

No. 09-837

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IN THE  
**Supreme Court of the United States**

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

*Petitioners,*

*v.*

UNITED STATES,

*Respondent.*

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

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**BRIEF OF DOCTORS COUNCIL S.E.I.U.  
AS *AMICUS CURIAE* IN SUPPORT  
OF RESPONDENT**

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**QUESTION PRESENTED**

Whether the Treasury Department correctly categorized resident physicians as employees rather than students within the meaning of 26 U.S.C. § 3121(b)(10).

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**INTEREST OF *AMICUS CURIAE*<sup>1</sup>**

Doctors Council S.E.I.U. is a labor organization that represents approximately 2,600 attending physicians in the public and private sector in New York, New Jersey, Pennsylvania and Illinois. Although we represent attending physicians, Doctors Council S.E.I.U. is concerned about the rights, working conditions and well-being of all physicians, including residents.

Doctors Council S.E.I.U.'s interest in this case is in seeing that resident physicians, who work a grueling schedule of up to 80 hours per week, are not excluded from the protections enjoyed by other employees on the pretext that they are only "students". In particular, we are concerned that a finding by the Court that resident physicians are students will be used as a tool to erode many of the legal protections that residents currently possess, such as the right to take family medical leave, the right to collectively bargain over their working conditions and their right to unemployment insurance should the hospital that employs them close.

In this case, a finding that resident physicians are "students" would result in the loss of social security death and disability benefits, a potentially devastating result for physicians who are at risk of suffering from

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1. Pursuant to Rule 37.6, amicus affirms that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus made a monetary contribution to its preparation or submission. The parties have consented in writing to the filing of this brief.

employment-related injuries and deaths such as transmission of infectious diseases due to needlesticks, depression and motor vehicle accidents. Najib T. Ayas, MD, MPH. et al., *Extended Work Duration and the Risk of Self-reported Percutaneous Injuries in Interns*, 296 JAMA 1055 (September 6, 2006); Laura K. Bargar, PhD, et al., *Extended Work Shifts and the Risk of Motor Vehicle Crashes among Interns*, 352 New. Eng. J. Med. 125 (January 13, 2005).<sup>2</sup> The loss of those protections and benefits are all the more significant for those resident physicians with families.<sup>3</sup>

Many of our members are attending physicians in teaching hospitals who work closely with resident physicians. The description of the work of resident physicians presented by Petitioners and their supporting *amici* is contrary to our experience working with residents on a daily basis.

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2. See also, David B. Reuben, MD, *Depressive Symptoms in Medical House Officers*, 145 Archives of Internal Med. 286 (February 1985)(Interns and residents on intensive care rotations suffer from high rates of depression); Tracie M. O'Neill, MD et al., *Risk of Needlesticks and Occupational Exposures Among Residents and Medical Students*, 152 Archives of Internal Med. 1451 (July 1992)(Residents at high risk of exposure to patients' blood and body fluids).

3. Glese Verlander, MD, JD, *Female Physicians: Balancing Career and Family*, 28 Acad. Psychiatry 331 (December 2004)(Residency is the most common period for female physicians to give birth to their first child); Susan Riddle Brian, *Women in Medicine*, 64 Am. Family Physician, 174 (July 1, 2001)(More than one-half of female physicians have their first child during residency.)

The practice of medicine in our society, where the volume of scientific knowledge is expanding at a constantly increasing rate, requires that all physicians engage in a program of study and self-education throughout their careers. That residents are engaged in such a process at the outset of their career should not devalue the work that they do and should not be used as an excuse to treat them as if they were not the essential part of the patient care team which the current model for delivery of patient care requires that they be.

### **SUMMARY OF ARGUMENT**

#### **I. Resident physicians perform essential services for Petitioners. They are engaged in on-the-job training and are not students.**

A. The resident physicians employed by the Mayo Foundation and University of Minnesota treat patients on their own and make independent patient care decisions. They are an essential part of the patient care team at teaching hospitals and provide many patient care services which would be performed by other employees if they were not present. Residents perform a substantial part of their work without any direct supervision. The delivery of patient care in hospitals requires a team effort. Resident physicians routinely see patients on their own, perform procedures without supervision and make independent decisions about the type of care to provide.

