No. 09-837

IN THE
Supreme Court of the United States

THE 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 COMMITTEE OF INTERNS AND RESIDENTS AND AMERICAN MEDICAL STUDENT ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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STATEMENT OF INTEREST

The Committee of Interns and Residents, SEIU ("CIR") is the primary national voice for resident physicians in the United States.[1] CIR is party to dozens of collective bargaining agreements covering more than 13,000 resident physicians in the States of Massachusetts, New York, New Jersey, Florida, New Mexico and California as well as the District of Columbia. CIR negotiates contracts with hospitals establishing wages, hours, job security, health and disability insurance benefits and paid leave for its members just as other union contracts do for hundreds of thousands of other hospital employees. CIR is therefore intimately familiar with the facts pertinent to the employment of resident physicians.

The American Medical Student Association ("AMSA") is the nation's oldest and largest independent organization committed to representing the interests of the more than 67,000 medical students currently training in the United States. AMSA chapters include more than 33,000 pre-med and medical students organized around improving medical training. As an organization representing medical students, AMSA has specific familiarity with the responsibilities of medical students and the clinical role of interns and residents.

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1. No counsel for a party authored this brief in whole or in part, and no person or entity, other than the *amici curiae,* made a monetary contribution intended to fund the preparation or submission of this brief. The parties have consented to the filing of this brief.

CIR and AMSA have an interest in the Court having an accurate picture of the activities of resident physicians as it considers the question presented by this Petition. The issue of whether resident physicians are more like employees or more like students has arisen under multiple regulatory regimes which overwhelmingly treat resident physicians as employees rather than students.

Some *amici* have been unusually candid that their interest in this case includes obtaining a ruling that they can utilize to deprive resident physicians of employment-related benefits in areas other than Federal Insurance Contributions Act, 26 U.S.C. § 3101, *et seq.* ("FICA"). For instance, the University of Illinois argued in its amicus brief in favor of granting certiorari that a ruling finding resident physicians to be students under FICA will enable it to succeed in its efforts to convince the Illinois Department of Employment Security that resident physicians are not entitled to unemployment benefits if their employment is terminated. Brief of the Board of Trustees of the University of Illinois as Amicus Curiae in Support of Petitioners at 2, 7 (Feb. 16, 2010).

CIR and AMSA have a strong interest in demonstrating that resident physicians are employees entitled to the protection of labor and employment laws.

SUMMARY OF ARGUMENT

This case concerns the applicability of the student exception to a provision of the Internal Revenue Code at 26 U.S.C. § 3121(b)(10), and the regulations promulgated thereunder at 26 CFR § 31.3121(b)(10)-

2(d)(3)(iii), which treat resident physicians as employees under FICA. It is thus not disputed that resident physicians are employees at the institutions which employ them.

In arguing that the Treasury Department's construction of the statutory FICA student exemption is arbitrary, however, Petitioners and their supporting *amici* have seriously distorted the nature of medical residency. In fact, resident physicians are employees in the fullest sense of that term throughout their residency training programs; they are the primary care givers in many hospitals who daily make medical decisions with life and death consequences while providing real medical care to patients with real needs.

The extraordinary hours worked each week by resident physicians throughout the United States has been studied by the hospital industry since the 1980's. The resulting reports demonstrate the significant economic value of resident physicians to their hospitals. Depending on the number of hospitals included in each study, the cost of having other hospital employees perform the patient care work being done by resident physicians is in the millions or billions of dollars. It is apparent from the sheer cost of replacing them that resident physicians are not predominantly students who provide no financial benefit to their institutions.

The Court's judgment of the applicability of the statutory exemption should be informed by judicial and administrative determinations over decades in multiple forums. Despite the contrary assertion by Petitioners that "medical residents are widely classified as students

– by Congress, accrediting organizations and numerous courts – and medical residents consider themselves students," in truth Federal and State authorities have repeatedly concluded that the facts establish that resident physicians are covered by laws protecting employees (and not protecting students) over the objections of hospitals which have contended that residents should not be treated as employees. Brief for Petitioners at 31 (Aug. 6, 2010).

The demonstrated economic value of resident physicians to their hospitals and the repeated confirmations that resident physicians are entitled to the protection of labor and employment laws are relevant to the issue posed by this Petition.

ARGUMENT

I. RESIDENTS PROVIDE VALUABLE PATIENT CARE SERVICES AND IF RESIDENT WORK HOURS ARE REDUCED, HOSPITALS MUST REPLACE THEM WITH MORE EXPENSIVE HEALTHCARE PERSONNEL.

We write separately to provide the Court a fuller and more accurate sense of what resident physicians actually do than that presented by Petitioners and their *amici*. Numerous studies demonstrate that hospitals rely heavily on resident physicians to perform a wide range of critical patient care services every single day and would incur substantial costs if the resident physicians had to be replaced with other employees. The facts contradict Petitioners' assertion that they "permit their residents to care for patients purely for educational

purposes," Pet. Br., *supra* at 26, and that "residents do not provide a net economic benefit to petitioners." *Id.* at 27. Indeed, the decades-long and continuing struggle to reign in excessive work hours by resident physicians provides a window into the extent of hospitals' economic reliance on the substantial patient care and other work provided by resident physicians.

