Boston Medical Center Corporation *and* House Officers' Association/Committee of Interns and Residents, Petitioner. Case 1–RC–20574

November 26, 1999

DECISION ON REVIEW AND DIRECTION OF ELECTION

BY CHAIRMAN TRUESDALE AND MEMBERS FOX, LIEBMAN, HURTGEN, AND BRAME

On October 17, 1997, the Regional Director for Region 1 issued a Decision and Order dismissing a petition seeking certification of a unit of interns, residents, and fellows (house officers or house staff) because the house officers are not employees within the meaning of Section 2(3) of the Act. The Regional Director relied on *Cedars-Sinai Medical Center*[1] and *St. Clare's Hospital & Health Center*,[2] which held that medical interns, residents, and fellows are primarily students and, therefore, not "employees" within the meaning of Section 2(3) of the Act. The Regional Director also found that the Petitioner, inasmuch as it does not admit individuals into membership other than house officers, is not a labor organization within the meaning of Section 2(5) of the Act.

Pursuant to Section 102.67 of the National Labor Relations Board's Rules and Regulations, the Petitioner and the Employer each filed a timely request for review of the Regional Director's decision. By Order dated December 8, 1997, the Board granted those requests for review as they raised substantial issues warranting review.[3]

The Petitioner, mindful of the *Cedars-Sinai* and *St. Clare's Hospital* precedent, requests that the Board overrule that precedent. Boston Medical Center (BMC or the Employer) asserts, inter alia, that the Board should adhere to that precedent, that, under *Cedars-Sinai* and *St. Clare's Hospital*, the Petitioner is not a labor organization because it is not an organization in which "employees" participate, and that the unit is inappropriate because the individuals sought are primarily students rather than "employees."

Having carefully reviewed the entire record in this proceeding, including the briefs of the Employer and the Petitioner and the briefs of the various amici curiae,[4] with respect to the issues under review, the Board has decided to overrule *Cedars-Sinai*, *St. Clare's Hospital*, and other decisions following those cases, and to find that the interns, residents, and fellows employed by BMC, while they may be students learning their chosen medical craft, are also "employees" within the meaning of Section 2(3) of the Act.

I. THE FACTS

The Regional Director fully set forth the salient facts in her Decision and Order (pertinent portions of which we have attached as an Appendix). We will not attempt to repeat all of those facts but will highlight those necessary for a cogent understanding of our decision.

BMC operates a 432-bed, nonprofit, acute-care teaching hospital in Boston, Massachusetts. It provides both inpatient and outpatient services, maintains a 24-hour emergency care facility, and serves as the primary teaching facility for the Boston University School of Medicine. As such, BMC sponsors some 37 different residency programs varying in length from 3 to 5 years, with some lasting longer.[5] Fellowships last from 1 to 4 additional years. There are about 430 house officers in the unit sought by the Petitioner.

BMC came into existence on July 1, 1996, as a result of the consolidation of Boston City Hospital (BCH) and Boston University Medical Center Hospital (known as University Hospital). BCH was a department of the City of Boston and a public hospital. BCH and University Hospital were located a block apart, with the Boston University School of Medicine situated between them. Both were affiliated with the Boston University School of Medicine, and some of their residency programs were integrated prior to the merger.

As a public sector hospital, BCH was subject to the Massachusetts public employee collective-bargaining law, under which the house staff had the right to organize. Accordingly, the Petitioner had represented a unit of interns, residents, and fellows at BCH since 1969 and had negotiated approximately ten successive collective-bargaining agreements with BCH since 1970. As a condition of the 1996 merger between BCH and University

[1] 223 NLRB 251 (1976).

[2] 229 NLRB 1000 (1977).

[3] Motions for oral argument were filed by the Employer and by amici curiae the Association of American Medical Colleges, the American Hospital Association, the American Council on Education, the American Board of Medical Specialties, and the Council of Medical Specialty Societies. On March 16, 1998, the Board denied these motions.

[4] Amicus status was granted to the following interested organizations, all of which filed briefs: the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO) and the American Nurses Association; the Association of American Medical Colleges, the American Hospital Association, the American Council on Education, the American Board of Medical Specialties, and the Council of Medical Specialty Societies; the American Medical Students Association; the University of Michigan House Officers Association; the Medical Society of the State of New York; the Ad Hoc Committee for House Staff Rights at University Hospital, Inc. and the Ad Hoc Committee for House Staff Rights at Prince George's Hospital Center; the California Medical Association; the American Medical Association and the Massachusetts Medical Society; and the American Public Health Association. Additionally, the American Medical Women's Association filed a position statement.

[5] The first year of residency is commonly referred to as an internship. In a 3-year residency program, for example, second-year residents are sometimes referred to as junior residents, and third-year residents are sometimes called senior residents. Interns, residents, and fellows are also sometimes referred to by their post-graduate year level (PGY or PL). For example, an intern is a PGY 1, a second-year resident is a PGY 2, and so on.

Hospital, the Boston City Council required that BMC recognize the Petitioner as the collective-bargaining representative of the 280 former BCH house staff. BMC signed a recognition agreement in which it further agreed to a representation election among all house officers at the merged entity. Ultimately, on August 29, 1996, the parties held a "card count," and based on the outcome of that count, the Petitioner became the representative of the house staff at BMC. In January 1997, the parties executed a revised version of the collective-bargaining agreement that had been in effect between the Petitioner and BCH prior to the merger, with effective dates from July 1, 1994, through June 30, 1997.

BMC's residency programs are funded, at least in part, through direct and indirect medical education payments from Medicare, with those payments being based on the historic costs of the medical center using a formula that incorporates the number of interns and residents enrolled in the medical residency programs at BMC. BMC, like all institutions sponsoring medical residency programs, begins its academic year on July 1 of each year. Students halfway through their fourth year of medical school decide what area of medicine they would like to pursue and apply to appropriate medical programs. Out of hundreds or thousands of applications received, a small percentage of applicants are picked to interview for particular residency programs at BMC. Thereafter, BMC, like other teaching hospitals, ranks the individual applicants and submits its top candidates to a national matching program. At about the same time, applicants submit a list of residency programs that they would like to attend. In March, the national matching program generates a "match" list that sets forth which applicants will attend which residency programs. There is no matching process for fellowships. Applicants for fellowships are hired directly by the teaching hospitals.

House officers enter a residency or fellowship program in order to become certified specialists in their chosen medical specialty. To become an intern, an individual must have graduated from medical school and passed Parts 1 and 2 of the U.S. medical licensing exam. The appropriate state board of registration in medicine then issues interns a temporary license, which permits them to practice only under the aegis of their particular residency program. The state boards require that in order for medical school graduates to practice as fully licensed physicians, they must successfully complete the 1-year internship and then pass part 3 of the U.S. medical licensing exam. This then allows them to practice outside their residency program, as well.

Residents who successfully complete their program receive a diploma from the Boston University School of Medicine. On approval by the specialty board that certifies physicians in their field, they are then considered to be "Board-eligible," i.e., they have successfully completed their training and are eligible to sit for an exam in their chosen specialty. After passing a written exam, these doctors can then hold themselves out as being "Board-certified" in their field. While it is not necessary for a doctor to be certified in a specialty to practice medicine, some medical institutions and practices are beginning to require certification. Accordingly, a physician's failure to be certified in a specialty may limit the employment opportunities of that physician. Most residents and fellows leave BMC upon the completion of their residency or fellowship program to pursue opportunities elsewhere. Only a small percentage remains to join the faculty.

House officers are assigned throughout the year to various rotations, usually about 4 to 6 weeks in length, which expose them to various types of patients in their chosen specialty. In some programs the residents perform one or more rotations at other institutions with which BMC has affiliation agreements. House officers work notoriously long hours, which vary depending on the specialty and the rotation. They are trained by and work under the medical direction of attending physicians who are referred to as "attendings" or faculty. When house officers are on rotations at other institutions, they are supervised by attending physicians from those institutions. Attendings are physicians on the staff of BMC, 99 percent of whom are also faculty members of the Boston University School of Medicine. The attendings are technically employed by the Faculty Practice Plan Foundation, Inc., which is an umbrella corporation for the various subsidiary practice plans in place for each department within the hospital. BMC and the School of Medicine are both members of the corporation, and attendings receive support from both the Faculty Practice Plan and the School of Medicine. They receive their paychecks from the School of Medicine, which hires them and acts as the common paymaster for the two entities.

Residency programs have essentially two elements: didactic lectures and clinical training. Medical residents attend didactic lectures on a variety of topics relevant to their particular residency program. In addition, residents gain experience in performing direct patient care by working in teams that include third- and fourth-year medical students, interns, junior and senior residents, and attending physicians. Each intern on an inpatient ward is generally assigned 12 to 15 patients. A more senior resident is responsible for overseeing the work of the interns, and the interns oversee the medical students. An attending physician must be the physician of record for every patient.

Interns start the day early in the morning by checking in with the "night float," i.e., the intern who has been on duty overnight, to learn of any developments during the night. Then they "pre-round" or check their patients on their own. From 7:30 to 9:30 a.m., the team of medical students, two to three interns, a more senior resident,

and, occasionally, an attending physician do "work rounds" in which they check on and discuss the status of each patient at the patient's bedside. Following that, the interns order X-rays, consults, and treatments. They start intravenous lines (IVs) and perform procedures such as arterial blood gases, which involve drawing blood, and thorancentesis, paracentesis, and lumbar punctures, which involve removing fluids. Attending physicians are rarely present when interns perform these procedures. Interns also perform critical patient-care procedures, such as intubating patients who cannot breathe for themselves. Residents, including interns, respond to "codes," i.e., life-threatening emergencies, without attending physicians. Interns are the primary physicians with whom patients' families have contact. Interns write "do not resuscitate" (DNR) orders for terminally ill patients at the request of patients and/or their families. Such orders must, however, be cosigned by an attending physician within 24 hours.

As noted by the Regional Director, interns are also responsible for hospital admissions,[6] which usually begin with a call from a physician from the emergency room or the clinic. When the patient arrives, interns take a history, perform a physical, draw blood, start an IV, initiate any necessary immediate treatments, and write admission orders, including any medication orders. The junior resident also does a more focused history and physical examination of the patient. The intern and junior resident consult with the senior resident on duty, and, together, they decide what tests or treatments should be performed. Interns are also responsible for writing daily progress notes on all their patients. On approval of an attending, they discharge patients, which involves writing a discharge summary and instructions, filling out prescription orders, and instructing the patient and/or caregivers about any necessary care after the hospitalization.

As residents progress through the program, they are given increased responsibility commensurate with their level of experience. For example, internal medicine interns see patients 80 to 90 percent of the time outside the presence of an attending physician. Interns do, however, discuss all patients with attending physicians, who are primarily responsible for their patients' care plans and who see their patients daily. In the emergency room or urgent care clinic, the interns consult with an attending physician after examining each patient. The intern on "night float" operates more independently, as there is not likely to be an attending physician on the inpatient wards overnight. Two residents and two interns take care of the entire ward at night, when there are no attendings on duty except in the emergency room.

A third-year pediatric resident testified that she makes 80 percent of patient-care decisions on her own[7] and consults with an attending the balance of the time over decisions such as whether to transfer a patient to the intensive care unit. She further testified that she has helped families make life or death decisions about the level of intervention to be used in the case of critically ill infants and children. The pediatric residents are the only physicians present on the pediatric wards for a 12-hour period at night, although there is always a chief resident and an attending on call at home. The pediatric resident testified that she does not frequently call an attending at night, perhaps twice a month.

Fellows in the cardiology program may perform certain noninvasive procedures on their own, but more risky procedures must be done in the presence of an attending physician. In an emergency situation, cardiology fellows may perform such procedures as CPR, defibrillation, and transthoracic echocardiograms without an attending physician being present, but those matters must be reviewed with an attending as soon as possible thereafter.

Residents in the radiology program draft a preliminary report for each film, but an attending physician must sign off on every final report. A radiology resident is on duty in the emergency room 24 hours per day. After 9 p.m., when there are no attending physicians in radiology present, radiology residents interpret films alone, and an attending signs off on them the following day.

Residents in the pathology program make a preliminary diagnosis with respect to each slide of tissue that they examine and discuss each diagnosis with a faculty physician. In those cases where a pathologist is required

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[6] BMC contests the Regional Director's finding in this regard. It argues that the record amply demonstrates that attending physicians are solely responsible for patient admissions. We do not find the two statements to be mutually exclusive. We read the statement of the Regional Director to mean that interns do the work necessary to get a patient admitted once that decision has been made. To be sure, the record does indicate that no house staff, including interns, have admitting privileges at BMC.

[7] BMC challenges this testimony and asserts that residents are supervised to a much greater degree than this testimony would suggest. BMC cites evidence, not directly contradicting this testimony, however, that pathology residents are not allowed to make patient diagnoses independently from an attending and than all autopsy work must be presented to an attending. Obviously, what is the rule in pathology is not necessarily the rule in pediatrics. BMC also cites testimony to the effect that residents formulate their patient care plans through a variety of interactive meetings with attending physicians and that attending physicians critique, review, and modify residents' patient care decisions. BMC points out that while interns may often make patient care decisions, those decisions are really not done independently from an attending physician, and attending physicians maintain constant supervision over all of the patients for whom they have ultimate responsibility. The Board recognizes that while the interns and residents are in many instances making patient care decisions, they have learned much from the attendings. The Board construes the 80-percent figure as an estimate of the instances where a patient care decision was made without direct input from an attending as to that specific decision regarding that particular patient, albeit, perhaps, in the past an attending had been involved in such a decision and therefore the resident, having "learned" from this past instance, can now comfortably make the same decision for another patient.

to make a diagnosis while a patient is undergoing surgery, pathology residents are not permitted to give a diagnosis to the surgeons without prior review by faculty. Pathology residents must present each autopsy report to an attending, who is legally responsible for the report.

Residents in the various surgical residency programs spend 8 to 10 hours a day in the operating room on those days that they perform surgery. They are permitted to perform increasingly more complicated surgery as their experience increases. An attending physician must be "scrubbed in" for the significant or critical portion of each operation. A chief orthopedic resident testified that in the case of a knee arthroscopy, one of the most common procedures performed by orthopedic surgeons, the entire procedure takes about 2 hours, out of which time an attending would be present for 30 minutes to an hour. This same resident testified that she does complicated procedures in the emergency room on her own, such as fracture manipulations or immobilizing a pelvic fracture.[8]

In addition to their time spent in direct patient care, house staff also attend so-called "didactic" conferences. In some residencies, such conferences take place at noon and cover various topics. Residents spend varying amounts of time in conferences, ranging in some estimates from 5 to 8 hours per week. House staff also engage in rounds, a 1-hour "morning report" conference (6 days a week), clinic talks, and the like.[9]

Residents in each program are required to take an annual "in-training" exam offered by their specialty board, which is used to make comparisons with other programs throughout the country, to identify the residents' academic strengths and weaknesses, and to indicate the likelihood that they will pass the Boards. The Program Director for the general surgical residency program testified that those residents who score below the 25th percentile on the in-training exam are put on academic probation. Those who fall below that level for a second year could be held back a year in the program. However, according to a 1995 memorandum put into evidence by the Employer regarding the internal medicine in-training exam at BCH, the examination is not used to make decisions concerning acceptance, continuation, or advancement in residency or fellowship training positions. In addition to the in-training exam, residents in the surgery residency program take weekly or biweekly exams and are constantly quizzed by attendings using the Socratic method. In the otolaryngology program, residents take a written exam at the end of each lecture series on a given topic, every 2 to 3 months. In the pediatric program, residents are required to take a Pediatric Advanced Life Support (PALS) and a Neonatal Advanced Life Support (NALS) course, each of which culminate in a written exam.

Moreover, at the end of each rotation, the faculty member who has worked most closely with each resident fills out an evaluation form which rates him or her with respect to various factors, including medical knowledge, technical skills, clinical judgment, and humanistic qualities. (At the same time, the residents submit an evaluation form in which they rate the attendings and their educational experience during the rotation.) In the case of residents who fail to meet the programs' standards for medical knowledge or clinical competence, department chairpersons and/or program director may put them on probation, require them to fulfill additional time in training prior to advancing to the next level, terminate them from the residency program, decline to renew their contract, or decline to give them the certification of satisfac-

[8] BMC argues that unless there is an emergency, no surgery is performed without an attending present and that even if there is an emergency situation, a resident's work is reviewed immediately following the procedure. Again, there is no real factual dispute here. The evidence indicates that under emergency conditions, certain procedures are undertaken by residents (in the absence of an attending) that would not otherwise be performed under normal (nonemergency) conditions without an attending being present. BMC also points out that no operations are conducted by residents in the surgery program without an attending being present, and that the mark of a good teacher is to supervise the residents in such a manner so as to allow them to feel as though they are in control of a case, when in fact the attending physician never loses full control of the case. The corollary finding to this is that the evidence indicates that the residents do a sufficient amount of the work for them to feel that they are "in control" of the case.

[9] The Regional Director, recognizing that there is a "learning" aspect to the house staff's being at BMC, pointed out that in addition to the time spent in direct patient care (which is of course, as BMC points out, by and large how the house staff learn their craft), residents spend many hours each week attending various "didactic" conferences. She attempted to list some of these including "attending rounds," noon time 1-hour conferences, "grand rounds," and "journal club." BMC faults the Regional Director for not listing all of them and further asserts that the Regional Director failed to "adequately address other didactic sessions that . . . offer no direct benefit to BMC, and that are not even directly related to the treatment of current patients." It makes this criticism even though the Regional Director did point out in her decision that "in some conferences residents review slides or X-rays of individuals who are no longer or never were patients of BMC, in order to learn diagnostic skills." It would appear from the briefs that the Petitioner would want us to believe that a minimum amount of time is spent by the house staff in such "didactic" sessions, and the Employer would have us believe that "residents dedicate a significant portion of their time at BMC *not* performing services, but attending and participating in classes, conferences, rounds and other purely didactic activities." Rather, the reality lies somewhere in the middle.

ties." Rather, the reality lies somewhere in the middle. Moreover, as noted by the Regional Director in her decision, according to the "Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements," commonly referred to as "the Essentials," the "training of residents relies primarily on learning acquired through the process of their providing patient care under supervision . . . ." As noted by the Regional Director, this document sets forth the standards for sponsoring institutions and for each type of residency program. It is the product of the Accreditation Council for Graduate Medical Education (ACGME). The ACGME has five sponsors, each of which appoints members to the council: the American Medical Association; the American Association of Medical Colleges; the American Board of Medical Specialties; the Council on Medical Subspecialties; and the American Hospital Association. Accordingly, it would seem that whatever time is spent by residents in so-called purely "didactic" sessions, that time is substantially less than the time they spend in providing patient care.

tory performance needed to sit for the Board exam. These steps have, in fact, been taken with some residents.

After their internship year, when they have a full or permanent physician license, some residents "moonlight," i.e., work part-time as doctors elsewhere to make extra money. (Interns cannot moonlight because, as noted above, their limited license permits them to practice only within the residency program.) The Regional Director noted that two residents testified that they perform the same work when they moonlight at local clinics and a local community hospital as they do at BMC, without having to attend ward rounds, grand rounds, or conferences. She also noted that they are paid much more for their moonlighting work than for their work at BMC, but that they remain at BMC because they want the training necessary to become Board-certified in their respective specialties.[10] Also in regard to "moonlighting," the chief orthopedics resident testified that she occasionally serves as the orthopedic doctor on duty at Boston University home basketball games, for which service she receives $125 per game directly from the University.

Physicians continue their medical education throughout their lifetime by reading medical journals, taking courses, and attending rounds, conferences, and scientific meetings in their field. Massachusetts requires physicians to have 100 hours of continuing medical education over a 2-year period in order to maintain their state licensure, and most have more.

Unlike other BMC employees, house officers are not recruited, interviewed, or hired by BMC's human resources department. They receive, however, annual compensation ranging from about $34,000 to over $44,000, depending on the number of years in the residency program. They also receive paid vacation and sick, parental, and bereavement leave. Like other BMC employees, house officers are entitled to health, dental, and life insurance, and they may use the employee health service. BMC also provides malpractice insurance at its expense for its house staff.

BMC deducts Federal and state taxes from house officers' pay. House staff receive W-2 forms for income tax purposes. BMC also maintains a workers compensation policy that applies to all employees, including house staff, and treats house staff as covered by the various state and Federal laws that regulate employment, such as the Family and Medical Leave Act, the Americans with Disabilities Act, and other state and Federal laws that prohibit various forms of discrimination in employment.

[10] This evidence, offered by the Petitioner to show that in many ways the fully licensed residents function as full-fledged doctors in these moonlighting situations, is characterized by BMC as evidence that demonstrates that these doctors are students while in the BMC residency programs and that comparing the two situations "only serves to highlight the very essence of the academic nature of the graduate medical programs, and the student status residents have while enrolled."

There are, however, some differences in the treatment of house officers as compared to other BMC physicians and/or employees in general. House officers are much lower paid than attending physicians, and their compensation is generally unrelated to the number of hours they work. House officers cannot participate in the retirement program, which is made available to other employees, although about 24 of them participate in a tax-sheltered annuity. The group malpractice insurance policy maintained by BMC for its house staff is separate from the individual policies provided for the faculty and paid for by their department practice plans. Other benefits available to other BMC employees but not to house officers include vision care, disability insurance, health care and dependent care reimbursement accounts, extended sick leave, and earned time. Unlike other BMC employees, residents are allowed to defer payments of some of their Federal and bank loans for medical school during a portion of their residency because they are still considered to be training for a job.

II. POSITIONS OF THE PARTIES

The Petitioner contends that there are compelling reasons for the Board to reconsider its determination in *Cedars-Sinai* and *St. Clare's Hospital* that interns, residents, and fellows are not employees within the meaning of Section 2(3) of the Act. The Petitioner argues that a substantial question of law is raised by the conflict between the Board's current position and the interpretations of Section 2(3) by the Supreme Court in several cases since the Board decided *Cedars-Sinai* and *St. Clare's Hospital*. It contends that the national policies of promoting peaceful collective bargaining and effective graduate medical training programs are best effectuated by recognizing that residents are employees entitled to the protections of and regulation by the Act. It further argues that the Board's unfounded speculation in *Cedars-Sinai* and *St. Clare's Hospital* regarding the alleged subjective intent of residents in pursuing graduate medical training is inappropriate and erroneous. In this regard, it points out that residents do inquire and are informed about the terms and conditions of their employment, and that if residents were unconcerned about the terms and conditions of their employment, they would not support unionization. Moreover, the Petitioner argues that the Supreme Court has rejected an analysis of employee status based on subjective intent.

The Petitioner further asserts that the legislative history of the 1974 Health Care Amendments[11] supports the conclusion that residents are employees under the Act, and that the Board should also consider that the prevailing weight of opinion in public sector jurisdictions is that residents are employees. The Petitioner also argues that

[11] See 88 Stat. 395, Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974 (P.L. 93–360) (S. 3203).

the Board must acknowledge that other Federal agencies have rejected the premise of *Cedars-Sinai* that house staff are students.

The Petitioner contends that a unit of house staff—interns, residents, and fellows—is an appropriate unit for bargaining. Lastly, it contends, contrary to the position taken by the Employer, that the chief residents are neither supervisory nor managerial, and should be included in the bargaining unit.

The Employer contends that *Cedars-Sinai* is controlling and that it should not be overruled. It asserts that interns, residents, and fellows are primarily students and not employees and, accordingly, the Petitioner is not a labor organization as defined in the Act since it is not an organization in which employees participate. It further argues that the Board should not extend coverage of the Act to residents because graduate medical education is not compatible with the economic relationship contemplated by the Act. In this regard, it contends that the academic pursuit that characterizes the training hospital setting prevents the parties from actualizing the goals of an economic relationship; that the student/teacher relationship that exists in graduate medical education programs is not compatible with Congress' desire for equality of bargaining power between employees and employers; and that the process of graduate medical education is not suited to the collective treatment of residents. Finally, the Employer asserts that collective bargaining will undermine both the educational process and academic freedom.[12]

The Employer further argues that extending coverage of the Act to an academic relationship conflicts with the overall statutory scheme of the Act. Thus, it contends that the academic nature of the relationship between residents and BMC does not allow for equal participation by a labor organization in determining standards for evaluation, promotion, and discipline and dismissal; and that extending coverage of the Act to academic relationships will result in inevitable violations of Section 8(a)(2) of the Act because the Employer is compelled under applicable academic standards to organize committees, in which house staff participate, that have an effect on traditional collective-bargaining issues.

The Employer also contends that the Board's determination that residents are not employees gained legislative support when a proposed amendment to include residents within the definition of employee was defeated in Congress. It argues that the Supreme Court precedent relied on by the Petitioner is inapposite here. It contends that residents are not "employees" within the meaning of the Act because they are primarily engaged in graduate educational training. It also points to certain ways that residents at BMC are treated differently from hospital employees and contends that this supports its contention that residents are students rather than employees.

The Employer also argues that numerous administrative problems will arise if the Board exercises jurisdiction over the primarily educational relationship between BMC and its residents because of the diversity, number, and complexity of its joint programs with other hospitals, including some public hospitals, and because of the transient status of residents.

The Employer further contends that assuming, arguendo, its house officers are employees, the petition must be dismissed because the petitioned-for unit directly contravenes the Board's Rule on collective-bargaining units in the health care industry[13] and is therefore inappropriate. It also asserts that the petition must be dismissed because the unit sought is inappropriate as it is based solely upon the Petitioner's extent of organization, and that, despite its petition, the Petitioner seeks to represent certain residents who are not even on the payroll of BMC. Lastly, the Employer argues that if the Board finds that residents are employees, then its chief residents should be excluded from the proposed bargaining unit because they are Section 2(11) supervisors and managerial employees.

In addition, amici took the following positions:

The AFL–CIO and the American Nurses Association argue, in support of the Petitioner, that BMC's house staff are employees as defined in the Act, especially given that the term "employee" must be broadly construed. They urge that the Board "reverse" its decisions in *Cedars-Sinai* and *St. Clare's Hospital* and hold that house staff are employees under the Act.

The American Medical Students Association urges, in support of the Petitioner, that the Board overturn *Cedars-Sinai* and hold that house staff are employees under Section 2(3) of the Act. It contests as factually contrary to the experience of the membership of its organization, the Employer's argument that the relationship between the house staff and the Hospital is similar to the academic relationship between medical students and the Hospital. The most significant distinction between medical students and house staff, it argues, is the ability of the latter to write medical orders, which are essentially the mechanism used to implement patient care. Lastly, it argues that the adequacy of salary, benefits, and working conditions offered by a residency program is an important part of the relationship between a resident and the hospital and that, without the ability to bargain collectively, house staff will have no protection against unilaterally imposed

[12] Contrary to these assertions, the Petitioner points to a "successful" history of collective bargaining at BMC. It asserts that the parties (actually BMC's predecessor) have had a collective-bargaining relationship since 1969, that the collective-bargaining agreement focuses on employment-related issues, that the Petitioner has never sought to bargain over academic prerogatives, and that the collective-bargaining agreements have actually been used by BMC to satisfy the ACGME Essentials standards.

[13] Sec. 103.30 of the Board's Rules, 29 CFR § 103.30.

increases in work hours and/or reduction in their salaries and benefits.

The University of Michigan House Officers Association, arguing in support of the Petitioner, points out that, as an organized association of self-governing resident physicians, it has collectively bargained on behalf of residents at the University of Michigan Hospital since about 1973, successfully negotiating 16 consecutive collective-bargaining agreements with the University of Michigan Hospital. It argues that its 25-year successful bargaining history should dispel the Board's speculation in *St. Clare's Hospital* that collective bargaining might "prove detrimental to both labor and educational policies." It further argues that its experience proves the fear, expressed in *St. Clare's Hospital*, that collective bargaining might "unduly infringe upon traditional academic freedoms" of a hospital's residency program is unfounded.

The Medical Society of the State of New York argues, in support of the Petitioner, that the issue concerning the status of house officers should not be addressed as an "either-or" question, and that the fact that house officers may be students should not preclude them from also possessing the status of employees under the Act. It also states that it supports the longstanding policy of the American Medical Association that house officers should be able to organize in any manner they choose regarding negotiations with the institution sponsoring the residency program. It is, however, opposed to permitting the use of strikes where patient care is withheld for the purpose of gaining leverage in collective bargaining, although it believes that affording house officers NLRA protection will reduce the likelihood of strikes.

The Ad Hoc Committee for House Staff Rights at University Hospital, Inc. and the Ad Hoc Committee for House Staff Rights at Prince George's Hospital Center, in support of the Petitioner, assert that their house staff associations, both with longstanding collective-bargaining rights which were initiated when the respective hospitals were public institutions, lost those rights after privatization of the hospitals. They aver that in both instances, it was the private employer's reliance on the Board's *Cedars-Sinai* policy that caused their loss of bargaining rights. They further contend that, because of the state of the law, these committees are effectively denied any realistic opportunity to obtain a fair and binding vote of the house staff at their hospitals to ascertain whether there is majority support for a union, and that committee members are subject to recrimination and retaliation for their concerted activities, without any recourse to a legal process or remedy. Accordingly, they jointly urge the Board to void *Cedars-Sinai* and *St. Clare's Hospital* and to deem house staff to be "employees" under the Act.

The California Medical Association, arguing in support of the Petitioner, asserts that it specifically supports the right of house staff physicians to unionize and to negotiate collectively. It notes that modifications in Federal and state reimbursement programs, and the programs and policies designed to promote competition among health care providers, are generating new economic pressures. Thus academic medical centers face major challenges resulting from both private market driven forces and public reforms, and that these changes profoundly affect the work environment of house staff, as well as the poor and high-risk patients they care for. Accordingly, it argues that it is critically important that house staff have the right to bargain collectively as academic medical centers adapt to economic and political challenges now and in the future. Finally, it points out that speculation about the harm which would result from granting house staff collective-bargaining rights is not borne out by experience.

The American Medical Association and the Massachusetts Medical Society together argue that residents should have a right to negotiate as a group on issues of patient care and resident well being, but they should not have the right to strike. They further assert that the standards and procedures of the Accreditation Council for Graduate Medical Education (ACGME) provide the appropriate forum to address the concerns of residents. They point out that those standards and procedures are currently under development, and request that the Board rule consistently with their positions.

The American Public Health Association, in support of the Petitioner, argues that because quality of patient care and working conditions of the care-givers are closely related, the Board should recognize that house staff are employees entitled to engage in collective bargaining to improve their working conditions. It also recounts the story of Libby Zion, who died after going to the emergency room at a major New York City teaching hospital, and the resulting grand jury investigation and subsequent Bell Commission's study of, inter alia, residents' work schedules. It also argues that the dichotomy between "student" and "employee" is false. While house staff in their capacity as "trainees" are certainly the "beneficiaries" of training, likewise the hospital certainly is the beneficiary of the services and health care delivered to patients by house officers in their capacity as "doctors" and "employees." It further points out that house staff provide the bulk of physician-type services to the traditionally underserved in hospital emergency rooms and clinics, and that it would perhaps be insulting, if not disquieting, to the underserved to be told that their medical care is being provided not by "doctors" but by "students."

The American Medical Women's Association submitted a statement in support of the Petitioner, concurring in the position of the California Medical Association that interns, residents, and fellows are employees under the

Act, and urging that the Board reverse its decision in *Cedars-Sinai*.

The Association of American Medical Colleges, the American Hospital Association, the American Council on Education, the American Board of Medical Specialties, and the Council of Medical Specialty Societies together argue, in support of the Employer, that the Board in *Cedars-Sinai* and *St. Clare's Hospital* properly sought to avoid any involvement in academic decision making, and that the Board's rationale for such noninvolvement is even more compelling today than it was then. They contend that the reversal of *Cedars-Sinai* and *St. Clare's Hospital* would wrongly involve the Board and labor organizations in academic decision making. In response to the Petitioner's argument that its 40-year bargaining history "empirically demonstrates that the Board's fears expressed in *Cedars-Sinai* concerning the impact of collective bargaining upon medical training are unfounded," they point out that if the law is changed and house staff are held to be employees under the Act, any labor organization may seek to represent those employees and those unions may aggressively seek to become involved in "academic" issues.