B. The oversight of the work of residents by attending physicians is at arm's length. While residents report to attending physicians who review their work,

the residents are not closely supervised. Residents often see patients by themselves and perform many medical procedures without an attending physician present. All of these patient encounters are billed for by institutions such as the Mayo Clinic.

**II. The nature of medicine requires that all physicians must be committed to life-long learning.**

A. Board-certified physicians are required to participate in an educational program and pass a test to remain certified. The American Medical Association's principles of medical ethics require physicians to engage in medical education throughout their careers. Most states require physicians to participate in continuing medical education as a condition of maintaining their medical licenses. Moreover, the American Board of Medical Specialties and the individual medical specialty boards require board-certified attending physicians to participate in continuing medical education in order to maintain board certification. In order to maintain board certification, a physician is required to pass a re-certification exam in which attending physicians are evaluated in the same competencies as resident physicians.

For example, the American Board of Surgery requires board-certified surgeons to complete a minimum of 50 hours of continuing medical education each year. Thirty of those hours must be satisfied through live learning activities such as attendance at conferences and seminars or participation in workshops or journal clubs. Attending physicians may earn their

required educational credits by attending the same lectures that resident physicians attend. Board-certified physicians in other specialties must also comply with similar requirements and pass an exam to retain their certification.

B. Residency training is simply part of the continuing education all physicians must undergo. Physicians are required to continue their education throughout their professional careers. Residency training is a crucial component of that continuum. But it is more analogous to on-the-job training than the structured classroom and textbook study that are the primary components of an educational program for those who are commonly understood to be students.

The majority of a resident's time is spent providing patient care. The educational requirements for residents parallel those for board-certified attending physicians. The on-the-job learning that resident physicians undergo is very different from the traditional concept of what constitutes a student. The educational activities in which residents participate do not make a physician a "student".

**ARGUMENT****I. RESIDENT PHYSICIANS PERFORM ESSENTIAL SERVICES FOR PETITIONERS. THEY ARE ENGAGED IN ON-THE-JOB TRAINING AND ARE NOT STUDENTS.**

Resident physicians are an essential part of the patient care team at teaching hospitals. Resident physicians provide many patient care services and if they were not present, then other health care workers such as attending physicians, nurses, physician assistants, techs and transporters would have to perform this work. Attending physicians at teaching hospitals rely upon residents to perform many of the rudimentary, albeit important, aspects of patient care. As resident physicians progress, they are relied upon to oversee the work of junior residents and perform many medical procedures. J.A. 38a, 58a, 87a–89a, 99a-101a.

While attending physicians are ultimately responsible for the patients cared for by resident physicians, residents perform a substantial part of the work independently. In addition, while the guidelines of the Accreditation Council of Graduate Medical Education (“ACGME”) require that residents be closely supervised, most oversight of the work of residents is conducted at arm’s length. J.A. 41a-43a, 67a-68a, 99a-101a.

In arguing that resident physicians are students, Petitioners note that residents are not as efficient as attending physicians and do not have the same practice opportunities as attendings. That, however, misses the point. The question is not whether resident physicians

are attending physicians. Instead, the key question is whether a regulation that disqualifies resident physicians from consideration for the student exemption under the Federal Insurance Contributions Act is reasonable in light of the fact that residents perform work for 40 or more hours each week. J.A. 72a, 113a. In light of the overwhelming evidence that resident physicians perform valuable services for not only the Petitioners, but hospitals nationwide, the question presented must be answered in the affirmative. Accordingly, the decision of the Eighth Circuit Court of Appeals should be affirmed.

**A. The Resident Physicians at the Mayo Foundation Treat Patients on Their Own and Make Independent Patient Care Decisions.**

The successful delivery of healthcare in hospitals requires a team effort. While attending physicians such as those represented by Doctors Council S.E.I.U. are responsible for the overall care of a patient, the provision of that care requires the services of nurses, physician assistants, techs and resident physicians. J.A. 34a-35a.

The record shows that residents are an important part of the health care team at the Mayo Foundation for Medical Education and Research (“Mayo Foundation”) and the University of Minnesota. Resident physicians routinely see patients on their own, perform procedures without supervision and make independent decisions about the type of care to provide. J.A. 36a, 41a-43a, 67a-68a, 99a-101a, 134a-138a.

