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The National Labor Relations Board Redefines Medical Employee under the Wagner Act Regarding Residents and Interns Thereby Opening the Door to Unionization and Collective Bargaining Demands

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THE NATIONAL LABOR RELATIONS BOARD REDEFINES "MEDICAL EMPLOYEE" UNDER THE WAGNER ACT REGARDING RESIDENTS AND INTERNS THEREBY OPENING THE DOOR TO UNIONIZATION AND COLLECTIVE BARGAINING DEMANDS

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I. INTRODUCTION AND BACKGROUND

On March 23, 1976, the National Labor Relations Board (NLRB or the Board) decided the *Cedars-Sinai Medical Center*[1] case, in which it concluded that a private, non-profit California Corporation engaged in the operation of a medical center with numerous medical interns and residents did not have employees working for it.[2] The NLRB reached this conclusion based upon the meaning of "employee" as interpreted under the provisions of the National Labor Relations Act (NLRA or Wagner Act).[3] The Board found it difficult to effectuate the policies of the NLRA by finding that these individuals were employees and entitled to the privileges accorded by the statute.[4] In this particular case, the employer operated general hospitals, which were licensed to handle 530 beds, as well as the Mount Sinai hospital division, which was licensed for up to 230 beds.[5] The petitioner sought to represent a portion of the medical school's residents, interns, and clinical fellows and contended that these individuals should be considered employees because most of their work endeavors were more akin to those of a worker, than those of a student.[6] Phrased differently, the time spent as a resident was not necessarily part of the educational process, but rather was more like being a low-paid employee learning the nuts and bolts of the profession. Thus, residents, interns, and clinical fellows were deprived of the protections of the NLRA simply due to an arbitrary classification.

The Board initially took a hard look at the process by which an individual becomes a licensed physician. It noted that the medical education and training of a physician necessarily involved a progression

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1. 223 N.L.R.B. 251 (1976).
2. *Id.* at 254.
3. 29 U.S.C. §§ 151-169 (1994).
4. Cedars-Sinai Med. Ctr., 223 N.L.R.B. at 252-53.
5. *Id.* at 251.
6. *Id.*

from classroom and laboratory work to basic and clinical sciences. This in turn evolved into an internship or residency where the individual specialized in one aspect of medicine.[7] The residency is the period of time where the individual learns the preventive diagnosis aspect of treatment and therapy, as well as the management of patients. These aspects of medical education cannot be taught in the classroom.[8] Accordingly, the rationale was that any training received by the residents was in their status as students in a non-classroom environment, thus, yielding insufficient justification to seek collective bargaining and unionization rights as employees under the Wagner Act.[9]

An intern is defined as a medical school student who successfully completed his or her first year of medical school and is receiving training in a hospital.[10] In California, one year is required in order to practice medicine.[11] A resident is defined as a physician who has completed an internship plus a period of more advanced training lasting anywhere from one to five years in a particular specialty.[12] A clinical fellow is defined as a physician who has completed both an internship and residency and is doing post-graduate work a certification in a particular specialty of medicine not taken during his or her residency period.[13] In the *Cedars-Sinai* opinion, the NLRB refers to the term "house staff." This term is used to refer to a variety of medical and hospital personnel, which includes all interns, residents, and clinical fellows.[14]

At the time the of the hearing, thirty-four interns, eighty-six residents, and twenty-four clinical fellows worked at Cedars-Sinai.[15] The National Intern and Resident Matching Program (NIRMP) governs the training of medical students at Cedar-Sinai and their placement at the institution.[16] This program takes graduating medical students, along with their preferred graduate training institution, and attempts to match them with an institution based on the institution's need and the student's abilities.[17] Students and hospitals register with the service or program and sign an agreement binding them to the matching results.[18]

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7. *Id.* at 252.
8. *Id.* at 251-52.
9. *Id.* at 251.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.* The term itself has now become one of common usage in referring to medical personnel, and it will be used as such throughout this article.
15. *Id.* at 252.
16. *Id.*
17. *Id.*
18. *Id.*