III. ANALYSIS

Over 20 years ago, this Agency—despite the dissent of one member—concluded that hospital house staff were "primarily" students, and thus were not employees within the meaning of Section 2(3) of the Act. *Cedars-Sinai*, 223 NLRB at 253. The Board "clarified" its position shortly thereafter to explain that it did not mean to find that private sector house staff were not covered by the statute, but that as a particular type of student they were not entitled to collective-bargaining rights. *St. Clare's Hospital*, 229 NLRB at 1003.

We are convinced by normal statutory and legal analysis, including resort to legislative history, experience, and the overwhelming weight of judicial and scholarly opinion, that the Board reached an erroneous result in *Cedars-Sinai.* Accordingly, we overrule that decision and its offspring, conclude that house staff are employees as defined by the Act, and find that such individuals are therefore entitled to all the statutory rights and obligations that flow from our conclusion.

A. Background

In *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976), decided shortly after the enactment of the Health Care Amendments to the Act, a Board majority concluded that interns, residents and fellows were not statutory employees. Although recognizing that house staff received many benefits characteristic of employee status, the Board majority concluded that house staff were primarily engaged in graduate educational training, and therefore were students rather than employees entitled to bargaining rights under the Act. The majority reasoned that house staff entered into a relationship with a hospital not primarily to earn a living, but to fulfill educational requirements of state or specialty boards. The majority placed little reliance on the fact that house staff spent most of their time in direct patient care, finding that "this is simply the means by which the learning process is carried out." Concerning the stipends house staff received, the Board majority concluded that such pay was more in the nature of a living allowance than compensation for services. The Board majority noted that stipends were fixed depending on the year of training, and did not vary depending on hours worked or with the nature of the services rendered. The majority further found significant that house staff tenure was related to the particular education program, that such a relationship was of relatively short duration, and that there was little chance that a regular employment relationship would be established following completion of the program.[14]

In *St. Clare's Hospital & Health Center*, 229 NLRB 1000 (1977), the Board attempted to clarify its *Cedars-Sinai* decision by emphasizing that the decision was one involving students. Because of intervening litigation,[15] and a "misunderstanding" that "can perhaps justifiably be laid at our feet for we may not have been as precise as we might have been in articulating our views," the Board majority attempted to rearticulate its *Cedars-Sinai* decision. The majority set forth what it identified as four categories of cases involving students. The majority concluded that house staff fell within the fourth category, "that in which students perform services at their educational institutions which are directly related to their educational program." 229 NLRB at 1002 (citation omitted). The majority reasoned that such individuals are serving primarily as students and not primarily as employees, that their relationship with their institutions is therefore predominantly academic rather than economic in nature, and thus that such interests are not "readily adaptable to the collective-bargaining process." 229 NLRB at 1002.

B. Section 2(3) of the Act

We find the Board's determination in *Cedars-Sinai* and *St. Clare's Hospital* of the status of house staff to be flawed in many respects. We begin our analysis with reference to Section 2(3) of the Act. That key statutory language is as follows:

> The term "employee" shall include any employee . . . unless the Act [this subchapter] explicitly states otherwise . . . but shall not include any individual employed as an agricultural laborer, or in the domestic service of any family or person at his home, or any individual employed by his parent or spouse, or

[14] As discussed more fully below, Member Fanning dissented from the majority's decision.

[15] The Board's *Cedars-Sinai* opinion begat a tangled web of litigation. See the discussion in *St. Clare's Hospital,* 229 NLRB at 1000, 1005.

> any individual employed as an independent contractor . . . .

The "breadth of §2(3)'s definition is striking. The Act specifically applies to 'any employee.'" *Sure-Tan, Inc. v. NLRB*, 467 U.S. 883, 891–892 (1984) (undocumented aliens "plainly come within the broad statutory definition of 'employee'"). The exclusions listed in the statute are limited and narrow, and do not, on their face, encompass the category "students." Thus, unless there are other statutory or policy reasons for excluding house staff, they literally and plainly come within the meaning of "employee" as defined in the Act. We find no such reasons.

In his dissent in *Cedars-Sinai*, then-Member Fanning traced the Act's definition of "employee" as an outgrowth of the common law concept of the "servant." 223 NLRB at 254. In turn, the master-servant relationship itself finds its antecedents in common law agency doctrine. Id. at 254–255. See also *NLRB v. Town & Country*, 516 U.S. 85, 93–95 (1995). At common law, a servant was one who performed services for another and was subject to the other's control or right of control. Consideration, i.e., payment, is strongly indicative of employee status. Id. Cf. *WBAI Pacifica Foundation*, 328 NLRB 1273 (1999). We agree with this analysis.

The Supreme Court in *Town & Country* echoed the same logic in its analysis of Section 2(3). Specifically, the Court noted that the Board's definition of the term "employee" as used in the Act reflected the common law agency doctrine of the conventional master-servant relationship. 516 U.S. at 93-95. In this recent case, the Court reiterated that the language of this section of the statute is "broad":

> The ordinary dictionary definition of "employee" includes any "person who works for another in return for financial or other compensation." American Heritage Dictionary 604 (3d ed. 1992). See also Black's Law Dictionary 525 (6th ed. 1990) (an employee is a "person in the service of another under any contract of hire, express or implied, oral or written, where the employer has the power or right to control and direct the employees in the material details of how the work is to be performed"). The phrasing of the Act seems to reiterate the breadth of the ordinary dictionary definition, for it says "[t]he term 'employee' shall include *any* employee." 29 U.S.C. § 152(3) (1988 ed.) [Emphasis added.]
>
> For another thing, the Board's broad, literal interpretation of the word "employee" is consistent with several of the Act's purposes, such as protecting "the right of employees to organize for mutual aid without employer interference" . . . and "encouraging and protecting the collective-bargaining process.". . . And, insofar as one can infer purpose from congressional reports and floor statements, those sources too are consistent with the Board's broad interpretation of the word. It is fairly easy to find statements to the effect that an "employee" simply "means someone who works for another for hire." H.R.Rep. No. 245, 80th Cong., 1st Sess., 18 (1947), and includes "every man on a payroll." 79 Cong. Rec. 9686 (1935) (colloquy between Reps. Taylor and Connery). . . . At the same time, contrary statements, suggesting a narrow or qualified view of the word, are scarce, or nonexistent—except, of course, those made in respect to the specific (here inapplicable) exclusions written into the statute.

Town & Country Electric, 516 U.S. at 90–91 (some citations omitted). As the Court noted, the Board's historic, broad, literal reading of the statute finds support in Supreme Court precedent. Id. at 91–92; *Sure-Tan*, supra; *NLRB v. Hendricks County Rural Electric Membership Corp.*, 454 U.S. 170, 189–190 (1981); *Phelps Dodge Corp. v. NLRB*, 313 U.S. 177, 185–186 (1941).

We believe, therefore, that whatever other description may be fairly applied to house staff, it does not preclude a finding that individuals in such positions are, among other things, *employees* as defined by the Act.

Ample evidence exists here to support our finding that interns, residents and fellows fall within the broad definition of "employee" under Section 2(3), notwithstanding that a purpose of their being at a hospital may also be, in part, educational. That house staff may also be students does not thereby change the evidence of their "employee" status. As stressed above, nothing in the statute suggests that persons who are students but also employees should be exempted from the coverage and protection of the Act. The essential elements of the house staff's relationship with the Hospital obviously define an employer-employee relationship.

First, house staff work for an employer within the meaning of the Act. Second, house staff are compensated for their services. The house staff, as noted, receive compensation in the form of a stipend. There is no exclusion under the Internal Revenue Code for such stipends. The Hospital withholds Federal and state income taxes, as well as social security, on their salaries.

Further, the interns, residents, and fellows receive fringe benefits and other emoluments reflective of employee status. Workers' compensation is provided. They receive paid vacations and sick leave, as well as parental and bereavement leave. The Hospital provides health, dental, and life insurance, as well as malpractice insurance, for house staff and other Hospital employees.

Third, house staff provide patient care for the Hospital. Most noteworthy is the undisputed fact that house staff spend up to 80 percent of their time at the Hospital engaged in direct patient care. The advanced training in the specialty the individual receives at the Hospital is not inconsistent with "employee" status. It complements,

indeed enhances, the considerable services the Hospital receives from the house staff, and for which house staff are compensated. That they also obtain educational benefits from their employment does not detract from this fact. Their status as students is not mutually exclusive of a finding that they are employees.

As "junior professional associates,"[16] interns, residents, and fellows bear a close analogy to apprentices in the traditional sense. It has never been doubted that apprentices are statutory employees eligible to vote in elections with their more experienced colleagues. See, e.g., *The Vanta Co.,* 66 NLRB 912 (1946).[17] Nor does the fact that interns, residents and fellows are continually acquiring new skills negate their status as employees. Members of all professions continue learning throughout their careers, and many professions, including those in the healthcare industry, require individuals to be trained further after graduation in order to be licensed or received in the field. See, e.g., *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; "[t]he 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). "[F]ledgling lawyers employed by a law firm spend a great deal of time acquiring new skills, yet no one would contend that they are not *employees* of the law firm." *Regents of the University of Michigan v. Michigan ERC*, 204 N.W. 2d 218, 226 (Mich. 1973). Plainly, many employees engage in long-term programs designed to impart and improve skills and knowledge. Such individuals are still employees, regardless of other intended benefits and consequences of these programs.

Additionally, while house staff possess certain attributes of student status, they are unlike many others in the traditional academic setting. Interns, residents, and fellows do not pay tuition or student fees.[18] They do not take typical examinations in a classroom setting, nor do they receive grades as such. They do not register in a traditional fashion. Their education and student status is geared to gaining sufficient experience and knowledge to become Board-certified in a specialty.

Review of our decisions concerning students does not lead to a different result. In prior cases, there has been no question that students are statutory employees. Rather, the issue has been the eligibility of student workers based on community of interest considerations. It is true, as found by the Board in *St. Clare's Hospital*, that the Board has, on occasion, excluded students from bargaining units. But it has not done so, as posited in *St. Clare's Hospital*, on the basis of some broad delineation of categories of students. Rather, as Member Fanning noted in his *St. Clare's Hospital* dissent, the Board has analyzed the placement of students, as it has other categories of employees, under community-of-interest principles, determining on that basis whether such workers may be included in the unit. See, e.g., *NLRB v. Action Automotive*, 469 U.S. 490, 496 (1985) (relatives of owners of closely held corporation excluded from unit as they do not share a community of interest with unit employees); *Town & Country*, 516 U.S. at 97 (identifying confidentials as employees who are nonetheless excluded from bargaining units). The Board traditionally looks to whether students work in the same capacity as other workers and what their stake in the outcome of negotiations would be, just as it does with every other set of employees. *St. Clare's Hospital*.

C. Other Statutory Considerations

Our interpretation of Section 2(3) of the Act to include house staff as statutory employees is further supported by reference to Section 2(12) of the Act. That provision defines a professional employee as:

> (a) any employee engaged in work . . . (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital . . . or
>
> (b) any employee who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a) and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph (a).

Literally read, Section 2(12)(b) embraces house staff. Interns, residents, and fellows clearly are individuals who have completed a course of specialized intellectual instruction and study "in an institution of higher learning or a hospital." Just as plainly, they are "performing related work under the supervision of a professional to qualify" to be a professional as defined in the Act. The legislative history of the Taft-Hartley amendments (the Labor Management Relations Act) supports the conclusion that this section of the

[16] 1 Leg. Hist. 540 (LMRA 1947).

[17] Indeed, in the construction industry, it has long been the case that apprentices are included in units with journeymen. The practice is so well established that it has rarely been litigated. See, e.g., *Heating, Piping & Air Conditioning Contractors,* 110 NLRB 261, 263 (1954) (plumber and pipefitter apprentices included in respective craft units).

[18] The only exception appears to be that several dental residents pay some tuition.

Act was crafted to include "such persons as legal, engineering, scientific and *medical personnel along with their junior professional associates*." I Leg. Hist. 540 (LMRA 1947) (emphasis added). As Member Fanning stated in his *Cedars-Sinai* dissent, this "definition fits, *precisely*, housestaff officers." 223 NLRB at 258. See also *Physicians Nat. House Staff Assn. v. Fanning*, 642 F.2d 492, 500 (D.C. Cir. 1980) (Chief Judge Wright, dissenting).[19] We find, therefore, based on the foregoing and the record as a whole, that house staff clearly fit within the statutory definition of "employee."

D. Legislative History of the 1974 Healthcare Amendments

Were there any lingering doubt about our interpretation of Section 2(3) as applied to interns, residents, and fellows, it is put to rest by consideration of the legislative history of the 1974 Healthcare Amendments.[20] Member Fanning, in his dissent in *Cedars-Sinai*, as well as Chief Judge Wright in his dissent in *Physicians Nat. House Staff*, extensively analyzed this history. In agreement with them, we believe, based on our own review, that the legislative history amply demonstrates that Congress, to the extent it considered the question, thought house staff to be statutory employees.[21]

In 1974, Congress extended the Board's jurisdiction to nonprofit healthcare facilities. In repealing the exemption of private, nonprofit hospitals from the definition of "employer," Congress was responding to the spate of recognition strikes in the healthcare industry, *Physicians Nat. House Staff*, 642 F.2d at 505, and stressed the need for continuous health services.[22] In Senate hearings on the amendments, representatives for the house staff, while urging that Congress adopt the amendments, advanced a new provision that would have excluded house staff from the ambit of Section 2(11) of the Act, which sets forth the definition of "supervisor," thus ensuring that house staff were not excluded from coverage of the Act on that basis. The committee report on why this legislative provision was not adopted bears reciting:

> Various organizations representing health care professionals have urged an amendment to Section 2(11) of the Act so as to exclude such professionals from the definition of "supervisor." The Committee has studied this definition with particular reference to health care professionals, such as . . . interns, residents, fellows . . . and concludes that the proposed amendment is unnecessary because of existing Board decisions. The Committee notes that the Board has carefully avoided applying the definition of a "supervisor" to a health care professional who gives directions to other employees, which direction is incidental to the professional's treatment of patients and thus is not the exercise of supervisory authority in the interest of the employer.[23]

This statement clearly assumes that house staff are employees. For if they were thought to be students, their status as supervisors would not be pertinent. *Physicians Nat. House Staff*, 642 F.2d at 505; *Student-Workers* at 768.

This view is underscored by the remarks of Senator Cranston, cosponsor and floor manager of the Senate bill. Senator Cranston, in introducing the bill, explained that one of the conditions the bill was designed to remedy was the "notoriously underpaid . . . average annual salary for all hospital employees—including doctors . . . . According to [the] president of the Physicians National House staff Association, the average house staff officer—intern, resident, or fellow—works 70 to 100 hours per week, and earns about $10,000 per year. His hourly wage then ranges from $1.92 to $2.74."[24] Senator Cranston's remarks about interns, residents, and fellows obviously reflect his assumption that they were to be covered by the legislation he was offering. *Physicians Nat. House Staff*, 642 F.2d at 505–506.[25]

This legislative history is very persuasive. Yet, the Employer does not address it. Rather, the Employer argues that the failure of Congress to pass legislation, formally considered in 1979, that would have set aside the Board's *Cedars-Sinai* and *St. Clare's Hospital* decisions, means that Congress approved the Board's decisions in those cases, and thus we are not free to overrule them. The argument lacks merit.

It is a canon of statutory construction that opinions of legislatures expressed years after an Act was passed should not be given weight as to the meaning of the earlier Act. *Teamsters v. U.S.*, 431 U.S. 324, 354 fn. 39

[19] The *Cedars-Sinai* majority responded to this argument with sleight of hand simply by stating that since house staff are not employees within the meaning of the Act, there is no reason to refer to other sections of the Act (223 NLRB at 253 fn. 4).

[20] Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974 (P.L. 93–360) (S. 3203).

[21] It is telling that the Board majority failed to address this legislative history in *Cedars-Sinai*. See Note, *Student-Workers or Working Students? A Fatal Question for Collective Bargaining of Hospital House Staff,* 38 U. Pitt. L. Rev. 762, 767 (1977) (hereafter *Student-Workers*); *Physicians Nat. House Staff*, 642 F.2d at 505–506.

[22] *Student-Workers* at 767.

[23] Legislative History of the Coverage of Nonprofit Hospitals at 13; S.Rept. 93–766, 93d Cong., 2d Sess. 6 (1974). See also Legislative History of the Coverage of Nonprofit Hospitals at 275, H.R. Rep. No. 1051 at 7 (1974).

[24] Legislative History of the Coverage of Nonprofit Hospitals at 93, 120 Cong. Rec. 12937 (1974). As the dissent noted in *Physicians Nat. House Staff,* even the opponents of the 1974 Amendments assumed that house staff were employees. Senator Dominick "referred repeatedly to the coverage of house staff under the bill, grouping house staff together with other hospital employees." 642 F.2d at 506. See 120 Cong.Rec. 12971, 12580 (remarks of Senator Dominick).

[25] The *Cedars-Sinai* majority's response to this legislative history was simply to posit that house staff were not employees, and thus there was no merit to the arguments based on the legislative history. It may be that such history does not *require* the Board to find house staff to be statutory employees. But it is no answer simply to ignore the contemporaneous understanding of those who sponsored the statute as to its meaning.

(1977) ("views of members of a later Congress . . . are entitled to little if any weight"); *U.S. v. Mine Workers*, 330 U.S. 258 (1947); *Physicians Nat. House Staff*, 642 F.2d at 509–510. Indeed, when the language of a statute is plain—as it is here—one is to give the words their plain meaning. *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68, 75 (1982).

It is a dubious proposition indeed that the inaction of one house of Congress could be relevant evidence of what a previous entire Congress meant to do when it acted in its "full constitutional cycle." *Physicians Nat. House Staff*, 642 F.2d at 510. The germaneness of subsequent congressional action is further diminished where, as here, the alleged "action" is, in fact, inaction. Our reconsideration of *Cedars-Sinai* and related cases cannot appropriately be foreclosed merely because of the failure of one house of Congress to reverse that and related cases.[26]

E. Other Considerations

As detailed above, we find persuasive the dissent by Member Fanning in *Cedars-Sinai*. The majority in that case set forth no coherent rationale and never answered satisfactorily any of the dissent's criticisms, nor, as we have seen, was their later attempt to justify the result in *St. Clare's Hospital* equal to the task. Similarly, we find it instructive that four judges of the Court of Appeals for the District of Columbia Circuit believed that the Board's decision in *Cedars-Sinai* was so aberrant as to cause them to vote to reverse it in *Leedom v. Kyne*[27] litigation. *Physicians Nat. House Staff Assn. v. Fanning*, 642 F.2d 492, 500 (D.C. Cir. 1980). *Leedom v. Kyne* is limited to only those cases in which the Board has so erred as a matter of law that a United States District Court asserts jurisdiction over a suit to set aside a Board finding in a representation proceeding. *Physicians Nat. House Staff*, 642 F.2d at 502–503.

Further, we reach our decision here to overrule *Cedars-Sinai* and its progeny on the basis of our experience and understanding of developments in labor relations in the intervening years since the Board rendered those decisions. Almost without exception, every other court, agency, and legal analyst to have grappled with this issue has concluded that interns, residents, and fellows are, in large measure, employees. *Regents of the University of Michigan v. ERC*, supra, 204 N.W.2d at 225 (evidence on doctors' pay, benefits, amount of time devoted to patient care, and duties and responsibilities to diagnose and prescribe patient care program and put it into effect "far more indicative of an employee (i.e.—in this case a doctor) than a student"); *House Officers Assn. for the University of Nebraska Medical Center v. University of Nebraska Medical Center*, 255 N.W.2d 258 (Neb. 1977) ("the obvious conclusion from the recitation of facts is that House Officers are both students and employees"); *University Hospital v. SERB*, 587 N.E.2d 835 (Ohio 1992), rehearing denied 590 N.E.2d 753 (May 6, 1992); *The Regents of the University of California v. PERB*, 715 P.2d 590 (Cal. 1986); *Walls v. North Mississippi Medical Center,* 568 So.2d 712 (Miss. 1990); *Long Beach Veterans Administration Medical Center, Long Beach, CA*, 7 FLRA 134 (1981); *Veterans Administration Medical Center, Brooklyn, NY*, 8 FLRA 289 (1982); *Veterans Administration Medical Center, East Orange, NJ*, 20 FLRA 900 (1985); *City of Cambridge*, 2 MLC 1450 (Mass. Lab. Rel. Comm. 1976); *Student-Worker,* supra; Note, *Medical Housestaff: Scholars or Working Stiffs? The Pending PERB Decision*, 12 Pac. L.J. 1127 (1981); Malin, *Student Employees & Collective Bargaining*, 69 Ky. L.J. 1 (1980). Cf. *Ross v. University of Minnesota* 439 N.W.2d 28 (Minn. 1989). But see *Philadelphia Assn. of Interns & Residents v. Albert Einstein Medical Center*, 369 A.2d 711 (Penn. 1976); Sepinuck, *Hospital Residents & Interns: Inconsistent Treatment Under Federal Law*, 29 St. Louis L.J. 665 (1985).

These judicial bodies, and other commentators, have concluded that house staff are employees, in addition to being students, on similar facts as exist here. In each case, the courts and others have rejected the analysis the Board adopted in *Cedars-Sinai*. In its stead, these courts and commentators have assessed the realities of the relationship between house staff and the hospitals that they serve, and have concluded that the relationship exhibits sufficient factors to warrant a finding of employee status.

Moreover, there is no indication that any of the negative problems flowing from such a finding, as predicted by the *Cedars-Sinai/St. Clare's Hospital* opinions, have occurred, or would occur. It is plain that collective bargaining by public sector house staff has been permitted and widely practiced. No party or amicus in the instant proceeding has pointed to any difficulty arising from this bargaining. Indeed, the American Medical Association, although opposed to granting house staff the right to strike under the Act, urges that house staff be accorded bargaining rights.[28] Further, since an overriding purpose of the 1974 Healthcare Amendments was the elimination of recognition strikes and picketing, according house staff employee status will have the beneficial purpose of bringing them within the ambit of the Act, and providing a mechanism for resolving recognition and other representation issues without resort to such tactics.

[26] To the extent that post-*Cedars Sinai* congressional responses might be deemed relevant to consideration of the issue of employee status of house staff, we note that Representative Frank Thompson, a co-sponsor of the 1974 Health Care Amendments, stated that "[w]hen we passed the . . . Amendments in 1974 . . . we all thought, proponent and opponent alike, that medical house staff were included." 125 Cong. Rec. 33943 (1979).

[27] 358 U.S. 184 (1958).

[28] The American Medical Association proposes that matters between hospitals and house staff in this regard be governed by ACGME guidelines.

As a policy matter, we do not believe that the fact that house staff are also students warrants depriving them of collective-bargaining rights, or withholding the statutory obligations attendant to those rights. The Employer and Member Brame argue strenuously that by granting employee status to house staff, the Board will improperly permit intrusion by collective bargaining into areas involving academic freedom. This argument puts the proverbial cart before the horse. The contour of collective bargaining is dynamic with new issues frequently arising out of new factual contexts: what can be bargained about, what the parties wish to bargain about or concentrate on, and what the parties are free to bargain about, may change. But such problems have not proven to be insurmountable in the administration of the Act. We need not define here the boundaries between permissive and mandatory subjects of bargaining concerning interns and residents, and between what can be bargained over and what cannot. We will address those issues later, if they arise. But we note that there are often restrictions on bargaining due to outside influences, e.g., contracts an employer may have with other concerns that require the employer to conduct its business in a specific manner, or specifications in a contract that limit what an employer may or may not do. An employer is always free to persuade a union that it cannot bargain over matters in the manner suggested by the union because of these restrictions. But that is part of the bargaining process: the parties can identify and confront any issues of academic freedom as they would any other issue in collective bargaining. The parties in this case are not novices to collective bargaining. If the parties cannot resolve their differences through bargaining, they are free to seek resolution of the issues by resort to our processes, and we will address them at the appropriate time.

The arguments raised by the Employer regarding possible intrusion on academic freedom reflect those raised before state courts that have confronted the issue of the employee status of house staff. Those courts' responses to these arguments echo those we have set forth herein. For example, the Michigan Supreme Court faced a constitutional argument that by finding house staff to be employees, the court would infringe on the constitutional autonomy of the Board of Regents. *Regents of the University of Michigan*, supra. The court noted that because of the "unique nature" of the University of Michigan, the scope of bargaining "may be limited" if the matter fell "clearly" within the educational sphere. 204 N.W.2d at 224. The court continued:

> For example, the Association clearly can bargain with the Regents on the salary that their members receive since it is not within the educational sphere. While normally employees can bargain to discontinue a certain aspect of a particular job, the Association does not have the same latitude as other public employees. For example, interns could not negotiate working in the pathology department because they found such work distasteful. If the administrators of medical schools felt that a certain number of hours devoted to pathology was necessary to the education of the intern, our Court would not interfere since this does fall within the autonomy of the Regents under Article VIII, § 5. Numerous other issues may arise which fall between these two extremes and they will have to be decided on a case by case basis.

204 N.W.2d at 224.

The Supreme Court of California addressed a similar argument:

> The University asserts that if collective bargaining rights were given to housestaff the University's educational mission would be undermined by requiring bargaining on subjects which are intrinsically tied to the educational aspects of the residency programs. This "doomsday cry" seems somewhat exaggerated in light of the fact that the University engaged in meet- and–confer sessions with employee organizations representing housestaff prior to the effective date of [the relevant statute]. Moreover, the University's argument is premature. The argument basically concerns the appropriate scope of representation under the Act. (See § 3562, subd. (q).) Such issues will undoubtedly arise in specific factual contexts in which one side wishes to bargain over a certain subject and the other side does not. These scope-of-representation issues may be resolved by the [PERB] when they arise.

The Regents of the University of California v. PERB, 715 P.2d at 604 (footnote omitted).

Today, we accord individuals who clearly are employees within the meaning of the Act the rights that are afforded all such employees, and likewise impose the responsibilities commensurate with those rights. We believe that our interpretation of the statute, informed by analysis of the facts here and experience, is a reasonable one that takes into account the entire nature of the house staff-hospital relationship.[29]

We cannot subscribe to dissenting Member Brame's forecast of doom to medical education as a consequence of our decision today. We simply cannot say, either as a matter of law or as a matter of policy, that permitting medical interns, residents and fellows to be considered as employees entitled to the benefits of the Act would make them any less loyal to their employer or to their patients. Nor can we assume that the unions that represent them will make demands upon them or extract concessions form their employers that will interfere with the educational mission of the institutions they serve, or prevent them from obtaining the education necessary to complete

[29] *Action Automotive*, supra.

their professional training. If there is anything we have learned in the long history of this Act, it is that unionism and collective bargaining are dynamic institutions capable of adjusting to new and changing work contexts and demands in every sector of our evolving economy. We have no doubt that they can also adjust to accommodate the special functions of medical house staff. To assume otherwise is not only needlessly pessimistic, but gives little credit to the intelligence and ingenuity of the parties.

IV. ANCILLARY ISSUES

Having determined that BMC's house staff are employees within the meaning of Section 2(3) of the Act, we now turn to consideration of other issues raised by the parties.[30]

A. Labor Organization Status

BMC contends that the petition must be dismissed because the Petitioner is not a labor organization within the meaning of Section 2(5) of the Act in that it is not an organization in which "employees" participate. Since we are finding herein that interns, residents, and fellows employed by BMC are employees within the meaning of Section 2(3) of the Act, and since the record establishes that the Petitioner is an organization in which employees (house staff) participate and that exists at least in part for the purpose of dealing with employers concerning wages, hours, and terms and conditions of employment, we conclude that the Petitioner is a labor organization within the meaning of Section 2(5). *Alto Plastics Mfg. Corp.*, 136 NLRB 850, 851–852 (1962).

B. Joint Employer Issues

As noted by the Regional Director, BMC argues that several administrative problems would result if the Board were to find that its house officers are statutory employees. First, BMC contends that it has various affiliations with other institutions which will raise complex questions about joint employer status. Second, BMC contends that, because some of those institutions are government entities not subject to the Board's jurisdiction, our assertion of jurisdiction over the house officers will present numerous bargaining and enforcement problems.

The record shows that BMC's house officers are assigned to various clinical rotations throughout BMC. In addition, as found by the Regional Director, house officers in some BMC residency programs perform one or more rotations at other institutions with which BMC has an affiliation agreement. As they rotate through the various clinical assignments, house officers remain part of BMC's residency program. This is so regardless of where they are actually performing their duties and although they may perform their duties under the medical direction of one or more physicians at the site of the rotation. Importantly, however, residents in all BMC programs spend the vast majority of their residency at BMC's facilities.

Although this situation potentially presents various, and perhaps unusual, issues for resolution through collective bargaining, in that employees (residents) are for discrete periods performing services at the facility of another employer or employers, these issues do not appear to be novel or insurmountable. In any event, at this juncture any such potential problems are speculative.[31]

In addition to the clinical rotations discussed above, BMC operates at least two joint residency programs with other institutions. As described by the Regional Director, one is a joint residency program in Oral and Maxillofacial Surgery with Tufts University, and another is the Boston Combined Residency Program in Pediatrics, which includes individuals in BMC's residency program as well as those in Children's Hospital's program, with some of the residents being paid by BMC and others by Children's Hospital. The Regional Director did not address whether these programs operate so as to require a finding that house staff enrolled in the two programs are jointly employed by BMC and either Children's Hospital or Tufts University. We find that the present record is insufficient to enable us to resolve this issue. Accordingly, we do not at this time make a final determination as to the unit placement of house staff assigned to joint residency programs such as that in Oral and Maxillofacial Surgery with Tufts University, and the Boston Combined Residency Program in Pediatrics, but shall permit them to vote under challenge.[32]

C. Temporary Employees

BMC contends that numerous problems will arise as a result of the transient status of its house staff. It points

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[30] In addition to the issues discussed below, BMC contends that if the Board finds that house staff are employees, then the chief residents should be excluded from the unit on the basis that they are 2(11) supervisors and managerial employees. The Regional Director thoroughly considered this issue and concluded that chief residents are *not* statutory supervisors or managerial employees. We affirm the Regional Director's conclusion in this regard, for the reasons stated by her.

[31] That some of the institutions with which BMC maintains affiliations may be government entities over which the Board does not have jurisdiction does not foreclose our assertion of jurisdiction over BMC. See, e.g., *Management Training Corp.,* 317 NLRB 1355 (1995).

[32] The Regional Director noted that there are a number of house officers who are enrolled in BMC's residency program but are paid by other institutions, including approximately 15 house officers who are included in the bargaining unit presently represented by the Petitioner. All of these house officers are treated no differently from other house officers on BMC's payroll, including with respect to their training and rotations. The 15 house officers who were included in the bargaining unit receive the same wages and benefits as all other house staff. The Petitioner seeks to include in the unit herein the 15 house officers who it has historically represented. It appears that neither the Petitioner nor the Employer contend that other house staff not on BMC's payroll must be included in the unit. Under these circumstances, we shall not at this time determine whether the 15 historically represented house officers shall be included in the unit found appropriate, but direct that those individuals be permitted to vote under challenge.

out that while the length of the residency training programs may vary, nearly all of the residents and fellows leave BMC once they complete their respective training program. It cites Board rulings that "temporary" employees are not eligible to vote in representation elections, because they do not have a sufficient interest to participate in a representation election. It also contends that there exists an even more fundamental issue regarding the temporary nature of these house staff. Thus, it avers that, because the house officers' goal is to obtain the necessary training to become Board certified and independent practicing physicians, it is questionable whether any of them have sufficient interest in terms and conditions of employment to warrant participation in an election. BMC argues that while house staff "may wish to soften the more rigorous and demanding elements of their own educational experience, they hold no genuine interest in affecting the enduring relationship between their program and future medical trainees." Finally, BMC contends that the rapid turnover of residents entering and graduating from the programs frustrates the intent of the Act. It claims that between the time an election petition is filed, the election results are certified, and a collective-bargaining agreement is negotiated and ratified, those residents who voted in the election would likely be transferred to a different rotation and, equally likely, would have graduated from the residency program.

