THE AILING LABOR RIGHTS OF MEDICAL RESIDENTS: CURABLE ILL OR A LOST CAUSE?

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I. INTRODUCTION

Patients of academic hospitals receive most of their direct care from medical interns, residents, and fellows who are one, two, three, or more years out of medical school.¹ Although these doctors have graduated from medical school, their post-graduate training is essential for board certification.² Most doctors cannot work in private practice until they have completed an accredited residency program.³ While residents are M.D.'s and D.O.'s, hospital faculty does not treat them as full-fledged doctors. The lack of status classification of medical residents has left a void in labor law protection for medical interns and residents. This void is confounded by the lack of congressional direction for the National Labor Relations Board (NLRB or “Board”) and the lobbying efforts by the American Medical Association (AMA) and the Association of American Medical


¹ See Nat'l Resident Matching Program (NRMP), Residency Match: About Residency, http://www.nrmp.org/res_match/about_res/index.html (last visited Jan. 6, 2006) (“To provide direct patient care, physicians in the United States are required to complete a three to seven year graduate medical program—accredited by the Accreditation Council for Graduate Medical Education (ACGME)—in one of the recognized medical specialties. Certification requirements, as determined by individual specialty boards, usually include formal training (residency) and the passing of a comprehensive examination.”); see also Fed’n of State Med. Bds., Directory of State Medical Boards, http://www.fsmb.org/directory_smb.html (last visited Jan. 6, 2006) (providing links to state medical boards, which set medical licensure requirements assuming one to two years of internship/residency).

² See Katherine Huang, Note, Graduate Medical Education: The Federal Government’s Opportunity to Shape the Nation’s Physician Workforce, 16 YALE J. ON REG. 175, 176 (1999) (“These residencies serve as the sole entry point into the physician workforce for both domestic and foreign medical school graduates.”).

Colleges (AAMC). As a result of the confusion regarding the status of medical residents, residents are offered virtually no labor law protection by virtue of their position as employees of hospitals. The ambivalence with which Congress treats medical resident labor rights is further complicated by the particular nature of the medical profession and its inherent extra-legal duties to patients and to institutions.

Public safety concerns have prompted states to regulate some working conditions of residents, including their hours. The media has consistently pointed to the deleterious effects of long intern and resident hours on health care and even on the safety of others on the road.

The lack of coherent labor law protection for medical residents originates from the original refusal of the national labor law system to cover the health care industry at all until 1974. When the federal government did allow the National Labor Relations Act (NLRA or "Act") to cover the health industry, it cautioned the NLRB to ensure that the new labor law protection did not lead to a proliferation of bargaining units in American hospitals. Congress feared labor disputes and work stoppages would impede the service of patients in hospitals.

The NLRB struggled with the precise definition of "over


10. See S. REP. No. 93-766, at 5, 1974 U.S.C.C.A.N. 3951 ("It was this sensitivity to the need for continuity of patient care that led the Committee to adopt amendments with regard to notice requirements and other procedures related to potential strikes and picketing.")
proliferation” and in 1989 decided to allow a maximum of eight bargaining units in acute care hospitals. These units extended to nurses, physicians, all other professionals, technical employees, skilled maintenance, clerical employees, guards, and all other non-professional employees. However, physicians could not unionize due to other restraints; they were either self-employed, or those employed by hospitals, such as attendings, were considered “supervisors” and thus not entitled to unionize. NLRB precedent prevented resident and intern unionization by referring to residents as students, rather than employees.

Boston Medical Center Corp. overturned NLRB precedent and classified residents as employees for the purposes of union organization. If residents had successfully unionized, they would have the same rights and privileges as any other union member, including the right to strike.

Organized labor is stepping up and offering residents money to organize the profession. While unionization may offer physicians stronger control over their practices, residents are in a category of their own. They train for a specific amount of time and are bound to serve their host programs for this training. The AMA and other health organizations consider the prospects of more resident control over their training, including unionization, as a potential threat to American health care.

Part II of this Comment will discuss the match program, residency placement, and medical training. Part III will discuss the Health Care Amendments and their effect on house-staff labor protection. Part IV will evaluate the NLRB path from the Cedars-Sinai decision, in which the NLRB classified medical residents as students, denying them NLRA coverage, to the Boston Medical decision, which overruled twenty-five years of NLRB precedent denying residents unionization rights. Part V will explore residents’ attempts to achieve bargaining rights while choosing
their respective hospitals and Congressional attempts to squash these efforts.