The first comprehensive study of how much it would cost hospitals to replace resident physician labor was published in 1990 in connection with the then recently enacted New York State regulations that limited residents' work hours.[2] The study observed that "given the thrust of New York State's regulations, physician

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2. In 1984, a young woman, Libby Zion, died in the emergency room of a New York hospital at night while under the care of resident physicians. A grand jury report concluded that she died from preventable error, but rather than indict individual physicians, the report indicted the system of excessive resident physician work hours and grossly inadequate supervision. As a result of this report, the New York State Commissioner of Health appointed the Ad Hoc Advisory Committee on Emergency Services (chaired by Bertrand Bell, MD, and known as the Bell Committee). David A. Asch, MD and Ruth M. Parker MD, *The Libby Zion Case, One Step Forward or Two Steps Backward,* 318 New Eng. J. Med. 771 (1988). New York State commissioned the 1990 study to find out how much it would cost hospitals to comply with the recently enacted New York State Department of Health regulations that, among other things, capped resident work hours at 80 per week. Despite the strong opposition of the teaching hospitals, the Department of Health enacted regulations that limited the number of hours residents could work per week and consecutively. N.Y. Comp. Codes R. & Regs. Health tit. 10 §405.4(b)(6) (2010).

extenders would not be expected to substitute completely for the reduced hours worked by resident physicians. More likely, hospitals would hire a mix of new physicians and physician extenders to substitute for the reduced hours worked by resident physicians." Kenneth E. Thorpe, PhD, *House Staff Supervision and Working Hours: Implications of Regulatory Change in New York State,* 263 J. Am. Med. Ass'n 3177, 3179 (1990).

Dr. Thorpe concluded that if New York hospitals hired a mix of physicians and physician extenders (nurses, physician assistants, etc.) to replace the lost resident physicians' work hours spent on patient care, it would cost more than $89 million, but if New York hospitals only hired additional physicians to replace these lost resident hours, the annual cost would jump to $159.6 million. *Id.* at 3179. Thorpe further pointed out that residents not only did the work of physicians, but that they also did work that should be done by other staff (intravenous teams, phlebotomists, messengers and transporters). Given the amount of time that resident physicians spent doing such work, a substantial number of these other replacement staff would also be needed - at an additional cost of $64.6 million. *Id.* at 3180.

In 1995, the Greater New York Hospital Association (GNYHA)[3] published a study regarding the cost impact of federal regulatory proposals that would provide a financial incentive to hospitals to reduce the number of residents that they trained. Barbara A. Green and Tim

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3. GNYHA represents 92 hospitals in the Greater New York City area, the overwhelming majority of which are teaching hospitals.

Johnson, *Replacing Residents with Midlevel Practitioners: A New York City Area Analysis,* 14 Health Affairs 192 (1995). GNYHA was deeply concerned that "reductions in residency training programs could jeopardize the ability of inner-city hospitals to care for patients unless adequate personnel are in place." *Id.* at 193. Assuming a 25% reduction of residents, the study evaluated two cost models. Under one cost model 10,000 Full Time Employees ("FTEs") were needed at a cost of $600 million; under a second model, 4,400 FTEs were needed at a cost of $336 million. *Id.* at 197. The GNYHA concluded with a warning that if a policy of decreasing the number of resident physicians were implemented without adequate funding, "these hospitals – many of which serve the poorest communities in the country – may be unable to continue providing high-quality patient care to our most vulnerable populations." *Id.* at 198.

Forty-nine New York City area hospitals participated in a demonstration project in the late 1990's designed to test a proposed federal policy of providing a financial incentive to hospitals to reduce the number of residents that they were training. The project enabled hospitals to continue to receive the same level of Medicare payments for residents while reducing the actual number of residents by 20% to 25% over six years. But after two years, one-half of the hospitals dropped out because they could not "function without the low-cost labor provided by… residents…" Lisa W. Foderaro, *Many Hospitals in New York Quit Plan for Fewer Doctors,* N.Y. Times, Apr. 1, 1999, http://www.nytimes.com/1999/04/01/nyregion/many-hospitals-in-new-york-quit-plan-for-fewer-doctors.html. The GNYHA President admitted that not only did the project fail,

but it spotlighted the centrality of the resident physician workforce for the hospitals: "It became clear how indispensable the residents are to providing high-quality care on a day-in, day-out basis…" *Id.* In the end, 42 of 49 hospitals withdrew from the program. *GNYHA President Discusses Medicare GME Demo Project and Other GNYHA Initiatives at AAHC Spring Meeting*, April 5, 2004, http://www.gnyha.org/1536/Default.aspx. The demonstration project's failure ended any consideration of a government policy to pay hospitals to decrease their resident complement; residents simply proved to be too cheap a labor source to be replaced by anyone else.[4]

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4. Recent studies have demonstrated the direct link between resident work, effective billing and hospital economic solvency. For example, a 2010 study of Petitioner Mayo Clinic concluded that the financial success of academic medical centers depends on appropriate billing for encounters between resident physicians and patients:

> The financial success of academic medical centers depends on appropriate billing for encounters between resident physicians and patients. This is particularly true in resident physicians' primary care clinics, where resident-patient encounters generate the majority of revenue…[S]ome institutions, including the Mayo Clinic, allow licensed residents to determine billing codes, with attendings providing only supervisory assistance.

Suraj Kapa, MD, et al, *A Reliable Method for Internal Medicine Resident Clinics: Financial Implications for an Academic Medical Center*, 2 Journal of Graduate Med. Educ. 181, 181 (2010). The Mayo study discovered that because of inappropriate coding by resident physicians, the Mayo Clinic was losing $450,368.54 annually for work attributable to

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In part to forestall regulation of resident physician work hours by the Occupational Health and Safety Administration, the Accreditation Council of Graduate Medical Education ("ACGME")[5], the central accrediting authority in the United States for resident physician programs, enacted its first resident work hour guidelines in 2003.[6] The guidelines, applied to all

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resident physicians. *Id.* at 184. *See also*, Kelly A. Carter, MD, et al, *RVU Ready: Preparing Emergency Medicine Resident Physicians in Documentation for an Incentive-based Work Environment,* 16 Academic Emergency Med. 423 (2009). (Increases in billing per second- and third-year Emergency Medicine resident physician and per patient seen by the Emergency Medicine resident physicians resulted in a large increase in billing performance of nearly $1.5 million annually).