Although, at first blush, the Employer seems to raise a troubling point, we ultimately find no merit to its argument. Ordinarily, "temporary" employees are not eligible to vote in a representation election. As we stated in *St. Thomas-St. John Cable TV*, 309 NLRB 712, 713 (1992), citing *Pen Mar Packaging Corp.*, 261 NLRB 874 (1982):

> It is established Board policy that a temporary employee is ineligible to be included in the bargaining unit and that an employee's eligibility status is determined by his status as of the eligibility payroll date. . . . The critical inquiry on this date is whether the "temporary" employee's tenure of employment remains uncertain. . . . [The] "date certain" eligibility test for temporary employees . . . does not require a party contesting an employee's eligibility to prove that the employee's tenure was certain to expire on an exact calendar date. It is only necessary to prove that the prospect of termination was sufficiently finite on the eligibility date to dispel reasonable contemplation of continued employment beyond the term for which the employee was hired.

As we have set out above, every house officer at BMC is there for a set period of time, in some instances for 3 years, or for as many as 7 years, depending on the particular residency program. Relatively few of these house officers go on to become permanent staff physicians at BMC.[33] In this sense, then, all of BMC's house staff arguably are "temporary" employees because their employment will terminate on a date certain.

Nevertheless, we do not find that house staff are "temporary" employees as the Board has defined that term. Thus, the Board has never applied the term "temporary" to employees whose employment, albeit of finite duration, might last from 3 to 7 or more years, and we will not do so here. In many employment relationships, an employee may have a set tenure and, in that sense, may not have an indefinite departure date. Athletes who have 1, 2, or greater years' length employment contracts are, theoretically at least, employed for a limited time, unless their contracts are renewed; work at a legal aid office may be for a set 2-year period; a teaching assignment similarly may be on a contract basis. To extend the definition of "temporary employee" to such situations, however, would be to make what was intended to be a limited exception swallow the whole.

D. The Appropriate Bargaining Unit

BMC argues that if its house staff are employees under the Act, the petition must be dismissed because the Petitioner seeks to represent a unit that is not appropriate under the Board's Rule on collective-bargaining units in the health care industry.[34]

BMC notes that in 1989, the Board promulgated the Rule defining appropriate bargaining units for acute health care facilities. BMC contends that, absent extraordinary circumstances in which there are existing nonconforming units, in acute care hospitals only the following eight bargaining units will be found appropriate by the Board: (1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. BMC argues that, even if its house staff are to be regarded as physicians, the petition must be dismissed because it does not seek a unit of *all* physicians. It notes that house staff are generally regarded as "doctors" although some, as noted above, have only temporary licenses. BMC further notes that it has on its payroll at least two nonmanagement staff physicians, who are also regarded as "doctors." It contends that since the Petitioner does not seek to include these two nonmanagement staff physicians, the petition must be dismissed as contrary to the Rule.

BMC further contends that the Rule's exception for "existing non-conforming units" will not solve this dilemma in that there is no such unit of *employees* but only

[33] See fn. 29 of the attached Regional Director's decision.

[34] 54 Fed.Reg. 16336 (1989), reprinted at 284 NLRB 1580.

a unit of *students*, since BMC has never recognized its house staff to be anything but students, and certainly not as *employees*. Accordingly, BMC contends, the Board will be creating a ninth appropriate bargaining unit if it finds appropriate a separate unit of house staff. BMC further argues that the consequences of the Board certifying a "partial unit of physicians" will have "significant ramifications on a nation-wide basis." In this regard, BMC contends that, contrary to the Board's rulemaking and the admonition from Congress against undue proliferation of bargaining units in the health care industry, physicians at teaching hospitals could be fragmented into two groups.

The Petitioner counters these arguments with the contention that since, by its petition, it "seeks reversal of a Board policy of 21 years' duration and brings into the ambit of the Act a whole class of previously excluded employees, it is apparent that these circumstances are extraordinary." The Petitioner argues that the so-called "attending physicians" have a "separate and distinct community of interest" from the house staff, given that they are significantly better paid and are appointed to the faculty of the Boston University Medical School, and that they regularly evaluate the performance of interns, residents, and fellows under their supervision and direction. It does not address the possible inclusion of the two nonmanagerial staff physicians in the bargaining unit. It does argue, however, that should the Board reverse its long-held policy that house staff are not employees under Section 2(3) of the Act, the existing history of collective bargaining in a distinct unit of house staff at BMC, and the evidence of very sharp differences in salary, hours, and duties plainly warrant a determination that extraordinary circumstances exist which render appropriate a departure from the Rule.

In considering the merits of the parties' contentions, it is obvious that when the Rule was considered and adopted, house staff were excluded from all proposed bargaining units, as well as from the units found appropriate in the final Rule, since under *Cedars-Sinai*, supra, they were students who did not possess statutory organizational rights. See Notice of Proposed Rulemaking and Notice of Hearing, 52 Fed.Reg. 25142, 25417 (1987), reprinted at 284 NLRB 1516, 1523. However, in addressing the appropriateness of a separate unit of physicians in the Notice of Proposed Rulemaking, the Board stated:

> [M]ost physicians employed by hospitals are considered either supervisors, managerial employees, or (in the case of interns and residents) students, and hence do not have statutory organizational rights. . . .

Id. (Footnote omitted.) This language clearly indicates that the Board deemed interns and residents to be "physicians" for purposes of the Rule,[35] and that but for their student status, interns and residents under the Rule properly would be included in the physicians unit, just as supervisory or managerial physicians would be included in the physicians unit but for the statutory and Board policies mandating their exclusion.

In addition, even absent consideration of the above-cited language in the Proposed Rule, the facts in the instant case lead to the same conclusion; i.e., that house staff properly are included in the unit of "All physicians" under the final Rule, 54 Fed.Reg. 16336, 16348 (1989). Thus, as more fully set forth above in the Facts portion of our decision and in the attached Regional Director's decision, all house staff are medical school graduates who have passed Parts 1 and 2 of the U.S. medical licensing exam. The large majority (all except first year residents) also have passed Part 3 of the licensing exam, and are fully licensed physicians who may legally practice medicine, without restriction.[36] All house staff are qualified to perform, and in fact do perform, medical procedures that only licensed physicians are permitted by state law to perform. Hence, it can fairly be said that house staff possess the types of skills and are required to perform the types of job duties common to other physicians, at similar, albeit not identical, skill levels.[37]

To be sure, there are some differences between the duties performed and the skills possessed by BMC's staff physicians and the duties performed and the skills possessed by its house staff. But we find that these differences are insufficient to warrant creation of a ninth appropriate unit in acute care hospitals (with two of those nine units consisting of physicians). Similarly, we find that the skills, duties, and training possessed by all physicians, including house staff, is sufficiently similar that to place them in separate units would unduly fragment a fairly homogeneous grouping of medical professionals.

Although the Petitioner does not explicitly argue the matter, its unit contentions implicitly raise the question of whether the Board should find the requested unit of

[35] For this reason, and because the employment of house staff at some acute care hospitals was well known to the Board, we find that the Extraordinary Circumstances Exception of the Health Care Rule does not apply herein. See Second Notice of Proposed Rulemaking, 53 Fed.Reg. 33900 (1988), which provides, in relevant part:

> To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding," [such] as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust or an abuse of discretion for the Board to apply the rules to the facility involved.

53 Fed.Reg. at 33933 (footnotes omitted).

[36] First-year residents (interns) possess a limited license to practice medicine within the parameters of their residency program.

[37] Cf. *St. Luke's Health Care Assn.,* 312 NLRB 139, 141 (1993).

house staff appropriate as an historically recognized nonconforming unit. The Health Care Rule explicitly permits representation elections in nonconforming units in only two situations—where the parties have stipulated to an otherwise acceptable nonconforming unit, Section 103.30(d),[38] or where a petition is for an *additional* unit in the face of an existing nonconforming unit, Section 103.30(c).[39] Neither situation is present here. The parties have not stipulated to a house staff unit, and, although the recognized house staff unit might be considered an existing nonconforming unit, the petition is not for an *additional* (i.e., different) unit. An example of the latter situation could be a petition for a unit of physicians where there is an existing unit of house staff, but where there is such a petition, the Board will find appropriate such additional units which comport, "insofar as practicable," to the Rule. See generally, *Kaiser Foundation Hospitals*, 312 NLRB 933 (1993) (severance of skilled maintenance unit from larger nonconforming unit inappropriate); *St. John's Hospital*, 307 NLRB 767 (1992) (unit including only a portion of the remaining unrepresented skilled maintenance employees inappropriate).

Nor do we agree, at least in the circumstances of this case, that the existence of the historical unit of house staff, established under the Massachusetts state public employee collective-bargaining law, should be found to be an "extraordinary circumstance" under Section 103.30(b) of the Rule,[40] such that the requested unit of house staff should be found appropriate notwithstanding the provisions of the Rule. It is undisputed that there are only two staff physicians employed by the Employer who would be eligible for inclusion in a bargaining unit of "all physicians." Even assuming, but without deciding,[41] the existence of the historical unit constitutes an extraordinary circumstance in this regard, the fact that there are only two employee-staff physicians convinces us that the appropriate unit in this case must include those individuals.

Accordingly, pursuant to the Board's Final Rule on collective-bargaining units in the health care industry,[42] we find that the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of the Act:

> All physicians, including interns, residents and fellows, employed by the Employer at its hospital located in Boston, Massachusetts; excluding all other employees, guards, and supervisors as defined in the Act.

[Direction of Election omitted from publication.]

MEMBER HURTGEN, dissenting.

For more than 20 years, the Board has held that interns, residents, and fellows (house staff) are not employees entitled to bargain collectively under the Act.[1] As discussed infra, the courts have endorsed this position, as has the Congress of the United States. I see no reason now to proceed 180 degrees in the opposite direction. Instead, I agree with the result and rationale reached in those cases. I incorporate by reference the rationale of those cases, and thus need not repeat it here. I need only to add a few further thoughts.

First, the majority relies on two Supreme Court decisions that have issued since *Cedars-Sinai* and *St. Clare's*.[2] Those cases do not support the position of the majority. Those cases hold only that it is *permissible* for the Board to treat illegal aliens and paid union organizers as employees. They do not *require* that these employees be included in bargaining units. Similarly, it may be *permissible* for the Board to treat house staff as employees. But surely the Board is not compelled to take the position that they are entitled to be in bargaining units. Rather, in all these cases, the Board makes a policy choice to include or exclude the group at issue. This is precisely what the Board did in *Cedars-Sinai* and *St. Clare's*. The Board there exercised its *discretion* by holding that "collective bargaining should not be applied to what is fundamentally an educational relationship."[3]

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[38] "(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable."

[39] "(c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to section 9(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section."

[40] "(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication."

[41] We note that the existing house staff unit is one that did not arise under the auspices of Board law but is one that was established under state authority. Thus, any request to have the Board recognize the existing house staff unit as an historically recognized unit raises comity issues similar to those presented to the Board after Congress gave it jurisdiction over nonprofit hospitals. The Board's attempts to grant comity to state-recognized units were rejected by the courts as contrary to Sec. 9(b) of the Act. See *Long Island College Hospital v. NLRB,* 566 F.2d 833, 841 (2d Cir. 1977); *Memorial Hospital of Roxborough v. NLRB,* 545 F.2d 351 (3d Cir. 1976). Also, see generally *LaCrosse Tel. Corp. v. Wisconsin Employment Relations Board,* 336 U.S. 18, 26 (1949) ("A certification by a state board under a different or conflicting theory of representation may therefore be as readily disruptive of the practice under the federal act as if the orders of the two boards made a head-on collision.").

[42] In view of our finding that the unit must, consistent with the Board's Health Care Rule, consist of all physicians employed by BMC, the Employer's contention that our finding a unit limited to house staff to be appropriate would be based on the Petitioner's extent of organization, and thus violative of Sec. 9(c)(5) of the Act, is moot.

[1] *Cedars-Sinai Medical Center,* 223 NLRB 251 (1976); *St. Clare's Hospital & Health Center,* 229 NLRB 1000 (1977).

[2] *NLRB v. Town & Country Electric,* 516 U.S. 85 (1995); *Sure-Tan v. NLRB,* 467 U.S. 883 (1984).

[3] *St. Clare's Hospital*, 229 NLRB at 1004. In *St. Clare's,* the Board made it clear that it was "not renouncing entirely our jurisdiction over [house staff]." Id. at 1003. Rather, the Board was simply declining, for policy reasons, to place house staff in units for purposes of collective bargaining.

The majority goes to some length to establish that house staff fall within the statutory definition of employee. They thereby miss my essential point. I am *not* necessarily suggesting that house staff cannot fall within the statutory definition. Rather, I conclude that, as a policy matter, the Board should continue to exercise its discretion to exclude them for purposes of collective bargaining.

No case has held that the Act *compels* a conclusion that house staff are employees for purposes of collective bargaining. Nor does the language of Section 2(3) compel that result. That section provides that "the term 'employee' shall include any employee." Thus, the Act defines the word "employee" by reference to the word itself. This is hardly a statutory command that house staff must be regarded as employees for bargaining purposes.[4]

Second, I note that all courts considering the matter have upheld the Board's discretion to exclude house staff from the status of employees who are entitled to the collective-bargaining provisions of the Act.[5]

Further, I note that, in 1979, Congress was presented with a bill that would have specifically overruled *Cedars-Sinai/St. Clare's*, and would have *required* the Board to treat house staff as unit employees. The proposed legislation was rejected.

With respect to the legislative history of the 1974 healthcare amendments, the majority notes that Congress rejected a bill that would have excluded house staff from the ambit of supervisory status under Section 2(11) of the Act. They argue that this legislative action demonstrates that house staff are statutory employees. The argument has no merit. The legislative proposal was based on a concern that house staff would be supervisors, and the proponents of the proposal wished to avoid that result. The rejection of the proposal was based on a desire to leave things as they were. Thus, if a house officer is a supervisor under Section 2(11), he would remain a supervisor (because the proposal was rejected). But, if the house officer is not a supervisor under Section 2(11), it does not follow that he is made into an employee by reason of the rejection of the proposal. The proposal and its rejection dealt only with the issue of whether these persons are Section 2(11) supervisors. The debate did not focus at all on the issue of whether house staff are employees within the meaning of Section 2(3). Thus, that legislative history does not support the proposition that house staff must be treated as employees. Indeed, I think it ironic that the majority is quick to draw an inference from this rejection of a legislative bill, but seeks to reject the much clearer inference to be drawn from the rejection of the 1979 bill that would have specifically endorsed the proposition that house staff are Section 2(3) employees.[6]

The majority observes that no problems have developed in the public sector where house staff are involved in collective bargaining. I would remind them that these governmental employees do not have the right to strike. The majority would now thrust house staff into the NLRA sector where there is a right to strike. In these circumstances, it surely does not follow that the absence of strikes in the public sector will translate to an absence of strikes under the NLRA.

The Board decision in *Cedars-Sinai* spoke correctly about the danger of imposing collective bargaining on academic issues. The majority responds by suggesting that the parties will voluntarily forego bargaining with respect to academic issues. I concede that it will likely be the case that *the employer* will agree to this, but I am far from certain that the union will voluntarily forego bargaining in this area. In apparent recognition of this, the majority goes on to suggest that, in this situation, the Board will resolve whether a union proposal is a mandatory subject of bargaining. However, it may be years before the Board and courts resolve the issue, and the parties will be in the dark for this prolonged period. Surely, this is not a recipe for stability.

Although the Board has the power to change longstanding precedent, that change should be grounded in experience. An agency can change its rules and policies if there are "change[d] circumstances."[7] But, there is no record evidence herein of "change[d] circumstances." More particularly, there is no record evidence that the essentially educational nature of the house staff experience has changed to any appreciable degree in the past 20 years. Indeed, the Regional Director found, in the instant case, that the graduate medical programs of Respondent are substantially the same as those in *Cedars-Sinai* and *St. Clare's*.

In essence, there is no change in circumstances, but only a change in Board member composition. I would not alter longstanding and workable precedent simply because of a change in Board membership. In my view, the interests of stability and predictability in the law require that established precedent be reversed only upon a

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In view of my position stated herein, I do not pass on the issue of whether house staff are employees under Sec. 2(3) of the Act. I assume arguendo that they are.

[4] The section contains explicit exceptions (e.g., agricultural laborers). These persons *must* be excluded. As explained above, others *may* be excluded.

Sec. 2(12) of the Act (defining professional employees) does not compel a finding of employee status. House staff have not "completed" their education within the meaning of that section. Rather, their work at the hospital includes continuing education. Further, even if house staff fit the statutory definition of professional employees, the Board, as a matter of policy, can choose to exclude them from bargaining units.

[5] *Physicians National House Staff Assn. v. Fanning*, 642 F.2d 492 (D.C. Cir. 1980), cert. denied 450 U.S. 917 (1981); *NLRB v. Committee of Interns & Residents,* 566 F.2d 810 (1977), cert. denied 435 U.S. 904 (1978).

[6] I note that, in both cases, Congress was dealing with a proposed amendment of earlier legislation. In 1974, the proposal was to amend Sec. 2(11); in 1979, the proposal was to amend Sec. 2(3).

[7] See *Permian Basin Area Rate Cases,* 390 U.S. 747, 784 (1968).

showing of manifest need. There is no such showing here.

Finally, in making my decision herein, I do not suggest that collective bargaining for house staff would necessarily have disastrous consequences for medical education or for patient care. I simply believe that the risks were sufficiently high that the Board chose, in 1976, to refrain from granting bargaining rights to house staff. As discussed above, I do not believe there have been any subsequent changes that would warrant a change from that policy choice.

MEMBER BRAME, dissenting.

The majority today overrules 23 years of well-established precedent and places in jeopardy the finest system of medical education in the world. In finding that medical interns, residents, and fellows are employees as defined in Section 2(3) of the Act, the majority ignores evidence clearly establishing that these individuals are not employees but rather students, and thus are not entitled to engage in collective bargaining. Accordingly, I dissent from the Direction of Election.[1]

I. FACTS

BMC operates a teaching hospital in Boston, Massachusetts, which, in addition to providing acute care medical services to patients, serves as the primary teaching facility for the Boston University School of Medicine. As such, BMC offers 37 residency programs to medical school graduates who seek to further their medical education. The Petitioner seeks an election in an existing, voluntarily recognized unit of interns, residents, and fellows (residents) enrolled in these residency programs.[2]

A. History of American Medical Education[3]

During the colonial period, the primary mode of American medical education was the apprenticeship system. During the 19th century, apprenticeships were first supplemented and then largely supplanted by training at one of several dozen "proprietary" medical schools. These schools were owned by their faculties and often operated on a for-profit basis. Most were wholly independent institutions, and even those which were affiliated with a hospital or university retained nearly complete autonomy.[4]

Admission standards for medical schools of this era were virtually nonexistent. Most medical students had only an elementary school education, and some were illiterate. There were no official standards governing these schools. The typical course of instruction consisted of two 4-month terms of lectures on basic principles of medical practice, with no laboratory or clinical training or experience of any sort. After completing this cursory program, students were awarded the M.D. degree. Because states at that time did not independently license physicians, a medical school diploma itself was a license to practice medicine anywhere in the United States.[5]

In response to the obvious deficiencies of these medical schools, some students elected to supplement their education with practical experience through various means. These included an apprenticeship with a skilled preceptor; clinically oriented, nondegree-granting medical schools; serving in a hospital as a "house pupil"; or European study following completion of an American medical degree. Most 19th century physicians, however, either did not, or could not, avail themselves of these educational supplements.[6]

Throughout this period, it was thought to be unnecessary and undesirable to provide physicians with a background in the basic sciences such as physics, biology, and chemistry as these disciplines were seen to have no application to the practice of medicine. Rather, the aim of medical education at the time was to provide students with the facts they needed for clinical practice.[7]

This state of affairs proved increasingly unsatisfactory in the years following the Civil War. It became apparent that medical schools were failing to provide their students with the education required for the practice of medicine. Practitioners also were unsatisfied with the quality of medical education, as they associated the lack

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[1] I join the majority in denying the Employer's Request for Review of the Regional Director's factual findings concerning the nature of its residents' duties and the extent of their supervision by the Employer's attending physicians, as I agree with my colleagues that the Employer has not established that the Regional Director's findings are incorrect. In light of my conclusion that the petition should be dismissed for the reasons stated herein, I find it unnecessary to pass on the remaining questions presented, concerning the applicability of the health care unit rule, the joint employer and jurisdictional issues raised by the Employer, the placement of residents who are not on the Employer's payroll, and the supervisory and/or managerial status of the Employer's senior residents.

[2] See *General Box Co.,* 82 NLRB 678 (1949) (voluntarily recognized union may petition for election in order to secure benefits of NLRB certification).

BMC is the successor institution to Boston City Hospital (BCH), a department of the City of Boston and a public hospital, and Boston University Medical Center Hospital (BUMC). The two institutions merged in July 1996. Prior to the merger, BCH had recognized and bargained with the Petitioner as representative of its residents pursuant to state law. As a condition of the merger, BMC agreed to recognize the Petitioner as representative of the former BCH residents. In August 1996, following a card check, BMC recognized the Petitioner as representative of all residents at the merged entity.

As discussed below, residency programs are of varying length but all require several years to complete. Residents are sometimes referred to by their post-graduate year level, e.g. (PGY 1 for first-year residents). First-year residents are sometimes referred to as interns. Following the completion of a residency program, some physicians elect to continue their medical education through postresidency training programs known as fellowships.

[3] The following discussion of the history of medical education is drawn from Ludmerer, Kenneth, *Learning to Heal* (New York 1985).

[4] Id. at 11–15.

[5] Id. at 11–13.

[6] Id. at 16–18.

[7] Id. at 22–24.

of meaningful training with the low status and pay prevailing among physicians at the time. With the development of experimental science during the 19th century, especially in Germany, didactic educational methods increasingly lost favor in American higher education generally. American universities shifted their focus from delivering predigested wisdom to passive students to research and experimentation, as the proper means for scientific education. Many of the brightest American physicians experienced this form of education while furthering their education in Germany after receiving their M.D. degree in the United States, and they later sought to apply the same principles to medical education in the United States.[8]

These trends were consolidated and reified in the Carnegie Foundation's seminal 1910 report "Medical Education in the United States and Canada," now known as the Flexner Report after its author, Abraham Flexner. The Flexner Report asserted that medicine was a scientific discipline and that the scientific method of observation and evaluation of results was the only proper method for its practice. Accordingly, Flexner advocated a system of medical education in which students would learn by doing, as contrasted with the passive reception of facts through lectures which prevailed in many medical schools of the time.[9] Learning by doing, for Flexner, encompassed both clinical experience and the pursuit of basic research, and represented the best means for both transmitting scientific knowledge and teaching medical students the scientific method which, in Flexner's view, should inform all aspects of the practice of medicine.

The achievement of these goals required a complete transformation of the structure of medical education. In order to support an aggressive program of experiential learning, medical schools required both modern laboratories and access to a teaching hospital where their faculty could teach, and their students could acquire the skills of a physician through the treatment of patients. This advanced scientific training required stringent admission standards and, to support those standards and ensure a vigorous program of basic scientific research, medical schools generally affiliated with research universities.[10]

The Flexner Report's recommendations were widely accepted and completely changed the face of U.S. medical education. Freestanding medical schools which emphasized teaching instead of research were largely eliminated. The proprietary schools were the first to go. The remaining medical schools were reorganized and devoted significant financial resources to upgrading their facilities. These new standards were initially enforced through invigorated state licensing procedures which, among other things, provided that "only graduates of 'approved' medical schools were permitted to apply for the license to practice medicine."[11] Medical schools associated themselves with research universities and acquired control of teaching hospitals. Control over medical education thus passed decisively from practitioners, who had held sway until then, to academic physicians, who often were full-time employees of the medical school, and who focused their efforts on research and teaching. These reforms were largely implemented by the 1920s, and continue to form the guiding principles of U.S. medical education.

B. Medical Education Today

1. Background

U.S. medical education today is a continuum beginning with the first year of medical school and, for most physicians, continuing on through completion of a residency or fellowship program. For many physicians, this process continues with board certification in their specialty or subspecialty.

The first 2 years of medical school primarily consist of lecture courses in which students further their education in the basic sciences that are the underpinning of the modern practice of medicine. In the third and fourth years, medical students spend increasing amounts of their time in a teaching hospital affiliated with their medical school, learning practical skills and acquiring experience by observing and participating in patient care activities. These activities include: examining patients and taking their medical history; drawing blood; inserting an IV; and putting in a catheter.[12]

On graduation from medical school, students are awarded the M.D. degree. They are then eligible, after taking and passing parts 1 and 2 of the U.S. national medical licensing examination, to receive a limited state license to practice medicine. This limited license only authorizes medical practice under the aegis of a residency program.

After successfully completing a 1-year internship and passing part 3 of the U.S. national medical licensing examination, a resident is eligible for an unlimited state license to practice medicine. However, without more training, a physician would not generally qualify for admitting privileges at most hospitals. Rather, the vast expanse of medical knowledge today makes specialization necessary, and residency programs are the usual means by which the necessary specialized training is obtained.[13]

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[8] Id. at 29–46.

[9] Id. at 166–175. Flexner's faith in the value of "learning by doing" drew heavily on the principles of the progressive education movement which, led by reformer John Dewey and others, held that this was the only proper means for effective education at all levels of the education system. Id. at 167, 189–190.

[10] Id. at 177–178.

[11] Id. at 236.

[12] Brief of Amicus American Medical Students Association at 4, 6.

[13] Once they receive a general license from the state, some residents choose to "moonlight," i.e., practice medicine independently of their residency program and sponsoring institution. Moonlighting residents are employees: they work primarily for compensation; they contract

Most residency placements are made through the National Residency Matching Program (NRMP). After a period of interviews and school visits, graduating medical students, and residency programs, mutually rank their preferences. Participating residency programs agree to accept the medical students matched to their program, and participating students agree to accept a residency in the program to which they are matched.[14] Each set of rankings is sent to the NRMP, which matches the highest-ranking choices of the teaching hospital with the highest-ranking choices of the medical students and notifies the parties of the selection(s). Residency programs are required to select successful applicants "on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate should be considered in the selection."[15] Residency programs all start on the same date, July 1.

In sum, residency programs follow an academic model in all respects. They begin on the same day; run for a specific number of years, which varies depending on the discipline or specialty involved; and students who are accepted into a particular residency program generally stay at the same institution for the complete course of instruction.

Residents who successfully complete an accredited residency program receive a diploma from the sponsoring institution and, because the program is accredited, are generally eligible to sit for an examination in their chosen specialty administered by the appropriate medical specialty board. The requirements for board certification vary from one specialty to another. In general, however, a candidate must: (1) have graduated from an accredited medical school; (2) have a valid state license to practice medicine; (3) have completed an accredited residency program and any additional training required by the specialty board; and (4) take and pass the required examination(s). Upon successful passage of the certification process, a physician may hold him or herself out as "Board-certified" in the relevant specialty. It is after receiving their Board certification that most physicians actually begin their chosen vocation.

2. The accreditation process

Residency programs and the institutions that sponsor them are accredited by the Accreditation Council for Graduate Medical Education (ACGME), which has promulgated detailed standards for accredited residency programs and institutions.[16] These standards, known as the "Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements,"[17] specify detailed standards which all residency programs must meet in order to become and remain accredited. These include: eligibility standards for admission; criteria for resident selection; and rules respecting compensation and benefits as well as the conditions under which residents receive training and participate in patient care.[18]

ACGME also maintains residency review committees (RRCs) for each specialty. Each RRC consists of representatives appointed by the American Medical Association, the appropriate specialty board, and, in some cases, a national specialty organization.[19] The RRCs establish the specific curricular standards for that medical specialty's accredited residency programs, and also periodically review residency programs for compliance with both the general and specific ACGME requirements and grant accreditation to programs which meet the standards.

The Essentials limit eligibility for appointment to a residency program to graduates of accredited U.S. or Canadian medical schools or foreign medical graduates who satisfy specified criteria. Enrollment of noneligible residents may result in withdrawal of accreditation. The Essentials require residency programs to provide compensation based on a resident's program year (as opposed to merit-based pay) and require programs to justify exceptions. Residency programs are also required to provide professional liability insurance to all residents meet-

individually with their employer; they generally may admit patients; their work is not subject to the supervision imposed by residency programs; work is assigned based on their employer's needs and usual considerations of efficiency and ability; and they are paid according to work performed as defined by their individual contract.

[14] Fellows are not subject to the NRMP process; they apply for and are accepted to fellowships on an individual basis.

[15] See Graduate Medical Education Directory 1996–1997 (GME Directory) (P. Exh. 19) at 27.

[16] ACGME has five sponsors, each of which appoints members to the council: the American Medical Association (AMA), the American Association of Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the Council of Medical Specialty Societies (CMSS), and the American Hospital Association (AHA). ACGME's sponsoring organizations also review and accredit medical schools. Hospitals, including teaching hospitals, are periodically evaluated and accredited (or reaccredited) by the Joint Committee on Hospital Accreditation.

[17] See GME Directory at 23–28.

[18] Id. at 27. The ABMS, an association of national medical specialty boards, also plays a role in the accreditation process for residency programs. Its membership consists of the following national medical specialty boards: Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Medical Genetics, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Opthamology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, Urology, and Allergy and Immunology. ABMS is a constituent of the ACGME and of the Council for Medical Affairs, the Accreditation Council for Continuing Medical Education, the NRMP, the National Board of Medical Examiners, and the Educational Commission for Foreign Medical Graduates. Both through the ACGME and independently, the ABMS and its members participate in the establishment of national standards and requirements for graduate medical education, continuing medical education for practicing physicians, and state medical licensing exams.

[19] GME Directory at 11.

ing specific criteria as well as access to disability insurance where available.[20]

Each sponsoring institution must establish a graduate medical education (GME) committee with responsibility for advising on and monitoring all aspects of residency education. These committees are expected to include residency program directors, faculty, and residents among their membership. In addition, the GME committees are responsible for establishing and implementing institutional policies for discipline and adjustment of grievances relating to the institution's residency programs. Grievance procedures must satisfy the requirements of fairness and due process and apply equally to all residents, faculty, and residency programs in the sponsoring institution.[21]

The Essentials require residency programs to "provide appropriate supervision for all residents as well as a working environment and duty hour schedule that are consistent with proper patient care and the educational needs of residents."[22] Supervision must afford each resident with increasing levels of responsibility for patient care, in line with their increasing experience and ability. Residency programs must insure that teaching staff are readily available to residents on duty, and may not rely on residents to fulfill institutional service obligations to the detriment of their educational and learning objectives, or impose excessive duty or on-call schedules. Residency programs are required to provide backup when patient care responsibilities are especially difficult or prolonged, and to allow residents to participate in the educational, scholarly, and other medical staff activities of the sponsoring institution.[23]

3. Curricular standards

Each residency program must also meet the specific curricular standards established by the appropriate RRC. Some specialties require programs to enroll a minimum number of residents to achieve or retain accreditation; others do not. Residency programs vary in duration, with most lasting 3, 4, or 5 years, although some are of longer duration. Residents' hours vary substantially between specialties, as does the mix between academic and clinical time. All residents spend some of their time in purely didactic educational settings (lectures, journal clubs, and the like) and some of their time in direct patient-related activities. These differences turn in large part on the nature of the specialty for which the resident is training. In this regard, a comparison between the requirements for general surgery and pathology residencies is instructive.