In conclusion in Part VI, I will argue that without congressional clarification of its intentions for professional health care workers, attempts at achieving labor rights through unionization or other appeals to the NLRB will be futile. The recently failed graduate student movement for unionization has added to congressional vagueness. This recent failure seems incongruent in light of Boston Medical, because the NLRB faced similar questions when deciding how to classify residents and graduate students.

I will posit that the reasons for the current futility of the resident labor movement no longer solely depend upon the classification of medical residents, but on the perceived effect that a successful labor movement would have on the medical profession, the future careers of medical residents, and congressional health care funding.

II. RESIDENT AND INTERN TRAINING AND THE MATCH PROGRAM

The National Residency Matching Program (NRMP), a non-profit corporation known to most medical students as the "the match," places graduating medical students in residency programs throughout the nation using a computerized system that matches medical graduates' preferences for various residency programs with the preferences of various hospitals.21 The match receives a confidential list from hospitals and assigns fourth year students to programs on the same day each year.22 The Accreditation Council on Graduate Medical Education (ACGME) authorizes the approximately 7,800 residency programs across the country.23 The hospitals and the fourth year medical students must both agree in advance to accept the match.24 Students are then locked into their choices and if they choose not to accept their match, they will be barred from the match program for three years or, on occasion, permanently.25

Fourth year students have no opportunity to bargain for better wages or for better working conditions at their respective hospitals prior to signing a contract. If they withdraw due to labor related issues, they might be permanently barred from the medical profession. Thus if residents wish to change their working conditions, they must do so after the fact through

22. Id.
23. Id.
24. NRMP, supra note 19.
25. Id.
unionization or similar efforts.

III. HEALTH CARE AMENDMENTS 1974

From 1947 to 1974, hospital staff members did not have the right to unionize. 26 Originally, the Wagner Act of 1935, the precursor to the NLRA, covered both non-profit and for-profit hospitals. 27 The Taft-Hartley Act of 1947 then excluded non-profit hospitals from its definition of "employer." 28 The Board chose not to exercise its jurisdiction over for-profit hospitals for twenty years after Congress passed the Taft-Hartley Act. 29 Congress then amended the NLRA in 1974 to include non-profit hospitals. 30 The Committee on Labor and Public Welfare report on the amendments stated that it could find no acceptable reason why 1,427,012 employees of these non-profit, non-public hospitals, representing 56% of all hospital employees, should continue to be excluded from the coverage and protections of the Act. 31 While the Amendments extended NLRA coverage to medical facilities, it added restrictions on the labor protections of health care workers, including notice requirements for termination of contracts and strikes. 32 These unique restrictions on the labor rights of health care workers illustrated congressional fears that offering unrestricted NLRA rights to health care workers could endanger American health care.

Although the Amendments specifically included the health care industry in the NLRA's coverage, Congress offered no guidance as to the

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27. Id.
28. Id.
32. See 29 U.S.C. § 158(d), (g) (2000). Section 158(d) increases the time for contract termination notice from sixty days to ninety days for employees in health care institutions when giving notice to the other party. 29 U.S.C. § 158(d). In case of notice to the Federal Mediation and Conciliation Service (FMCS) and state mediation agencies, sixty days notice instead of the usual thirty days is required. Id. In addition, when bargaining for an initial agreement occurs following certification or recognition, thirty days notice of the existence of a dispute must be given to FMCS and state mediation agencies. Id. Section 158(g) requires a labor organization to give ten days notice to the employer-health care institution and the FMCS before it engages "in any strike, picketing, or other concerted refusal to work." 29 U.S.C. § 158(g).
appropriate method of instituting bargaining units in private health care facilities. 33 This lack of guidance led to cumbersome litigation in which the NLRB struggled to establish its own limits on a case by case basis. 34 Eventually, the Board ruled that eight was an appropriate number of bargaining units for private hospitals and would not constitute an “over proliferation” of such units. 35

While the coverage extended labor protection to over one million hospital workers, 36 it neglected to specify which health care workers were actually entitled to unionization. This second deficiency in the clarification of health care worker labor protection led to more onerous litigation. 37 One source of confusion involved the dubious supervisory status of professional health care providers. Supervisors are excluded from the Act’s coverage. 38 The Board has applied various tests to determine which health care professionals exercised supervisory roles and were thus excluded from the right to unionize. 39

While the supervisor exclusion of the NLRA provided an ample source of confusion for the Board, the term “employee” provided just as much confusion and a source for litigation. 40 While a majority of medical staff in academic hospitals are interns and residents, residents have faced a tough road to unionization since the passage of the Health Care Amendments.