5. The Accreditation Council on Graduate Medical Education oversees and accredits U.S. allopathic medical training programs. It is made up of five groups: the American Hospital Association, the Association of American Medical Colleges, the American Medical Association, the Council of Medical Specialties and the American Board of Medical Specialties.

6. A petition seeking OSHA regulation of resident physician work hours was filed in 2001 and dismissed after ACGME announced that it would institute hours limits effective July 1, 2003. In September 2010, another OSHA petition was filed on behalf of resident physicians. Charles M. Preston, MD, MPH, et al, *Petition to Reduce Medical Resident Work Hours,* (Sept. 2, 2010), http://www.citizen.org/documents/1917.pdf. OSHA has taken jurisdiction and will investigate the worker safety issues raised in the petition.

> We are very concerned about medical residents working extremely long hours and we know of evidence linking sleep deprivation with an increased

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ACGME-approved programs across the country, required an 80-hour work week averaged over four weeks and a 30-hour maximum shift length, among other limitations.

Two California teaching hospitals reported on their actual costs of compliance with the reduced resident physician work hours at the March 8, 2008 meeting of an Institute Of Medicine[7] ("IOM") Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety. The University of California San Diego Medical Center hired additional residents, hospitalists, midlevel providers and paid for additional moonlighting coverage; the additional cost was $4,342,614 a year. Richard Liekweg, CEO, UC San Diego Medical Center, *Resident Work Hours: A*

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> risk of needle sticks, puncture wounds, lacerations, medical errors and motor vehicle accidents. We will review and consider the petition on this subject submitted by Public Citizen and others….It is clear that long work hours can lead to tragic mistakes, endangering workers, patients and the public. All employers must recognize and prevent workplace hazards. That is the law. Hospitals and medical training programs are not exempt from ensuring that their employees' health and safety are protected.

OSHA, Statement, *U.S. Department of Labor's OSHA Assistant Secretary Dr. David Michaels on long work hours, fatigue and worker safety* (Sept. 2, 2010): http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=18285

7. Established in 1970, the IOM is the health arm of the National Academy of Sciences.

Look at the University of California Experience at 7-8 (Mar. 4, 2008), http://www.iom.edu/~/media/Files/Activity%20Files/Workforce/ResidentDutyHours/ALookatthe UniversityofCaliforniaExperienceContemplatingthe CostsofReducingWorkHoursforPhysiciansinTraining Liekweg.pdf.

Cedars-Sinai Medical Center hired additional physicians and nurse practitioners; the additional cost was $2,170,100 a year. Mark Noah, MD, FACP, *Resident Duty Hour Restrictions: Cost Impact*, 9 (March 4, 2008), http://www.iom.edu/~/media/Files/Activity%20Files/Workforce/ResidentDuty Hours/ResidentDutyHour RestrictionsCostImpactNoah.pdf. Even the modest changes brought about by compliance with these ACGME rules produced evidence that resident physicians are essential components of the delivery of healthcare at teaching hospitals, not merely students who contribute nothing to the business of health care.

In 2007 the U.S. House of Representatives Committee on Energy and Commerce began a study of medical errors and requested assistance "in ascertaining if the long work hours of physicians and residents also are among the most serious threats to patient safety."[8] The resulting report went beyond work shift length and described the continued reliance by hospitals on resident physicians to perform the work of other staff. Cheryl

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8. Letter from Congressman John D. Dingell, House Energy and Commerce Committee Chair, to William Munier, MD, Acting Director of Agency for Healthcare Research and Quality (Mar. 29, 2007), http://energycommerce.house.gov/Press_110/110-ltr.032907.HHS.Munier.pdf.

Ulmer, et al., eds., Institute of Medicine, *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety* (2008), http://www.nap.edu/catalog/12508.html (hereinafter "IOM Report"). The IOM Report noted that despite the ACGME guidance "encouraging" the transfer of ancillary staff tasks to ancillary staff, "residents typically still spend a *substantial amount of time* searching for test results and supplies, completing paperwork, obtaining and transporting specimens for laboratory tests, moving patients, making appointments, and completing paperwork for patient discharges." IOM Report at 93. (Emphasis added).

The mix of personnel (nursing aides, laboratory technicians, licensed vocational nurses, physicians' assistants, nurse practitioners and attending physicians) used in the IOM replacement cost model demonstrates the extensive range of the resident physicians' work in the hospitals. In order to calculate replacement costs realistically, the IOM Report acknowledged that the more complex patient care duties of resident physicians can only be done by highly paid attending physicians. In the end, the IOM Report estimated the final replacement cost to be $1.7 billion:

> Recommendations for duty hour adjustments, enhanced supervision and workload reduction will best achieve the target goals when implemented in concert and implementation of all the committee's recommendations will require a significant investment of personnel to substitute for the hours that residents are no longer available. To cover some of the excess resident hours with substitute

> personnel would cost in the ballpark of $1.7 billion dollars, the equivalent of about 9 percent of direct and indirect graduate medical education payments made to teaching facilities from public and private sources.