A general surgery residency is a 5-year program which covers both "the fundamentals of basic science as applied to clinical surgery" and "experience in preoperative, operative, and postoperative care for patients in all areas that constitute the principal components of general surgery . . . ."[24] The surgery curriculum includes actual experience in the performance of endoscopic surgery, emergency medical and intensive care, and personal clinical experience in various surgical specialties.

While the total number of operations to be performed by each resident is not specified, "an acceptable range is from 500 to 1,000 major cases over all 5 years, with from 150 to 300 major cases in the chief [final] year." These surgeries must be distributed to provide a balanced experience in surgery on the "head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and endocrine system," and the comprehensive management of trauma, burns, and emergency surgery and surgical critical care.[25] This must include participation in preoperative and postoperative care as well as in operations themselves. All care provided by residents must be supervised by an attending physician, who must in all cases be immediately available for consultation and support.[26] To avoid inducing "undue stress and fatigue," it is considered "desirable" that residents' workloads be structured so that they have at least 1 day out of 7 free of routine responsibilities and be on call in the hospital no more often than every third night.[27]

A residency in anatomic and clinical pathology is 4 years long and must include 18 months of formal education in anatomic pathology and 18 months of formal education in clinical pathology.[28] The pathology residency curriculum must include education in, inter alia, anatomic and surgical pathology, immunopathology, cytopathology, microbiology, hematology, and medical microscopy. Residents are expected to perform at least 75 autopsies, examine and sign out at least 2000 surgical pathology specimens, examine at least 1500 cytologic specimens, perform at least 200 operating room consultations or frozen sections, and have a laboratory workload of at least 500,000 workload units during the course of the program.[29]

The teaching staff of a pathology residency program must, as a whole, demonstrate broad involvement in research and scholarly activity and programs are expected to encourage residents to participate in clinical or laboratory research projects.[30] To provide a broad educational experience, sponsoring institutions are required to have at least three additional accredited residency programs and should have at least two residents enrolled in each

[20] Id. at 27.
[21] Id. at 26.
[22] Id. at 28.
[23] Id.

[24] Id. at 286.
[25] Id. at 289.
[26] Id.
[27] Id. at 290. Programs must also insure that their on site library is "readily available during nights and weekends." Id. at 289.
[28] Id. at 176. Three year programs in either anatomic or clinical pathology are also available.
[29] Id. at 178–179.
[30] Id. at 179.

program year.[31] Pathology residents should, on average, have the opportunity to spend at least 1 full day out of 7 free from hospital duties and should be on call no more often than every third night.[32]

4. Supervision by attending physicians

Attending physicians play a critical role in a residency program's clinical education process. They are the physician of record for all patients seen by a resident and responsible for patient admissions and the formulation of each patient's plan of care. The attending physician is, thus, in effect the chief instructor for each resident's (and each medical student's) clinical education. They typically work in assigned teams consisting of an attending physician, a chief resident, junior residents, PGY 1s, and medical students.[33]

Each residency program must identify the attending physicians who constitute its faculty.[34] These physicians, in conjunction with the residency program director and the chief of service, supervise the residents and assign clinical responsibilities to them based on the residents' demonstrated skill and educational needs. These assignments are coordinated with the didactic component of the residency program as part of a systematic course of instruction. As indicated below, the exact nature of the supervision depends on the service to which the resident is assigned. Consistent with the mandatory requirements of the Essentials, however, all patient care provided by residents at the sponsoring institution must be supervised by an attending physician.[35]

5. Clinical functions

For most specialties, first-year residents rotate through different departments and areas of a hospital in line with the specific requirements of their residency program. In order to meet specific requirements of their clinical education, some residents also rotate through hospitals other than their sponsoring institution, and one or several cooperating institutions may jointly offer a residency program. After the first year, residents generally do not rotate, but instead increasingly focus on developing skills and acquiring experience in their chosen specialty.

The day-to-day clinical functions performed by a resident depend on the service to which he or she is assigned.

Internal Medicine. Resident begin the day with "rounds," in which a team of residents, interns, medical students, and an attending physician check on and discuss the status of each patient in their assigned ward. Thereafter, the residents order X-rays, consults, lab tests, and other treatments, and themselves perform certain procedures. In emergency situations, residents will respond and provide the required care (e.g., resuscitating a patient who has stopped breathing) without an attending physician. However, an attending physician is always the physician of record for all patients and must approve all hospital admissions, treatments, and discharges.

Radiology. Radiology residents review a patient's films and draft a preliminary report, which is then reviewed and signed off on by an attending physician. For emergency cases at night, when no attending is present, the resident will render an interpretation of the image and the attending will review and sign off on the interpretation the following day.

Pathology. Pathology residents review slides of tissue samples and make a preliminary diagnosis which is then discussed with an attending pathologist, who signs off on the final report. This is true even with respect to "frozen sections," i.e., cases where a pathology diagnosis is required while a patient is undergoing surgery. Residents are forbidden to give a diagnosis to the surgeon without prior review by an attending pathologist even under those circumstances. All autopsy reports also must be approved by an attending pathologist.

Surgery. Surgery residents personally perform part of or all of all surgical procedures, and are allowed to perform more complicated procedures (and/or parts of procedures) as their experience increases. However, an attending physician must be physically present (scrubbed in) for the critical parts of all procedures, and readily available for consultation during the entire operation.

6. Summary

In summary, medical education is a continuous process of at least 7 to 10 years in duration. It begins in medical school with didactic instruction in the basic sciences and clinical work and moves, according to a proscribed path developed by each specialty, through graduate medical education and board certification. All of this is a prelude to a physician's independent medical practice. The model of clinical education on which U.S. medical education is built necessarily requires increasing clinical responsibilities as a resident progresses through his or her course of study. However, those clinical duties must be performed under the supervision of an attending physician, whose

[31] Id. at 176, 178.

[32] Id. at 179.

[33] In practice, chief residents also oversee the work of more junior residents at least to some degree.

[34] At BMC, 99 percent of the attendings are also members of the faculty of the Boston University School of Medicine.

BMC's attendings are technically employed by the Faculty Practice Plan Foundation, Inc., which is an umbrella corporation for the various subsidiary practice plans in place for each department within the hospital. BMC and the School of Medicine are both members of the corporation, and attendings receive support from both the Faculty Practice Plan and the School of Medicine. Attendings receive their paychecks from the School of Medicine, which hires the attendings and serves as the common paymaster for the two entities.

[35] The Essentials provide as follows:

> Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility for patient care according to their level of training, their ability, and their experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty.

purpose is to further the resident's educational development and preparation for Board certification.

II. PRECEDENT

Under an unbroken line of precedent beginning with the first case in which the Board addressed the issue and reaching back more than 20 years, the Board has uniformly held that residents are students primarily involved in an educational process and therefore not "employees" entitled to engage in collective bargaining within the meaning of Section 2(3) of the Act.[36] Until today, the Board has, with court approval and Congressional acceptance, consistently dismissed petitions for elections in units of medical residents.[37]

III. THE MAJORITY'S OPINION

It is undisputed that, under the precedent set forth above, the residents sought to be represented in this case are not employees entitled to engage in collective bargaining and, accordingly, under existing law, the petition must be dismissed. The majority, however, rejects the Board's precedent in this area as wrongly decided and today seeks to overrule it. According to the majority, even if medical residents are considered to be students, they nevertheless meet the Act's definition of an "employee" because they (1) work for an employer within the meaning of the Act; (2) provide patient care for that employer; and (3) are compensated for their services.[38]

The majority also finds support in cases in which the Board has at least implicitly found that other workers in training programs are employees, including construction and manufacturing apprentices, architects, and embalmers. The majority asserts that the statutory definition of "professional employee" in Section 2(12) and the legislative history of the Act, as amended, further support their finding that residents are employees. Finally, the majority notes that residents are considered to be "employees" for the purposes of other federal statutes and for the purpose of collective bargaining under the public sector labor relations statutes of many States.

IV. ANALYSIS

The Supreme Court has consistently recognized that individuals may fall within the literal meaning of the term "employee" and yet be excluded from the Act's coverage entirely, or for certain purposes, based on a consideration of Congressional intent and national labor policy. See *NLRB v. Hendricks County Rural Electric Membership Cooperative,* 454 U.S. 170 (1981) (confidentials whose duties have "labor nexus" properly excluded from collective-bargaining units); *NLRB v. Bell Aerospace Co.,* 416 U.S. 267 (1974) (managerial employees excluded from protections of Act.).[39] As the D.C. Circuit recognized in *Physicians National House Staff Assn. v. Fanning,* supra, the absence of an express exclusion for residents therefore is not determinative of their status under the Act. Rather, "for policy reasons persons who are literally 'employees' may nonetheless be excluded from coverage under the Act." Id. at 497.

The majority, ignoring these principles, considers the statutory term "employee" in isolation, without taking into account the fact that all of the clinical duties—which they assert are indicia of employee status—take place in the context of the medical educational process. The majority's finding of employee status thus ignores the policies that the Act is designed to promote.

A. Residents are Students

My colleagues do not dispute that medical residents are students engaged in an educational process, for the record indisputably demonstrates this fact. Thus, residency programs are a continuation of the educational and training process that begins with medical school.[40] As noted above, the mix between medical school clinical and academic components changes over time, so that third- and fourth-year medical students, like residents, are necessarily involved in patient care services as part of their clinical educational program. This relationship is

[36] *Cedars-Sinai Medical Center,* 223 NLRB 251 (1976). See also *St. Clare's Hospital & Health Center,* 229 NLRB 1000 (1977).

[37] *Physicians National House Staff Assn. v. Fanning,* 642 F.2d 492 (D.C. Cir. 1980), cert. denied 450 U.S. 917 (1981). See also *NLRB v. Committee of Interns & Residents,* 566 F.2d 810 (2d Cir. 1977) (upholding Board's determination that state labor board's jurisdiction over residents preempted), cert. denied 435 U.S. 904 (1978).

[38] My colleagues cite, in support of this proposition, *Sure-Tan, Inc. v. NLRB,* 467 U.S. 883 (1984) (Board reasonably found that illegal aliens are "employees" covered by the Act), and *NLRB v. Town & Country,* 516 U.S. 85 (1995) (Board reasonably found that paid union organizers are "employees").

[39] When the Board has construed the scope of the Act too broadly, without regard for its underlying purposes, Congress has not hesitated to legislatively reverse the Board's error. See, e.g., *NLRB v. Hearst Publications, Inc.,* 322 U.S. 111, 130 (1947) (Board failed to apply common law agency principles in determining independent contractor issues); *Packard Motor Car v. NLRB,* 330 U.S. 485 (1947) (supervisors included in bargaining unit); *NLRB v. E. C. Atkins & Co.,* 331 U.S. 398 (1947) (affirming Board's order requiring employer to bargain with Machinists local as representative of its plant guards). Each of these decisions was legislatively overruled, *within a year of its issuance,* by the Taft-Hartley Act. Furthermore, in rejecting the position of the Board and the Supreme Court in *E. C. Atkins,* that plant guards were indistinguishable from other employees with regard to their rights under the Act, Congress "was impressed by the dissenting views of Board Member Reynolds in such cases as *Monsanto Chemical Co.,* 71 NLRB 11 (1946), wherein he argued that the Board has a duty to decline the use of its processes in order to avoid encouraging the creation of relationships which are incompatible with the Act and are inherently unsound labor practices." *Teamsters Local 807 v. NLRB,* 755 F.2d 5, 8 (2d Cir.), cert. denied 474 U.S. 901 (1985). Ignoring these lesson, the majority is apparently determined to repeat the errors of the past by encouraging the creation of bargaining relationships which are incompatible with the Act.

[40] The close relationship between medical education in medical school and graduate medical education in a residency program is highlighted in this case by the fact that 99 percent of BMC's attendings are also members of the faculty of the School of Medicine and the close relationship between BMC and the School of Medicine with regard to the operation of the residency programs, as discussed above.

reflected in the composition of teaching hospital teams which, as previously noted, include third- and fourth-year medical students as well as residents and an attending physician. While residents obviously perform more complicated procedures than medical students and with less oversight, chief residents likewise perform more complicated procedures than junior residents. This progression simply reflects the very nature of clinical education.

Every aspect of the resident's relationship to a teaching hospital is controlled by the national accreditation process and is educational in nature. As noted above, residents generally are appointed to residency programs pursuant to a computerized "match" process, by which residency programs agree to accept applicants chosen by an algorithm rather than through individual selection or negotiations. Thereafter, all residents at an institution are classified according to the number of years they have been at the institution, rather than by evaluations or merit, the particular specialty which they are studying, or on the value to the institution of the residents' clinical activities. Moreover, as noted above, the length in years, typical hours worked, and clinical/didactic components vary widely among different residency programs, even at the same sponsoring institution. In contrast, due to the uniform national accreditation requirements, residency programs in particular specialties at different institutions have similar curricula, hours of work, and other requirements.

Thus, medical residencies last for a fixed period of years, which varies according to the specialty program involved. Residents move through the program on a graduated basis according to a scheme devised by national accrediting authorities. The skills that they acquire are measured by the three parts of the U.S. medical licensing examination and serve as building blocks for the acquisition of further skills, all of which are required for graduation from the program and board certification in their chosen specialty.

On successful completion of the residency program, residents receive a diploma and then seek employment. With few exceptions, they do not seek or obtain employment at the hospital where they served as residents. Any such employment, whether at a hospital, in a general practice group, or at the sponsoring institution, is entirely separate from the residency program. All of these factors differ markedly from the usual elements found in employment relationships.

As noted above, the majority finds that residents nevertheless are employees for three reasons: they (1) work for an employer within the meaning of the Act; (2) provide patient care for that employer; and (3) are compensated for their services. As shown below, none of these asserted indicia support the majority's position.

1. Working "for" an employer

To be sure, residents work "at" teaching hospitals; however, the majority fails to justify their finding that residents work "for" the hospital in the usual manner in which an employee works for an employer. As noted above, residents are paid by the hospital which sponsors their residency program, but are overseen by attending physicians, who may be independent businesspersons or members of independent practice groups, and their curriculum is controlled by yet a third group—the ACGME and its various constituent organizations—which, through the RRCs, accredits the residency program. The clinical services provided by the resident benefit the resident, by furthering his or her education, not the hospital. These complexities are not present in an employment relationship. They further demonstrate the educational nature of residency programs, and call into question the majority's simplistic assertion that residents work "for" the hospitals which, in the majority's view, are their supposed employers.

2. Providing direct patient care

The majority relies on the fact that residents provide "direct patient care" as critical support for their finding that medical residents are statutory employees. In doing so, however, my colleagues ignore the undisputed evidence that the provision of direct patient care is an indispensable component of medical education.[41] The patient care responsibilities assigned to residents are made for the purpose of furthering the resident's medical education.[42] These assignments address the resident's educational needs, often by correcting a student's weaknesses, and thus are quite the opposite of employer assignments, which address the employer's needs, usually by focusing on an employee's strengths to achieve maximum output. Clinical assignments are, accordingly, carefully structured to provide residents with increasingly complex cases, thereby allowing them to build on their prior experiences in an organized fashion until they are able to leave the institution and practice medicine independently. As such, they are completely unlike employer training, where the focus is on obtaining a fully trained (and more valuable) employee—much less the normal assignment of work to a trained employee.

At every step of the educational process, attending physicians remain ultimately responsible for the patient's care and are required by the Essentials to supervise the work of the residents at all times.[43] And, consistent with

[41] Indeed, third and fourth year medical school students also provide "direct patient care." Under the majority's analysis, presumably they are hospital employees as well.

[42] For this reason, the ideal teaching hospital has a high volume of patients with a wide range of challenging medical conditions. In light of their educational mission, many teaching hospitals are affiliated with nonprofit institutions.

[43] As noted above, the attending physicians are not employed by BMC, the alleged employer of the residents in this case. The absence of

the educational nature of residents' clinical duties, Medicare regulations prohibit teaching hospitals from charging Medicare for the patient care services provided by residents. 42 CFR § 415.200. Thus, when a resident participates in a medical procedure or furnishes "direct patient care" in a teaching setting, Medicare reimbursement is available to the institution only if an attending physician is physically present and supervising the procedure or consultation as physician of record. 42 CFR § 415.172(a).

Appropriately recognizing the duplication of effort and institutional costs represented by the presence of medical students and residents in trainee status, Medicare provides direct subsidies to teaching hospitals as support for the cost of their teaching programs. See 42 CFR § 413.86. The fact that the Federal Government denies reimbursement for resident services but subsidizes graduate medical education further demonstrates the essentially educational nature of medical residencies, as these subsidies are akin to those provided to educational institutions for undergraduate and graduate education in other settings.

The historical development of medical education supports the view that residency programs are educational in nature. As noted above, clinical teaching methods were instituted to replace the antiquated didactic instructional methods used in medical education for most of the 19th century and to raise the level of medical education to that of other scientific disciplines. Then, as now, clinical education existed to promote educational objectives. It is, therefore, ironic that the majority would seize on the enormously successful clinical teaching methods which were developed for educational purposes and independently of the needs of hospitals, as the basis for finding that graduate medical education is employment and not education.

3. Receive compensation "for" their services

The majority appears to recognize that compensation, while an essential element of any finding of employee status, is not sufficient in and of itself. In this regard, the fact that residents receive a stipend does not, without more, establish that they are employees, as the stipend is not, contrary to the majority's assertion, compensation "for" their services. To the contrary, everything about the financial arrangements for residency programs demonstrates that the stipends received by residents are for the purpose of supporting the individual during a lengthy graduate education program. The payments are based upon status—a resident's program year—and do not vary based on the nature or amount of clinical work performed by a resident or program. Because residency arrangements are complex and often involve many institutions, it is not clear that the entity which pays the stipend is in all cases the entity which is reimbursed for the services provided to the patient nor, in light of the substantial costs of operating a residency program, is it clear that any of the parties to the transaction derives a net financial gain from the residents' clinical activities.[44] The majority fails to justify their conclusion that the stipend is a quid pro quo for some quantum of clinical services provided under these circumstances.

In contrast, there is no question that the compensation received by residents who "moonlight" outside their residency program is compensation for their services. Moonlighting residents are assigned work based on usual considerations of efficiency and the employer's needs and make patient care decisions without the supervision and review imposed by their residency program. This work, whether performed at the same institution as their residency program or a different institution, is governed by a separate contract unrelated to their residency training program and is based solely on their M.D. degree and state medical license. The contrast between the residents' status in the moonlighting setting and in their residency program illustrates the quintessentially educational nature of the latter relationship.

It is important to recognize that students are required by their educational program to acquire "hands on" experience in a variety of settings. See, e.g., *Pawating Hospital Assn.,* 222 NLRB 672 (1976) (co-op students); *Leland Stanford Junior University,* 214 NLRB 621 (1974) (research assistants). The Board has consistently taken the relationship between the educational program and the work performed into account in its decisions. Id. This course properly reflects the fact that educational interests "are completely foreign to the normal employment relationship and . . . are not readily adaptable to the collective-bargaining process." *St. Clare's,* supra, 229 NLRB at 1002. The majority fails to justify its departure from these wise principles in this case.

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direct supervision of residents by individuals employed by BMC further distinguishes this case from the typical employer-employee relationship. Compare, *Northeast Utilities Service Corp. v. NLRB,* 35 F.3d 621 (1st Cir. 1994) (distribution coordinators employed by utility consortium held not supervisors of employees of member utilities).

Contrary to the majority, that residents sometimes perform emergency procedures and surgery without *prior* discussion or approval by an attending does not undercut the evidence demonstrating that their work is pervasively supervised by attending physicians. Emergencies are, by definition, exceptions to the general practice and, in any event, the record is clear that residents report to an attending concerning any emergency procedures as soon afterwards as possible.

[44] The unprofitability of graduate medical education is well recognized. See, e.g., *Bitter Pills for Ailing Hospitals* (N.Y. Times Oct. 31, 1999 sec. 3 p. 1) ("Academic medical centers play a vital role in American health care . . . . They treat the toughest cases and train the best new doctors."); *New Doctors Step Into a Turbulent World* (N.Y. Times Nov. 14, 1999 pp. 1, 32–33) (discussing effects of cost cutting on training programs). In a related vein, medical schools absorb a disproportionate share of higher education dollars reflecting the expensive, and highly subsidized nature of medical education. See Ludmerer, supra at 272.

B. Finding that Residents are Employees is Inconsistent with the Policies of the Act

The majority's finding that residents are employees is inconsistent with the underlying structure and assumptions of the Act as well as the policies the Act was intended to promote.[45]

First, the Congressional findings and declaration of policy reflect the belief of Congress that "the inequality of bargaining power between employees . . . and employers" was a root cause of the Great Depression and of strikes and other interruptions to commerce, and that the Act was therefore designed to "restor[e] equality of bargaining power between employers and employees." 29 U.S.C. § 151. As Senator Wagner, the principal architect of the Act, stated, the purpose of the Act is to counterbalance the power of employers

> by the equal organization and equal bargaining power of employees. Such equality is the central need of the economic world today. It is necessary to insure a wise distribution of wealth between management and labor, to maintain a full flow of purchasing power, and to prevent recurring depressions

I Leg. Hist. 15 (NLRA) (remarks of Sen. Wagner, 78 Cong.Rec. 3443 (Mar. 1, 1934). And "[t]he main purpose of such collective dealing is to establish minimum standards in wages, hours, and working conditions." I Leg. Hist. 318 (NLRB). See also *American Ship Building Co. v. NLRB,* 380 U.S. 300, 316 (1965) (a purpose of the Act is "to redress the perceived imbalance of economic power between labor and management."); *NLRB v. Yeshiva University,* 444 U.S. 672, 680 (1980 (the Act was intended to accommodate industrial management-employee relations, as contrasted with the collegial practices of academic institutions).

The primary purpose for which a physician undertakes a residency, in contrast, is to gain certification in a specialty—not the wages, benefits, or working conditions that the residency program affords. Indeed, one of Petitioner's witnesses acknowledged that residents would immediately leave a program that had lost its accreditation "because they would be crazy to spend a moment of time working in a situation where you weren't going to get credit for it."

The Act is also premised on the view that there is a fundamental conflict between the interests of the employers and employees engaged in collective bargaining under its auspices. As the Supreme Court observed in *General Bldg. Contractors Assn. v. Pennsylvania,* 458 U.S. 375, 394 (1982) (quoting *NLRB v. Insurance Agents,* 361 U.S. 477, 488 (1960)), "[t]he entire process of collective bargaining is structured and regulated on the assumption that '[t]he parties . . . proceed from contrary and to an extent antagonistic viewpoints and concepts of self-interest." The Board has also recognized that collective bargaining "is largely predicated upon conflicting interests of the employer to minimize costs and the employees to maximize wages, and is thus economic in nature." *St. Clare's,* supra, 229 NLRB at 1002.

The Act directs that the parties seek to reconcile their interests through collective bargaining, a process in which an incumbent union serves as the exclusive representative of unit employees for the purpose of negotiating "rates of pay, wages, hours of employment or other conditions of employment," and is thus invested with "wide authority over those whom it represents: 'As collective bargaining agents, unions help determine when a man shall work, what he shall do, how much he shall make, when he shall have holidays and the terms on which he shall retire. As exclusive representative, the union alone speaks for him in obtaining these terms, and he can speak only through the union. Even his personal grievances are not free of the union's controlling hand." *Randell Warehouse of Arizona,* 328 NLRB 1034 (1999), (Member Brame, concurring) (quoting Clyde W. Summers, *Union Powers and Workers Rights,* 49 Mich. L. Rev. 805, 815 (1951)).[46]

By contrast, the educational process "is predicated upon a mutual interest in the advancement of the student's education and is thus academic in nature." *St. Clare,* supra, 229 NLRB at 1002. In addition, the educational process, including clinical education, is inherently "personal" and individualized. Id. Thus, the goal of equalizing bargaining power through collective action, a fundamental purpose of the Act, is

> largely foreign to higher education. . . . the teacher-student relationship is an inherently inequalitarian one, it being assumed that the teacher, by virtue of superior knowledge and experience, is in a better position to de-

[45] That residents are considered to be employees for the purpose of other Federal laws, and are required to pay taxes on their stipend, does not compel the conclusion that they are employees for the purposes of the Act. Thus, the laws prohibiting discrimination on the basis of race, religion, age, sex, etc., serve different policies than the Act, and compliance with them imposes different burdens than are involved in the case of the Act. Prohibiting residency programs from engaging in prohibited discrimination may be consistent with the purpose of Federal antidiscrimination laws (certainly it is consistent with the treatment of other educational programs under Federal civil rights laws). But these laws require only that the institution refrain from engaging in prohibited discrimination. The Act requires covered employers to bargain with the representative of their employees concerning a host of matters not regulated by the antidiscrimination laws. Before finding that residents are employees under the Act, the Board must determine whether imposing these requirements on teaching hospitals is consistent with the national labor policy. As shown, it is not.

[46] Elsewhere in his article, Professor Summers comments: "Unions, under the protection and authority of the law, govern the lives of individual workers, controlling their jobs, regulating their conduct, and determining their economic welfare. Unions are the workers' economic government and only through them can individuals have any voice in making the laws under which they work." Id. at 837–838.

termine the most appropriate course of instruction and method of proceeding.

Id. Whereas employment relationships should ideally represent a bargain struck by equals with at least a rough parity of bargaining strength, "[e]ducation by its very nature—the transfer of knowledge from those who know to those who don't—is ineradicably authoritarian to some degree."[47] Because education requires inequality, the concept of bargaining parity on which the Act is based, and the view that equal bargaining strength will serve the national interest, are simply inapplicable.

Elsewhere, the Board has recognized that "the industrial model cannot be imposed blindly on the academic world as though there were a one-to-one relationship," in light of the distinctive nature of academic bodies. *Syracuse University,* 204 NLRB 641, 643 (1973) (law school faculty entitled to special opportunity to vote on separate representation in light of unique circumstances of their relationship to university). Consistent with this principle, the Supreme Court in 1980 rejected the Board's attempt to expand the Act to include university faculty who participated in the collegial governance of the institution. *NLRB v. Yeshiva University,* supra. These considerations apply with equal force in this case and militate against a finding that residents are employees.

Second, the Act addresses inequality in bargaining power by providing for the right of employees to choose to bargain collectively through their duly selected collective-bargaining representative over all "terms and conditions of employment." Petitioner's own briefs, and those of various supporting amici, tacitly acknowledge the poor fit between collective bargaining under the Act, which presupposes that employment terms are under the control of the employer, and the process of graduate medical education, which is to a large degree controlled by national accrediting agencies independent of the putative employer. Indeed, rather than tout its aggressive representation of residents, the Petitioner boasts that it refrains from making proposals or pressing grievances that would "interfere with the educational prerogatives of graduate medical education programs."[48] In making these claims, the Petitioner implicitly acknowledges the wide scope of academic matters which could be considered "terms and conditions of employment" over which a putative employer would be obligated to bargain. The Petitioner thus appears to recognize that aggressive representation of its members across the range of mandatory subjects of bargaining would inevitably, and inappropriately, intrude on academic prerogatives.

Likewise, several amici support extending collective-bargaining rights to residents only if they are deprived of the right to engage in strikes. According to these amici, engaging in a work stoppage would violate a physician's ethical responsibilities to his or her patients.[49] Of course, once residents are found to be Section 2(3) employees, they must possess the same statutory rights, including the right to strike, as other health care employees.

The majority states that any restrictions on the scope of bargaining that may be established in an academic setting do not affect the status of residents as employees.[50] This misses the point and turns the issue on its head. The fact that a collective-bargaining representative *could* demand that the employer bargain in good faith regarding these items demonstrates the poor fit between the Act and graduate medical education. That voluntary restraint on the part of unions may circumscribe the scope of bargaining in practice in some cases does not make coverage under the Act appropriate any more than a dog standing on two legs becomes a biped.[51]

Indeed, the problems created by this ill-considered decision are manifold. Even when such core subjects of bargaining as job assignments and rotations, training opportunities, starting dates, and "promotions" are considered, it is evident that traditional collective bargaining is completely unsuited to resolve differences that many arise. Many of these issues are under the control of attending physicians, and thus are not subject to direct resolution through bargaining with the hospital, even

[47] Kernan, Alvin, *In Plato's Cave* 297 (1998).

[48] The Petitioner claims that it has never "made a proposal which would limit a teaching hospital's academic prerogatives in grading, course content, course materials, teaching methods, course length, or the duration of a residency program," or proposals which would "limit a teaching hospital's ability to set standards for advancement and successful completion of the residency programs it administers." P. Brief on Review at 16.

[49] See brief of amici American Medical Association and Massachusetts Medical Society at 3; brief of amicus Medical Society of New York at 4.

[50] Amici Association of American Medical Colleges, American Hospital Association, American Council on Education, American Board of Medical Specialties, and Council of Medical Specialty Societies assert that course length and content, standards for appointment, advancement and graduation, assignment and hours of work, among other things, all would be mandatory subjects of bargaining under the Act. Brief on Review at 26–28. See also Boston Medical Center Brief on Review at 22. My colleagues appear to maintain that the Employer's duty to bargain may be limited by its obligations to third parties. The majority, however, cites no precedent in support of the contention that an employer may limit its statutory obligation to bargain under Sec. 8(a)(5) and (d) by entering into contracts or business arrangements with other private entities.

[51] During the public debates leading to ratification of the Constitution, concern was expressed over possible abuses of power by the proposed Federal Government. When supporters of the Constitution asserted that these concerns were baseless because the new government would act with restraint, "Brutus" retorted:

> The just way of investigating any power given . . . is to examine its operation supposing it to be put in exercise. If upon enquiry, it appears that the power, if exercised, would be prejudicial, it ought not to be given. For to answer objections made to a power given . . . by saying it will never be exercised, is really admitting that the power ought not to be exercised, and therefore ought not to be granted.

II Bailyn, Bernard (ed.), *The Debate on the Constitution* 267 (1993).

though the hospital is the putative employer.[52] The scope of bargaining is further clouded because many of these subjects are governed by national standards imposed on hospitals, residency programs, and their faculty on a national basis by accreditation agencies and directed toward preparing the resident for board certification. As such, a hospital presumably will be required to delay implementation of residency program changes which are mandated by accrediting authorities until good-faith bargaining has taken place—despite the risk to the program's accreditation.

Third, when efforts to bargain break down, as they inevitably will in some cases, the Act contemplates that the parties will resort to "economic warfare," including strikes and lockouts, to resolve their differences.[53] These tools also fit poorly with graduate medical education. Striking employees withhold their labor for the purpose of pressuring the employer to accede to their demands; of course, they retain the right to seek work with another employer as well. Because residency programs are educational in nature, residents generally remain with the same program until they complete their course of study. Thus, by striking a resident would on the one hand extend by the duration of the strike the amount of time required to complete the residency program, and, on the other hand, be limited, relative to striking employees, in his or her ability to secure equivalent employment with another program.[54]

The experience with public sector collective bargaining by residents establishes the incompatibility of collective bargaining under Section 8(d) with graduate medical education. State statutes which have been held to permit or require collective bargaining by medical residents generally circumscribe the topics which are subject to bargaining, the use of economic pressure, or both. See, e.g., *Regents of the University of Michigan v. ERC,* 204 N.W. 2d 218, 224 (Mich. 1973) (scope of bargaining limited if the subject matter falls within the "educational sphere"); *Regents of The University of California v. PERB,* 41 Cal. 3d 601, 715 P.2d 590 (Cal. 1986) (scope of negotiations governed by particular provisions of state labor relations law).[55] Compare *Philadelphia Assn. of Interns & Residents v. Albert Einstein Medical Center,* 369 A.2d 711 (Pa. 1976) (residents are students and thus not employees for purposes of state labor relations law). By contrast, the Act provides for mandatory bargaining over all matters involving wages, hours, and other terms and conditions of employment, and authorizes strikes. In light of the evident difficulties inherent in extending the Act to cover residents, any decision to do so should be made by the Congress and not, as my colleagues have done, by overruling the Board's longstanding interpretation of the law.