33. See Sharo, supra note 26, at 790 (discussing litigation over the issue of appropriate bargaining units).
34. Id.
35. See 29 C.F.R § 103.30 (2005) (enumerating eight bargaining units); see also Am. Hosp. Ass’n v. NLRB, 499 U.S. 606, 621 (1991) (holding that the NLRB rule authorizing up to eight bargaining units in health care facilities was not “arbitrary or capricious”).
36. See supra note 31 and accompanying text.
37. See Mercy Hosp. of Sacramento, Inc., 217 N.L.R.B. 765 (1975) (certifying a bargaining unit of professional nurses); see also Children’s Habilitation Ctr., Inc. v. NLRB, 887 F.2d 130, 134 (7th Cir. 1989) (addressing the status of nurses); NLRB v. Res-Care, Inc., 705 F.2d 1461, 1461 (7th Cir. 1983) (applying a “patient care test” to determine if the apparent supervisory role of registered nurses was exercised for the interest of the patients or for the interests of the employer).
39. Id.
IV. THE PATH FROM CEDARS-SINAI 1976 AND “THE PRIMARY PURPOSE TEST” TO BOSTON MEDICAL 1999 AND “THE SERVICE TEST”41

A. The Cedars-Sinai Decision

In Cedars-Sinai Medical Center,42 the NLRB held that the residents, interns, and clinical fellows of Cedars-Sinai were not “employees” within the meaning of the NLRA.43 Thus, they had no right to unionize and residents were ordered to dismantle the house-staff association.44 The Board specified a variety of educational aspects of an internship and residency at academic hospitals, including grand rounds, teaching rounds, laboratory instruction, seminars, and lectures.45 The Board referred to activities of medical residents as “training” activities.46 The Board also noted that the “Essentials of an Approved Internship” referred to the stipend residents receive as “a scholarship for graduate study.”47

The Board thus concluded that interns, residents, and clinical fellows were primarily students, noting the relationship between residents and Cedars-Sinai was primarily educational, and not an employment relationship.48 The NLRB emphasized the purpose of residency as training in its opinion, rather than the professional services residents and interns actually performed with regard to direct patient care in an employment capacity.49 Some legal scholars thus refer to this reasoning as an application of the “primary purpose test.”50 The decision remarked that interns “participate in these programs not for the purpose of earning a living; instead they are there to pursue the graduate medical education that is a requirement for the practice of medicine.”51 This statement implies that residents do not actually “practice medicine,” but merely are training to do

41. See Gregory Gartland, Of Ducks and Dissertations: A Call for a Return to the National Labor Relations Board’s “Primary Purpose Test” in Determining the Status of Graduate Assistants Under the National Labor Relations Act, 4 U. PA. J. LAB. & EMP. L. 623, 625-26 (2002) (describing the NLRB’s “primary purpose test” and “service test”).
42. 223 N.L.R.B. 251 (1976).
43. Id. at 251.
44. The term “house-staff” is often used to describe hospital medical personnel. Id.
45. Id.
46. Id.
47. Id. at 252.
48. Id.
49. See Univ. of Cal. v. Pub. Employment Relations Bd., 715 P.2d 590, 595 (Cal. 1986) (“[The Board] found that housestaff participate in such programs to gain an education, not to earn a living, and that their selection of programs is primarily motivated by the quality of the training they will receive, rather than the amount of compensation.”).
50. See Gartland, supra note 41, at 630 (citing the Cedars-Sinai decision as an example of the Board’s application of the primary purpose test).
Perhaps most notable of this decision is the famed dissent of Chairman Fanning criticizing the Board's decision to deprive residents of unionization rights. Fanning criticized the Board for failing to adhere to the simple definition of text in § 2(3) of the NLRA defining the term "employee." He specifically noted that students were not excluded from the Act, thus "the relationship between 'student' and 'employee' cannot be said to be mutually exclusive." The hospitals charge fees for the services of house-staff and pay the house-staff from those fees. Residency programs offer no official grades or degrees. In fact, Fanning cited an AAMC study that found that eighty percent of house-staff's time is spent in direct patient care.