IOM Report at 295. Moreover, while the $1.7 billion estimate is substantial, it only considers the *lost* resident physician hours. Depending on other reasonable assumptions, the replacement costs could be as high as $2.5 billion.[9]

> The labor costs associated with transferring all the excess work [of resident physicians] to alternative providers would be relatively high. ($1.1 billion to $2.5 billion), and the effectiveness of doing so is unknown. If the changes were highly effective, they could prevent patient harm at reduced or no cost to society.

Teryl K. Nuckols et al., *Cost Implications of Reduced Work Hours and Workloads for Resident Physicians,* 360 New Eng. J. Med. 2202, 2213 (2009). It is forceful testimony of the extremely high value of the total hours that resident physicians work at the hospitals and how much they contribute to the hospitals' financial well-being.

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9. *Amici* American Association of Medical Colleges and others admit that the cost to teaching hospitals to comply with a limitation in resident work hours is $3.2 million annually for each hospital and $1.6 billion in the aggregate annually. Brief of the Association of American Medical Colleges, et al., as *Amici Curiae* in Support of Petitioners at 26 (Aug. 13, 2010).

The Medicare Payment Advisory Commission (MedPAC), the independent Congressional Agency on issues affecting Medicare, also recognizes that residents provide comparatively inexpensive labor for the valuable clinical services they provide.[10] In 2009, MedPAC noted

> For hospitals, residents provide valuable clinical services, particularly on-call duties that may include writing timely prescription orders and conducting patient admissions. Hiring or contracting other physicians, physician assistants, or nurse practitioners to provide these activities and services is more expensive for the hospital because hospitals must pay them higher wages (Rich, E.C., et al. 2002 Medicare Financing of Graduate Medical Education: Intractable Problems, Elusive Solutions. *Journal of General Internal Med.* 12:283-292 et al. 2002)

MedPAC, *Report to Congress: Improving Incentives in the Medicare Program*, 27 (June 2009), http://www.medpac.gov/documents/Jun09_Entire Report.pdf.

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10. Medicare is the largest payer of graduate medical education — $9.5 billion in 2009. (MedPAC, *Report to Congress: Aligning Incentives in Medicare*, 103 (June 2010), http://www.medpac.gov/documents/Jun10_EntireReport.pdf. MedPAC has always recognized the essential employee relationship of residents and hospitals. In 1999, MedPAC stated that "[r]esidents earn a stipend because they provide patient care and perform other services that are of value to the hospital…The services provided by residents and other trainees are just one part of the enhanced patient care furnished in teaching hospitals." (MedPAC, *Rethinking Medicare's Payment Policies for GME and Teaching Hospitals*, 8 (Aug. 1999), http://www.aamc.org/advocacy/teachhosp/medpac/rethinking medicare.pdf.

These studies demonstrate that resident physicians provide significant economic value to their hospitals and that it is far from arbitrary to treat them as employees rather than as students.

II. RESIDENT PHYSICIANS ARE EMPLOYEES WHOSE WORK CONSISTS PRIMARILY OF PATIENT CARE.

A. The Agencies That Accredit Residency Programs Require Teaching Hospitals to Provide Residents With Terms and Conditions Associated with Employment.

Petitioners cite to the training requirements laid out for resident physicians by ACGME but give scant attention to the terms and conditions for the employment of residents that are also set out by the ACGME. The ACGME requires that resident physicians be presented annually with a written contract that outlines the terms and conditions of their residency training.[11] *See*, ACGME, *Institutional Requirements* 4, http://www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf. The ACGME requires that these written contracts outline compensation ("financial support"), professional liability insurance, leaves of

11. The Internal Revenue Service, in response to refund claims filed by teaching hospitals, conducted an investigation of several common residency programs and subspecialty programs. The IRS found that the contracts provided to resident physicians "resemble[ ] an employment contract of a typical non-student/employee." Memorandum of Mary Oppenheimer, Assistant Chief Counsel, 15, ILM 200212029 (January 24, 2002) ("IRS Memo") http://ficarefund.tennessee.edu/IRS%201-24-2002%20Memo.pdf.

absence, sick leave, parental leave, vacation, health insurance, disability insurance, and grievance procedures. ACGME, *supra* at 4.

Since every resident training program is accredited by either the ACGME or a similar organization,[12] every teaching hospital in the United States is obligated to provide resident physicians with an individual written agreement that contains employment-related provisions as set forth above.[13]

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12. For example, the American Osteopathic Association ("AOA") accredits osteopathic residency training programs. The AOA, like the ACGME, also requires that programs present resident physicians with an annual written contract outlining the terms and conditions of residency. AOA, *The Basic Documents for Postdoctoral Training*, 35 (July 2010), http://www.do-online.org/pdf/sir_postdoctrainproced.pdf.

13. For example, the agreement used for residents employed at the State University of New York at Buffalo is entitled "Medical Resident Employment Agreement" and contains terms and conditions of employment such as salary, leave time and employee benefits. State University of New York at Buffalo, *Medical Resident Employment Agreement,* http://www.smbs.buffalo.edu/GME/documents/Resident_Contracts.pdf. The Residency Agreement for Hennepin County Medical Center, one of the hospitals to which Mayo residents are assigned, identifies its resident physicians as "employees of Hennepin Healthcare Systems." Hennepin Cnty. Med. Ctr., *Residency Agreement,* 4 http://www.hcmc.org/education/documents/ 2009ResidencyAgreement.pdf. The "House Officer Agreement" for Boston Medical Center, *Amicus Curiae* in Support of Petitioner, states that resident physicians are "covered by the terms and conditions of the collective bargaining agreement between the Committee of Interns and Residents (a labor union) and the Boston Medical Center." Boston Med. Ctr., *House Officer Agreement*, 3, http://www.bmc.org/Documents/SAMPLE-HouseofficerContract.doc.

