are taught by the attending physicians.
- Finally, attending physicians are responsible for testing and grading their residents. Mesko Test. at 211. In the most critical of these, attending physicians administer, grade, and review yearly tests to determine whether the residents should be graduated to the next educational year of their program. Mesko Test. at 211, Katz Test. at 49. These major tests are supplemented throughout the year by smaller tests and quizzes, both oral and written, which help the attending physicians judge their residents' growth. Katz Test. at 141–143.

There is nothing unique about these educational tasks. Creating lesson plans, teaching classes, and administering tests are the heartland of a teacher's job—and are the job attending physicians are hired to perform.

2. This educational role is reinforced by the relationship between attending physicians, residents, and the patients for whom they care.

Although residency programs are designed to give residents meaningful experiences in providing patient care, it is undisputed that attending physicians, not residents, “own” their patients. Residents do not have ultimate responsibility for any patients under the hospital’s care—nor could they, as they are not yet certified to practice medicine. Even in circumstances where a resident has received his or her license under state law, the resident cannot take ownership over the patients whose care they assist with as part of their residency. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at\*54–55; Massie Decl. at ¶13; Dougherty Decl. at ¶18.

Rather, the residency program is designed such that attending physicians care for their patients, while involving residents in the process where pedagogically appropriate and medically safe. Even as limited responsibilities are delegated to residents, the attending physician’s control over this process is absolute:

The role of the attending is a constant in the sense that the attending is always the responsible physician. Patients are admitted under attendings and the attending faculty is ultimately responsible for the patients. They are responsible for seeing the patient, examining the patient, for writing a note.

But this time, if they have interns and residents working with them, they are responsible not only for doing the care by themselves, but for making sure that the residents are learning how to care for the patient. So, an intern would go down, if it is a simple case,

the resident may let the intern see the patient alone, come back, report to them. The resident would go in, report the findings and teach the intern how perhaps the resident's findings differed. Then the attending would then discuss the case and say how their findings differed and then they all decide on a plan together.

Very often, as the year goes by, I will say to the intern "pretend I am not here, write all of your orders" and then go through them, correct them, sometimes rewrite all of them before they are entered. However, if I have a patient in shock, I'm not letting an intern go in first and a resident go in second. I am there with them at that time because time is critical and it's a more urgent situation.

So, it's permitting progressive responsibility through the years in a training setting, but understanding that who is capable of what at what level. In some ways it is more difficult.

Weinberg Test. at 122–123. Thus, teaching hospitals employ a series of procedures to ensure that all patient care provided by residents is properly supervised and circumscribed by attending physicians, limiting resident involvement to educationally-appropriate assistance. Massie Decl. at ¶¶12–14, Dougherty Decl. at ¶18. Even patient care exigencies are not permitted to interfere with this educational model. For example, emergency departments are ordinarily staffed with sufficient coverage so that they can run without residents—ensuring that residents remain focused on their curriculum-mandated

courses of learning rather than being forced to respond to patient-care crises. Lang Test. at 64–65. As a result, even though residents do provide valuable services to hospital patients, it is *always* within the rubric of an educational experience administered and shaped by their teachers—the attending physicians.

That said, the pedagogical nature of graduate medical education invariably renders the resulting patient care less efficient—a tradeoff accepted only because of the educational value it provides. The time attending physicians devote to their teaching obligations could be directed exclusively towards patient care. Without question, diagnosis and treatment would go faster if the attending physicians were working alone. Weinberg Test. at 119, Mesko Test. at 220. These inefficiencies are in turn reflected in the compensation hospitals receive for resident “work.” As a rule, patients do not pay for treatment performed by a resident, and in some cases patients refuse treatment from residents altogether. Massie Decl. at ¶15, Dougherty Decl. at ¶21. Instead, Medicare partially subsidizes hospitals for the losses they incur by supporting the educational value of residency programs, but this subsidy stops well short of covering the complete cost. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*14.

Every aspect of the relationship between attending physicians, residents, and patients reinforces a common truth—in the system of graduate medical education, attending physicians are teachers, sacrificing some of their time and talents to educate residents, the next generation of medical practitioners.

**B. The Residency Systems Creates An Academic Culture In Which All Involved View Residents As Students.**

Even though they nominally work together, attending physicians and residents are at drastically different stages of their career. Attending physicians are already fully competent, specialized practitioners, hired to serve as both educator and caregiver. Massie Decl. at ¶11. Having already completed their residencies, they are board-certified and have full access to the hospital privileges that residents lack. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*38. Residents, on the other hand, are not yet qualified to practice—the whole point of the residency is for them to *become* qualified. Indeed, even though residents provide patient care (under supervision) as part of their residency, they have no expectation of employment by their teaching hospital. In the culture of medical practice, securing a residency is viewed like a school admission, not a first job. *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*19, 111; Massie Decl. at ¶11.