Fanning further cited a memorandum of "Guidelines for House-staff Contracts or Agreements" distributed by the AMA to all accredited teaching hospitals with residency programs. The memorandum called for "fair and equitable conditions of employment for all those performing the duties of interns, residents, and fellows." Thus, Fanning illustrated the irony in the NLRB majority decision and suggested that given the plain meaning of the NLRA, the NLRB decision was untenable. Chairman Fanning's dissent foreshadowed the future NLRB decision which later overturned its quarter century precedent.

The NLRB reaffirmed its Cedars-Sinai decision a year later in St. Clare's Hospital and Health Center, in which it held that house-staff were included in a category of students, "in which [they] perform services at their educational institutions which are directly related to their educational program."

The Cedars-Sinai decision reflected the NLRB's policy choice to deny unionization to medical residents. It did so, however, on narrow grounds and left quite a few unresolved issues. For example, the opinion assumes that the NLRA granted unionization rights only to employees whose jobs have little to no educational component. The opinion attempts to define the "primary purpose" of a residency program and ultimately concludes that its primary purpose is educational. It does not specify anywhere in the NLRA that an employee who receives training on the job is not entitled

52. Id. at 254.
53. Id.
54. Id. at 255.
55. Id. at 256.
56. Id.
57. Id.
59. Id. at 1002.
60. See supra notes 52–53 and accompanying text.
to the labor rights therein.

The fact that residency programs had educational components gave the NLRB fodder to support its denial of the residents’ petition for union certification. The basis for the Board’s later reversal of Cedars-Sinai closely resembles the reasoning of the Cedars-Sinai decision. In both decisions, the Board emphasizes the dual nature of residency programs. The Cedars-Sinai decision, however, seemed to focus on the primary purpose of residency programs, while the Boston Medical decision focused on the services residents provide.

B. Boston Medical 1999: “The Service Test”

In response to staunch legal criticism, the Board reversed Cedars-Sinai. Boston Medical, an oft-quoted case, involved a unit of house-staff at the Boston Medical Center (BMC) that attempted to unionize. To avoid withdrawal of their union, BMC house-staff sought certification as a unit with the NLRB. The hospital contested the certification on the grounds that members of the house-staff were not considered “employees” and thus could not unionize. The Board overruled its precedent in Cedars-Sinai and St. Clare's Hospital and held that medical interns and residents were both students and employees and thus were entitled to unionize. The Board ruled that “[t]he essential elements of the housestaff’s relationship with the Hospital obviously define an employer-employee relationship.” It added that house-staff pay taxes on their income, receive benefits, including sick leave, vacation, and malpractice insurance. The Board further analogized house-staff to apprentices, noting that apprentices have always enjoyed the protection of the Act.

While the Boston Medical decision was intended to overrule the Cedars-Sinai decision, it did not contradict the reasoning of the decision, but merely the outcome in the case—the Board’s denial of residents’ rights to unionization. The Boston Medical decision adopted the Fanning dissent,
which simply stated that the dual status of residents did not preclude them from NLRA rights, including the right to unionize. Residency programs did not undergo any significant changes which would warrant a renewed status for residents. This decision reflected a new Board policy, rather than a legal conclusion.

The NLRB recognition of house-staff’s plight has done little to encourage unionization among medical interns and residents. While the decision officially recognized house-staff’s right to unionization, it did not clarify what would be their predominant role in the hospital—trainees or employees. The NLRB granted added restrictions to residents’ right to unionize, as it did to the entire health care industry.

The residents' dual roles, however, present extra-legal barriers to unionization which are not present in other industries. Residents spend an inordinate number of hours in the hospital and often are directly serving patients for twenty-four hours at a time. They have to answer to superiors on a regular basis and their obedience directly affects the prospects of future training possibilities and fellowships.

In addition, the fears of Congress (and earlier fears of the AMA) that unionization may compromise the doctor-patient relationship or the quality of health care residents adds another layer of complication. Residents have tried other avenues to address their labor conflicts, including contacting the Occupational Safety and Hazard Association (OSHA) seeking regulation of hours. These efforts, while encouraging state regulation, have led to no federal labor protection for medical residents. A group of frustrated residents and fellows turned to the legal system to try an alternative avenue to the rights to control their labor conditions, but were quickly quieted.

71. Id. at 160.
73. See supra note 32 and accompanying text.
74. See Debra F. Weinstein, Duty Hours for Resident Physicians—Tough Choices for Teaching Hospitals, 347 NEW ENG. J. MED. 1275, 1275 (2002) (noting that residents’ shifts are permitted to last twenty-four hours and that residents often perform direct patient care during their shifts).
75. See supra note 5.
76. See Press Release, Public Citizen, supra note 6 (describing OSHA’s rejection of a petition seeking mandatory eighty-hour work weeks for medical residents, with one day off per week and no shift longer than twenty-four hours).
77. Many states have instituted mandatory maximums of eighty hours per week for residents. New York State was among the first states to do so. New York Has New Guidelines on Hours for Interns, Residents, THE JOURNAL RECORD, July 5, 1989, 1989 WL 5984517.