C. The Cases Cites by the Majority are Distinguishable

Contrary to the majority, cases in which the Board has directed elections in units including apprentices and trainees of construction and manufacturing employers provide no support for their contention that residents are employees. See *Wurster, Bernardi & Emmons, Inc.,* 192 NLRB 1049 (1971) (unlicensed architects); *UTD Corp.,* 165 NLRB 346 (1967) (apprentice machinists); *General Electric Co.,* 131 NLRB 100 (1961) (apprentice tool and die workers); *Riverside Memorial Chapel,* 92 NLRB 1594 (1951) (apprentice embalmers); *Vanta Corp.,* 66 NLRB 912 (1946) (apprentice knitting machine operators). First, the apprentices' employee status was neither disputed nor decided by the Board in any of these cases. Second, in *Wurster, Bernardi & Emmons, UTD Corp., Riverside Memorial Chapel,* and *Vanta Corp.,* there was no evidence or finding that the employer provided any specific training program for the disputed individuals. Rather, the "apprentices" in these cases were merely unskilled or less skilled new hires whose "training" consisted of performing unit work, albeit perhaps with greater assistance from more experienced coworkers.[56]

Further, there is a fundamental distinction, ignored by my colleagues, between employer-provided training and an educational program. None of the employer-based programs cited above took place in an accredited academic program, the purpose of which is to equip its graduates with the skills and professional certification required to leave the putative employer as an independent practitioner. Rather, these apprenticeship programs upgraded the skills of existing employees by providing them with the opportunity to work under the close supervision of a coworker or supervisor. A residency program, in contrast, provides medical residents with the education, under the direction of the program faculty, needed to undertake an independent medical specialty practice elsewhere.

[52] In particular, crucial promotional issues, such as recommendations to prospective employers, are made by the residency program's faculty and may not be subject to direct control by the hospital.

[53] See *First National Maintenance Corp. v. NLRB,* 452 U.S. 666, 678 (1981) ("The concept of mandatory bargaining is premised on the belief that collective discussions backed by the parties' economic weapons will result in decisions that are better for both management and labor and for society as a whole.").

[54] Indeed, as noted above, some of the amici supporting the Petitioner, in recognition of these troublesome issues, have argued that residents should somehow be deprived of the right to strike.

[55] See, e.g., Mass. Gen. Laws Ann. Ch 150 § 9A9(2) (West 1996); Minn. Stat. §§ 179.01–179.17, 179.35–179.39.

[56] *General Electric* is also distinguishable because, while the apprentices there were placed in a bona fide tool-and-die training program, the purpose of the program was to train individuals to work in the employer's plant, and the apprentices so trained normally went on to work for the employer. As noted above, it is expected that the vast majority of BMC's residents will not work for BMC after they graduate from their residency program.

D. The Majority's Decision is Inconsistent with Supreme Court Precedent

My colleagues are mistaken in their apparent belief that the Supreme Court's decisions in *Sure-Tan* and *Town & Country Electric* support the broad, literal reading of Section 2(2) they announce today. To the contrary, in both cases the Supreme Court approved the Board's finding that certain individuals were employees only *after* the Court had considered whether the Board's decision was consistent with the policies of the Act. Thus, in *Sure-Tan,* the Court approved the Board's finding that illegal aliens were employees entitled to the protection of the Act because "extending the coverage of the Act to such workers is consistent with the Act's avowed purpose of encouraging and protecting the collective-bargaining process." *Sure-Tan,* supra 467 U.S. at 892.[57] Likewise, in *Town & Country Electric,* the Court recognized that the Board's finding that paid union organizers were employees "is consistent with several of the Act's purposes, such as protecting 'the right of employees to organize for mutual aid without employer interference.'" *Town & Country Electric,* supra, 516 U.S. at 91.

Moreover, both *Sure-Tan* and *Town & Country* involved the extension of the Act to cover individuals working side-by-side with acknowledged employees, performing the same work under the same conditions of employment. The Supreme Court found that affording these individuals the protections of the Act was consistent with its underlying purpose; excluding them would undermine the Act's purposes and adversely affect the Section 7 rights of their coworkers. These considerations are not present here: residents occupy a unique position in the hospital hierarchy based on their status as students; their status under the Act, accordingly, has no effect on the Section 7 rights of health care employees.

In contrast, the Supreme Court has rejected the Board's contention that disputed individuals are employees where, as here, the policies of the Act are not promoted by extending the coverage of the Act to them.[58] In *NLRB v. Bell Aerospace Corp.,* supra, the Court held that managerial employees, even though not specifically excluded from reach of Section 2(3), nevertheless are not employees. As the Supreme Court recognized,

> the Wagner Act was designed to protect "laborers" and "workers," not vice presidents and others clearly within the managerial hierarchy. Extension of the Act to cover true "managerial employees" would indeed be revolutionary, for it would eviscerate the traditional distinction between labor and management. If Congress intended a result so drastic, it is not unreasonable to expect that it would have said so expressly. [Supra, 416 U.S. at 284.][59]

Likewise, in *Chemical Workers v. Pittsburgh Glass Co.,* 404 U.S. 157, 166 (1971), the Supreme Court rejected the Board's contention that retirees could be considered employees under Section 2(3) of the Act. In support of its determination, the Supreme Court stressed that the Act

> is concerned with the disruption to commerce that arises from interference with the organization and collective-bargaining rights of "workers"—not those who have retired from the work force. The inequality of bargaining power that Congress sought to remedy was that of the "working" man, and the labor disputes that it ordered to be subjected to collective bargaining were those of employers and their active employees.

In the present case, it is equally true that the Act was designed to protect "'workers," not students and others clearly within the educational system. The inequality of bargaining power that Congress sought to remedy was that of the "working' man," not of students. Extension of the Act to cover students would "indeed be revolutionary," for it would subject educational decisions to the processes of the Act. As in the case of retirees and managerial employees, if Congress intended a result so drastic, it is not unreasonable to expect that it would have said so expressly. Congress has not, and accordingly there is no proper basis for the Board's reversal of precedent.

E. The Legislative History of the Act does not Support the Majority's Position

My colleagues appear to concede that the legislative history of the Act does not require the Board to find that residents are statutory employees. I agree with this finding. While it is true that Congress in 1974 rejected a provision that would have *denied* supervisory status to medical residents, Congress did so because it preferred to allow the Board to determine such *supervisory* issues under its existing standards. This rejection of a proposed amendment to the statutory definition of a supervisor does not establish that Congress contemplated that residents would necessarily be found to be employees.

Likewise, the statutory definition of a "professional employee" is not dispositive of the issue before the Board today. Section 2(12)(b) defines "professional employee" to include an employee who has completed a course of specialized intellectual instruction and study as defined in Section 2(12)(a) and "is performing related

[57] The Supreme Court noted that if illegal aliens were excluded from the protections of the Act, "there would be created a sub-class of workers without a comparable stake in the collective goals of their legally resident co-workers, thereby eroding the unity of all the employees and impeding effective collective bargaining." 467 U.S. at 892.

[58] See also *Physicians National House Staff Assn. v. Fanning,* supra at 497 ("for policy reasons persons who are literally 'employees' may nonetheless be excluded from coverage under the Act.").

[59] See also *Yeshiva University v. NLRB,* supra (university faculty are managerial employees based on their participation in academic governance, consistent with the unique nature of an academic community).

work under the supervision of a professional person to qualify himself to become a professional employee . . . ." As the D.C. Circuit has recognized, "[b]ecause this definition is applicable to 'any employee' it is not a command to the Board to regard anyone as an employee." *Physicians National House Staff Assn. v. Fanning*, supra, 642 F.2d at 497. In any event, it appears that Section 2(12)(b) more closely fits individuals such as architects, who are required to complete an apprenticeship in order to be licensed, rather than residents, who are licensed, and who are engaged in, and thus have not "completed," their course of "specialized intellectual instruction." A contrary reading of this provision would compel the conclusion that a "moonlighting" resident is not a "professional employee" under Section 2(12)(a).

Moreover, following the issuance of *Cedars-Sinai* and *St. Clare's*, Congress refused to amend the Act to overturn the Board's finding that residents are not employees. See H.R. 2222 (96th Cong., 1st Sess.); H.R. Conf. Rep. No. 96–504 (1979); 125 Cong. Rec. 33942–33952 (Nov. 28, 1979). While not determinative of the issue, the defeat of this legislation supports the view that *Cedars-Sinai* and *St. Clare's* are consistent with the wishes of Congress. At the very least, I submit that the Board should show more respect for established precedent of longstanding where, as here, Congress has considered that precedent and expressly declined to overturn it.

Conclusion

Today's decision exemplifies an inherent weakness in our statute and our process. Congress entrusted us with the first responsibility of interpreting and applying the Act. In theory, we have the accumulated experience of the agency and bring that to bear in understanding and applying the policies of the Act. Today, however, the majority focuses on isolated parts of existing methods of clinical education to support a finding that residents are statutory employees but refuses to recognize their essential role in the larger *process* of graduate medical education. The majority thereby demonstrates yet again that the Board is more enticed by expanding its jurisdiction than by a reasoned analysis of the Act's policies.[60] The Supreme Court has previously had occasion to instruct the Board on the congressional policies which necessarily exclude core business decisions from collective bargaining,[61] and exclude managerial employees from the ambit of Section 2(11).[62] Once again, however, we are like a foolish repairman with one tool—a hammer—to whom every problem looks like a nail; we have one tool—collective bargaining—and thus every petitioning individual looks like someone's "employee."

Having designated residents as employees, we cannot then limit Petitioner's statutory rights to demand bargaining over all "terms and conditions of employment" nor restrict its right to engage in "economic warfare," including strikes and work to rule. We have blinded our eyes to the fact that every state legislature which authorized bargaining by state medical institutions not covered by the Act has in one way or another limited either the topics or weapons used by students, and that the Petitioner and most of the supporting amici have explicitly or implicitly acknowledged the ill fit of full statutory collective bargaining by either foreswearing the full expression of their statutory rights or suggesting some limitation on those rights.

The majority thus forces medical education into the uncharted waters of organizing campaigns, collective bargaining, and strikes. If the majority is successful in this endeavor, American graduate medical education will be irreparably harmed. Today, residency programs are a cooperative project in which many different institutions and accreditation authorities together determine the nature and content of medical residency training in each recognized specialty. These various entities further cooperate with physicians and sponsoring institutions to provide the physical resources, access to patients, and clinical instruction which make America's board-certified physicians the envy of the world. Collective bargaining, by contrast, presupposes a bipolar relationship between one employer and a relatively stable group of employees. By imposing the Act's alien processes on graduate medical education, the majority jeopardizes this delicate web of relationships on which the astounding success of American medical education depends.

Exposing hospitals which sponsor residency programs to the costs and uncertainty of union elections and collective bargaining may accelerate the trend among for-profit hospitals of eliminating residency programs, and increase the existing burdens on already struggling private non-profit institutions. Medical education can only suffer. Subjecting academic decision-making to collective bargaining, and to review by this agency, will also hinder residency program faculty from developing and implementing a curriculum that, in their judgment, is best suited to confer on a resident the knowledge and experience needed for that specialty. That the Petitioner claims it will voluntarily avoid this result is beside the point as it would, under the majority's position, have every right to do so under the Act, and no legal basis for refraining.

[60] The Board has been the target of pointed court criticism for its tendency in making supervisory determinations, to "promote policies of broadening the coverage of the Act, maximizing the number of unions certified, and increasing the number of unfair labor practice findings [the Board] makes." *Glenmark Associates v. NLRB*, 147 F.3d 333, 340 fn. 8. (4th Cir. 1998). See also Sowell, Thomas, *Knowledge and Decisions* (1980) at 141: "[G]overnmental agencies with mandated activities have every incentive to push their particular activities as far as possible—even into regions of negative returns to society."

[61] See *First National Maintenance Corp. v. NLRB,* 452 U.S. 666 (1981).

[62] See *NLRB v. Bell Aerospace Co.,* supra.

I cannot accept the majority's speculation that the gains that may be derived from granting collective-bargaining rights to residents will outweigh these costs. More fundamentally, however, balancing interests and tailoring economic weapons is the province of the Congress, not this Agency. The legislative history of the Act, and its longstanding interpretation, show that it was not designed or intended to apply to academic relationships like that between residents and teaching hospitals. By overturning these longstanding principles, the majority ignores the Act's policies and usurps the authority of the Congress in the establishment of national labor policy.

I fear that my colleagues' reversal of longstanding precedent holding that residents are not employees entitled to engage in collective bargaining will be viewed by the courts as another example of overreaching by this Agency. For all of the foregoing reasons, I dissent.

APPENDIX

REGIONAL DIRECTOR'S DECISION AND ORDER

4. No question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

[Boston Medical Center Corporation] (BMC) operates a teaching hospital in Boston, Massachusetts. The Petitioner seeks to be certified as the representative of a unit composed of all house officers employed by BMC. In filing its petition, the Petitioner requests the Board to reverse its holding in *Cedars-Sinai Medical Center*[19] and *St. Clare's Hospital & Health Center*[20] that interns, residents, and fellows are primarily students and, therefore, not "employees" within the meaning of Section 2(3) of the Act. BMC asserts that such a reversal is unwarranted. It seeks dismissal of the petition on the ground that, under *Cedars-Sinai*, the Petitioner is not a labor organization because it is not an organization in which "employees" participate and on the ground that the unit is inappropriate because the individuals sought are primarily students rather than "employees."

BMC also seeks dismissal of the petition on the ground that the unit sought is inappropriate under the Board's health care rules, because the Petitioner only seeks to represent interns, residents, and fellows, rather than all physicians employed by BMC. BMC further contends that the complexity of its relationships to other institutions with which it has affiliation agreements will pose numerous problems for the Board which warrant dismissal of the petition. BMC seeks dismissal on the additional ground that the unit sought is based on the extent of organization, in that the Petitioner does not seek all physicians and seeks to include some, but not all, house officers who are on payrolls other than BMC's.

If the petition is not dismissed, BMC takes the position that chief residents should be excluded from the unit both as statutory supervisors and as *Yeshiva*-type managerial employees.[21] The Petitioner maintains that the chief residents are neither supervisors nor managerial employees and would include them in the unit.

[19] 223 NLRB 251 (1976).
[20] 229 NLRB 1000 (1977).
[21] *NLRB v. Yeshiva University*, 444 U.S. 672 (1980).

I. EMPLOYEE STATUS OF INTERNS, RESIDENTS, AND FELLOWS

A. Facts

Each year approximately 16,500 students graduate from medical schools in the United States. Approximately 90 percent of them immediately enter graduate medical education programs commonly referred to as residencies. There are currently about 7500 residency programs in the United States offered by some 1100 institutions. Typically, the sponsor of a residency program is a teaching hospital that is affiliated with a medical school. Residency programs offer training in particular medical specialties. After completing a residency program, some physicians pursue further training in a medical subspecialty. Such training programs are commonly referred to as fellowships.

BMC currently sponsors 37 different residency programs.[22] The programs vary in length, with most lasting from 3 to 5 years, but some are longer.[23] Fellowships last from 1 to 4 years. There are about 430 house officers in the unit sought.[24]

BMC is a 432-bed, nonprofit teaching hospital that is affiliated with Boston University School of Medicine. BMC came into existence on July 1, 1996, as a result of the consolidation of Boston City Hospital (BCH) and Boston University Medical Center Hospital (commonly referred to as University Hospital). BCH was a department of the city of Boston and a public hospital. BCH and University Hospital were located a block apart, with the Boston University School of Medicine situated between them. Both were affiliated with the School of Medicine, and some of their residency programs were integrated prior to the merger.

As a public sector hospital, BCH was subject to the Massachusetts public employee collective-bargaining law,[25] under which residents have the right to organize into unions.[26] The Petitioner had represented a unit of interns, residents, and fellows at BCH since 1969 and had negotiated approximately 10 successive collective-bargaining agreements with BCH since 1970. As a condition of the merger, the Boston City Council required BMC to recognize the Petitioner as the representative of the 280 former BCH interns, residents, and fellows. BMC

[22] BMC sponsors residencies in allergy and immunology, anesthesiology, cardiology, child psychiatry, critical care, cytopathology, dermatology, dermatopathology, emergency medicine, endocrinology, gastroenterology, geriatrics, hematology/oncology, infectious disease, internal medicine, nephrology, neurology, neuroradiology, OB/GYN, ophthalmology, oral surgery, general practice, orthopedic surgery, otolaryngology, pathology, pediatrics, physical medicine and rehabilitation, preventive medicine, psychiatry, pulmonary/critical care, radiology, rheumatology, general surgery, thoracic surgery, urology, vascular radiology, and vascular surgery. E. Exh. 4. (The exhibit lists two additional programs to be voluntarily withdrawn as of July 1, 1997.)

[23] The first year of a residency is commonly referred to as an internship. In a 3-year residency program, for example, second-year residents are sometimes referred to as junior residents, and third-year residents are sometimes referred to as senior residents. Interns, residents, and fellows are also sometimes referred to by their postgraduate year level (PGY or PL). For example, an intern is a PGY 1, a second-year resident is a PGY 2, and so on.

[24] This number includes 30 to 40 chief residents, as well as 15 residents on the payrolls of other hospitals, all of whom BMC would exclude. About 56 out of the 430 are fellows.

[25] M.G.L. Ch. 150E.

[26] *City of Cambridge*, 2 MLC 1450 (1976); *Worcester City Hospital*, 4 MLC 1373 (1977).

signed a recognition agreement in which it further agreed to a representation election among all house officers at the merged entity. Ultimately, on August 29, 1996, the parties held a "card count," as a result of which the Petitioner became the representative of all interns, residents, and fellows at BMC. On January 31, 1997, the parties executed a revised version of the collective-bargaining agreement that had been in effect between the Petitioner and BCH prior to the merger, with effective dates from July 1, 1994, through June 30, 1997.[27]

House officers enter a residency or fellowship in order to become certified specialists in their chosen medical specialty.[28] Residents who successfully complete their program receive a diploma from the Boston University School of Medicine. On approval by the specialty board that certifies physicians in their field, they are then considered to be "Board-eligible," i.e., they have successfully completed their training and are eligible to sit for an exam in their chosen specialty. Most hospitals will permit Board-eligible physicians to practice in their field for a period of time until they have taken the exam. After passing a written exam, these doctors can hold themselves out as being "Board-certified" in their field. It is not necessary to be certified in a specialty to practice medicine. Because some institutions and practices are beginning to require certification, however, failure to be certified in a specialty may limit the employment opportunities of uncertified physicians. Most residents and fellows leave BMC when they have completed their residency or fellowship program to pursue opportunities elsewhere. Only a small percentage remain to join the faculty.[29]

House officers are assigned throughout the year to various rotations, usually about 4 to 6 weeks in length, which expose them to various types of patients in their chosen specialty. For example, pediatric residents are assigned to rotations on inpatient wards, the emergency room, the pediatric intensive care unit, and the neonatal intensive care unit, as well as to rotations in cardiology, adolescent medicine, and elective rotations.[30] In some programs the residents do one or more rotations at other institutions with which BMC has an affiliation agreement. The program director for each residency program determines what rotations each resident must experience in order to complete the program, based on the curriculum for the residency.

House officers work very long hours, which vary depending on the specialty and the rotation. Residents in internal medicine work 6 to 7 days per week anywhere from 60 hours per week when assigned to the emergency room or 80 to 90 hours per week when assigned to the cardiac care unit. When assigned to the wards, they work a 36-hour shift every fifth day. Surgical residents average 60 hours per week, but work longer hours when assigned to the surgical intensive care unit. Residents in otolaryngology[31] average 100 hours per week, but can work up to 120 hours on certain rotations. Radiology residents work about 60 hours per week, while rheumatology fellows work about 50 hours per week.

House officers are trained and supervised by attending physicians (referred to as attendings or faculty).[32] Attendings are physicians on the staff of BMC, 99 percent of whom are also faculty members of the Boston University School of Medicine.[33]

House officers work in teams that include third- and fourth-year medical students, interns, junior and senior residents, and attending physicians. Each intern on an inpatient ward is generally assigned 12 to 15 patients. A more senior resident on the service is responsible for overseeing the work of the interns, while the interns oversee the medical students.[34] An attending physician must be the physician of record for every patient.

PGY 3 Camilla Graham and Intern Andrew Yacht, both residents in BMC's internal medicine program, testified about the duties of interns in BMC's internal medicine residency program. Interns start the day early in the morning by checking in with the "night float," i.e., the intern who has been on duty overnight, to learn of any developments during the night. Then they "pre-round" or check their patients on their own. From 7:30 to 9:30 a.m., the team of medical students, two to three interns, a more senior resident, and, occasionally, an attending physician do "work rounds" in which they check on and discuss the status of each patient at the patient's bedside. Following that, the interns order X-rays, consults, and treatments. They start intravenous lines (IVs) and perform procedures such as arterial blood gases, which involve drawing blood, and thorancentesis, paracentesis, and lumbar punctures, which in-

[27] Although this contract had apparently expired by the close of the hearing on July 17, 1997, there was no evidence in the record concerning a successor agreement.

[28] To become a resident, an individual must have graduated from medical school and passed parts 1 and 2 of the U.S. medical licensing exam. Interns are issued a temporary license by the appropriate state board of registration in medicine, which permits them to practice only under the aegis of their particular residency program. The state boards require that in order for medical school graduates to practice as fully licensed physicians, they must successfully complete the 1-year internship and then pass part 3 of the U.S. medical licensing exam. This allows them to practice outside their residency program, as well.

[29] For example, out of about 100 residents who completed the pediatric residency in the last ten years, about 20 stayed on as faculty and 10 to 15 stayed on for a fellowship. Only one out of the 20 to 24 residents who completed the pathology program in the last 6 years has remained at BMC. Less than 10 percent of the oral surgery residents remain as faculty. Five out of 20 graduating radiology residents have stayed on as junior faculty in the last 5 years. Radiology residents generally do a fellowship elsewhere and then enter private practice or join the faculty of another institution.

[30] Dr. Joseph Korn, program director of the rheumatology program, testified that residents select elective rotations based on their interests and career goals. Dr. David Batinelli, program director for the internal medicine program, testified that residents have 28 to 32 weeks of electives over the course of the 3-year program. The residents choose from a menu of options. Their choices must be approved by Batinelli, who sometimes denies residents' requests if he feels, based on their progress, that they need additional time in another rotation.

[31] Otolaryngology refers to surgery of the ear, nose, throat, head, and neck.

[32] As noted above, the exception to this is when house officers are on rotation at other institutions, where they are supervised by attending physicians from those institutions.

[33] The attendings are technically employed by the Faculty Practice Plan Foundation, Inc., an umbrella corporation for various subsidiary practice plans in place for each department within the hospital. BMC and the School of Medicine are both members of the corporation. Attendings receive support from both the Faculty Practice Plan and the School of Medicine. Attendings receive their paychecks from the School of Medicine, which hires them and acts as the common paymaster for the two entities.

[34] Medical students typically follow only two patients on an inpatient unit and are closely observed. A licensed physician, typically an intern (who, as indicated above, has a temporary license), signs all their notes and orders. Medical students pay tuition to the medical school and receive no pay or benefits. Unlike residents, they receive grades for each rotation.

volve removing fluids. Attending physicians are rarely present when interns perform these procedures. Interns perform critical patient-care procedures, such as intubating patients who cannot breathe for themselves. Residents, including interns, respond to "codes," i.e., life-threatening emergencies, without attending physicians. Interns are the primary physicians with whom patients' families have contact. Interns write "do not resuscitate" (DNR) orders for terminally ill patients at the request of patients and/or families. Such orders must be cosigned by an attending physician within 24 hours, however.

Interns are also responsible for hospital admissions, which usually begin with a call from a physician from the emergency room or clinic. When the patient arrives, interns take a history, perform a physical, draw blood, start an IV, initiate any necessary immediate treatments, and write admission orders, including any medication orders. The junior resident also does a more focused history and physical examination of the patient. The intern and junior resident consult with the senior resident on duty, and, together, they decide what tests or treatments should be performed. Interns are responsible for writing daily progress notes on all their patients. On approval of an attending, they discharge patients, which involves writing a discharge summary and instructions, filling out prescription orders, and instructing the patient and/or caregivers about any necessary care after the hospitalization.

As residents progress through the program, they are given increased responsibility commensurate with their level of experience. Internal medicine interns see patients 80 to 90 percent of the time outside the presence of an attending physician. Interns do discuss all patients with attending physicians, who are primarily responsible for their patients' care plans and who see their patients daily. In the emergency room or urgent care clinic, the interns consult with an attending after examining each patient. The intern on "night float" operates more independently, as there is not likely to be an attending physician on the inpatient wards overnight. A PGY 3, PGY 2, and two interns take care of the entire ward at night, when there are no attendings on duty except in the emergency room.

Jodi Wenger, a third-year pediatric resident, testified that she makes 80 percent of patient-care decisions on her own and consults with an attending the balance of the time over decisions such as whether to transfer a patient to the intensive care unit. She testified that she has helped families make life or death decisions about the level of intervention to be used in the case of critically ill infants and children. The pediatric residents are the only physicians present on the pediatric wards for a twelve-hour period at night, although there is always a chief resident and an attending on call at home. Wenger testified that she does not call an attending very frequently at night, perhaps twice a month.

Fellows in the cardiology program may perform certain noninvasive procedures on their own. More risky procedures must be done in the presence of an attending. Cardiology fellows may perform some procedures, such as CPR, defibrillation, or transthoracic echocardiograms,[35] on an emergency basis without an attending, and then review the matter with an attending as soon as possible.

In the radiology program, residents draft a preliminary report for each film, but an attending physician must sign off on every final report. A radiology resident is on duty in the emergency room 24 hours a day. After 9 p.m., when there are no attendings present at the facility, radiology residents interpret films alone, and an attending signs off on them the following day. Residents in the pathology program make a preliminary diagnosis with respect to each slide of tissue that they examine, and discuss each diagnosis with a faculty physician. In those cases where a pathologist is required to make a diagnosis while a patient is undergoing surgery, pathology residents are not permitted to give a diagnosis to the surgeons without prior review by faculty. Pathology residents must present each autopsy report to an attending, who is legally responsible for the report.

Residents in the various surgical residency programs spend 8 to 10 hours a day in the operating room on those days that they perform surgery. They are permitted to perform increasingly more complicated surgery as their experience increases. An attending physician must be "scrubbed in" for the significant or critical portion of each operation. Chief Orthopedic Resident Linda D'Andrea testified, for example, that a knee arthroscopy, one of the most common procedures performed by orthopedic surgeons, takes about 2 hours, out of which an attending would be present for 30 minutes to an hour. She does complicated procedures in the emergency room on her own, such as fracture manipulations or immobilizing a pelvic fracture, which involves putting pins into stable portions of the bone and attaching them to an external frame.

In addition to time spent in direct patient care, residents spend many hours per week attending various "didactic" conferences. In the internal medicine program, for example, residents have "attending rounds" each Monday, Wednesday, and Friday for an hour and a half in a conference room. During these sessions, a resident, intern, or medical student presents a current case, and the attending physician gives a short, formal lecture about the topic. In addition to attending rounds, there is a 1-hour conference on various topics at noon, 5 days a week. One of them is "grand rounds," a lecture usually attended by about 100 physicians, including residents and attendings, in an auditorium. Another is "journal club," in which residents discuss an article from a scientific journal in their field. Some of the didactic sessions involve topics that are not directly related to the treatment of current patients. For example, in some conferences residents review slides or X-rays of individuals who are no longer or never were patients of BMC, in order to learn diagnostic skills.

Interns often miss parts of conferences because they are frequently "beeped" and must leave to attend to patients. Interns do not attend conferences when they are doing a "night float" or emergency room rotation, and rarely attend during rotations in the medical intensive-care unit and coronary-care unit, due to lack of time. A 1-hour noontime conference for interns is the only one which is considered "protected time" for interns, i.e., they give up their beepers for 1 hour each week to attend that conference. Junior and senior residents are beeped less often than interns, and they spend more time attending didactic conferences. In addition to the attending rounds and noontime conferences, PGY 2s and PGY 3s attend a 1-hour conference, called "morning report," 6 days a week. These sessions are led by a chief resident, with an attending usually present. There are many other types of conferences offered, such as a primary care series from 8 to 9 a.m. 5 days a week, subspecialty rounds, and ambulatory a.m. clinic talks.

[35] This procedure involves placing a venous catheter in a patient's vascular system.

There were various estimates in the record with respect to the number of hours or percentage of time that residents spend in these "didactic" conferences. Yacht testified that he spends about ten percent of his time in didactic conferences not directly related to his current patients. Dr. David Batinelli, director of house staff training, testified that the average PGY 3 in internal medicine attends about 5 hours of conferences weekly, in addition to the attending rounds. Wenger testified that there are about 10 to 12 hours of didactic conferences offered per week in the pediatric program, but each resident attends only about 5 or 6 hours, amounting to 10 percent of their time, due to conflicting demands. Other estimates of the number of hours residents typically spend in didactic conferences each week were 8 to 10 hours for surgical residents, 2 to 4 hours for orthopedic residents, 5 to 8 hours for otolaryngology residents, 4 hours for rheumatology residents, 20 hours for pathology residents, and 5 to 7 hours for cardiology fellows. The program director for the radiology program estimated that residents spend 35 to 40 percent of their time in educational activities such as lectures and one-on-one teaching. Interns in the oral and maxillofacial surgery program spend 50 percent of their time in didactics, including rounds. This figure drops to about 30 percent of their time in subsequent years of their residency.

Dr. Joseph Korn, program director for the rheumatology residency program, testified that the bulk of a resident's training occurs not necessarily in formal lectures and conferences, but rather in one-on-one teaching by attendings in the course of patient care. Faculty employ the "Socratic" method of teaching in which they question the residents regarding patients' diagnoses and treatments. Dr. James Becker, program director for the general surgical residency program, testified that the main classroom for surgeons is in the operating room, where there is a continuous exchange between faculty, residents, and medical students during the course of surgery.

Residents in each program are required to take an annual "in-training" exam offered by their specialty board, which is used to make comparisons with other programs throughout the country, to identify the residents' academic strengths and weaknesses, and to indicate the likelihood that they will pass the Boards. Becker testified that residents whose score falls below the 25th percentile on the in-training exam are put on academic probation. Those who fall below that level for a second year could be held back a year in the program. According to 1995 memoranda regarding the internal medicine in-training exam at BCH,[36] however, the examination is not used in making decisions concerning acceptance, continuation, or advancement in residency or fellowship training positions.

In addition to the in-training exam, residents in the surgery residency program take weekly or biweekly exams and are constantly quizzed by attendings using the Socratic method. In the otolaryngology program, residents take a written exam at the end of each series of lectures on a given topic, every 2 to 3 months. In the pediatric program, residents are required to take a Pediatric Advanced Life Support (PALS) and Neonatal Advanced Life Support (NALS) course, each of which culminates in a written exam.

At the end of each rotation, the faculty member who has worked most closely with each resident fills out an evaluation form which rates him or her with respect to various factors, including medical knowledge, technical skills, clinical judgment, and humanistic qualities.[37] In the case of residents who fail to meet the programs' standards for medical knowledge or clinical competence, department chairpersons and/or program directors may put them on probation, require them to fulfill additional time in training prior to advancing to the next level, terminate them from the residency program, decline to renew their contract, or decline to give them the certification of satisfactory performance needed to sit for the Board exam. These steps have, in fact, been taken with some residents.