Petitioners can and do bill for this work. While resident physicians cannot bill directly for patient care services under their own name, attending physicians can bill for the services provided by residents as long as the attending is “in the vicinity” of the resident. J.A. 66a. Hospitals typically bill for procedures performed by residents. Suraj Kapa, MD, et al., *A Reliable Billing Method for Internal Medicine Resident Clinics: Financial Implications for an Academic Medical Center*, 2 Journal of Graduate Med. Educ. 181 (June 2010). Although the attending physician signs the billing sheet, it can be and often is the resident physician who does much of the work.

Thus, while the resident physicians employed by Petitioners and other teaching hospitals may be improving their skills as they gain experience caring for patients – as is the case for any professional in the early stages of his/her career – the fact remains they are working and the hospital is earning revenue from that work.

The record reflects that Petitioners’ resident physicians routinely act independently in their care of patients. While it is indisputable that the work of resident physicians is overseen by attending physicians in that residents report to and review their work with an attending, much of their reporting to attendings occurs *after* patient care has been provided. J.A. 67a-69a, 91a-92a. In addition, there are times when an attending is not available and in such situations residents will consult with each other where there are questions as to the appropriate care to provide. J.A. 36a-37a, 40a-41a.

For example, the record reflects that Petitioners' residents working overnight in the hospital could determine that a patient has meningitis and decide to perform a lumbar puncture.<sup>4</sup> J.A. 36a. If the resident was uncertain about the procedure, he/she would seek the assistance of a senior resident rather than contact an attending, who typically would not be at the hospital. J.A. 36a-37a.

Similarly, resident physicians employed by Petitioners write hospital orders – the primary method of carrying out patient care – independently and without the need for an attending to co-sign them. J.A. 132a-133a. Those decisions are made without the initial input of an attending.

This level of independent activity by resident physicians is consistent with the experience of Doctors Council S.E.I.U. at the teaching hospitals at which its members work. Residents are highly trained physicians who, while not at the level of attending physicians, are employees who provide essential patient care. J.A. 58a.

Whether or not residents ultimately report to an attending physician on the care they have provided, the care provided and the decisions made cannot be undone. When a physician, any physician, decides on a course of treatment and in furtherance of that plan orders tests, performs procedures and provides medication based upon that treatment plan, no matter how routine, he

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4. A lumbar puncture involves the insertion of a needle into the spine to extract spinal fluid. J.A. 135a. Lumbar punctures can be performed by a resident physician without the supervision of an attending. J.A. 37a, 42a.

has made an independent decision. That he may later report to a superior on that course of treatment and the decisions that were made does not alter the independent nature of the decision-making process.

**B. The Oversight of the Work of Resident Physicians by Attendings Is at Arm's Length.**

Petitioners argue that resident physicians are directly and closely supervised by attendings and that this supervision renders residents students. This argument fails for two reasons: (1) much of the "supervision" of residents is actually conducted at arm's length by an attending after the treatment has been rendered; and (2) whether or not, and to what degree, an individual is supervised does not make him/her any more or less an employee.

While resident physicians report to attendings and attendings will review their work, residents are not closely supervised. Contrary to the claims by the Petitioners, attendings are not "looking over a resident's shoulder." J.A. 54a. The record is clear that residents often see patients by themselves and perform many medical procedures without an attending present. J.A. 41a-43a, 99a-101a.

At some point during their first year, resident physicians working in a clinic typically conduct physical examinations without an attending present. J.A. 99a-101a. Resident physicians can also perform a number of invasive procedures with an attending present. J.A. 41a-43a. The facts at the Mayo Clinic and the University of Minnesota are similar to the experiences of the members of Doctors Council S.E.I.U.

Resident physicians do, of course, report to attendings. After completing all of the work necessary to admit a patient, the resident will contact the attending to review the resident's treatment plan. In addition, a resident physician will review the results of a clinical examination with the attending assigned to a clinic. This team approach to health care allows multiple patients to be seen simultaneously by several residents at a clinic while one attending – referred to as a “preceptor” – oversees their work. All of these patient encounters are billed for by institutions such as the Mayo Clinic. Suraj, *supra*.

## **II. THE NATURE OF MEDICINE REQUIRES THAT ALL PHYSICIANS MUST BE COMMITTED TO LIFELONG LEARNING**

### **A. Board-Certified Physicians Are Required to Participate in an Educational Program and Pass a Test to Remain Certified.**

The American Medical Association's ethical code states that a “physician shall continue to study, apply, and advance scientific knowledge [and] maintain a commitment to medical education.” American Medical Association, *Principles of Medical Ethics*, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml>.