A. The Jung Case

A group of residents, interns, and fellows challenged the NRMP and member academic hospitals alleging that the hospitals and the NRMP violated § 1 of the Sherman Antitrust Act. The complaint was filed by aggravated residents and interns on May 5, 2002 in the District of Columbia. The residents claimed that academic hospitals and the non-profit matching program colluded to keep resident salaries artificially low and resident working conditions similarly taxing. The residents argued that the match program along with participating academic hospitals perpetuated an anti-competitive program which constituted an unreasonable restraint on trade.

"The match" is responsible for the placement of 23,000 graduating medical students in residency programs across the country. When medical students participate in the match program they agree to honor the match commitment, thereby locking them into whichever residency program a computer selects for them. This program leaves interns and residents with little bargaining power.

This Comment will not analyze the antitrust jurisprudence that relates to the NRMP challenge, but instead will focus on the response of Congress to the Jung complaint. Generally, the complainants alleged that the match program involves horizontal restraints on price or salaries of residents. These particular restraints are generally regarded as per se violations of the Sherman Act "because of their pernicious effect on competition and lack

81. Id.
84. See, e.g., AMA, FREIDA Online Specialty Training Search, http://www.ama-assn.org/vapp/freida/spcindx/0,2654,TR,00.html (noting that the average first year internal medicine resident salary is $38,172 per year with an average workweek of 64.3 hours).
85. See, e.g., Crall, supra note 79, at 256 n.87 (defining horizontal restraint as one perpetrated by competitors at the same level of the market (citing WALTER NICHOLSON, MICROECONOMIC THEORY (2d ed. 1978)).
86. See United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940) (finding horizontal price-fixing per se illegal); see also N. Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958) (justifying the per se illegal rule as efficiently avoiding a long investigation into the history of the particular industry involved).
of any redeeming virtue.”

However, few cases present such overtly anti-competitive effects as to trigger the per se illegality rule. For other cases, courts will apply the “rule of reason” test to an alleged anti-competitive industry. This rule analyzes “whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.” Under this rule, after a plaintiff alleges anti-competitive effects of a particular industry, the court will then analyze the market to determine if the defendant’s behavior provides any pro-competitive effects on the market.

Courts have developed a third test, known as the “quick look” test to evaluate a restraint that appears obviously anti-competitive. When courts apply the “quick look” test, a plaintiff does not have an initial burden of proving anti-competitive effects of a restraint, but the court presumes such effects. The defendant then has an opportunity to rebut the presumption of unreasonable restraint on trade by proffering legitimate justifications or pro-competitive reasons for the restraint. If these justifications appear plausible, the court will use the full “rule of reason” analysis; otherwise, it will censure the practice. The Jung court did not reach a full antitrust analysis of the NRMP. The court dismissed the action because Congress had secretly passed 15 U.S.C. § 37b(b)(2), retroactively preempting any antitrust actions against the NRMP.

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89. Cont’l T. V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49 (1977) (“Since the early years of this century a judicial gloss on this statutory language has established the ‘rule of reason’ as the prevailing standard of analysis.”).
90. Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).
91. *See* United States v. Brown Univ., 5 F.3d 658, 669 (3d Cir. 1993) (“If a plaintiff meets his initial burden of adducing adequate evidence of market power or actual anti-competitive effects, the burden shifts to the defendant to show that the challenged conduct promotes a sufficiently pro-competitive objective.”).
92. *See* Cal. Dental Ass’n v. FTC, 526 U.S. 756, 770 (1999) (noting that the “quick look” test applies when “an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets”).
93. *Id.* at 770.
94. *Id.* at 771.
96. For an analysis of the NRMP under a “quick look” test, see *id.* at 266–71.
B. Congressional Response to Jung

Congress titled 15 U.S.C. § 37b “Confirmation of anti-trust status of graduate medical resident matching programs.” The legislation states as follows:

Antitrust lawsuits challenging the matching process, regardless of their merit or lack thereof, have the potential to undermine this highly efficient, pro-competitive, and long-standing process. The costs of defending such litigation would divert the scarce resources of our country’s teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research. In addition, such costs may lead to abandonment of the matching process, which has effectively served the interests of medical students, teaching hospitals, and patients for over half a century.