B. Resident Physicians are Employees Who Provide Patient Care Services for the Hospitals that Employ Them.

For several decades, in multiple forums, teaching hospitals have attempted to deprive resident physicians of the legal protections afforded to employees by arguing that they are students. However, nearly every federal agency, state agency, and state court that has received evidence and ruled on the subject in a variety of contexts has determined that residents are employees whose paramount activity is providing patient care.

The National Labor Relations Board ("NLRB" or "Board") is the federal agency vested with the responsibility of protecting the rights of private sector employees. 29 U.S.C. § 151, *et seq.* In 1999, the NLRB held that resident physicians were employees because they provided patient care for the hospital that employed them and were compensated for their services. *Boston Medical Ctr.,* 330 N.L.R.B. 152, 160 (1999).

Resident physicians "work notoriously long hours, which vary depending on the specialty and rotation." *Id.* at 153. For example, the Board determined that internal medicine residents at Boston Medical Center worked 60 to 90 hours per week over six or seven days depending on the unit to which they were assigned.[14]

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14. According to Dr. Roger Nelson, the Dean of Graduate Medical Education for the Mayo Foundation, Mayo residents "work[ ] in the hospitals and clinics between fifty and eighty hours per week." Joint Appendix 21a (hereafter "J.A. __"). Dr. Mark Melin, stated in a deposition that resident physicians work 75 to 80 hours per week. J.A.72a. See also, IRS Memo at 7 (IRS agents confirm that resident physicians, in most cases, work in excess of 80 hours per week.)

Surgical residents averaged 60 hours per week but worked longer hours when working in the intensive care unit. *Id.* at 184.[15] The direct patient care work performed by residents may assist their training but its primary purpose is to deliver the health care services that are the product of all hospitals, including teaching hospitals.

Resident physicians spend up to 80 percent of their time providing direct patient care by working on patient care teams and taking on responsibilities commensurate with their experience.[16] *Id.* at 153-154. They also spend five to eight hours per week at didactic conferences and one hour, six days per week, at morning reports. *Id.* at 155. Patient care activities take precedence over these didactic activities, as resident physicians are often required to miss didactic conferences to care for patients.[17] *Id.* at 185.

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15. *See*, IRS Memo at 7 (Residents in surgical and OB/GYN residencies report working in excess of 100 hours per week)

16. Resident physician programs typically last from three to seven years and frequently lead to subspecialty fellowships of one to two additional years. The package of employment benefits offered to resident physicians by the University of Minnesota appears at J.A.199a-200a. The salary the University of Minnesota offered to its resident physicians in 2005 through their 12th year of residency goes up to $51,629 per year. J.A. 172a. Resident physicians are frequently in their mid to late 30's or older and supporting a spouse and children. For example, approximately 50% of the resident physicians entitled to medical benefits in CIR sponsored health plans elect to receive family coverage.

17. *See also*, IRS Memo at 9 (IRS agents find that "didactic activities were secondary to patient care" because "if a patient needed a resident's attention, didactic activities gave way to

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Residents on inpatient wards are assigned 12 to 15 patients. *Id.* at 153-154.[18] Residents are responsible for hospital admissions and are the primary physicians interacting with patients' families.[19] They take medical histories, perform physicals, draw blood, start IV lines, and write admission and medication orders, as well as patient progress notes. Residents also order x-rays, consults, treatments[20] and write "do not resuscitate" orders that are only later co-signed by an attending physician. *Id.*

When residents see patients, they frequently do so outside the presence of an attending physician.[21] Residents even perform medical procedures outside the

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patient care needs. Residents reported that it was not uncommon to be 'beeped out' in order to handle a patient emergency."); *Regents of the Univ. of Cal. v. Public Emp't Relations Bd.*, 41 Cal.3d 601, 619, 715 P.2d 590, 602 (S. Ct. Cal. 1986) (Because patient care is the "primary responsibility" of resident physicians, "it is not uncommon for [resident physicians] to be absent from didactic activities").

18. *See*, IRS Memo at 11 (Surgical residents reported to IRS agents that they saw "between 10 and 40 patients on a daily basis").

19. *See*, Affidavit of Roger Nelson, Mayo Clinic Dean of GME J.A. 21a ("Virtually all patients admitted to the Mayo hospitals" are seen by resident physicians).

20. *See*, Deposition of Dr. Michael Belzer, Hennepin County Medical Center, J.A. 34a-35a (Resident physicians do histories and physicals, order lab tests and x-rays.)

21. The contention that resident are always working under the watchful eye of faculty physicians is wildly inconsistent with the actual working lives of residents, who may see an attending

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presence of an attending physician, including arterial blood gases, thorancentesis, and lumbar punctures.[22] They also perform procedures as critical as the intubation of patients. *Id.* at 154.[23]

After their first year, resident physicians typically receive a medical license. *Id.* at 156.[24] They are then expected to perform more focused patient histories and physical exams, and they oversee the work of first-year residents. *Id.*[25] More senior resident physicians also perform more complicated procedures. Surgical residents, for example "are permitted to perform increasingly more complicated surgeries as their

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physician for as little as two to three hours of their regular 13-hour or even 30-hour shift. See, Deposition of Dr. Gordon Alexander, J.A. 69a. (Supervision is not literally an attending looking over a resident's shoulder at all times. See, Deposition of Dr. Terrill Rosborough, J.A. 54a).

22. *See*, Resident and Fellow Scope of Practice (Hennepin County Medical Center), J.A. 41a-43a (List of dozens of procedures that resident physicians do "independently").