Essentially, the graduating student makes out a preference list of positions in conjunction with a personal interview at participating hospitals approved by the American Medical Association (AMA).[19] The hospitals also make a preference list of the student applicants. The NIRMP attempts to accommodate the wants and needs of both the institutions and the students by combining the graduating student's preference list with the participating hospital's preference list.[20] The department director at Cedars-Sinai appoints residents and clinical fellows, generally filling most of the positions with interns originally placed there through the national matching program and who have completed their first year as interns.[21] These accrediting bodies are well known within the medical field and have codes, procedures, and programs that set forth the activities that all house staff follow throughout their educational programs.[22]

All educational or training programs consist of constant patient care activities and are coordinated through a number of teaching and educational processes, all of which are designed to assist the student in developing his or her clinical proficiency prior to being authorized to practice a particular specialty or sub-specialty.[23] Student experiences generally include: the taking of medical histories, performing examinations, and insuring that patient medical records and charts are up to date. Students perform some diagnostic and therapeutic planning during educational service rounds. These experiences are generally considered an integral part of a physician's training, since the lead doctor will supervise a group of individuals from patient to patient in order to aggregate a significant number of learning experiences into a short period of time.[24] In fact, "making rounds" has become a staple of the house staff curriculum. The students are permitted to take elective courses and to participate in rotations at other hospitals if they do not conflict with their requirements and obligations at Cedars-Sinai.[25]

On November 26, 1999, in a three-to-two decision, the NLRB issued its opinion in *Boston Medical Center Corp.*,[26] and overruled a quarter century of precedent on the "medical resident as student" issue as determined pursuant to the *Cedars-Sinai* case.[27] The *Boston Medical*

19. *Id.*
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. 162 L.R.R.M. (BNA) 1329 (1999).
27. In *Boston Medical Center Corp.*, the majority ruled that the petitioner house staff were employees within the context of the NLRA and entitled to its protection. *Id.* at 1332.

decision held that medical house staff are employees and have the same rights relative to collective bargaining, joining unions, and striking as enjoyed by their fellow workers.[28] No longer would these individuals be viewed as "students" completing their medical training and subject to the austere work standards and conditions allowed under *Cedars-Sinai*.

A new day dawned, and it was not long before academic institutions and leaders began denouncing the decision. Jordan C. Cohen, president of the Association of Medical Colleges, stated that labor arbitration "opens the door to all kinds of mayhem."[29] This was typical of the overreaction from the academic-medical community so heavily dependent upon the inexpensive skilled labor provided by house staff personnel.[30]

In the *Boston Medical* opinion, Member Brame concluded that house staff personnel are "employees," but noted that this was far from the end of the inquiry regarding employee status.[31] The critical factors used by the Board in determining employee status included the receipt of fringe benefits, a taxable stipend, and worker's compensation insurance, in addition to the incredible total of work hours spent at the hospital completing the "duties" of the "educational experience."[32] Interestingly, Brame first turned to the dictionary definition of "employee" before reviewing any legislative approaches offered by Congress in the NLRA.[33] While the dictionary definition proved sufficient, the majority also analyzed the definition included in the NLRA and found it to be in concert with the dictionary reading, as well as the Board's holding.[34] The majority pointed to the medical profession's post-graduation apprenticeship requirement for licensing and therefore concluded that the profession essentially thrusted a worker status upon the individual.[35]

The majority also stated that a professional employee includes anyone who performs work that requires knowledge pursuant to a prolonged course of study and which requires the supervision of a qualified, sometimes licensed, professional.[36] This covered house staff

28. *Id.*

29. Katherine S. Mangan, *Academic Medicine Becomes a Target for Labor Organizing*, CHRON. HIGHER EDUC., Aug. 6, 1999, at A14.

30. *Id.*

31. *See* Richard M. Kobdish, *National Labor Relations Board Rules that Interns and Residents May Unionize*, 12 HEALTH LAW. 18 (Feb. 2000) (citing *Boston Med. Ctr.*, 162 L.R.R.M. (BNA) 1329).