The President signed this legislation into law as part of the Pension Funding Equity Act of 2004. The legislation thus formed a prime example of pork barrel legislation tacked onto a bill which was intended to update interest rates for the purposes of reducing employer contributions to pension funds. As the bill went into conference meetings, the above rider did not exist. In fact, a few senators objected staunchly to this seemingly unrelated rider. Senator Bingaman (D-New Mexico) who sits on the Health, Education, Labor, and Pensions Committee commented:

[T]here were provisions included in this bill—at least one provision that I think is highly objectionable.

Section 207 of the conference report creates an antitrust exemption for the graduate medical residency program that currently assigns medical students to hospitals where they are required to work for 60 to 100 hours per week for an average of $9 or $10 an hour. To people who are not familiar with the way this place functions in recent years, they would be surprised to find that we have written into the pension bill a retroactive exemption from the antitrust laws related to this issue of medical residency programs.

99. Id. § 37b(a)(1)(E).
101. See Internal Revenue Serv., Pension Funding Equity Act of 2004 (2005), http://www.irs.gov/retirement/article/0,,id=19503,00.html (explaining how the Act’s use of a higher interest rate in the calculation of a pension plan’s current liability works to reduce the employer’s required contribution to the plan).
102. See 150 CONG. REC. S3968-03 (daily ed. Apr. 8, 2004) (noting the objections of various senators to the lack of vote on the rider).
103. See id.
That being said, the antitrust exemption that is established by subsection (b)(2) raises grave constitutional concerns. There has been no justification presented to this Congress, to any committee of this Congress for depriving medical residents of the same protections under the antitrust laws that are enjoyed by other workers and other Americans. I do not see how it is constitutionally permissible to take away the equal protection and the due process rights of medical residents without any showing that is necessary or beneficial.

Frankly, this is outrageous for Congress to be legislating in this way, without any hearings, without any testimony, without any knowledge of what it is doing.

The reason we have debate on the Senate floor is to allow Members to express views when we are getting ready to change the law. This is a time-honored process. It is one that was not honored in this case. As far as I know, there has been no debate on the floor nor has there been debate in committee about this issue.

This is a provision that was added in a conference, without participation of Democratic Senators, and clearly it is contrary to good policy and to proper procedure here in the Senate.

104. Id. at S3991-92. Senator Bingaman then drafted a letter to Senators Frist and Daschle. The letter reads:

GENTLEMAN: We are writing to express our concern about legislative proposals that have the potential to undermine ongoing antitrust litigation against the National Resident Match Program (known as the "Match") by granting the "Match" a retroactive antitrust exemption.

It is our view that Congress should subject proposals like this one that hold widespread implications for patient safety and the working conditions of hundreds of thousands of medical residents to the regular legislative process—including hearings and consideration in the appropriate committees—before allowing it to move through Congress. This is particularly important considering that such proposals would retroactively interfere with pending litigation, in which the factual record has not yet been developed and the court has not yet ruled on the merits of the claims. In addition, it is important for the Committee to consider the specific language of any such proposal, as legislation intending to exempt the Match could have broader, unintended effects, including effectively immunizing price-fixing and other anticompetitive practices alleged in the litigation.

By permitting such a bill to go forward without full consideration of all the factual and legal issues, we would set a precedent that will encourage defendants in all types of pending litigation to come to Congress for relief. We request, therefore, that the Senate convene hearings on this matter before taking further action.
Thus, controversy enveloped the passing of this legislation, and it is
doubtful the rider would have existed without intense lobbying efforts from
the NRMP, ACGME, and participating hospitals. 105

The AAMC, the representative body of all accredited medical schools
in the United States and Canada, as well as over 400 teaching hospitals,
vehemently opposed all resident unionization efforts. 106 Coincidentally, the
AAMC, named as one of the defendants in the Jung suit, stepped up its
lobbying efforts after Jung filed suit and expressed uncompromising
support for the above amendment. 107 Allowing the unraveling of the match
would greatly diminish the AAMC’s power over post-graduate medical
training. It comes as no surprise that the AAMC would oppose every effort
of house-staff to achieve more control over the process of resident
placement. Offering more labor rights to medical residents would cost
academic hospitals inordinate amounts of money. The cost of replacing
one surgical resident with a “physician extender,” or other physician, is
$210,000 to $315,000 a year. 108 In addition, residents perform many
responsibilities generally assignable to other hospital faculty, which allows
hospitals to offer less privileges or compensation to some faculty
members. 109

Thank you for your consideration.