23. *See*, Deposition of Jared Austin, J.A. 134-138a (Resident physicians perform intubations and lumbar punctures without an attending physician present).

24. *See*, Internal Medicine residency program description, J.A. 199a (Minnesota medical license available to residents who have completed their first year of residency).

25. *See*, Resident and Fellow Scope of Practice (Hennepin County Medical Center), J.A. 39a-41a (Discussion as how responsibilities increase as resident physicians proceed in their residency training).

experience increases." *Id.* at 155.[26] More senior resident physicians also make patient care decisions on their own. One resident, for example, testified that she made patient care decisions on her own 80% of the time. *Id.* at 154.[27]

The NLRB concluded that while resident physicians obtain an educational benefit by performing patient care, the hospital benefits from their services and the training does not detract from the residents' employee status. *Id.* at 160-161.[28]

The NLRB recently had the opportunity to reconsider the work status of resident physicians, and after developing an extensive record, reaffirmed its *Boston Medical Center* decision. In *St. Barnabas Hospital*, the Director of NLRB Region 2 issued a decision noting that the residents' working conditions at St. Barnabas Hospital were "nearly identical" to those

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26. *See*, Deposition of Dr. Gordon Alexander, J.A. 201a-202a (Residents perform procedures during gall bladder removal surgery including opening patient, exposing gall bladder, and closing patient).

27. *See also, Regents of the Univ. of Cal.v. Pub.Emp't Relations Bd.*, 41 Cal.3d 601, 619, 715 P.2d 590, 602 (S. Ct. Cal. 1986) ("In some cases, a patient may be admitted and discharged from the hospital without ever seeing an attending physician.")

28. *See also*, IRS Memo at 7 ("Facts developed by [IRS] agents consistently demonstrate that although programs have a significant educational component, patient services are not incident to a course of study. Instead, patient care is the paramount activity in the relationship between the resident and the employer.")

found by the Board in *Boston Medical Center. St. Barnabas Hosp.,* Decision and Direction of Election, Case No. 2 RC-23356, 17 (May 22, 2009).[29] In June of 2010, the NLRB upheld the Regional Director's decision. *St. Barnabas Hosp.*, 355 N.L.R.B. No. 39 (June 3, 2010).

In addition, over the last several decades, multiple agencies and state courts determined that resident physicians are entitled to legal protections afforded to employees. In all but one jurisdiction where the matter has been ruled on,[30] resident physicians have been found to be more like employees than students and therefore are not exempt from legal protections as students.

In *Regents of the Univ. of Cal. v. Public Emp. Relations Bd.,* 41 Cal. 3d 601, 224 Cal. Rptr. 631, 715 P.2d 590 (1986), the Supreme Court of California found that there was substantial evidence to support the findings of the state Public Employment Relations Board

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29. The Regional Director's decision, in addition to discussing facts that were identical to those found in *Boston Medical Center*, also cited, as evidence of employee status, the badges worn by resident physicians at St. Barnabas that identified them as "doctors" and "resident." *Id.* at 8.

30. Pennsylvania is the only jurisdiction to hold that resident physicians are more like students than employees and therefore are exempt from legal protections available to employees. *Philadelphia Ass'n of Interns & Residents v. Albert Einstein Medical Ctr.,* 92 L.R.R.M. 3410, 369 A.2d 711 (Pa. 1976) (Pennsylvania Supreme Court, in reversing Pennsylvania Labor Relations Board, found house staff to be students rather than "public employees.") This decision, however, is over 30 years old and is an outlier.

that the "educational objectives [of a residency training program] are subordinate to the services performed by [resident physicians]" and that resident physicians should, therefore, be granted collective bargaining rights pursuant to state statute. *Id.* at 41 Cal. 3d at 624, 224 Cal. Rptr. at 646, 715 P.2d at 605. The Court, in reaching its decision, cited "abundant testimony that [resident physicians] provide valuable patient care services" for their employers. *Id.* at 41 Cal. 3d at 618, 224 Cal. Rptr. at 642, 715 P.2d at 601. The testimony is strikingly similar to the facts discussed in the *Boston Medical Center* decision, and the facts cited in the record below. The Court reported that:

> From their first year of residency, [resident physicians] are immersed in all aspects of direct patient care. They perform physical examinations, obtain patient's medical histories, develop treatment plans, prescribe drugs, administer dangerous drugs which nurses are not permitted to administer, and perform various operations and procedures. First-year residents normally write all orders for patient treatment and prescriptions. [Resident physicians] are also required to supervise other personnel such as nurses and technicians.
>
> Some of the procedures performed by house staff—in most cases with no attending physician present – include bone marrow biopsies, intubation, running of respirators, drawing blood, cardiopulmonary resuscitation, administering barium enemas, upper GI's

> (evaluations of the intestinal tract), IVP's (evaluations of the urinary tract), bone marrow aspirations, and placement of catheters. Also house staff perform procedures in life-threatening situations without the presence of attending physicians, including open chest massage and placement of pacemakers and chest tubes.
>
> [Resident physicians] also deliver babies. They are often called upon to perform Caesarean sections, forcep deliveries, and emergency D and C's (dilation and curettage). In many instances these procedures are performed in the absence of an attending physician.

Id. at 41 Cal. 3d at 618-619, 224 Cal. Rptr. at 642-643, 715 P.2d at 601-602.