To everyone involved in the process, the perception is that attending physicians are teachers and residents are their students. In many cases, attending physicians are actually called “faculty.” *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*38; Weinberg Test. at 93. They regularly refer to residents as “students,” just as they did not view themselves as doctors until after they had completed their residencies. Massie Decl. at ¶9. By contrast, first-year residents often are taught during rounds alongside third- and fourth-year undergraduate students,

reinforcing the gap between them and the attending physicians who oversee their education. Katz Test. at 184. Attending physicians view themselves as constantly teaching; residents view themselves as gaining the final stage of their education. Dougherty Decl. at ¶21; *Mount Sinai*, 2008 U.S. Dist. LEXIS 57808, at \*111–112.

### **III. As Both The Statutory And Common-Sense Definitions Of “Student” Include Medical Residents, The 2004 Treasury Regulation Is Invalid.**

The heart of Petitioners’ case is their challenge to the 2004 Treasury Regulation, which created the “full-time employee” rule that purportedly excludes medical residents from coverage under FICA’s Student Exception. The Eighth Circuit concluded that, under the familiar analysis articulated by *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the new Treasury Regulation is a “reasonabl[e]” construction of the statutory exemption, and therefore entitled to deference. See Pet. App. 10a–12a.

Petitioners have already demonstrated the Eighth Circuit’s legal error. Under ordinary standards of *Chevron* review, courts evaluating the validity of an agency’s interpretive regulation must first determine whether Congress has spoken to the relevant issue and, then, only defer to a reasonable agency interpretation in cases where Congress’s legislation is ambiguous. *Chevron*, 467 U.S. at 842. Here, four circuits—the Second, Sixth, Seventh, and Eleventh—have correctly recognized that FICA’s Student Exception is *not* ambiguous, and that, under

the statute’s plain language, medical residents are *not* categorically barred from claiming the exemption. See *United States v. Mem’l Sloan-Kettering Cancer Ctr.*, 563 F.3d 19, 27 (2d Cir. 2009) (holding that Student Exemption “is not ambiguous” and that applicability to medical residents is “a question of fact, not a question of law”); *United States v. Detroit Med. Ctr.*, 557 F.3d 412, 417–418 (6th Cir. 2009) (rejecting government argument that “as a per se matter a resident can never be a student”); *Univ. of Chicago Hosps. v. United States*, 545 F.3d 564, 567 (7th Cir. 2008) (Student Exemption is unambiguous; “The interpretation the government advances—that the student exception is categorically inapplicable to residents—is textually untenable”); *Mount Sinai*, 486 F.3d at 1252 (“By its plain terms, the student exemption does not limit the types of services that qualify for the exemption.”). The government has no authority to promulgate a regulation that contradicts the statute’s plain command: it cannot define “student” in a way that categorically excludes residents when residents are covered by the unambiguous statutory text.

But the failings of the Treasury Department’s new regulation are made clearer by the historical, logistical, and cultural details discussed above—medical residents are “students” in any meaningful or colloquial way. This is not a case in which the government, in an effort to make sense of an unclear statute, adopts a reasonable regulation that reflects and respects common sense. Rather, the government’s actions here are fundamentally out of step, not only with the governing law, but also with the medical world at large. Upholding the unfounded

new regulation would directly contradict the ordinary understanding of the nature of residency programs. Invalidating it would restore harmony between the law and the fact of medical education.

In the end, the clearest proof that medical residents are students lies in the everyday observations of those most familiar with those residents—the attending physicians who oversee them. Attending physicians at teaching hospitals are hired to serve as teachers, and they recognize the residents as their students. Under the terms of FICA and fundamental principles of administrative law, the Treasury Department has no power to adopt a regulation that conflicts with this simple, well-understood fact.

CONCLUSION

For the reasons set forth above, *amici* BJC HealthCare, Capital Area Health Consortium, Inc., Henry Ford Health System, Memorial Sloan-Kettering Cancer Center, and Oregon Health & Science University respectfully submit that the decision of the United States Court of Appeals for the Eighth Circuit should be reversed and urge this Court to incorporate into its decision the points that *amici* have submitted.

Respectfully submitted,

Mark H. Churchill  
Paul M. Thompson  
*Counsel of Record*  
Robin L. Greenhouse  
Jeffrey W. Mikoni  
MCDERMOTT WILL & EMERY LLP  
600 Thirteenth St., NW  
Washington, DC 20005  
(202) 756-8000  
pthompson@mwe.com

*Attorneys for BJC HealthCare, Capital Area Health Consortium, Inc., Henry Ford Health System, Memorial Sloan-Kettering Cancer Center, and Oregon Health & Science University*

August 2010