Sincerely,

Larry E. Craig,
Jeff Bingaman,
Russell D. Feingold,
Herb Kohl.

Id.

that the rider “will end many of the claims in an ongoing lawsuit brought by a number of
medical students and residents” against hospitals).

LEGAL MED. 115, 135 (1999) (discussing the reasons behind the AAMC’s continued
opposition to unionization by residents (citing Memorandum from Jordan Cohen, M.D., on
House-Officer Unionization in the Boston Medical Center Case to the Council of Deans
(July 24, 1997))).

107. See Press Release, Ass’n of Am. Med. Colls., D.C. District Court Dismisses Jung
040813.htm (“[T]he National Resident Matching Program has provided a fair and efficient
process . . . . [W]e are hopeful that . . . medical students and residency programs can
continue to reap the benefits of this valuable program.”).

108. Marvin A. McMillen, The Value of Surgical Residencies to Community Teaching

109. See Weinstein, supra note 74, at 1275 (explaining that teaching hospitals are able to
retain faculty members at lower salaries because residents have such a wide range of
responsibilities).
It must be noted as well that the federal government is by no means an objective observer in the matter of medical residency funding and regulations. Currently, the federal government is the main financier of graduate medical education, "contributing $6.8 billion through Medicare, plus additional sums through the Departments of Defense and Veteran Affairs."\footnote{110} The federal government is constantly looking to reduce the cost of medical care. Offering residents more control over their working conditions would likely lead them to demand more money, money that would have to come from the federal government or from private university hospitals. Thus, the government and academic hospitals are appropriate bedfellows in opposing resident labor rights.

Another suspicious element to the rider is that while it preempts antitrust suits against the match regardless of their merit, it refers to the program as "pro-competitive."\footnote{111} So it seems that Congress made an independent finding that the match does not violate the Sherman laws, but it provided no data to support this finding. The rider further established that Congress preferred to deal with the antitrust issue directly, as opposed to the medical resident unionization issues, which were addressed by the courts, specifically the NLRB.

The rider, perhaps as a result of its swift passage, has ambiguous justifications. It is unclear whether Congress' main motivation for its passage was a perceived effect on medical education or another reason. Perhaps Congress believed that patient care would be compromised if residents were able to bargain, as it did before, and while passing the Health Care Amendments. That interpretation would more closely resemble the AMA's early position on physician unionization and its recent ambivalent opinion of the Boston Medical decision.\footnote{112} It is clear that intense lobbying efforts by both the AMA and AAMC affected the passing of this rider.

The history of labor rights in the medical profession reveals a pattern of congressional ambivalence. Congress passed the Health Care

\footnote{111. See supra note 99 and accompanying text.}
\footnote{112. See S. Martin, AMA Treads Middle Ground on Residents' Unions, 40 AM. MED. NEWS 34 (1997); see also GRACE BUDRYS, WHEN DOCTORS JOIN UNIONS 118 (1997) (stating the AMA's position that physician unionization conflicts with the goals of physicians of personal autonomy and patient welfare). In 1999, the AMA established its own house-staff union, known as Physicians for Responsible Negotiation or PRN. The union guarantees strict adherence to the "AMA's Principles of Medical Ethics." PRN's bylaws require its members to take a "vow never to strike." Membership in the AMA and other equivalent medical societies are also prerequisites for PRN membership. These requirements may compromise the power of its members to contest various conditions in health facilities due to its AMA sponsorship, but they also balance the duties of residents as physicians with an opportunity to receive fair labor conditions.}
Amendments begrudgingly and tacked on a series of restrictions on the exercise of health care professionals' labor rights. With the Cedars-Sinai decision, Congress had little concern about residents' unions. However, the Board's reversal in Boston Medical changed the setting and brought to the forefront resident labor concerns once again.

VI. CONCLUSION: EFFECTS ON HEALTH CARE AND GRADUATE STUDENT UNIONIZATION

A. Further Barriers to Unionization

If Congress continues to offer ambiguous support to resident labor rights or worse, thwart the efforts of medical residents to gain more labor rights, the NLRB might reverse its Boston Medical decision and turn back the clock yet again. The Boston Medical decision made it clear that little legal basis exists to deny medical residents unionization rights or any NLRA specified rights for that matter. Thus, unless Congress amends the NLRA, no legal barriers exist to house-staff unionization.