Most states require that physicians participate in continuing medical education as a condition of maintaining a medical license. Report of the Council on Medical Education, “Expectations for Lifelong

Learning” CME Report 13-A-10, 3 <http://www.ama-assn.org/ama1/pub/upload/mm/377/cme-rep13-a10.pdf>. That report continues:

“Physicians may gain AMA PRA Category 1 CME Credits™ by participation in a variety of learning formats, such as:

- Live activities where a physician attends an educational session in person or virtually (for example, over the Internet).
- Use of enduring materials, including printed, recorded, audio, video and/or online activities that may be used over time and at various locations and that, in themselves, constitute a structured CME activity.
- Journal-based CME where the physician selects and reads a designated article in the peer-reviewed medical literature and engages in reflection or interaction based on the article’s content (for example, through an evaluation or examination).
- Test item writing where the physician contributes to the development of a designated high-stakes examination or specific self-assessment module by researching, drafting, and defending a test item.
- Manuscript review where the physician critically reviews assigned journal

manuscripts under the direction of a journal editor and an accredited CME provider.

- Performance improvement where a physician or group of physicians can, using a structured, long-term process, learn about selected performance measures, apply such measures to respectively or prospectively assess their practices, and re-evaluate their performance after an interval.
- Internet point of care learning where physicians engage in structured, self-directed online learning on topics relevant to their practices.”

*Id.* at 3

In recognition of the duty of a physician to continue to obtain training throughout his/her career, the American Board of Medical Specialties (“ABMS”) and the individual medical specialty boards require board-certified attending physicians to engage in an extensive educational program in order to maintain certification. The ABMS is an umbrella organization comprised of 24 medical specialty board members such as the American Board of Surgery (“ABS”) and the American Board of Internal Medicine (“ABIM”). [www.abms.org](http://www.abms.org). The ABMS is responsible for developing common standards for the evaluation and certification of physicians. When a resident physician becomes board-certified, it is the individual medical specialty boards that set out the specific certification requirements and give the certification exam. In most cases, board certification lasts 10 years.

To remain board-certified, physicians are required to participate in an educational program called Maintenance of Certification (“MOC”). MOC is a program of educational activities, culminating in a recertification exam, in which attendings are evaluated in the *same core competencies as resident physicians*.

The MOC program evaluates board-certified physicians on a continuous basis in the six areas known as the essential core competencies: (1) medical knowledge, (2) patient care, (3) interpersonal and communication skills, (4) professionalism, (5) practice-based learning and improvement and (6) systems-based practice. [http://www.abms.org/Maintenance\\_of\\_Certification/MOC\\_competencies.aspx](http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx).

These are the identical categories in which the ACGME requires residents to be assessed. ACGME, *Common Program Requirements*, 7-9 [http://www.acgme.org/acWebsite/dutyHours/dh\\_dutyhoursCommonPR07012007.pdf](http://www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf). To prove their competency in these core areas, the MOC program requires board-certified physicians to (1) provide evidence of professional standing, (2) participate in an educational and self-assessment program as determined by their medical specialty board, (3) pass a recertification exam to prove they possess “cognitive expertise” in their medical specialty and (4) demonstrate that they use best practices based upon established national benchmarks and the work of their peers. The method of achievement is determined by the individual specialty boards. [http://www.abms.org/Maintenance\\_of\\_Certification/MOC\\_competencies.aspx](http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx).

For example, to fulfill the learning and self-assessment educational requirements, the ABS requires board-certified surgeons to complete a minimum of 50 hours of CME annually. <http://home.absurgery.org/default.jsp?exam-mocreqs>. Thirty of those hours must be satisfied through live learning activities such as attendance at conferences and seminars; participation in workshops or journal clubs; computer, video or audio-based activities; or through critical review of a journal manuscript, among other methods. Many of these activities require the physician to engage in a post-activity assessment of what he/she learned, such as a test. American Medical Association, *The Physician's Recognition Award and credit system*, 4-7 <http://www.ama-assn.org/ama1/pub/upload/mm/455/prabooklet.pdf>. (2010). Some of the learning activities physicians may engage in to complete the remaining 20 hours include research, reading authoritative medical literature and participating in small group discussions. <http://www.ama-assn.org/ama1/pub/upload/mm/455/prabooklet.pdf>. *Id.* at 10.