32. *Boston Med. Ctr.*, 162 L.R.R.M. (BNA) at 1340.

33. *Id.*

34. *Id.* at 1340-41.

35. *Id.*

36. *Id.*

personnel.[37] Additionally, Congress included references to residents and interns in the legislative history of the 1974 amendments to the NLRA, an important point since the amendments brought non-profit healthcare institutions under coverage of the statute.[38] The opinion stressed that congressional concern as to resident and intern pay and working conditions impliedly brought the forces of the NLRA into play.[39] It was the very manner in which workers were being mistreated by their employers that initiated the struggle that resulted in passage of the NLRA. Finally, the NLRB reviewed the developments in labor relations subsequent to the decision in *Cedars-Sinai* and found that many courts and legal analysts have concluded that interns, residents, and fellows are, in large measure, employees.[40] The majority was not persuaded that a change in precedent would cause problems regarding patient care or endanger the experience value that the house staff received as a result of being reclassified as employees.[41]

The thrust of this article deals with the differences between the *Cedars-Sinai* and *Boston Medical* cases and the attendant controversies within both legal and medical-academic circles. Emphasis is placed on an explanation of the earlier case precedent in the context of the factors and circumstances that surrounded it, as well as to provide adequate explanation of *Boston Medical* and the contemporary need to treat budding physicians with more consideration.[42] The process of becoming a licensed physician or specialist, combined with a financial disincentive inadequate to meet family household needs, should not require a commitment of time that exceeds all standards of reasonableness. *Cedars-Sinai* and *Boston Medical* present these issues, and individuals on both sides of the debate have squared off in a heated discussion regarding the soundness of the change.

The author is firmly in favor of the *Boston Medical* decision and feels that its opponents view the physician development process as a form of fraternity hazing that is unhealthy in today's environment and that has no place in the contemporary education and training of physicians. This is not just a legal decision. It has severe social policy overtones and says much about how the United States believes would-be

37. *Id.*
38. *Id.* at 1341-42.
39. *Id.*
40. *Id.* at 1343.
41. *Id.* at 1343-44. The Board stated, "We cannot subscribe to dissenting Member Brame's forecast of doom to medical education as a consequence of our decision today." *Id.* at 1344.
42. Barry H. Bloch & Steven K. Sanborn, Boston Medical Center: *The NLRB Changes Course*, CAMPBELL L. OBSERVER (Campbell Univ., Buis Creek, N.C.), Mar. 2000, at 3, 9.

healthcare professionals should be treated.[43] Should they be denied a personal and family life during the intern and residency periods, or should a more humane approach be undertaken? As a society, we would not sanction house staff treating their patients in the same manner that the medical profession has treated them during the reign of the *Cedars-Sinai* case. This article concludes with a brief look at the dissent in the *Boston Medical* case, which substantiates the view that all compass points aim toward a more humane environment for house staff, regardless of what vested members of medical fraternity may say.[44] These opponents are clearly stuck in the quicksand of the past.

II. *CEDARS-SINAI*—THE STUDENT STATUS ERA

The Cedars-Sinai house staff received an annual graduated stipend based on the length of time that they had served as an intern through fifth year residency.[45] The stipend was essentially a graduate study scholarship, and it was not based upon the nature of the services provided, the number of hours that they spent in patient care, the type of rotation in which they were involved, or the type of patients that they saw on a regular basis.[46] The house staff also received fringe benefits including: medical and dental care, an annual vacation, paid holidays, uniforms, meals while on duty, and malpractice insurance.[47] They were not eligible for the retirement program offered by Cedars-Sinai to its other employees.[48] A committee of peers handled any discipline problems among the house staff.[49]

The length of the program an intern decided to pursue determined the length of the time spent at the facility.[50] At the time that *Cedars-Sinai* was decided, the average stay of interns and residents was less than two years.[51] Regarding the clinical fellows, research demonstrates that in 1974-75, seven fellows were completing their first year.[52] After the completion of the Cedars-Sinai program, the vast majority of house staff went on to a private practice, practice group, or some type of health organization.[53] Very few interns or residents expected to maintain any