Many other internal barriers, however, hinder medical residents from acquiring labor rights. Unionization takes more effort than residents have time for and many fear unions will compromise their goals as physicians. A national survey of residents found that residents' willingness to get involved in forming a union or serving as a member of union management was inversely proportional to the difficulty and amount of time their specialty required them to be in the hospital. Residents are accountable to their superiors for their future careers and would rather endure a few years of grueling working conditions than do anything which might compromise their careers. Divisiveness exists among residents of different specialties because each specialty seeks different benefits and residency programs vary in duration. A resident is less likely to sacrifice any opportunity to unionize for such a short period of time.

B. Graduate Student Unionization: A Different Animal

The NLRB has been similarly ambivalent with regard to graduate student unionization. The main issue in contention in the graduate

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113. See supra note 62 and accompanying text.
114. See Cramm, supra note 72, at 1640 ("The analysis of willingness to get involved in forming a union . . . was strongly correlated with a resident's area of specialty.").
116. See Cramm, supra note 72, at 1637-42 (speaking to the perceptions of different residents on the possible benefits of a union and the likelihood of residents to strike).
student unionization cases is whether or not graduate students are "employees" under the NLRA. The NLRB confronted the same issue with regard to medical residents and concluded that residents were both trainees and employees. The Board decided the same with respect to graduate students in 2000 and reversed that decision in mid-2004. The New York University decision in 2000 relied heavily on the Boston Medical Board decision. The Board has not reversed its decision in Boston Medical nor has it implied that it will.

Medical residents have qualitatively different positions than graduate students. These differences can help, but in the present case also hinder medical residents' fight for labor rights. Residents are an integral part of the national health care system and as physicians owe duties to their patients and to their superiors that graduate students do not owe to their advisors or to the students they assist. From the most ancient codes of medical ethics to recent manifestations, doctors are charged with a duty of non-maleficence, or to do no harm, and beneficence. These duties often require a degree of selflessness that is difficult to reconcile with unionization and other avenues to labor rights. Doctors are fiduciaries to their patients. Physicians have a duty to protect their patients' privacy. What if patient records are required in an NLRB certification hearing or

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118. See, e.g., New York Univ., 332 N.L.R.B. at 1205 ("The principle issue presented by this case is whether a university's graduate assistants (teaching assistants, graduate assistants, and research assistants) are employees within the meaning of Section 2(3) of the Act.").
120. See supra note 117.
121. See New York Univ., 332 N.L.R.B. at 1206.

The Board concluded in Boston Medical Center that these cases were wrongly decided as a matter of statutory construction and policy and that the house staff in Boston Medical Center were employees under Section 2(3), notwithstanding that they also were students.

Applying these principles, we reach the same conclusion with respect to graduate assistants.

Id.

123. Id. at 85.
124. See id. at 87 ("Maintaining patient confidentiality is key to the patient-doctor relationship... ").
another proceeding to enforce a resident's labor right? Residents' and physicians' tepid reactions to the prospects of unionization are a further impediment to congressional clarity. The medical profession has not offered clear directions for balancing the duties of physicians and the rights owed to those working physicians.

Managed care and medical integration has gradually eroded the intimate doctor-patient relationships of the past.125 The role of physicians has changed. Doctors have to deal with different pressures and access to labor rights can ease some of these burdens. The role of residents has become even more complicated than that of regular physicians. They have to deal with their training, superiors, and the long, grueling hours. It is these further complications that have confused the labor rights status of medical residents beyond that of regular physicians and beyond that of graduate students.

A combination of congressional policy clarification, professional health organizations' involvement, and NLRB direction might serve to encourage medical resident unionization that could accommodate the nature of a residency program and the medical profession appropriately. Medical students and graduates should have the opportunity to contribute to the discussion. Congress continues to struggle to find an appropriate solution to physician shortages in this country, as well as a lack of sufficient funds to support further residencies across the United States.126

Hospitals should give residents a real opportunity to unionize. This may involve hiring labor consultants who are not physicians or assigning more duties to hospital administrators. An informed, inclusive dialogue will serve to clarify legal and extra-legal barriers to accomplishing these congressional goals as well as to alleviate medical residents' labor burdens.

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125. See Phan, supra note 106, at 117 (noting that erosion of “the foundation of the physician-patient relationship . . . . is primarily caused by managed health care plans exercising a significant amount of economic leverage over physicians”).

126. See supra note 110 and accompanying text.