Other courts and agencies have also determined, after examining the work-life of resident physicians, that they are not exempt as students from the protection of the law. See, *Univ. Hosp., Univ. of Cincinnati Coll. of Med. v. State Emp't Relations Bd.,* 63 Ohio St. 3d 339, 344, 587 N.E.2d 835, 839 (1992) (Supreme Court of Ohio upholds hearing officer's determination that "the primary purpose of [resident physicians] was not educational training but patient care" and therefore they were entitled to the protection of the State Public Employees' Collective Bargaining Act); *Regents of the Univ. of Mich. v. Emp't Relations Comm'n*, 389 Mich. 96, 112-113, 204 N.W. 2d 218, 225-226 (1973) (Michigan Supreme Court, citing testimony that "the principal

duty and responsibility of interns and residents is to diagnose and prescribe a patient care program and put it into effect," held that resident physicians are employees entitled to the protections of the Michigan Public Employees Relations Act.)[31]

In sum, federal agencies, state courts, and state agencies have thoroughly reviewed the patient care services provided by resident physicians as well as the educational components of residency training programs. Almost universally, these courts and agencies have determined that resident physicians are covered by various labor and employment laws as employees who perform work for the hospitals that employ them. While

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31. *See also*, *Long Beach Veterans Admin. Med. Ctr., Long Beach,Cal.,* 7 FLRA 434, 439-441 (1981). (Federal Labor Relations Authority found that resident physicians work long and irregular hours, exercise independent judgment, spend most of their working time performing patient care responsibilities and are thus employees entitled to the protection of the Federal Service Labor Management Relations Act); *House Officers Ass'n v. Univ. of Neb. Med. Ctr.,* 198 Neb. 697, 700-701, 255 N.W.2d 258, 260-261 (1977) (Supreme Court of Nebraska, noting that residents worked more than 80 hours per week, spent as much as 90 percent of their time providing primary patient care, and performed a variety of tasks and procedures without supervision, upheld trial court finding that resident physicians are employees entitled to the protection of the State Employee Collective Bargaining Act); *New York Bronx Eye Infirmary, Inc. and House Staff Ass'n of the Bronx Eye Infirmary, Inc.*, 33 S.L.R.B. 245, 250 (N.Y. 1970); *Brooklyn Eye & Ear Hosp. and House Staff Ass'n of Brooklyn Ear & Eye Hosp.*, 32 S.L.R.B. 65, 74 (N.Y. 1969); *Comm'n on Mental Health Serv. Dep't of Human Serv., D.C. Gov't and Comm. of Interns & Residents*, 38 DCR 1628, Slip Op. No. 269, P.E.R.B. Case No. 90-R-04 (1991).

these statutory and regulatory regimes are not identical to that at issue here, they represent a nearly uniform collection of fact-findings that establish that it is eminently reasonable for an agency to treat resident physicians as employees rather than students.

C. Federal Tax, Immigration And Anti-Discrimination Laws Recognize That Resident Physicians Are Employees.

The Tenth Circuit reasoned that resident physician income was subject to income tax because it was "difficult to imagine a more perfect example of an employer-employee relationship." *Woddail v. Comm'r of Internal Revenue,* 321 F.2d 721, 724 (10th Cir. 1963). See also *Rockswold v. U.S.*, 620 F.2d 166, 167 (8th Cir. 1980). Compensation paid to the Petitioners' residents is subject to income tax like all of their other employees. J.A. 171a-172a, 199a. The United States Tax Court has compared residency to the early stages of other professionals. "There can be no serious doubt that work as a resident physician provides highly valuable training, particularly in preparing for specialties in the various fields of medicine. Yet virtually all work as an apprentice, whether in medicine or law, carpentry or masonry, provides valuable training." *Proskey v. Comm'r*, 51 T.C. 918, 925 (1969).[32]

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32. *Boston Medical Center* also concluded that the fact that residents receive post medical school training does not differentiate them from other early career professionals or apprentices whose status as employees has never been questioned.

> Nor does the fact that interns, residents, and fellows are continually acquiring new skills negate their status as employees. Members of all professions

(Cont'd)

Many residency programs, including that of Petitioners Mayo Clinic and University of Minnesota[33], rely on H-1B work visas to recruit graduates of foreign medical schools. AMA, *International Medical Graduates In American Medicine: Contemporary*

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> continue learning throughout their careers, and many professions including those in the healthcare industry, require individuals to be trained after graduation in order to be licensed or received in the field. *See,* eg. *Wurster, Bernardi,& Emmons, Inc.,* 192 NLRB 1049, 1050-1051(1971) (describing licensing process for graduates of architecture schools); *UTD Corp., 165 NLRB 346 (1967)* (apprentices in 4-year training program included in production and maintenance unit); *General Electric Co., 131 NLRB 100, 104 (1961)* (describing employer training program for apprentices in tool and die trade; 'the very purpose of an adequate apprenticeship program is to broadly train apprentices in their craft so that they may practice it in any industry or company or advance into executive or managerial responsibilities'); *Riverside Memorial Chapel, 92 NLRB 1594, 1595 (1951)* (describing steps necessary for apprentice embalmers to be licensed). 'Fledgling lawyers employed by a law firm spend a great deal of time acquiring new skills, yet no one would contend that they are [**47] not *employees* of the law firm.' *Regents of the University of Michigan v. Michigan ERC, 204 N.W. 2d 218, 226 (Mich. 1973).*

Boston Med. Ctr. at 161.

33. Mayo Clinic, *Summary of Terms and Conditions of Appointment*, 2, http://www.mayo.edu/pmts/mc0400-mc0499/mc0437-68.pdf; University of Minnesota, *Visa Sponsorship Policy,* http://www.med.umn.edu/gme/residents/instpolicyman/VisaSponsorshipPolicy/index.htm

Challenges and Opportunities, 29-30, (Jan. 2010), http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf. (Residency programs prefer H-1Bs over other types of visas when recruiting foreign-born resident physicians). H-1Bs are employment-based visas in which an employer petitions the United States Citizenship and Immigration Services (USCIS) to allow an alien to come to the United States to "perform services in a specialty occupation." USCIS, *Instructions for Form I-129, Petition for a Nonimmigrant Worker* at 3 (Dec. 4, 2009), http://www.uscis.gov/files/form/i-129instr.pdf.