43. *Id.*
44. *See infra* Part IV.
45. Cedars Sinai Med. Ctr., 223 N.L.R.B. 251, 252 (1976).
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.* at 253.
52. *Id.*
53. *Id.*

type of employment relationship with Cedars-Sinai post-residency because of its understood mission as a training facility.[54]

The Board found that based on the record, as presented, the house staff were primarily engaged in graduate education training and were not employees.[55] The primary factor in the Board's decision was based on the fact that the house staff participated in programs not for the purpose of earning a living, but rather to pursue graduate medical education.[56] Physicians were required to complete an internship in order to become licensed to practice medicine.[57] Therefore, at least the first year spent at Cedars-Sinai was as a qualifying student and not as an employee.[58] As for residency and fellowship programs, they were necessary to qualify for specialty and sub-specialty certifications, although the house staff spent a great deal of time in direct patient care.[59] It is important to understand that this is the manner in which the hands-on learning process is carried out during this phase of medical school education with no acceptable substitute found as yet, or at least sanctioned, by the professional licensing agencies.[60] Member Brame pointed out that it was this direct involvement with patients that allowed the graduate medical students the opportunity to acquire the type of diagnostic and clinical skills that are critical to the practice of medicine.[61] In essence, the majority was sympathetic to the position taken by the members of the profession that house staff members were not employees. The entire Board affirmed the decision on appeal, with Member Fanning dissenting.[62]

Regardless of how many hours the house staff worked or the quality of the care that they rendered to their patients, the amount of monetary compensation was not changed.[63] The stipend remained fixed, and the payments did not even cover living allowances, let alone constitute adequate compensation for services rendered.[64] Furthermore, it was also clear in *Cedars-Sinai*, as it is today, that house staff members do not give much importance to the stipend since there is little difference regardless of location; instead, their choice of matching hospitals was based upon the quality of the educational program and the opportunities that existed

54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.*

in terms of training experience at a particular institution.[65] The quality and reputation of the internship and residency program would have an important impact on on an individual's placement once the residency or fellowship period is over.[66] There is clearly a tiering of matched locations that determine a candidate's ultimate earning power and attractiveness in the marketplace.

As stated previously, the whole purpose, even though not openly espoused, was to provide skilled staffing at bargain basement prices. House staff endured these conditions just to get their desired match, while clinical proficiency was not the governing factor despite the AMA's protestations. The strictures of the medical profession at that time described the standards for approved internships and residencies designating their primary function as educational, regardless of location. Clearly, the majority applied the "thinking of the time" in ruling that house staff members were students, not employees and with this conclusion evaded any other "employee status" issues under section 9(c) of the NLRA.[67]

Not so easily evaded was the strong dissent penned by Member Fanning, which was premised on the fact that the Board had acknowledged and held in other cases that students could be part of a bargaining unit and vote in an election.[68] This slight wrinkle required that the majority at least address Fanning's position, because his exhaustive dissent was directed point blank at the student-employee issue.[69] It was his thoughtful rationale that became the basis for the *Boston Medical* opinion, and it deserves a thorough analysis at this point.

As the majority stated, it was well aware that students had been included in bargaining units and that elections had been held where students composed the bargaining unit entirely. However, what made this case different, according to the majority, was the fact that the house staff who would file the petition were primarily engaged in graduate educational training.[70] Fanning saw little merit to this argument because he found the issue to be one of employee status as enunciated by the NLRA and as interpreted by the Board.[71] The majority accused the dissent of advancing considerations that had no bearing on the house

65. *Id.*
66. *Id.* A resident may be placed in private or organizational practice after completion of a residency fellowship. *Id.*
67. *Id.*
68. *Id.* at 254.
69. *Id.*
70. *Id.*
71. *Id.*

staff with regard to the meaning of the Wagner Act.[72] For example, the dissent suggested that "hospital[s] charge[ ] fees in amounts which have sparked national debate."[73] The majority also disagreed with the dissenting opinion's consideration of the proposition that the primary interest of the house staff's petition was an increase or an improvement in primary care of the patients involved.[74]