After their internship year, when they have a full license, some residents "moonlight," i.e., work part time as doctors elsewhere to make extra money.[38] Residents Wenger and Graham testified that they perform the same work when they moonlight at local clinics and a local community hospital as they do at BMC. When they moonlight, however, they attend no ward attending rounds, grand rounds, or conferences. Both Wenger and Graham are paid much more for their moonlighting work than for their work at BMC. They testified that they remain at BMC despite the lower pay because they want the training necessary to become Board-certified in their respective specialties.

Physicians continue their medical education throughout their lifetime by reading medical journals, taking courses, and attending rounds, conferences, and scientific meetings in their field. Massachusetts requires physicians to have 100 hours of continuing medical education over a 2-year period in order to maintain their state licensure, and most have more. Attendings at BMC fulfill this requirement, in part, by attending grand rounds and other conferences at BMC, including those in which the talks are given by residents. About 23 or 24 of the 40 or more medical specialty boards have adopted time-limited certifications that are valid for periods ranging from 7 to 10 years. When their certifications expire, physicians may be recertified as specialists by passing another exam. The recertification exam, which is shorter than the original exam, assumes mastery of the basics and focuses on advances in the field.

Unlike other BMC employees, house officers are not recruited, interviewed, or hired by BMC's human resources department. The vast majority are selected through the National Residency Matching Program, which is used by residency programs throughout the country.[39] All residency programs begin on July 1 of each year. Medical students apply to residency programs during their last year of medical school.[40] At BMC, a small percentage of those who apply are granted interviews. After the interview process, the program director for each residency ranks the candidates in order of preference, and the applicants rank the residency programs in their order of preference. The rankings are sent to the Matching Program, which matches the highest-ranking choices of the teaching hospitals

[36] E. Exh. 46.

[37] At the same time, residents submit an evaluation form in which they rate the attendings and their educational experience during the rotation.

[38] Interns cannot moonlight because, as noted above, their limited license permits them to practice only within the residency program.

[39] There is no matching process for fellowships. Applicants for fellowships are hired directly by the teaching hospitals.

[40] Dr. Robert D'Alessandri, dean of the School of Medicine at West Virginia University and member of the Accreditation Council on Graduate Medical Education, testified that about 10 medical schools across the country offer joint programs in which medical students' fourth year of medical school is also their first year of residency. There is no evidence that BMC offers such a program.

with the highest-ranking choices of the medical students. The matches are announced simultaneously in March. Participating hospitals agree to accept the residents matched to their programs, and medical students agree to accept a residency in the program to which they are matched.

Several program directors at BMC testified that, during the interview process, residency candidates rarely inquire about compensation and benefits. Instead, they inquire about matters such as the passing rate of past residents who have taken the Board exam, the availability of faculty, research opportunities, the volume of cases, call schedule, and the like. Applicants are informed, however, of the compensation and benefits associated with the residency at various stages in the application and interview process, either by administrators or through brochures and handouts distributed during the application and interview process.[41] During the orientation for new residents at BMC, a representative from the Petitioner makes a presentation, and a representative from the BMC human resources department makes a presentation on benefits.

House officers are treated by BMC in some respects as if they are employees. Pursuant to the collective-bargaining agreement between the Petitioner and BMC, house officers receive compensation for their services. The collective-bargaining agreement refers to the compensation as an annual salary.[42] Under the collective-bargaining agreement, house officers receive paid vacation and sick leave, parental leave, and bereavement leave. Like other BMC employees, house officers are entitled to health insurance, dental insurance, and life insurance, and they may use the employee health service. A description of benefits available to house staff[43] describes "your benefits as a Boston Medical Center (BMC) employee." The forms for the various insurance plans offered to house officers refer to BMC as the employer and the house officers as employees. Residents are issued an employee number by BMC, as are other BMC employees. BMC provides malpractice insurance at its expense for all interns, residents, and fellows covered by the collective-bargaining agreement. The affiliation agreement between BMC's urology department and Children's Hospital Medical Center refers to the BMC residents who rotate through Children's Hospital as "employees" of BMC.[44]

BMC also treats the house officers as employees with respect to various state and Federal laws that treat them as employees. Federal and state income taxes are deducted from the house officers' pay, and they receive a W2 form for income tax purposes like other BMC employees. BMC maintains a workers compensation policy that applies to all employees, including house officers, should they be injured in the performance of their duties. BMC treats house officers as if covered by the various state and Federal laws that regulate employment, such as the Family and Medical Leave Act, the Americans with Disabilities Act, and other state and Federal laws that prohibit various forms of discrimination in employment. BMC's human resources department maintains a file for each house officer that includes an "I-9" or visa form. BMC must submit a labor condition application to the U.S. Department of Labor for foreign house officers in which BMC describes itself as the employer of a nonimmigrant worker and attests that "[t]he employment of H-1B non-immigrant will not adversely affect the working conditions of workers similarly employed in the area of intended employment."[45]

According to the record, there are some differences in the treatment accorded to house officers versus other BMC physicians and/or employees in general.[46] House officers are much lower paid than attending physicians.[47] The compensation received by house officers is generally unrelated to the number of hours they work.[48] Unlike other employees, the eight residents in the oral surgery program pay about $7000 tuition per year to the Boston University School of Dental Medicine over the term of their 4-year residency.[49] House officers may not participate in the retirement program, which is made available to other employees, although about 24 of them participate in a tax-sheltered annuity. BMC maintains a group malpractice insurance policy for all house officers, while the faculty have individual malpractice policies paid for by their department practice plans. Other benefits available to other BMC employees but not house officers include vision care, disability insurance, health care and dependent care reimbursement accounts, extended sick leave, and earned time.[50] Unlike other BMC

[41] See, e.g., E. Exh. 19G, "Information for Radiology Resident Applicants," which includes a "Summary of Benefits," which describes salary, vacation, malpractice insurance coverage, maternity/paternity leave, and health insurance. Further, the Accreditation Council for Graduate Medical Education (ACGME), discussed below, which accredits teaching hospitals, states in its institutional requirements that candidates for residencies must be fully informed of benefits, including financial support, vacation, professional leave, parental leave, sick leave, insurance, etc. P. Exh. 19, p. 27.

[42] The compensation is commonly referred to either as a salary or a stipend.

[43] P. Exh. 4.

[44] According to the affiliation agreement, "BMC agrees to provide the salary, fringe benefits and professional liability coverage for five (5) residents from July 1, 1996, to June 30, 1997. Said residents will be deemed employees of BMC." P. Exh. 114. A 1994 affiliation agreement between the Boston University School of Medicine and the former University Hospital with respect to the internal medicine program provided that residents would have a written employment contract with University Hospital that would provide the salary and fringe benefits for a certain number of residents. P. Exh. 103. A 1994 affiliation agreement between the radiology department of the former BCH and Brockton Hospital stated that the city of Boston would provide the salary and benefits for a certain number of residents, who "will be deemed employees of the City of Boston," while Brockton Hospital would provide the salary and benefits for some number of residents, "who are Brockton Hospital employees."

[45] P. Exh. 112.

[46] BMC has collective-bargaining agreements with unions representing several other bargaining units, each of which may have negotiated different benefits. It also has various unrepresented employees.

[47] According to the 1994–1997 contract, house officers' pay for the 1996–1997 year ranged from $34,502 for a PGY 1 to $44,939 for a PGY 6. In contrast, it appears that faculty at a teaching hospital or physicians in private practice earn over $200,000 more than the amount paid to house officers.

[48] The one notable exception is that under art. XIV, sec. 6 of the 1994–1997 collective-bargaining agreement, house officers who are required to or who volunteer to work an extra on-call shift are paid $200 per call.

[49] Of the eight residents, six receive a "stipend" from BMC, one receives a stipend from the dental school, and one receives no stipend.

[50] Accrued earned time can be used by BMC employees for time off for any purpose such as illness, vacation, or holidays. Unused earned time is a vested benefit for which employees are paid when they leave BMC. House officers accrue sick leave rather than earned time, and unused sick leave lapses at the termination of their residency.

employees, residents are permitted to defer payment of some of their Federal and bank loans for medical school during a portion of their residency because they are still considered to be training for a job.[51]

Residency programs as well as the institutions that sponsor them are accredited by the Accreditation Council for Graduate Medical Education (ACGME).[52] Institutions and individual residency programs must be accredited every 3 to 5 years.[53] The ACGME establishes standards for sponsoring institutions and for each type of residency program, which are set forth in a document entitled the "Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements," commonly referred to as "the Essentials."[54] The ACGME may withdraw or withhold the accreditation of institutions or residency programs that fail to meet the standards in the Essentials, or put them on probation.

The Essentials specify requirements that must be met by each type of residency program in order to be accredited, including educational content, faculty, instructional activities, responsibilities for patient care, supervision, equipment, and library facilities. It requires residency programs to offer experiences with certain patient populations, diagnostic techniques, and procedures. Residency programs are required to offer many conferences and seminars, and to give residents the opportunity to conduct research and to attend national scientific meetings.

According to the Essentials:

> [t]he training of residents relies primarily on learning acquired through the process of their providing patient care under supervision. . . . A proper balance must be maintained so that a program of graduate medical education does not rely on residents to meet patient care needs at the expense of educational objectives.

Dr. Robert D'Alessandri, a member and prior chair of ACGME, testified that there has been a shift in graduate medical education from a predominantly "service-oriented" approach in the 1970s to the current purely educational approach. Those programs that lose their accreditation tend to be more service-oriented, i.e., they tend to provide patient care services without supervision and without regard to educational value. Some of the major reasons why such residency programs lose their accreditation or are put on probation include excessive duty hours, lack of supervision of residents by faculty, insufficient scholarly/research activity by faculty, and inadequate educational experience in a particular area.

Maxine Kessler is director of graduate medical education at BMC and the School of Medicine and held an equivalent position at the former BCH. Her role is to ensure that BMC stays in compliance with ACGME requirements. She was responsible for coordinating the accreditation process at the former BCH, and now at BMC, and has participated in about 50 to 60 residency and institutional reviews for accreditation since 1982. She testified that ACGME never indicated in any of those reviews that collective bargaining was detrimental to graduate medical education.[55]

In 1994, when the former BCH last went through the institutional accreditation process,[56] BCH attached its collective-bargaining agreement with the Petitioner in its submission to the ACGME and cited various of its provisions to demonstrate that it satisfied certain requirements set forth in the Essentials.[57] These requirements include the establishment of policies relative to the promotion and dismissal of residents; the establishment of policies and procedures for discipline and the adjudication of complaints and grievances, which must satisfy the requirements of fairness and due process; provisions for resident participation in various committees; the requirement to ensure that all residents at similar levels of experience in all programs receive a comparable level of financial support; the requirement to provide full liability insurance; the requirement to have a written policy on leave and the effect of leaves of absence on satisfying the criteria for completion of a program; the establishment of formal policies governing resident duty hours and on-call schedules; the provision of adequate ancillary support; and the obligation of sponsoring institutions to provide an individual contract to residents which sets forth their terms of employment.

D'Alessandri testified that hospitals would be much more efficiently run without residents, because teaching residents makes each case take longer than it otherwise would. Under Medicare and Medicaid rules, BMC cannot bill for the services its residents provide to individual patients; an attending must be the physician of record and be present for many procedures and consultations in order to bill Medicare or Medicaid.

The Petitioner asserts, however, that although teaching hospitals cannot bill Medicare for specific services residents perform for individual patients, Medicare reimburses teaching hospitals for the services of its residents in a more general manner by direct payments based on the number of residents and the hospital's Medicare patient load. See generally 42 CFR § 413.86. According to a 1994 budget recommendation by a committee at the former BCH:

> [u]nder the current reimbursement system, the cost of house staff and attending physicians is virtually free. The cost of

[51] The Petitioner asserts, however, that under the regulations governing Federal Stafford and SLS loans, 34 CFR § 682.210(b)(2)(v) and (c), such loans are deferred only for the first 2 years of residency, and that the deferment for residents is distinct from a separate deferment for "students." The Petitioner also asserts that the residents' 2-year deferment for repayment of Federal Perkins loans has been eliminated. 34 CFR § 674.35(d)(1) and (4); 34 CFR § 674.34(a) and (b)(2).

[52] The ACGME has five sponsors, each of which appoints members to the council: the American Medical Association, the American Association of Medical Colleges, the American Board of Medical Specialties, the Council on Medical Subspecialties, and the American Hospital Association.

[53] Sponsoring institutions, such as BMC, are accredited by the ACGME's Institutional Review Committee. Individual residency programs are accredited by the ACGME's various Residency Review Committees (RRCs) established for each specialty.

[54] The Essentials is a section of the ACGME's Graduate Medical Education Directory, P. Exh. 19.

[55] In July 1995, the Medical and Dental Staff (faculty) of the former BCH unanimously passed a resolution to express its support for the house staff of the newly created BMC to have the option of organizing themselves for the purpose of collective bargaining and urging BMC to recognize the house staff's chosen representative. (P. Exh. 109).

[56] There has been no more recent application for institutional accreditation by either BCH or BMC. ACGME standards are the same for public institutions, such as the former BCH, and private institutions, such as BMC.

[57] P. Exh. 111, pp. 5–6, 9, 11–12, 13–14.

> providing services without a teaching program would be significantly higher.[58]

Battinelli testified that if there were no interns and residents to staff the BMC's Urgent Care Center, the hospital would either have to see fewer patients or hire more attendings. For example, a March 15, 1997 memo[59] from the medical director of BMC's Urgent Care Center to all junior and senior residents states:

> Over the past several months, there have been multiple occasions where residents have left the Urgent Care Center for interviews and other planned absences without providing adequate coverage. This has often left the UCC critically short of MD coverage and has forced the clinic to close to incoming patients on several occasions.
>
> This is an intolerable situation. . . . During sessions when absences will result in a staffing shortage, coverage must be arranged and the name of the covering House Officer must be submitted to the UCC staff in advance.
>
> This process should alleviate the need to pull emergency coverage from your fellow House Officers and help provide better continuity of care for our patient population.

CIR negotiated its first collective-bargaining agreement in 1958 and is currently party to 20 collective-bargaining agreements covering approximately 7500 house officers at 30 private and public sector hospitals. Standard provisions cover matters such as wages, vacation, health insurance, hours,[60] the adequacy of the rooms where residents sleep while on call, the availability of ancillary support,[61] meals, parking, and beepers. CIR has made proposals concerning matters such as more regular evaluations, extra on-call pay, the availability of a medical library, and the availability of small laboratories where house officers can run their own tests nights and weekends. CIR has never made proposals regarding the duration of a residency program, course content, teaching methods, examinations, or the criteria for advancement from year to year or for graduation. Some provisions attempt to avoid possible conflicts with medical training requirements, e.g., by permitting the reduction of vacation days in accordance with medical specialty board requirements.[62]

CIR files about 20 grievances per year, the vast majority of which are resolved informally. Past grievances have concerned salary issues, maternity leave, the availability and cleanliness of call rooms, parking, and discipline, e.g., for leaving the hospital without permission. CIR has taken to arbitration grievances concerning premiums for health insurance, the provision of ancillary services, and house officers' hours.[63] During the years it represented the house officers at BCH, the Petitioner filed unfair labor practice charges at the Massachusetts Labor Relations Commission over such matters as the unilateral closing of parking lots, cafeterias, and medical libraries, while the City filed a charge over whether the provision of ancillary services is a permissive subject of bargaining.

The Petitioner also plays a role in decisions not to renew a resident's contract and in the evaluation process. Under the current contract between the Petitioner and BMC, for example, BMC must make every effort to make offers of reappointment by December 31 for the following year, or offer a "conditional renewal," which outlines what aspects of the house officer's performance must improve in order for his/her services to be renewed.[64] The contract requires BMC to use standardized evaluation tools, with input from the Petitioner, and to complete evaluations within 30 days of each rotation. It gives house officers the opportunity to dispute evaluations and to examine material in their personnel files. It requires the department chair or designee to meet with house officers individually twice a year to review their progress. It requires the department to communicate to each house officer in a timely fashion if his/her performance is substandard and to make clear what issues must be addressed in order to raise performance to an acceptable standard.[65]

The contract provides for just cause for suspension or discharge, under a bifurcated system.[66] "Alleged administrative misconduct" is subject to the standard grievance and arbitration process. "Alleged professional or clinical misconduct based on issues of clinical performance or competence" is not subject to the grievance procedure, and there is no appeal to an arbitrator. Such allegations are investigated and resolved by the chief of service for the department or a designee. If discipline is imposed, the resident can appeal only to an ad hoc committee of seven members of the BMC medical and dental staff, which may overturn the discipline by majority vote. The resident is entitled to representation by the Petitioner during this process. At least one other contract provides that an arbitrator may not review medical judgments.[67]

Mark Levy, associate director of CIR, testified concerning cases in which CIR has grieved and/or arbitrated a hospital's decision to terminate a resident or not renew a resident's con-

[58] More specifically, according to the budget report, all direct graduate medical education costs at BCH were fully reimbursed, as well as a portion of indirect overhead costs. Overall, more than 82 percent of total GME costs were reimbursed. The report also noted that the cost of alternative providers such as physician assistants and nurse practitioners was higher than the cost of residents, that the availability of alternative providers remained problematic, and that a service delivery model without a teaching relationship did not appear to be a viable option. P. Exh. 113.

[59] P. Exh. 86.

[60] The contracts usually limit the frequency with which residents are assigned to be on call to one night in three. Some adopt the "Bell regulations," the New York State Health Code rules limiting the hours of work for residents to 80 hours per week and shifts to no longer than 24 hours.

[61] These provisions typically limit the obligation of busy residents to perform ancillary services such as IV services, clerical work, phlebotomy services, routine vital signs and weights, and patient transport services, and require the hospital to provide such services.

[62] P. Exh. 49, art. VII; P. Exh. 55, art. VI.

[63] See, e.g., P. Exh. 71, a 1981 arbitration award over whether BCH was paying its contractual share of residents' group health insurance premiums; P. Exh. 72, a 1996 arbitration award concerning the issue of equal pay for University Hospital and BCH residents; P. Exh. 33, a 1994 arbitration award over whether Bellevue Hospital, a public hospital in New York, had violated the "Bell Regulations," which had been incorporated into the contract, by requiring surgical residents to work excessive hours.

[64] P. Exh. 1, art. XV. This is a standard type of provision.

[65] P. Exh. 1, art. XVI.

[66] P. Exh. 1, art. XI. A similar provision appears in some of the Petitioner's other collective-bargaining agreements, e.g., P. Exh. 39, its contract with Catholic Medical Center.

[67] P. Exh. 53, states at art. XIV, "The arbitrator shall not substitute his or her judgment for academic or medical judgments rendered by the person charged with making such judgments, nor shall the arbitrator review such decisions except for the purpose of determining whether the decision has violated this Agreement."

tract. Arbitrators have reinstated such residents to their employment position and, thus, given them the opportunity to obtain certification in their field. He testified, however, that certification is a separate procedure, i.e., arbitrators never mandate a department chairman either to issue a letter certifying that a resident has satisfactorily completed the year or to issue a letter to a specialty board certifying that the resident has satisfactorily completed the program and should be eligible to sit for the requisite board exam.[68]

Several examples of grievances involving nonrenewal or termination, some of which went to arbitration, were submitted into the record. In several instances CIR filed a grievance over untimely nonrenewal letters and sought an offer of a contract for the following year.[69] Two arbitration awards involved instances of alleged medical malpractice by a resident, in which an arbitrator reduced the penalty of termination to a letter of reprimand or suspension without pay.[70]

A grievance filed against a New Jersey hospital in 1996[71] concerned a third-year resident who was informed in February of that year that she had to leave the program effective March 15 because she had never passed part 3 of the medical licensing exam. CIR argued in a letter that the hospital's policy did not put residents on notice of the consequences of failing the exam. CIR further argued that the resident should at least be allowed to finish out the last 3 months of her third year, inter alia, in order to have the opportunity to obtain a certificate of satisfactory completion at the end of the year. This would permit her to qualify for the certifying exam of the Board of Psychiatry, which requires applicants to satisfactorily complete 2 years of training in the same program. The grievance was settled by allowing the resident to complete the year, but requiring her to move on to another program for her fourth year of training.

A 1995 grievance[72] involved a PGY 3 who received a nonrenewal letter from Bronx Lebanon Hospital and had been told he would not receive even 1 year of satisfactory credit from the hospital. Arguing that the resident could not have been advanced to PGY 3 unless he had satisfactorily completed his PGY 1 and PGY 2 years, CIR sought and received as a settlement 1 year of credit to enable him to apply for a license. In a 1996 grievance against the same hospital over the nonrenewal of a resident,[73] CIR's representative wrote to the hospital that the reasons for the resident's nonrenewal were never adequately explained to him and "his work performance and grade scores indicate a level of competence that warrant his moving into a PGY 3 position at Bronx Lebanon Hospital."

In 1996, CIR filed a grievance against a New Jersey hospital[74] over the nonrenewal of a resident for receiving the lowest possible grades for medical knowledge, substandard skills and understanding of orthopedic knowledge, difficulty describing clinical and radiographic findings, substandard knowledge of anatomy, poor dexterity, and failure to complete necessary assigned readings. Ultimately, the grievant decided not to pursue the grievance.

CIR's constitution states that it "was formed for the purpose of organizing and representing house officers . . . in their collective efforts pertaining to compensation, benefits, hours, working conditions, and such other matter affecting their employment, *education and training*."[75] Many of CIR's agreements give CIR access to Residency Review Committee findings concerning accreditation, and CIR has made information requests concerning such findings. In 1992, when the former BCH proposed to integrate the BCH and University Hospital internal medicine residency programs, the Petitioner, in expressing its agreement with BCH's position that new PGY 1s would be the first group affected, indicated that it supported this position because it "serves as a guarantee that the program is committed to providing the current PGY IIs and PGY IIIs with the educational choices they were told they would get when they decided to come to BCH's Internal Medicine Program."[76] In 1994 contract negotiations with BCH, the Petitioner made a proposal that house officers "who remain in good standing shall be allowed to complete their training for board eligibility."[77]

Levy testified that CIR has been involved in a few strikes against private hospitals that either refused to grant recognition after an organizing drive or withdrew recognition during contract negotiations. After two such strikes, an 11-day strike at Interfaith Hospital in 1985 and a 9-day strike at Bronx Lebanon Hospital in 1990, CIR was able to negotiate agreements with the two hospitals. At two other hospitals, the house staff held rallies in support of their quest for recognition, but voted not to strike. When those hospitals still declined to recognize CIR, the organizing drives ended, as there was no option to petition the NLRB for an election. Two other private hospitals have withdrawn their voluntary recognition of CIR in the past year, although there was no evidence of loss of majority support. In 1980, the Petitioner engaged in a 6-day strike against the former BCH over contract negotiations.[78] The strike was resolved when, after the Massachusetts Labor Relations Commission ordered mediation, the parties agreed upon a new contract.

Finally, the Petitioner introduced several studies by Amy McCarthy, who has a Ph.D. in economics and specializes in labor economics. One study purports to show that unionized house staff receive higher wages and better benefits than the non-unionized house staff in certain family practice residencies. A second study purports to show that house staff wages and benefits are much higher than those of graduate level teaching assistants, who are not currently considered to be employees under the Act. A third study purports to show, inter alia, that house staff receive higher wages and benefits than post-graduate architect interns, who are considered by the Board to be employees. It also compares the postsecondary apprenticeships and internships of construction electricians, certified public accountants, and architects to that of doctors. A fourth study is an "age times earnings profile," which purports to show that

[68] One of CIR's collective-bargaining agreements, for example, states, "Decisions as to whether a housestaff officer has successfully completed the residency program are not grievable or arbitrable." P. Exh. 44, art. XI, sec. 2.

[69] See, e.g., Emp. Exhs. 79 and 91.

[70] Emp. Exh. 76 and 77.

[71] Emp. Exh. 88.

[72] Emp. Exh. 89.

[73] Emp. Exh. 90.

[74] Emp. Exh. 83.

[75] P. Exh. 30 (emphasis added).

[76] Emp. Exh. 3.

[77] Emp. Exh. 6. This proposal was apparently not included in the 1994–1997 agreement.

[78] The strike was apparently in violation of the Massachusetts collective-bargaining law, which prohibits strikes by public employees. M.G.L. Ch. 150E, § 9A.

the initial relatively low earnings of interns, residents, and fellows is followed by a steep increase over time, which is similar to the profile for various other professions.[79]

B. Existing Board Law with Respect to the Employee Status of Interns, Residents, and Fellows

In filing this petition, the Petitioner seeks the reversal of *Cedars-Sinai Medical Center*[80] and *St. Clare's Hospital*,[81] issued some 20 years ago, in which the Board found that interns, residents, and fellows, while possessing certain employee characteristics, are primarily students and, therefore, not employees within the meaning of the Act. In first reaching this conclusion in *Cedars-Sinai*,[82] the Board found that house staff participate in residency and fellowship programs in order to pursue the graduate medical education that is a requirement for the practice of medicine, rather than to earn a living. While recognizing that house staff spend a large percentage of their time in direct patient care, the Board concluded that this was simply part of the learning process. The Board found that the stipend paid to residents, which was unrelated to the number of hours worked or the quality of patient care, was more in the nature of a living allowance than compensation for services rendered. The Board noted that applicants for residencies were more interested in the quality of the educational program than in the amount of their stipend. The "Essentials" indicated that the primary function of the programs was educational, and programs were designed to permit residents to develop clinical proficiency rather than to meet the hospital's staffing requirements. Finally, the Board observed that few interns, residents, or fellows remained to establish an employment relationship with the hospital after the completion of their programs.

The Board clarified its views on the status of house staff the following year in *St. Clare's Hospital*. The Board found that the relationship between residents and teaching hospitals is academic in nature in that residents and their teachers have a mutual interest in the advancement of the residents' education, in contrast to the employee-employer relationship, which is economic in nature and predicated on conflicting interests. The Board expressed its view that the imposition of collective bargaining in a higher education setting posed the danger of infringement upon traditional academic freedoms such as the right of educators to determine program duration, course content, and teaching methods; to establish standards for advancement and graduation; and to administer examinations and give grades. The Board expressed its concern, for example, that the notoriously long hours residents work, which may be necessary from an educational standpoint, could become bargainable. Similarly, failure to recommend program advancement, a subject of academic concern in the Board's view, would be tantamount to discharge and, thus, subject to arbitration. In sum, the Board found such intrusions into traditional academic freedoms to be detrimental to the quality of the educational process and to the public interest.

C. Positions of the Parties

1. Petitioner

The Petitioner contends that BMC and its predecessor, BCH, have treated house staff as employees for all purposes. In this regard, the terms and conditions of their employment have been determined for almost 20 years by the successive collective-bargaining agreements similar to those negotiated for other groups of BMC employees. They receive a salary, paid vacation and sick leave, and various health and life insurance benefits typical of those given to employees.[83] With respect to the Board's observation in *Cedars-Sinai* that residents' salaries are unrelated to the number of hours worked or the quality of care rendered, the Petitioner points out that this scenario is a commonplace indicium of professional employment. BMC provides malpractice insurance coverage for house staff, and they are covered by BMC's workers compensation policy. BMC applies various Federal and state employment laws to them and refers to its house staff as "employees" in its affiliation agreements with other institutions.

The Petitioner argues that the Board's conclusion in *Cedars-Sinai* that residency programs are not designed for the purpose of meeting hospitals' staffing requirements ignores the very real staffing needs that could not be met without house staff.[84] Thus, house staff spend the vast majority of their time in direct patient care. They are fully responsible for working up and assessing newly admitted patients, ordering tests, consultations, and medications, and performing both routine and complicated medical procedures. Surgical residents perform common operative procedures with minimal involvement by attendings. Interns and residents are required to make independent patient care decisions of both a routine and critical nature, from altering dosages of medication to intervening in life-threatening situations. They are the primary contact for patients and their families. They are the only physicians to staff the wards at night. The Urgent Care Center, which is a site of the ambulatory clinic, is so dependent on the work of house officers that it has been forced to close when the house officers have left for planned absences without securing coverage.

[79] I need not reach the issue of whether or not these studies are procedurally flawed, as BMC contends, because I find them to be of little or no value in determining whether or not the interns, residents, and fellows at BMC are students or employees.

[80] Supra, 223 NLRB 251.

[81] Supra, 229 NLRB 1000.

[82] Based on the Board's factual description of the residency programs under consideration in *Cedars-Sinai Medical Center*, it appears that they were substantially similar in all major respects to the current residency programs at BMC.

[83] As noted below, BMC argues that applicants for residencies never even inquire about the compensation and benefits associated with these programs, because their purpose in entering residencies is to obtain Board certification rather than to earn a living. To this argument, the Petitioner responds that applicants are, in fact, informed about salary, benefits, and employment-related topics such as work hours in interviews and informational materials sent to applicants and that, if they are as uninterested in their salary, benefits, and working conditions as BMC suggests, they simply will not organize into unions. Finally, the Petitioner contends that the Supreme Court has rejected an analysis of employees status grounded in the subjective motivations of job applicants. See, *NLRB v. Town & Country Electric,* 516 U.S. 85, 93–96 (1995), in which the Supreme Court rejected an employer's argument that union organizer "salts" were not employees under the Act because they had dual motives in accepting the job.

[84] In response to BMC's apparent argument that because BMC cannot bill Medicare for the individual services performed by its house staff, their services are commercially worthless, the Petitioner points out that Medicare does reimburse teaching hospitals for the services provided by residents, albeit in a more general manner, through a formula based on the number of residents and the Medicare patient caseload.

With respect to the Board's assertion in *Cedars-Sinai* that completion of a residency is a requirement for the practice of medicine, the Petitioner points out that, after completion of their internship year, house staff are fully licensed physicians who can and do practice as physicians outside of their residency programs. As for the academic component of their residencies, the Petitioner contends that house staff spend less than ten percent of their time in didactic conferences, and that patient care responsibilities routinely prevent them from attending such conferences. While house staff, like many other professionals, learn their craft while performing it, this does not mean that they are not employees. Further, because the medical profession requires life-long continuing education and recertification in the various medical specialties, there is no basis to distinguish between the house officers' training for certification as specialists and specialists in continuing training for recertification in their specialty. The true "students" at a teaching hospital, in the Petitioner's view, are the medical students, who, unlike the house staff, pay tuition, receive no compensation, receive academic grades for the clerkships at BMC, are unlicensed, and cannot issue medical orders.

The Petitioner points to CIR's 40-year history of successful collective bargaining with public and private hospitals, including 18 years of collective bargaining with BCH and its successor, BMC, in which it has peacefully and productively resolved the issues facing residents in their employment. Its collective-bargaining agreements have focused on traditional employment-related issues such as compensation, hours of work, vacation, and benefits, as well as on employment-related issues of unique concern to house staff, such as call schedules, the adequacy of on-call rooms, ancillary services, access to medical libraries and laboratories, parking, meals, and beepers. Most grievances it has pursued involve nonacademic matters such as compensation, health insurance premiums, and the provision of ancillary services.

The Petitioner maintains that it has never sought to interfere with educational and training prerogatives, which are separate and distinct from the employment relationship. In this regard, it has never made proposals or filed grievances regarding academic issues such as teaching methods, course materials, program duration, standards for advancement or completion of programs, and the like. Its contract with BMC provides for a special procedure in cases of disputes involving issues over clinical performance or competence, where the final determination is made by an internal hospital committee, with no appeal to an arbitrator. CIR has left matters pertaining to the educational component of residency programs to the discretion of the teaching hospitals and the ACGME. Although teaching hospitals are regulated by the Essentials with respect to academic matters, the Board concluded in *Management Training Corp.*[85] that it would not refuse to exercise jurisdiction over an employer because of concerns that collective bargaining could encompass some areas over which the employer did not have meaningful discretion.