Attending physicians may earn their required educational credits by attending the same lectures that resident physicians attend. J.A. 71a; *see also Boston Medical Center*, 330 NLRB 152, 186 (1999)(BMC attendings fulfilled their CME requirements in part “by attending grand rounds and other conferences at BMC, including those in which the talks are given by *residents*.” Emphasis supplied).

Board-certified surgeons must also participate in a quality assessment program that measures their performance against professional standards. In

addition, they must provide evidence that they possess an unrestricted medical license. Evidence that they have completed these requirements, in addition to documenting that they have satisfied the annual medical education requirements, must be submitted to the ABS every three years. <http://home.absurgery.org/default.jsp?exam-mocreqs>.

To remain board-certified, surgeons must pass a recertification exam near the end of their 10-year certification period. However, they must fulfill their MOC educational requirements throughout the 10-year period to be eligible to take the examination. Failure to complete the educational requirements or pass the exam will result in loss of board certification for the surgeon. <http://home.absurgery.org/default.jsp?exam-mocqa>.<sup>5</sup> Board-certified physicians in other specialties, such as radiology, must also comply with MOC requirements and pass an exam to avoid having their certification withdrawn. [http://www.theabr.org/moc/moc\\_faq\\_happens.html](http://www.theabr.org/moc/moc_faq_happens.html)

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5. Even physicians who are not board-certified or who do not wish to remain certified still must comply with continuing medical education requirements imposed upon them by the medical board of the state in which they are licensed. For example, physicians licensed in Minnesota must complete 75 hours of CME credits every three years as a condition of licensure renewal. [http://www.state.mn.us/mn/externalDocs/BMP/Physician\\_Fact\\_Sheet\\_041703095702\\_Form-MDFactS2009.pdf](http://www.state.mn.us/mn/externalDocs/BMP/Physician_Fact_Sheet_041703095702_Form-MDFactS2009.pdf).

**B. Residency Training Is Simply Part of the Continuum of Education That All Physicians Must Undergo.**

*Amicus* agrees with Petitioners that the medical education of a doctor begins, but does not end, in medical school. In fact, the education of a physician never ends as it is the expectation and duty of all physicians to “continue their education throughout their professional careers.” Report of the Council on Medical Education, *supra* at 2.<sup>6</sup> A medical career involves a continuum of education in which all physicians are required to maintain their skills and build upon their fund of knowledge throughout their careers.

Residency training is a crucial component of that continuum. But residency is more analogous to on-the-job training than the structured classroom and textbook study that are the primary components of the educational program for those who are commonly understood to be students. That resident physicians are learning on the job does not make them students and does not alter the fact that the majority of their time is spent providing valuable patient care services. They are no different than any other young professional who while possessing a degree, still needs to acquire the practical knowledge and judgment that only comes with experience.

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6. The Council on Medical Education formulates policy on medical education and makes recommendations on such policies to the AMA’s House of Delegates. <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-medical-education.shtml>.

There are clear parallels between the educational requirements for resident physicians and board-certified attending physicians. Both have already earned a medical degree. Both are required to earn educational credits, which are satisfied in a number of different ways such as attendance at conferences and participation in activities such as journal club. Both are evaluated in the same six core competencies. Both are engaged in an ongoing assessment of their abilities and knowledge. And, finally, the process for both culminates in a certification exam offered by a specific medical specialty board.

In the case of both resident physicians and attending physicians, the overwhelming majority of the work week is committed to direct patient care. The mandatory educational component for each is essential to providing high quality patient care at a state-of-the-art level. While it is true that the educational component represents a larger part of the work week for resident physicians, this does not make them students. Their primary focus is patient care. In the process, they acquire valuable experience and training which qualify them for what they will do for the balance of their careers. Attending physicians continue to learn and acquire experience and training in their first years after completion of a residency and throughout their careers.

Physicians are students of medicine throughout their careers; educational activities and a program of self-study are an essential *part of the job of being a physician*, whether one is a resident or an attending physician. Participation in such activities does not make a physician a “student.”

**CONCLUSION**

For the foregoing reasons, the judgment below should be affirmed.

Respectfully Submitted.

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