In applying for an H-1B work visa on behalf of the residency program and resident physician, a residency program must identify itself as the "employer" and must provide "evidence that the proposed employment qualifies as a specialty occupation." USCIS, *supra* at 3. The I-129 also identifies the resident physician as a "worker," and requests a "job title" and "nontechnical job description," as well as the "wages" and "dates of intended employment." USCIS, *Form I-129, Petition for a Nonimmigrant Worker*, 1-4 (Dec. 4, 2009), http://www.uscis.gov/files/form/i-129.pdf. Programs seeking to employ residents pursuant to an H-1B visa must also file a Labor Condition Application for Nonimmigrant Workers ("LCA") with the United States Department of Labor. http://www.foreignlaborcert.doleta.gov/pdf/ETA_Form_9035_2009_Revised.pdf. On the LCA, residency programs must agree to pay the resident physician "at least the local prevailing wage." *Id.*

Resident physicians are recognized as employees under Title VII of the Civil Rights Act, *Amro v. St. Luke's of Bethlehem*, 1986 U.S. Dist. LEXIS 30559 (E.D.

Pa 1986); *Navato v. Saint Luke's Hosp. of Kansas City*, 1991 U.S. Dist. LEXIS 18456 (W.D. Mo. 1991)(Court rejected hospital's argument that resident physicians were not employees protected by Title VII). The Equal Employment Opportunity Commission ("EEOC") has also ruled that resident physicians are employees for purposes of the Age Discrimination in Employment Act ("ADEA") and the Equal Pay Act ("EPA"). EEOC Decision No. 88-1, 47 Fair Empl. Prac. Cas. 1887 (June 27, 1988). In addition, resident physicians have been allowed to seek redress for violations of the Family Medical Leave Act ("FMLA"), *Balogun-Awosika v. Univ. of Md. Med. Sys. Corp.*, 2002 U.S. Dist. LEXIS 26932 (D. Md. 2002) *aff'd*, 60 Fed. Appx. 509 (2003); and the Americans With Disabilities Act. *Zechman v. Christiana Care Health Sys.*, 2007 U.S. Dist. LEXIS 47349 (D. Del. 2007).

D. Resident Physicians Nationwide Can Be Held Liable for Medical Malpractice and in Many States They Are Held to the Same Standard of Liability as Attending Physicians.

The fact that State decisional laws also equate resident physicians with attending physicians employed by a hospital for purposes of medical malpractice liability further demonstrates that they are hospital employees engaged in independent patient care. When the actions of a resident physician are judged in a medical malpractice case, they "must conform at least to the standard of care expected of a general practitioner." Allen Kachalia, M.D., J.D., and David M. Studdert, LLB, *Professional Liability Issues in Graduate Medical Education*, 292 J. Am. Med. Ass'n 1051, 1052 (Sept. 1,

2004). Thus, there is no medical malpractice "student" exemption for resident physicians as they are held to the same standard of care as attending physicians. *McBride v. U.S.*, 462 F.2d 72, 74 (9th Cir. 1972) (Resident who had completed one-and-one-half years of residency was evaluated by the standard applicable to a general licensed physician staffing an emergency room.) In fact, "Courts have held resident physicians in specialty training to the same standard expected of the *average specialist* in that specific field." Kachalia, *supra* at 1052 (emphasis supplied).

E . Medical Students Are Not Employees and Do Not Have the Same Patient Care Responsibilities as Resident Physicians.

Petitioners and *amici* attempt to blur the distinction between resident physicians who are employees and medical students who are not. There are, however, stark and important differences between being a resident physician and being a medical student.

While medical students have limited interaction with patients, they do not have anywhere near the level of patient care responsibility that resident physicians have, and are limited as to what they can do in regard to patient care. For example, as detailed in the Joint Appendix, if a medical student writes a patient order it must be countersigned by a resident physician or attending physician, and if they administer intravenous medications it must be under the direct supervision of a resident physician.[34]

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34. Resident and Fellow Scope of Practice (Hennepin County Medical Center) J.A. 43a.

The Internal Revenue Service detailed the differences between resident physicians and students in a report, see note 16 *infra*, which noted that, unlike resident physicians, medical students "do not get paid for the services they perform; receive employee benefits; develop and initiate specific patient treatment plans; order tests, and write prescriptions; make any independent medical decisions - - such as changing medicine dosages; or take charge of a ward or other service areas, especially during the night. They are generally not even allowed to write notes for the medical record." IRS Memo at 17. In addition, the IRS found that medical students are not permitted to work more than 19 hours per week.[35] *Id.* at 18.

In sum, resident physicians, unlike medical students, are professional employees who provide valuable patient care services for the hospitals that employ them and have been categorized as employees, and not as students in a wide variety of regulatory and judicial procedures.

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35. *See also*, *Boston Med. Ctr.,* 330 N.L.R.B. at 157 (citing brief of AMSA in which the organization contests as "factually contrary to the experience of the membership of its organization" the argument that resident physicians have an academic relationship with their hospitals that is similar to the one medical students have with their hospital.)

CONCLUSION

Resident physicians are employees entitled to the protections of Federal and State labor and employment laws and therefore, the judgment of the Eighth Circuit Court of Appeals should be affirmed.

Respectfully submitted.

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