The Petitioner asserts that, in any event, far from conflicting with the requirements of the Essentials, collective bargaining provides a mechanism by which teaching hospitals can fulfill certain requirements set forth in the Essentials. Thus, the former BCH cited its contract with the Petitioner to demonstrate, e.g., that it fulfilled ACGME requirements to provide a procedure for adjudication of complaints, to provide adequate financial support and benefits, and to prohibit excessive hours of work. The Petitioner notes that the ACGME has never indicated that collective bargaining is detrimental to graduate medical education, and that the BCH faculty's enthusiastic endorsement of collective bargaining demonstrates that it is not antithetical to graduate medical education.

As for the Board's reasoning in *Cedars-Sinai* that few residents stay beyond the completion of their program, the Petitioner argues that many industries frequently experience turnover in their workforce, and that a minimum tenure of 3 years would be regarded as a symbol of stability in many industries.

The Petitioner contends that the legislative history of the Act supports a broad reading of Section 2(3) of the Act. Thus, the legislative history of the Wagner Act describes "employee" as "every man on a payroll,"[86] while the legislative history of the Taft Hartley amendments indicates that the term "employee" simply "means someone who works for another for hire."[87]

Supreme Court cases since *Cedars-Sinai* have undercut the Board's reasoning in that case by interpreting Section 2(3) in an expansive manner. Thus, in *Town & Country Electric, Inc.*,[88] the Supreme Court found that workers who are also paid union organizers are nonetheless "employees" under the Act, noting that a broad, literal interpretation of the word "employee" is consistent with the Act's purpose to encourage collective bargaining and consistent with other Supreme Court decisions. See, e.g., *Sure-Tan, Inc. v. NLRB*[89] (the Act covers undocumented aliens); *Phelps Dodge Corp. v. NLRB*[90] (job applicants are employees). As the Supreme Court noted in *Sure-Tan*:

> The breadth of Sec. 2(3)'s definition is striking: the Act squarely applies to "any employee." The only limitations are specific exemptions for agricultural laborers, domestic workers, individuals employed by their spouse or parents, individuals employed as independent contractors or supervisors, and individuals employed by a person who is not an employer under the NLRA.[91]

The Petitioner contends that the legislative history of the Taft-Hartley amendments demonstrates that Congress considered interns, residents, and fellows to be professional employees within the Act's coverage. In this regard, a House Conference Report specifically states the term "professional employees" under Section 2(12) includes "such persons as legal, engi-

[85] 317 NLRB 1355 (1995). *Management Training Corp.* involved the issue of whether the Board should assert jurisdiction over private employers that contract with an exempt government entity. Overruling *Res Care, Inc.,* 280 NLRB 670 (1986), the Board held that jurisdiction should no longer be determined on the basis of whether the employer or the Government controls most of the employees' terms of employment. Rather, the question of whether there are sufficient employment matters over which unions and employers can bargain will be left to the parties at the bargaining table and to the employee voters in each case.

[86] 79 Cong.Rec. 9686 (June 19, 1935); see also *NLRB v. Town & Country Electric, Inc.,* supra (summarizing legislative history).

[87] H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947), cited in *NLRB v. Town & Country Electric, Inc.,* supra.

[88] Supra at 454.

[89] 467 U.S. 883, 891–892(1984).

[90] 313 U.S. 177, 185–186 (1941).

[91] 467 U.S. at 891.

neering, scientific and medical personnel together with their junior professional assistants."[92]

The Petitioner also finds support for its position in the legislative history of the 1974 health care amendments, in which Congress deleted the statutory exemption of nonprofit hospitals from the Act. A House and Senate conference committee considering the amendments found that it was unnecessary to explicitly state that interns, residents, and fellows were not supervisors under Section 2(11) of the Act, given the Board's analysis of responsible direction of work in the health care context.[93] This demonstrates, argues the Petitioner, that Congress presumed house staff to be employees under the Act.

The Petitioner asserts that the overwhelming majority of jurisdictions considering this issue have rejected the arguments cited by the Board in *Cedars-Sinai* and *St. Clare's* and have concluded that house staff are employees for purposes of collective bargaining.[94] Finally, the Petitioner argues that the NLRB stands alone among Federal agencies in viewing house staff as students. The Internal Revenue Service, for example, has taken the position that payments to medical residents are taxable compensation for service rendered rather than nontaxable grants for purposes of study.[95] The Equal Employment Opportunity Commission treats house staff as employees for purposes of Title VII.[96] House staff are deemed employees for purposes of the Family and Medical Leave Act, the COBRA provisions of the Employee Retirement Income and Security Act, and social security taxes.[97]

With respect to BMC's allusion to the threat of disruptive strikes if *Cedars-Sinai* is overturned, the Petitioner argues that the only private sector strikes by the Petitioner have occurred when private hospitals refused to recognize the Petitioner. As the Board noted in *Management Training Corp.,*[98] the Congressional findings upon which the Act is based assume that granting employees the right to bargain collectively encourages the friendly adjustment of disputes and will decrease strikes and other forms of industrial strife. The protections of the Act bring with it measures that will reduce teaching hospitals' exposure to strikes, such as access to representation procedures, the notice requirements of Section 8(g), and the Board's prohibition against partial and intermittent strikes.

2. BMC

BMC argues, first, that the Board's holding in *Cedars-Sinai* was subsequently approved by Congress. After the issuance of *Cedars-Sinai*, Congress considered for nearly 4 years a proposed bill, H.R. 2222, which would have set aside *Cedars-Sinai* by amending Section 2(3) and (12)(b) of the Act to make explicit the intent of Congress that house staff be considered employees under the Act.[99] The bill was defeated by a vote of 227 to 167 in November 1979.

BMC contends that house officers are not "employees" within the meaning of the Act because they are primarily engaged in graduate educational training. In this regard, the training of physicians involves a continuum of education, which begins in medical school and continues through internship, residency, and possible fellowship programs through board certification. The educational nature of the programs is evident from the fact that residency programs are required to have an affiliation with a medical school and its faculty. House officers who complete their programs receive a diploma. Because medical students now begin their clinical training in the third year of medical school, rotating through the various specialties, there is little distinction between the last 2 years of medical school and the first years of residency. House officers are simply students along this continuum. In fact, residents in the oral and maxillofacial program at BMC pay tuition.

BMC maintains that the mutual interests of the hospital and house officers are academic rather than economic. House officers enroll in residency programs for the purpose of becoming certified in their specialty, rather than for the purpose of earning a living. In this regard, applicants for residency programs rarely inquire about compensation and benefits, but are much more concerned about matters such as the program's pass rate for the Board exams. Although house officers who have completed their internship year could make significantly higher pay by moonlighting at other hospitals, they choose to remain in their residency programs because of the training offered. Finally, BMC incurs significant financial losses due to the inefficiencies associated with teaching house officers, which it would not incur if its objectives were anything other than academic excellence. For example, it is not very cost effective for patients to be seen by teams of as many as six to seven individuals, including medical students, interns, residents, and faculty. Thus, the primary mission of BMC is not the profitable provision of health care but the training of physicians while providing quality medical care.

BMC maintains that the educational nature of the residency programs is manifest by the fact that they are regulated by the ACGME, which precludes hospitals from altering the educational experiences of house officers. Teaching hospitals must adhere to the Essentials' detailed requirements with respect to curriculum, faculty supervision, and scholarship, or risk having their accreditation withheld or withdrawn.

BMC points out that graduate medical education programs are a prerequisite to obtaining a full license. Only after completing their internship and passing part 3 of the medical licensing exam are house officers eligible to apply for a full license. Further, successful completion of a residency is also a prerequisite for sitting for the board certification exams and becoming certified in a specialty. Failure to obtain board certification substantially limits a physician's employment opportunities.

The house officers' status as students, BMC asserts, is demonstrated by the significant portion of their time which is spent participating in conferences, rounds, and other purely didactic activities, as required by the ACGME. Many of these didactic activities have no direct relation to the care of current patients. The true "classroom" in a residency program, however, extends to the wards and operating rooms. The bulk of the educational activity occurs in the course of direct patient care. Thus, the Essentials require house officers, for example, to perform a certain number of various types of procedures in order to successfully complete a training program. Residents are assigned

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[92] H.R. Conf. No. 510, on H.R. 3020 at 36 (1947). [reprinted in I Legislative History of the Labor Management Relations Act 540].

[93] S. Rep. No. 93–766 at 6 (1974); H.R. 93–1051 at 7 (1974).

[94] In this regard, the Petitioner cites in its posthearing brief numerous cases involving public sector hospitals.

[95] *Christman v. Commissioner*, 57 T.C.M. (CCH) 538 (1989).

[96] Empl. Prac. Guide (CCH) ¶ 6870 (1988).

[97] 29 U.S.C. § 1163 (1965); 29 U.S.C. § 1002(4); 29 U.S.C. § 2611(2)(A); 42 U.S.C. § 410.

[98] Supra at 1359, citing 29 U.S.C. § 151.

[99] H.R. Rep. No. 504, 96th Cong., 1st Sess. (1979).

to rotations based on the dictates of the curriculum, which require exposure to certain types of patients within each specialty. That assignment to rotations is not based on the hospital's staffing needs is illustrated particularly by the fact that house officers are permitted to choose 28 to 32 weeks of "elective" rotations, based on their own training needs.

BMC notes that, consistent with the academic nature of the programs, house officers are required to take and pass graded examinations. House officers are evaluated by their attending physicians and may be required to repeat a year for poor test scores or unsatisfactory performance. Unlike evaluations of employees, however, the house officers' evaluation have no bearing on pay or benefits but, rather, are an assessment tool in the decision to promote house officers to the next PGY level.

BMC argues that because of the house officers' inexperience and status as trainees, their level of supervision is unparalleled. They perform substantial procedures only if an attending physician is present at the time or, in the case of emergencies, with subsequent review by an attending. In this regard, for example, an attending must be scrubbed in for the critical portion of any surgical procedure, and radiology residents review all films with an attending.

BMC maintains that house officers are treated differently from BMC employees in many respects, which demonstrates their nonemployee status. Unlike other BMC employees, they are not recruited, interviewed, or hired by the hospital's human resources department, nor are there job postings for house officers. Rather, house officers are selected through the National Residency Matching Program, which is the antithesis of the traditional hiring process in that both hospitals and applicants give up any degree of discretion after the ranking orders are submitted. Thus, teaching hospitals have minimal control over which applicants will be assigned to their programs. House officers receive different benefits from other BMC employees. They are denied long-term disability insurance or retirement plans, for example, because those benefits are designed for long-term employment.

BMC argues that house officers are paid a set stipend that does not vary based on the number of patients treated or hours worked. Rather than compensation for services rendered, the stipends are provided simply to defray the ordinary costs of living and to ensure that house officers do not have to endure severe economic hardship during their training period. The fact that these stipends are not even remotely comparable to the sizable salaries of attending physicians demonstrates that the house officers are not employees performing services equivalent to those performed by attendings, but rather trainees who need not be impoverished during the learning process.

BMC argues that, unlike ordinary employees, who hope to establish a long working relationship with their employer, most house officers enter residency programs with the intention of leaving upon the completion of the program. Few intend to or do stay beyond the length of their program. Further, the transient nature of their tenure carries with it additional complications. The Board will be called on to determine whether a particular house officer or a group of house officers are temporary employees who are ineligible to vote in a representation election, under either of the two standards used by the Board, the "reasonable expectation of further employment test," or the "date certain" test. *St. Thomas-St. John Cable TV.*[100]

BMC contends that other Federal agencies treat house officers as nonemployees. In this regard, house officers' may defer repayment of their Federal student loans during their residency because the government considers them to be still in training and not "employed." Medicare does not reimburse teaching hospitals for individual services performed by house officers; only attendings perform billable services.

BMC asserts that the manner in which house officers are trained remains essentially the same as it existed 20 years ago, and that, in asking the Board to overrule established precedent, the Petitioner has offered no compelling reasons not previously considered by the Board. To the contrary, the Board's reasoning in *Cedars-Sinai* and *St. Clare's* remains valid. The education process at the graduate level is an intensely personal and individual one, which is not amenable to the collective treatment afforded by the collective-bargaining process. The Board correctly recognized the grave danger that could be posed to traditional academic freedoms if collective bargaining were imposed on the structure of higher education, and its fears would come to fruition if it decided to deem house officers "employees." In its collective-bargaining relationships outside the Act, CIR has filed grievances and demanded arbitration over many matters involving academic freedom, such as the discharge or nonrenewal of house officers. CIR has requested remedies, such as issuing a letter of credit for partial completion of a residency program, which directly impinge on a teaching hospital's certification of residents. Such a purely educational matter as the decision to renew or not to renew a resident for the next year of training should not be subject to a grievance procedure.

BMC asserts that CIR's activities clearly establish its inclination to bargain, arbitrate, and even strike about those freedoms the Board held sacred to academic institutions. CIR's past history of bargaining is hardly illustrative of the future, as CIR has never before been Board-certified and afforded the protections of the Act under which the mechanism for resolving disputes when collective bargaining fails is the strike. Its intrusion into the academic affairs of all teaching hospitals will intensify should CIR be granted the protections of the Act. Teaching hospitals will be put into the precarious position of negotiating over mandatory subjects of bargaining, such as hours, the number of house officers allowed in the program, the number of procedures required, evaluations, program advancement, discharge and nonrenewals, program length, rotations, and testing, all of which are also heavily regulated by the ACGME. By declaring such matters to be mandatory subjects of bargaining, the Board will be interfering with the efforts of the ACGME to standardize medical education and involving itself in matters of academic concern.

D. Positions of the Amici Curiae

The Association of American Medical Colleges (the Association) is a nonprofit, voluntary association, the purpose of which is to advance medical education and the nation's health. Its members include all of the nation's 125 schools of medicine, 89 academic societies, and 356 teaching hospitals affiliated with medical schools. The Association is one of the five members of the ACGME, and it participated as amicus curiae before the Board in the *St. Clare's Hospital* case. The Association sought and was granted leave to file an amicus brief in this matter because of its great significance to the

[100] 309 NLRB 713 (1992).

matter because of its great significance to the graduate medical education community.[101]

The Association contends that the inevitable consequence of the Act's application to graduate medical education will be involvement by unions and the Board in the full panoply of academic decision-making. It asserts that CIR's history of bargaining with public sector hospitals provides no precedent for extending collective bargaining to house officers at private sector hospitals. In this regard, the fundamental difference between the Act and state public employment statutes is the right to strike, which is the essential element of collective bargaining under the Act but is prohibited in the public sector. CIR's contracts negotiated without the right to strike, it contends, are totally irrelevant to the Board's concerns about the impact on graduate medical education of collective bargaining under the Act. The Association claims that CIR's history, however, reveals its intrusion into academic matters, in that it has pursued arbitration in cases involving house staff terminated due to professional failures.

The Association asserts that the Board's rationale in *Cedars-Sinai* and *St. Clare's* is even more compelling today. In this regard, D'Alessandri testified that because of the tremendous expansion of medical knowledge and technology over the last 25 years, medical students cannot be adequately prepared to practice medicine within the confines of 4 years of medical school. Thus, graduate medical education programs are a necessary part of the continuum of formal medical education.

With respect to the Board's reasoning that there should be a national approach to labor relations in the health care industry, the Association contends that the ACGME, through its accrediting function, continues to provide national standards for graduate medical education. Further, graduate medical education has shifted away from the service-oriented approach of the early 1970's toward an almost purely educational approach, which emphasizes the instructional and scholarly aspects of residency programs. D'Alessandri testified, for example, that supervision of residents has increased in the last 20 years, and that ACGME passed a ruling in 1992 in response to the problem of house officers' excessive duty hours. In sum, the Association argues that the finest system of medical education in the world is functioning at the highest professional level, and that there is no basis for overruling *Cedars-Sinai* and *St. Clare's*.

The American Medical Association (AMA) was granted leave to file an amicus brief on behalf of the Petitioner. By letter dated August 28, 1997, the AMA informed the Region that it would not file a brief on behalf of any party but, instead, set forth its position in the letter. The AMA explained that, pursuant to long-standing AMA policy,[102] house staff should be able to organize in any manner they choose for the purpose of negotiating with institutional sponsors of residency programs over their working conditions. While the AMA believes that sponsoring institutions should recognize such organizations of house staff, the AMA believes that house officers should not have the right to strike, which may result in the withholding of patient care. It believes that collective-bargaining agreements should not require individual house officers to join a union.

The AMA stated its belief that house officers are both students and employees under the NLRA. It also believes that the ACGME is another forum where the concerns of house staff can be addressed, without the risk of compromising medical education and without the potential for strikes. In this regard, it has proposed to the other members of the ACGME that it review and revise its institutional requirements to more adequately address the concerns of residents over working conditions. It asserted that the ACGME has the expertise necessary to identify when issues of concern to residents involve working conditions that are appropriate for collective bargaining, and when they are matters of medical education over which the institution should retain discretion.

Because of the AMA's decision not to file an *amicus* brief, by letter dated August 29, 1997, the Massachusetts Medical Society (MMS) withdrew its request to join in the AMA's brief. In its letter, the MMS expressed views similar to those of the AMA. That is, MMS supports the right of house staff to form associations that negotiate collectively, but it does not support the house officers' right to strike and, thus, withhold patient care and does not support mandatory union membership. Therefore, it is working with the AMA to ask the ACGME to strengthen its standards by providing for the establishment of house staff associations and for the implementation of due process for house officers.

II. OTHER ISSUES RAISED BY BMC

A. Impact of the Board's Rule on Collective Bargaining in the Health Care Industry

Assuming house officers are employees, BMC argues that the petition must be dismissed because it is contrary to the Board's rulemaking on bargaining units in acute care hospitals, which requires a unit of "all physicians."[103] The Petitioner seeks a unit of all interns, residents, and fellows, and does not seek to include in the unit other nonmanagement staff physicians employed by BMC, of which there are at least two. In fact, Levy testified that CIR's constitution prohibits the Petitioner from representing physicians other than house officers. BMC asserts that the certification of a partial unit of physicians is contrary both to the rule and to the Congressional admonition against undue proliferation of bargaining units in the health care industry.

BMC maintains that the Petitioner is unable to establish that its petition falls within the rule's exception for existing nonconforming units, because BMC voluntarily recognized the Petitioner as a representative of students, not employees, and there is no such thing as an historical bargaining unit composed of students. Further, the broadened unit, which added the former University Hospital house officers to the former BCH unit, had only existed for about 6 months or so when the petition was filed, which is not the "historic" existence contemplated by the Board's rule.

The Petitioner argues that the rules provide for an additional exception, which reserves to the Board the right to determine appropriate units by adjudication "where extraordinary circumstances exist." Such circumstances exist because reversal of *Cedars-Sinai* would bring into the ambit of the Act a whole class of employees who were excluded from its coverage at the time of the rulemaking in 1989. Further, the existing history of

[101] As noted by the Association, there are approximately 100,000 house officers in approved programs of graduate medical education in the United States. See Emp. Exh. 75, 1996 annual report of the ACGME.

[102] AMA policy H-310.999(IIB)(3).

[103] 29 CFR § 103.30 (1996); 284 NLRB 1579, 1597 (1989).

collective bargaining in a distinct unit is an extraordinary circumstance. The Petitioner contends that house officers have a separate and distinct community of interest from the attending physicians, who are significantly better paid and are appointed to the faculty.[104] The Petitioner urges the Board to use its rulemaking authority to establish an appropriate modification to the health care rules or to establish an appropriate unit by adjudication.

B. Administrative Problems

BMC argues that several administrative problems would result if the Board were to assert jurisdiction over its house officers. First, BMC contends that its various affiliations with other institutions raise complex questions about joint employer status. Second, BMC contends that, because some of those institutions are government entities not subject to the Board's jurisdiction, asserting jurisdiction over the house officers would present numerous bargaining and enforcement problems.

House officers are assigned to various clinical rotations, both at BMC facilities and at other institutions. As they rotate through the various clinical assignments, house officers remain part of BMC's residency program and continue to be covered by the BMC collective-bargaining agreement, regardless of where they are actually performing their duties, although they are trained and supervised by physicians at the site of the rotation. Residents in all BMC programs spend the vast majority of their residency at BMC's facilities.[105]

Additionally, BMC operates at least two joint residency programs with other institutions. For example, the Boston Combined Residency Program in Pediatrics includes individuals in BMC's residency program as well as those in Children's Hospital's program. Residents in the primary care track are paid by BMC, while those in the larger categorical track are paid by Children's. Only those paid by BMC are in the existing bargaining unit and in the unit sought by the Petitioner.[106]

Finally, there are a number of house officers who are in BMC's residency program but on the payroll of other institutions.[107] Fifteen of these are in the bargaining unit currently represented by the Petitioner.[108] The record does not explain how this came about, or why. Historically, however, a certain number of house officers from various departments have been selected at random to be on the payroll of another institution while they complete their BMC residency. For example, there are approximately 41 house officers who are in BMC's program but on the payroll of the Boston Veterans Administration Medical Center (VA). Of these, the Petitioner seeks to represent only the six pathology residents who have historically been included in the bargaining unit. Similarly, there are about seven BMC house officers on Brockton Hospital's payroll, but the Petitioner seeks to represent only the single radiology resident who has been in the historic unit. An additional five BMC house officers are on Malden Hospital's payroll and in the unit sought by the Petitioner, and an additional three psychiatry residents paid by Brighton-Allston Mental Health Center are in the unit sought by the Petitioner.

The house staff who receive their stipends from other institutions are otherwise treated no differently from those on BMC's payroll, in that their training and rotations are identical to those of other house officers. Like other house officers, they spend the majority of their residency working at one of BMC's facilities. It is unclear from the record whether, in all cases, they receive the same stipend as those who are on the BMC payroll, but each affiliated institution has agreed to attempt to compensate the house staff according to the collective-bargaining agreement. All house officers who have historically been included in the bargaining unit, however, receive the same wages and benefits, regardless of whose payroll they are on.

BMC contends that the petitioned-for unit is inappropriate in several respects. First, BMC argues that, because residents rotate through various institutions, which supervise, train, and evaluate the residents while they are there, each of those institutions is potentially a joint employer. As a result, according to BMC, the Board will have to analyze complex joint employer questions in every case that comes before it, and may unwittingly create a morass of bargaining and enforcement problems. Second, BMC contends that the Board's jurisdiction will be constantly called into question whenever the affiliated institution is a government entity, such as the VA. According to BMC, any finding of joint employer status with a public entity will necessitate asserting jurisdiction over one institution, but not the other. In such situations, BMC argues, the Board may force BMC to bargain over a matter over which it has no control, or may expose BMC to a strike over economic issues which it cannot alter. Finally, BMC takes the position that if the Board decides to exercise jurisdiction over the house officers, the unit should include only those residents on BMC's payroll.[109]

The Petitioner asserts that BMC's various affiliations with other institutions do not raise any insurmountable administrative difficulties. First, the Petitioner takes the position that the rotation of residents through other institutions is no different from carpenters or other employees who work at various job sites. Noting that the Board has certified units of employees who work at different locations, the Petitioner argues that the unit it seeks is appropriate because BMC controls the terms and conditions of employment of house officers on its payroll, regardless of the site to which they are temporarily assigned; the house officers always rotate back to BMC; the skills and duties of the house officers are similar; and the long bargaining history justifies including all the residents in one bargaining unit.

[104] BMC does not appear to contend, however, that attending physicians should be included in a unit of all physicians. It appears to confine its argument to the inclusion of nonmanagerial physicians.

[105] In internal medicine, for example, residents spend an average of 8 weeks, combined over the course of a 2-year period, at Malden and Brockton Hospitals.

[106] BMC also operates a joint residency program in Oral and Maxillofacial Surgery with Tufts University.

[107] Notwithstanding the source of their income, these residents are part of the BMC's residency program insofar as they are selected by BMC and will complete their programs with BMC certificates or diplomas. The record is unclear as to exactly how many residents fit into this category.

[108] The exact number varies from year to year. In 1996–1997 there were 21 BMC residents who were paid by other institutions but included in the bargaining unit. In 1997–1998, there are 15.

[109] BMC notes two exceptions to this general description. There are currently approximately seven residents (referred to as the Brockton Hospital transitional employees), and one forensic pathology resident, who are on BMC's payroll because BMC is serving as their paymaster, but are otherwise unconnected to BMC's program. They have no residency functions at BMC and, as of the 1998–1999 year, will no longer be on BMC's payroll. As they have historically been excluded from the unit, the Petitioner agrees that they should not be part of any unit found appropriate.

Second, the Petitioner takes the position that, given the long bargaining history in the petitioned-for unit, the fact that some BMC house officers are paid by other institutions does not create any administrative problems. In this regard, the Petitioner initially points out that it is not seeking to represent any BMC house officers who are paid by other institutions and who have historically been excluded from the unit for undisclosed reasons. Accordingly, the Petitioner maintains, the application of a simple payroll-based rule would resolve most of the unit placement issues: house officers on BMC's payroll should be included in the bargaining unit. The only exception to this rule, notes the Petitioner in its reply brief, would be the four residents paid by Malden Hospital who have historically been included in the unit. I note, however, that the unit the Petitioner has historically presented appears to include approximately 15 individuals who receive their stipends from institutions other than BMC. Although the Petitioner takes the position that the parties' bargaining history justifies the unit it seeks, it agrees, in the alternative, to proceed to an election in a unit that excludes these 15 house officers.

Finally, the Petitioner takes the position that the unit placement issues are not complicated by the fact that some of the affiliated institutions are government entities. The Petitioner first argues that neither the VA nor any other government entity limits BMC's discretion to compensate its house officers. Second, the Petitioner cites *Management Training Corp.*[110] to support its contention that the Board will certify a unit even where there is direct government involvement in determining terms and conditions of employment for private sector employees. Finally, citing *Board of Education of Calvert County,*[111] the Petitioner argues that the Board will not decline jurisdiction over private sector employees simply because of the participation of a public entity as a joint employer.

C. Unit Based on Extent of Organization

BMC takes the position that the unit sought is inappropriate because it is based on the extent of the Petitioner's organizing effort. First, BMC argues that because the unit sought includes only house officers, rather than all physicians, the unit is inappropriate, and the petition should be dismissed. Additionally, BMC contends that because the unit includes some but not all house officers on the payrolls of other institutions, the unit is inappropriate, and the petition should be dismissed.

The Petitioner argues that the historic unit is not rendered inappropriate by the inclusion of a small number of residents with different paymasters.

III. CONCLUSION

With respect to the employee status of interns, residents, and fellows, I find that BMC's residency and fellowship programs operate in substantially the same manner as the graduate medical education programs considered by the Board some twenty years ago in *Cedars-Sinai* and *St. Clare's Hospital*. The Board held in those cases that interns, residents, and fellows are not employees within the meaning of Section 2(3) of the Act. The parties have each argued comprehensively as to why Board law with respect to this issue should be reversed or maintained. This is a matter that can only be resolved by the Board. Therefore, in accordance with Board precedent, the petition is dismissed.

In light of my dismissal of the petition on the ground that BMC's house officers are not employees, I need not reach the issues of whether the petitioned-for unit violates the health care rules, whether BMC's affiliations with other institutions present joint employer or jurisdictional issues, whether the petitioned-for unit is based on the extent of organization, or whether certain house officers not on the BMC payroll should be included in the unit.

IV. CHIEF RESIDENTS

Among the house officers the Petitioner seeks to represent are approximately 30–40 chief residents, who BMC contends should be excluded as either supervisors or managers. Chief residents have historically been covered by the parties' collective-bargaining agreement.

Chief residents cannot be adequately characterized as a group, as their duties, responsibilities, and authority vary widely from program to program. Indeed, the term "chief resident" does not mean the same thing from one residency program to another. In some programs, such as those in orthopedics and surgery, all those in the final year of their residency are called chief residents. In other programs, such as pediatrics and internal medicine, chief residents are selected to serve an additional year beyond the normal residency period. Some programs have one chief resident, while others have half a dozen or more; some have no chief resident in a given year.

Chief residents do not "hire" or "fire" other house officers, but several BMC witnesses testified that chiefs sit on the committee that selects applicants for the residency program, and that they frequently give input that is used to determine whether an intern or resident progresses to the next PGY level. This is particularly true in the Boston Combined Pediatrics Residency Program, which is offered by the Employer in conjunction with Harvard Medical School and Children's Hospital, and in the internal medical residency program.

Program Director Robert Vinci described the selection process in the pediatric residency program and testified about the involvement of chief residents in that process. The selection committee is chaired by a staff physician from each of the two hospitals in the Combined Residency Program. The chairpersons screen the approximately 3000 applicants and select approximately 250 for interviews. Each applicant selected for an interview has two to four interviews over 2 days at the two campuses. The interviews are conducted by faculty members and, sometimes, fellows. Although both of BMC's chief residents are involved in interviewing, the majority of applicants are interviewed only by attending physicians on the faculty. After each interview, the faculty interviewer completes an evaluation form, which is then reviewed by the selection committee for ranking.

In the internal medicine program, approximately 60 faculty and 2 to 4 house officers participate in the internship selection committee.[112] Applicants are interviewed by one or two people. Although Program Director David Battinelli did not testify about the frequency with which chief residents interview applicants, he did testify that no applicant is interviewed *only* by a resident. Following each interview, the faculty interviewer

[110] Supra, 317 NLRB 1355.

[111] 322 NLRB 860 (1997), citing *Management Training Corp.,* supra at 1358 fn. 16.

[112] Usually, only one of the house officers on the selection committee is a chief resident.

completes an evaluation form. After the interviews are completed, the selection committee reviews the applications and discusses the applicants' ranks. Battinelli has ultimate responsibility for ranking the applicants for submission to the matching program.

Battinelli testified that house officers frequently meet with candidates informally, outside the application process, and then give input to the program director regarding their impressions of the applicants. Although Battinelli is responsible for ranking the applicants, he testified that he gives "considerable weight" to the comments provided by house officers. About 20 percent of those interns admitted to the program had positive input from house staff, according to Battinelli, while about 5 percent of all applicants interviewed have negative input from the house staff. This informal input into the selection process is given by house officers in all PGY levels, not just chief residents, although Battinelli testified that he gives greater weight to the comments of more senior house staff.

In many residency programs, chief residents sit on evaluation committees, which are responsible for appraising house officers' performance at the end of each year of residency. In most programs represented at the hearing, house officers are evaluated at the end of each rotation by the attending physician or program director responsible for that rotation. Then, an evaluation committee reviews the appraisals given to each house officer and makes a composite evaluation for each to send to the program director. In the oral and maxillofacial surgery residency program, the evaluation committee is comprised of four to six individuals, one of whom is a chief resident.[113] The committee holds quarterly meetings in which it reviews the rotation evaluations, makes a report on the evaluations to send to the program director, and meets with the house officer to discuss the evaluation. According to Program Director Donald Booth, in making its report, the committee can recommend that a house officer be placed on probation, suspended from the program, or terminated, and the committee has recommended termination on at least one occasion. In the event that the committee recommends that a house officer be dismissed, suspended, or placed on probation, the program director independently reviews the rotation evaluations and the facts before making a decision.

The evaluation process is similar in the pediatrics program. House officers are evaluated at the end of every rotation by the attending physician on that service. Those evaluations are reviewed every 4 months by an evaluation committee, which is comprised of six faculty members and four chief residents. The full committee does not review each house officer's evaluations. Instead, each committee member is assigned three or four house officers, whose rotation appraisals the member reviews and for whom the member creates a composite evaluation based on those evaluations. The composite evaluations are then brought before the full committee, which discusses and approves them. According to Vinci, the chief resident has a "significant role" in this process because of his or her daily contact with the house staff. After the evaluation is completed, the chief resident meets with the house officer to deliver and discuss the evaluation.[114]

Vinci testified that house officers are occasionally asked to leave the program. In the last 5 years, however, no house officer has been terminated from the pediatrics program, and fewer than five percent have been denied promotion to the next PGY level.

In other programs, the input of chief residents in the evaluation process is less formal. For example, Battinelli testified that internal medicine chief residents contribute to the evaluation of other house officers by reporting performance problems to the program director. There does not appear to be a formal mechanism for such input, however. Similarly, in the surgery program, chief residents have no formal role in evaluating other house officers, but Program Director James Becker testified that faculty frequently consult with chief residents when evaluating house staff at the end of each rotation. Becker stated that he consults with the chief resident every time he fills out an evaluation on a house officer, and that the chief's input has influenced his evaluation.[115]

Some chief residents testified at the hearing that they have been asked for input on a house officer's evaluation, but that such input is simply part of the "pecking order" among house officers, rather than because of their role as chief residents. For example, Acting Internal Medicine Chief Resident Camilla Graham recalled three occasions on which she was asked for her impressions of a resident's performance. These occurred when Graham was a PGY 2, however, not during her tenure as acting chief. Similarly, Pediatrics Rising Chief Jodi Wenger[116] testified that, in completing an intern's evaluation, the attending physician might ask a PGY 2 or 3, as well as the chief, what he or she thinks of the intern. Otherwise, Wenger testified, the attending physician bases the evaluation on his or her own observations of the intern at rounds and in other settings.

In some residency programs, such as radiology and pathology, chief residents have no role in the evaluation process. Radiology residents, like those in other departments, are evaluated at the end of each rotation by a faculty member in that rotation. Additionally, Program Director Joseph Ferrucci or his associate conducts biannual review interviews with each house officer. If, during the course of the residency program, a house officer is not progressing as expected, Ferrucci confers with other faculty members to confirm the problem, and then meets with the house officer to discuss and design a corrective plan. In the pathology program, attending physicians and faculty members complete resident evaluations every 3 or 4 months, based on their personal observations of the house officer's performance. Chief Orthopedics Resident Linda Parke D'Andrea testified that she has never been asked for her impressions of a house officer's skills or performance, and that she has never given such input. Likewise, Chief Otolaryngology Resident Andrew Mester testified that attending physicians in that de-

[113] The chief residents rotate on this committee, however, so that there is a different chief at each evaluation committee meeting.

[114] This is not true if the evaluation is seriously negative. In that case, the resident's advisor and program director would also be present during the evaluation meeting.

[115] In the surgery program, a promotions committee comprised only of faculty reviews each resident at the end of each year and makes a recommendation to the program director as to whether the resident should progress to the next PGY level.

[116] A rising chief is one who has been selected to be a chief resident for the following year. At the time of the hearing, Wenger was a PGY 3 who had been selected to be a chief resident for the 1997–1998 year.

partment do not ask their chiefs for an assessment of house officers' performance in conducting performance evaluations.

Chief residents are involved in assigning work to other house staff. In virtually every department, chiefs are involved in creating the schedules of the house officers. Such scheduling and assignment duties generally fall into four categories: preparing the year-long rotation schedule, assigning on-call duties, assigning coverage for absent house officers, and directing house officers to perform specific tasks as needed.

With respect to the year-long rotation schedule, the aim in every department is to ensure that all residents in the department complete the same set of rotations by the end of the year.[117] Thus, for example, in the pediatrics program, one of two chief residents is responsible for filling in the block schedule for second- and third-year residents.[118] According to Wenger, in the pediatrics program, that task involves filling in a grid to permit each of 12 rotations to be filled every month, with every resident covering each rotation once. Wenger testified that, in making the rotation schedule, she takes residents' vacation preferences into account. The schedule must be approved by the program director.

Similarly, in the radiology program, chief residents make the schedule according to staffing patterns set by the program director. According to Radiology Program Director Joseph Ferrucci, the two chief residents in his department fill the slots in the schedule, with the aim of ensuring that all radiology residents complete the same rotations by the end of the year.

Chief residents also have responsibility for the on-call lists, which are prepared monthly according to department protocol. In general, the chief resident preparing the on-call list follows that protocol, taking into account before making the schedule residents' special requests for particular dates off. In pediatrics, for example, residents are on-call every fourth night, and the chief resident fills in the schedule accordingly. Wenger testified that she has some discretion to take into account requests for a particular night off-call to accommodate special circumstances such as weddings and other events, but that a resident who is aggrieved with the schedule must bring the problem to the program director. In preparing the orthopedic surgery on-call schedule, D'Andrea asks residents to submit their requests for time off, and tries to accommodate such special requests.[119] Then she fills in the schedule according to protocol. At the East Newton Street facility, residents are on call every third night. In otolaryngology, Mester described the process of making the on-call schedule as generally random, although he considers personal requests for days off and alternates major holidays. In preparing on-call schedule, chief residents do not consider individual skills and experience, but only the PGY level of the resident.

Chief residents have responsibility for arranging coverage for absent residents. In every program represented at the hearing, however, the chief has a limited list from which to select emergency coverage, and aims to rotate coverage among those on the list. For example, when all the pediatric residents on a particular ward have clinic on the same day, the chief resident is expected to find coverage from among the house officers who are on an "elective" rotation. When residents are absent because of illness, the chief selects from the two or three house officers who are assigned that month to sick call back-up duty. Likewise, in the internal medicine program, the chief resident is responsible for arranging emergency coverage, but must select from a list of three residents in each PGY level designated for emergency coverage. In making their selections, the chief residents simply call residents on a rotating basis so that back-up shifts are distributed equitably.

Finally, chief residents have substantial responsibility for overseeing the day-to-day work of the house staff in their programs. Chief residents frequently assign residents' daily tasks but generally have no authority to enforce them. For example, when a house officer needs assistance performing a particular procedure, the chief resident might ask another resident to help. D'Andrea testified that, in internal medicine, if she asks another resident and the resident is too busy or for some other reason refuses to help out, she has no authority to enforce such a request. D'Andrea testified that she has never reported any house officer for refusing to help out as requested. Similarly, although chief residents frequently instruct less senior residents on patient care issues, they have no authority to require the resident to carry out their patient care directives.

Several witnesses described the chief's duties with respect to assignment of tasks as part of a "pecking order" in which the more senior residents guide the junior residents, and the junior residents guide the interns and medical students. Surgery Department Program Director James Becker described this "pecking order" as a "continuum of graded responsibility and authority" in which chief residents oversee third- and fourth- year residents, who in turn watch over first- and second- year residents. In this regard, a more senior resident might suggest to a junior resident that he or she substitute a less expensive medication for the one prescribed. Also, chief residents, as well as other residents, may give input to program directors as to which junior residents are ready for a particular rotation.

Notwithstanding the "pecking order," some chief residents have greater authority than other residents for assigning and overseeing the work of junior residents. In the orthopedic surgery residency program, the five chiefs assign residents between the clinic and the operating room on a day-to-day basis. The chiefs do not independently decide how many residents are needed in the operating room versus the clinic. Instead, the ratio is determined by the number of operating rooms in use for orthopedics on a given day, and the types of procedures scheduled. According to D'Andrea, these assignments are based on a number of factors, including the PGY level of the resident, the resident's personal interest in a patient (for example, if the surgical patient was a clinic patient of the resident), and the goal of exposing house officers to a variety of procedures. D'Andrea also testified that in making such assignments she sometimes considers the skill level of the resident, but that her assessment of a resident's skill level is usually determined solely by his or her PGY level. Moreover, D'Andrea testified that any consideration of a resident's skills is based on the attending physician's assessment of those skills.

In the otolaryngology program, the two chief residents schedule cases for surgery and assign house officers to partici-

[117] Chief residents do not prepare the rotation schedule in every department. For example, in the internal medicine program, the rotation schedule is prepared by the program directors.

[118] Beginning with the 1998–1999 year, the schedule for second-year residents will be made by a secretary at Children's Hospital, the cosponsor of the combined pediatric residency program. Scheduling for pediatric interns is done by the same Children's Hospital secretary.

[119] According to D'Andrea, she has always been able to accommodate special requests and, thus, has never had to choose between competing requests.

pate in the operations according to established protocol. Chief Resident Mester testified that certain surgical procedures are designated for junior residents, others for senior residents, and still others for chief residents, and that he assigns them accordingly. Mester emphasized that he makes surgical assignments with no regard for the skills of the individual resident, because all residents need to complete their program with the same level of knowledge and skill.

Surgical chief residents appear to have the most discretion in making assignments to other residents. Based on their experience with the complexity of certain surgical procedures, the chief residents assign house officers to assist in the operating room. According to Becker, the chiefs consider the complexity of the case and the resident's level of training in deciding whether a resident could learn from the assignment. Becker testified that the chief residents have a good feel for what type of case is appropriate at each level of training, and that they base their assignments on that experience. Although the chief makes the surgical assignments, Becker testified, the attending physician is responsible for ensuring that the assignment is appropriate, and occasionally reassigns the case accordingly.

Including the chief residents on site, there are about nine surgical residents available at the East Newton Street facility on any given day.[120] On Becker's service, there are two residents (a PGY 2 and a PGY 3) and one chief to assist in one or two operating rooms. According to Becker, the usual practice is to assign one resident for each operating room and keep one available on the hospital's surgical unit. In making these assignments, Becker testified, the chief resident usually keeps the most complicated case for him or herself and divides surgical unit and operating room duties between the other two residents.

Chief residents are paid more than less senior residents. Under the wage scale set forth in the parties' collective-bargaining agreement, residents' salaries increase each year of their program. Accordingly, chief residents, like other residents, are paid according to their PGY level. There is no separate wage scale for a classification of chief residents, and there is no separate benefits package for chiefs. In some departments, chief residents share an office, while in others there is no office for chief residents.

Chief residents have more regular work schedules than other residents. While they are responsible for on-call coverage, they can usually provide such coverage from their homes. Other residents must remain in the hospital during on-call hours. Chief residents are not required to perform certain duties, such as overnight shifts and "long-call."

In most of BMC's residency programs, chief residents, unlike other residents, are actively involved in curriculum planning. They have responsibility for conducting rounds on the hospital units; organizing educational conferences; leading journal club discussions; and making case presentations at morbidity and mortality conferences, case of the week conferences, and morning report, among other duties. In some departments, chiefs decide when a particular lecture or conference should be presented, in order to complement residents' clinical experience. For example, if there are several patients on a service with a particular disease or condition, the chief resident might adapt the curriculum and present a lecture on that issue at that time, instead of at a later date. In this situation, the chief does not design the curriculum, but has some discretion to modify it to allow issues to be presented when they are most relevant. Where chief residents have responsibility for case presentations, such as in rounds, case of the week, and morbidity and mortality conferences, they are responsible for determining the content of these didactic sessions. Thus, chief residents can impact the learning experience of other house staff by selecting the cases to which house officers are exposed.

Chief residents serve on several committees that govern residency program and intradepartmental issues such as intern selection, curriculum, evaluations, and the like. Among those committees, some include interns and junior residents as well as chiefs. Other committees are comprised only of faculty members.

Chief residents serve on the pediatric program's executive committee, along with faculty representatives of the two sponsoring hospitals. Although Vinci testified that the executive committee determines the educational components of the program, he did not give any examples of the kinds of decisions the committee makes or the autonomy it possesses. Chiefs also sit on the pediatrics program's Residency Program Development Committee, which reviews curriculum development for the combined residency program. Chief residents also serve on the radiology program's research committee, whose purpose is to develop resources to obtain and pursue research projects and funding.

Some committees include interns and junior residents as well as chief residents. For example, the internal medicine program's curriculum committee is comprised of a program director, representatives of all disciplines within the department, faculty representatives, chief residents, and other residents. Its function is to oversee the curriculum for residents, discuss teaching methods, plan conferences, and review the rotations to ensure that residents are exposed to all essential issues in internal medicine. The same department has a scheduling committee made up of a program director and program administrators, the incoming chief residents for the following year, and one or two house officers from each PGY level. The committee is charged with making the schedule for the following year. The radiology program's education committee, which oversees curriculum development, clinical rotations, faculty performance, and other issues, consists of several faculty members, the program director and chairperson, chief residents, and a resident representative of each PGY level.

Still other committees exclude residents altogether. For example, oral and maxillofacial surgery's Program Advisory Committee meets biannually to evaluate the residency program, recommend program changes, and review individual residents' performance. There are no chief residents on the committee, but only senior faculty. As noted above, the surgery program's Promotions Committee, which determines whether residents progress to the next PGY level, is comprised only of faculty members. In orthopedics, chief residents do not sit on any committees.

A. Chief Residents as Supervisors

BMC contends that, if the house officers are found to be employees within the meaning of Section 2(2) of the Act, then chief residents are supervisors within the meaning of Section 2(11) of the Act and should be excluded from any unit found appropriate.

Section 2(11) of the Act defines a supervisor as one who has:

[120] There were five surgical chief residents in 1996–1997. All were in their fifth and final year of residency.

> authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

To qualify as a supervisor, it is not necessary that an individual possess all of the powers specified in Section 2(11) of the Act. Rather, possession of any one of them is sufficient to confer supervisory status. *Chicago Metallic Corp*.[121] Consistent with the statutory language and the legislative intent, however, it is well recognized that the disjunctive listing of supervisory indicia in Section 2(11) does not alter the requirement that a supervisor must exercise independent judgment in performing the enumerated functions. Thus, the exercise of supervisory authority in a merely routine, clerical, perfunctory, or sporadic manner does not elevate an employee into the supervisory ranks, the test of which must be the significance of the judgment and directions. *Opelika Foundry*.[122] Additionally, the existence of independent judgment alone will not suffice, for the decisive question is whether the individual has been found to possess the authority to use independent judgment with respect to the exercise of one or more of the specific authorities listed in the Act. *Advanced Mining Group*.[123] The burden of proving supervisory status rests on the party alleging that such status exists. *Tucson Gas & Electric Co*.[124] One's status as a statutory supervisor is determined by actual job duties, not by title or job classification. *Seven-Up Bottling of Phoenix*.[125] An employee cannot be transformed into a supervisor by the vesting of a title and the theoretical power to perform one or more of the functions enumerated in Section 2(11) of the Act. *Magnolia Manor Nursing Home*.[126] Whenever the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, the Board will find that supervisory status has not been established, at least on the basis of those indicia. *Phelps Community Medical Center*.[127] The Board will refrain from construing supervisory status too broadly because the inevitable consequence of such a construction is to remove individuals from the protection of the Act. *Quadrex Environment Co*.[128]

Based on the foregoing, I find that the chief residents employed by BMC do not possess the authorities enumerated in Section 2(11) of the Act and are not supervisors within the meaning of the Act. In particular, and contrary to BMC's contentions, I find that chief residents lack the authority to select house officers or effectively recommend their selection, or to evaluate or reward house officers. I also find that, although chief residents in some cases assign and responsibly direct the work of other house officers, they do not exercise independent judgment in doing so.[129]

I note at the outset that not all individuals with the title "chief resident" have the same duties, responsibilities, or authority. Because the role of the chief resident varies significantly from department to department, no conclusions about their common supervisory authority can be drawn from the testimony at the hearing, which related to only 7 out of the Employer's 37 residency programs.[130]

Chief residents lack the authority to transfer, suspend, lay off, recall, promote, or discharge employees, to adjust employee grievances, or to effectively recommend such action. BMC takes the position, however, that participation by chief residents in the selection of applicants into the residency program is tantamount to hiring and satisfies the statutory indicia for a finding of supervisory authority. I find that the level of their participation in this process is insufficient to establish that they are supervisors within the meaning of the Act, because they do not effectively recommend the selection of any candidate. The Board has described an effective recommendation as one that is acted upon without further investigation or review. *Waverly-Cedar Falls Health Care*.[131] Here, by contrast, the selection committee's ranking of applicants is not only reviewed by the program director, but is ultimately processed by the National Residency Matching Program, which has the ultimate "hiring" authority. Thus, the decisions made by the Selection Committee are so attenuated as to render them ineffective. Clearly, they do not rise to the level of effective recommendations required by the Board to support a finding of supervisory status.

Moreover, chief residents alone do not make the selection. For example, in the internal medicine residency program, the two to four chief residents constitute such a small percentage of the selection committee that their input is severely diluted by the approximately 60 attending physicians and faculty who serve on the committee. The Board has held that "mere participation in the hiring process, absent the authority to effectively recommend hire, is insufficient to establish . . . supervisory authority," even where the purported supervisor participates in the interview and assists in evaluating the candidates for hire. *North General Hospital*.[132]

Chief residents do not discipline other house officers. While a chief resident may speak to another resident about a problem such as tardiness, it appears that any disciplinary action would be imposed by the program director. Such initial counseling, without more, does not establish supervisory authority. See *Providence Hospital*.[133] A chief resident may report disciplinary or performance problems to a program director, but makes no recommendation as to how they should be handled. The obligation to report problems to management, without the accompanying authority to effectively recommend any responsive

[121] 273 NLRB 1677 (1985).
[122] 281 NLRB 879, 899 (1986).
[123] 260 NLRB 486, 506–507 (1982).
[124] 241 NLRB 181 (1979).
[125] 263 NLRB 596, 604 (1982).
[126] 260 NLRB 377, 385 fn. 29 (1982).
[127] 295 NLRB 486, 490 (1989).
[128] 308 NLRB 101, 102 (1992).
[129] In its brief, BMC argues that chief residents also possess secondary indicia of supervisory authority, such as higher pay, additional benefits in the form of more regular hours, and, in some cases, offices. The Board has often held that such secondary indicia can support a finding of supervisory status, but only when the employee also performs one or more of the functions set forth in Sec. 2(11). See, e.g., *Northcrest Nursing Home*, 313 NLRB 491, 500 (1993). In light of my finding that the chief residents do not perform any 2(11) functions, the secondary indicia do not affect their status.
[130] The Employer does not contend that certain individual chief residents are supervisors, but that the entire group of 30–40 have supervisory functions.
[131] 297 NLRB 390, 392 (1989).
[132] 314 NLRB 14 (1994).
[133] 320 NLRB 717, 719 (1996).

action, is not indicative of supervisory status. *Express Messenger Systems*.[134] The record here contains no other evidence of discipline by a chief resident.

Although chief residents participate in the evaluation of other house staff, the extent and nature of their participation do not confer supervisory status upon them. The Board will find supervisory status where an individual independently performs employee evaluations that lead directly to personnel actions, such as raises, promotions, or discipline. *Ten Broeck Commons*.[135] Where the evaluations do not directly affect employees' job status, however, the Board will not find supervisory authority. *Bayou Manor Health Center*.[136]

First, chief residents do not *independently* evaluate BMC's house officers. At most,[137] they sit on departmental evaluation committees, which generally meet about four times a year to review the evaluations prepared by attending physicians at the end of each rotation. The function of those committees, and of the chief residents who sit on them, is to create a summary evaluation for each resident's file so that a determination can ultimately be made by the program director as to whether the resident is ready to advance to the next PGY level.[138] Because so many other individuals contribute to the evaluations, they are not the sole product of the chief residents and do not confer supervisory status. See *Ten Broeck Commons*.[139]

Second, the evaluations that the committees prepare do not directly affect house officers' terms and conditions of employment. Evaluations have no effect on house staff wages, promotions, or assignments. Although a committee may recommend that a house officer be terminated from the program or denied advancement to the next PGY level, it appears from the record that these actions are rarely taken.[140] Moreover, all the program directors who testified on this issue stated that they would independently investigate such a recommendation before taking action.[141] Thus, it appears that advancement through the program is determined by a number of factors, not solely on a house officer's performance evaluations.[142]

Although chief residents frequently assign work to other house officers, these assignments are routine and do not require the exercise of independent judgment. Similarly, to the extent that chief residents responsibly direct the work of subordinate residents, their direction requires the use of professional, but not independent, judgment.

In *Providence Hospital*,[143] the Board addressed the impact of the Supreme Court's decision in *NLRB v. Health Care & Retirement Corp.*[144] on the determination of supervisory status in a health care setting.[145] Specifically, the Board addressed the issue of when the "exercise of discretion and judgment" by professional employees, as defined in Section 2(12) of the Act, becomes "independent judgment" sufficient to make an individual a supervisor under Section 2(11). Thus, *in Providence Hospital,* the Board attempted to interpret the statutory language "assign," "responsibly to direct," "routine," and "independent judgment" so as to harmonize Section 2(11) and (12). In determining that the charge nurses were not statutory supervisors, the Board distinguished between the "authority arising from professional knowledge" and the "authority encompassing front-line management."[146] Where the former alone is present, the Board will find that professional employees are not supervisors; where the latter also exists, the employees are supervisors as well as professionals. In a health care setting, where nurses and physicians frequently make critical decisions and give orders affecting the life and death of their patients, the distinction between professional judgment and independent judgment is easily blurred. The Board has cautioned, however, that "the possibility that severe consequences might flow from a professional's misjudgment does not necessarily make that judgment supervisory; critical judgment is the quintessence of professionalism." Id. at 725–26; see also *Ten Broeck Commons*.[147]

I find that the chief residents' authority to direct and oversee the work of other house officers flows not from any supervisory authority, but from their professional expertise, as well as from their superior knowledge, skill, and experience. One of the primary functions of all residents, not just chief residents, is to formulate and implement treatment plans for patients in their care, and to monitor those plans for effectiveness. Thus, although chief residents provide guidance and direction to junior residents regarding patient care issues, such direction is no different from that given to interns by junior residents. In other words, all residents, regardless of their title, guide and direct less experienced residents in the treatment of patients according to a "pecking order" that appears to be the *modus operandi* of the residency program. As a result, it is not surprising that the chief resident, who is frequently the most senior physician on hand at any particular time, is the most familiar with the tasks that need to be performed and the most effective way of carry-

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[134] 301 NLRB 651, 654 (1991).

[135] 320 NLRB 806 (1996).

[136] 311 NLRB 955 (1993).

[137] In addition to sitting on such committees, chief residents often have informal input into the evaluation process. Several program directors testified that they rely on the observations and reports of chief residents when they prepare their formal reviews of residents and interns. Such informal input, however, is not an indication of supervisory authority because there is no evidence to establish that such input constitutes an effective recommendation for a promotion or reward. *Arizona Public Service Co.,* 310 NLRB 477, 480 (1993). Moreover, the record demonstrates that the residency program relies on a pecking order in which junior residents oversee interns, chief residents oversee junior residents, and attending physicians oversee chief residents. Thus, it appears from the record that *all* residents, not just chief residents, provide informal input into the evaluation of other residents.

[138] In completing this evaluation, committee members have not necessarily observed the performance which they are evaluating, but simply base their appraisal on the observations of the attending physician who has conducted the review. Thus, there is nothing independent about these summary evaluations.

[139] Supra at 813.

[140] As noted above, fewer than five percent of pediatrics residents are denied promotion, while no one has been terminated from that program in the last 5 years. In oral and maxillofacial surgery, one resident was terminated from the program.

[141] In at least one department, chief residents are responsible for communicating the committee's evaluation to the resident. The authority to deliver an appraisal to an employee, however, is not evidence of supervisory authority, as it does not require the exercise of independent judgment. Moreover, in the Pediatrics Department, if an evaluation is seriously negative, the resident's advisor and program director are present for the evaluation.

[142] Id.

[143] 320 NLRB 717 (1996).

[144] 510 U.S. 810, 114 S.Ct. 1778 (1994).

[145] The disputed employees at issue in *NLRB v. Health Care & Retirement Corp.* and *Providence Hospital* were charge nurses. The analysis, however, applies equally to the chief residents at issue here.

[146] Id. at 728.

[147] Supra at 811.

ing them out. *Bozeman Deaconess Hospital*.[148] As the Board has often noted, the fact that those tasks may be highly technical or risky is irrelevant to the supervisory determination. Because the chief residents' decisions and direction are based on their knowledge and skill, they are routine in nature and not indicative of supervisory authority.

Similarly, the fact that chief residents sometimes intervene in a patient's diagnosis or treatment does not elevate them to supervisory status, but is merely a function of their professional responsibility. In this regard, chief residents are no different from other house officers, who have an obligation to intervene when they observe someone junior to them making an incorrect diagnosis or prescribing inappropriate treatment. See *Providence Hospital*.[149]

Chief residents' participation in the day-to-day allocation of duties does not make them statutory supervisors. In most departments, chief residents are responsible for assigning residents to cover the various areas in that service. For example, the surgical chief residents decide on a day-to-day basis which residents will assist in the operating room, and which will cover the surgical unit. In making these assignments, the chief considers the resident's skill in relation to complexity of the case, as well as the equitable distribution of surgical procedures among residents on the service. Familiarity with the procedures is, of course, a function of the chief resident's professional training and experience. The chief's assessment of the resident's skill is usually based on his or her PGY level, rather than on any independent evaluation.[150] Moreover, the attempt to be fair in distributing assignments is a reflection not of the chief's independent judgment, but of BMC's goal of ensuring that all residents complete the program with the same or similar experiences and skills. Thus, an important consideration in making assignments is whether exposure to a procedure would enhance and equalize a resident's clinical experience. Such attempts to balance workloads do not indicate supervisory authority. *Providence Hospital*.[151] Finally, it is the attending physician who is responsible for ensuring that the assignment is appropriate, and attendings occasionally reassign cases accordingly.

I also conclude that the various scheduling functions performed by some chief residents do not require the exercise of independent judgment and, therefore, do not confer supervisory status. The Board has held that, where assignments are "made to equalize employees' work on a rotational or other rational basis," they are routine and not indicative of supervisory authority. Id.; see also *Ten Broeck Commons*.[152] Here, the creation of the year-long rotation schedule is essentially a clerical task, in which a chief resident fills in the blanks to ensure that each resident rotates through each clinical rotation during the course of the year.[153] Similarly, the preparation of monthly on-call schedules does not require the exercise of independent judgment. In creating the on-call schedules, chief residents follow a predetermined protocol in which every resident is on call every so many nights, according to his or her department's practice.[154] Furthermore, the activation of emergency coverage by a chief resident does not require independent judgment, because chiefs are limited in their discretion by a short list of replacements whom they may call, and because they are expected to distribute such assignments on a rotating basis. See *Providence Hospital*,[155] citing *Ohio Masonic Home*.[156] Finally, BMC argues that the authority to activate the on-call list is also evidence of chief residents' authority to reward employees, because residents who are called in for an extra shift receive extra compensation. Because these assignments are distributed on a rotating basis, however, I find that they are not evidence of independent authority to reward employees.

Accordingly, I find that chief residents do not perform any of the functions enumerated in Section 2(11) and are not supervisors within the meaning of the Act.

B. Chief Residents as Yeshiva Managerial Employees

BMC also argues that, if the house officers are employees within the meaning of the Act, then the chief residents should be excluded as managerial employees.[157] Managerial employees, who are excluded from the Board's coverage, are those who "formulate and effectuate management policies by expressing and making operative the decisions of their employer." *NLRB v. Bell Aerospace Co.*[158] Professional employees, such as the chief residents at issue here, can be considered managerial only if their activities "fall outside the scope of the duties routinely performed by similarly situated professionals." *Montefiore Hospital & Medical Center*.[159] In *NLRB v. Yeshiva University,*[160] the Supreme Court held that university faculty were excluded as managerial employees where they formed committees which determined academic content, established grading policies and matriculation standards, and effectively decided which students would be admitted, retained, and graduated. In applying the managerial exclusion to the petitioned-for faculty, the Court considered that, while faculty recommendations were subject to the approval of a dean or other administrator, the "overwhelming majority" of faculty recom-

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[148] 322 NLRB 1107 (1997).

[149] Supra at 732.

[150] See, e.g., *Providence Hospital*, supra at 727 (assignment based on employee's skill level is routine where skills are obvious or well known).

[151] Supra at 727.

[152] Supra at 810.

[153] In *Providence Hospital*, the Board noted that the charge nurses did not prepare staffing schedules. It does not follow, however, that the Board would have reached a different conclusion if the charge nurses were involved in scheduling employees' hours. This is especially true in light of the Board's consistent holding that preparing schedules according to the Employer's predetermined requirements is tantamount to filling in the blanks and is clerical, not supervisory. I note that, in some BMC programs, it is in fact a clerical employee who creates the residents' schedules.

[154] Although chief residents testified that they might take into account a resident's request for a particular day or night off, there is no evidence in the record that such a consideration has ever resulted in an actual conflict requiring intervention or resolution. Thus, it is not clear how a chief resident would resolve such a scheduling conflict, or whether he or she even has the authority to do so.

[155] Supra at 732.

[156] 295 NLRB 390, 395 (1989) (Balancing work assignments among staff members or using other equitable methods does not require the exercise of supervisory independent judgment.).

[157] Although I need not reach this issue in light of my finding that the house officers are not employees, I reach it because it is closely related to the supervisory issue and because it was fully litigated in the hearing.

[158] 416 U.S. 267, 94 S.Ct. 1757 (1974).

[159] 261 NLRB 569, 570 (1982).

[160] Supra.

mendations were actually implemented.[161] Id. at 2528–2529, fns. 3–6.

Based on the foregoing, I find that BMC's chief residents do not formulate or effectuate management policies and are, therefore, not managerial employees. Some chief residents participate in committees which recommend, among other things, applicant ranking for admissions, curriculum changes, and research proposals. There is, however, little evidence in the record to establish the relative authority which these committees possess. For example, while several program directors testified generally about the committees on which chief residents sit, there is no testimony concerning the extent to which the committees' recommendations are implemented. Therefore, BMC has not met its burden of establishing that the committees on which chief residents sit actually formulate and effectuate management policies.

Moreover, unlike the committees in *Yeshiva*, which were comprised entirely of petitioned-for employees, the committees in BMC's residency programs are comprised primarily of faculty and attending physicians, and only minimally of the petitioned-for chief residents. In these circumstances, chief residents are so outnumbered as to render their collective voice ineffectual.[162]

Additionally, not all chief residents sit on the committees whose functions are purportedly managerial. Thus, any managerial authority which chief residents possess cannot be attributed to chief residents as a group.[163] Finally, several committees include junior residents as well as the chief residents who BMC claims are managerial. In these situations, whatever authority is vested in the chief residents sitting on the committees appears to be a function of their status as residents, not their status as chief residents. Therefore, I find that the chief residents' participation in some committees is insufficient to require their exclusion as managerial employees.

BMC also contends that the chief residents are managerial employees because they affect the academic content of their programs by selecting cases for presentation, organizing didactics and other conferences, and leading journal club discussions. The record contains insufficient evidence that the chief residents alone determine the academic content of their programs. In fact, in the one clear example in the record of the scope of the chief resident's authority in this respect, it appears that the chief resident can affect the sequence of didactic presentations, but not actual academic content.[164]

Accordingly, I find that the chief residents are not managerial employees and should not be excluded from the bargaining unit on this basis.

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[161] Id. at 2528–1429, fns. 3–6.

[162] Indeed, many committees have no chief residents at all. See *Joint Diseases, North General Hospital,* 288 NLRB 291, 299 (1988) (physicians not managerial employees, where, among other things, there was no evidence of how many physicians served on committees with purportedly managerial functions).

[163] BMC has taken the position that all chief residents should be excluded as managerial employees. Thus, BMC has not presented evidence sufficient to establish that particular individuals should be excluded on this basis. I note that BMC has the burden to demonstrate that either the entire class, or specific individuals therein, are managerial employees. *Montefiore Hospital & Medical Center,* 261 NLRB at 572 fn. 17.

[164] Even assuming, however, that chief residents formulate and implement policy with respect to academic content, they are not managerial employees because health care, not education, is the basic business of the Employer. *Montefiore Hospital & Medical Center,* 261 NLRB at 572.