The majority made it clear that this process is an important extension of the medical school educational program where the student has the opportunity to decide exactly which area of medicine he or she will concentrate in. This provides the house staff member with the opportunity to sample a wide variety of specialties before making this decision and allows him or her to do so under the tutelage of practicing physicians. This depth and breadth of diagnostic experience is simply not available in medical school.[75] A four-year medical school education does not provide the opportunity to develop the type of diagnostic skills that are critical to becoming a good physician. Accordingly, the majority determined that the Cedars-Sinai house staff was involved in an educational relationship with the institution and, thus, they were not employees within the meaning of the Wagner Act.[76] Based on this analysis, the majority dismissed the petition filed by the house staff personnel.[77] A review of many of the arguments contained within Member Fanning's lengthy and in-depth dissent indicated the basis for the *Boston Medical* decision that overturned the *Cedars-Sinai* decision several decades later.

Member Fanning's initial point made it clear that his objective was not focused on the semantic difference between student and employee, since that question had already been answered in previous NLRB cases.[78] Students had been part of bargaining units and had been authorized to hold elections in which they were the sole voting group numerous times before, and this was an established part of NLRB case law precedent.[79] Therefore, this particular case presented no revolutionary issue as far as the distinction between student and employee was concerned.

The key issue, as Fanning saw it, was whether students were employees in addition to being classified as students.[80] The medical students could not only perform part of their educational requirements but could

72. *Id.* at 253.
73. *Id.* at 256.
74. *Id.* at 253.
75. *Id.*
76. *Id.*
77. *Id.* at 254.
78. *Id.* at 254-55.
79. *Id.* at 254.
80. *Id.*

also work in a related environment deserving of the protection of the provisions of the Wagner Act. This issue concerned him the most. As he put it, "Are those doctors commonly denominated 'housestaff' entitled to bargain collectively under the auspices of our statute and, if so, do they possess a sufficiently distinct community of interests enabling them to constitute an appropriate unit unto themselves?"[81]

Fanning concluded that since the majority had taken this question as its primary approach, then he would look at it in similar fashion.[82] However, contrary to the majority, he emphasized the prospect of a finding that house staff members could be students would not justify the conclusion that they could not be employees within the letter and spirit of the Wagner Act.[83] This position was diametrically opposed to the rationale established by the Board. As Member Fanning pointed out section 2(3) of the Wagner Act provided that an employee is meant to include everyone, unless the NLRA explicitly states otherwise.[84] The statute goes on to enumerate a listing of worker categories that are excluded from the definition. Students are not among those exclusions.[85] Member Fanning suggests that the delineation between the two is due to federal policy provisions.[86]

However, he also noted that the NLRA had created two classes of employees, and given the absence of any legislative history, the relationship between students and employees was not mutually exclusive. Therefore, the key question centered on whether the evaluation being made regarding a particular individual had to be made outside the context of any statutory exclusion. This necessitates a certain imprecision with regard to defining the term "employee," but this was the result of a deliberate refusal of the Wagner Act drafters to be more specific.[87] According to Fanning, the drafters of the Wagner Act made certain that the definition of an employee was put forth in a "circular fashion": "An employee includes any employee."[88]

As a result, this multi-tiered statutory definition gave rise to several conflicting views. The first looked at whether there was some sort of declared policy and purpose under the NLRA that comprehended individual rights guaranteed to be protected by the statute. This par-ticular interpretation was bolstered by nothing more than the statement that it

81. *Id.*
82. *Id.*
83. *Id.* ("One does not, necessarily, exclude the other . . . .").
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*

was an effort to give something of an "ordinary meaning" to the term employee used under the common law.[89] Fanning then provided a more basic and broad common law definition of employee, which traced its roots to the relationship of master-servant law.

At common law a servant performed services for the master, with the full knowledge that the master had the right of control and that the servant had the right to be compensated upon completion of the work. Member Fanning viewed this as the *sine que non* of establishing the master-servant relationship.[90] As this relationship evolved, the formalities that made it part of the common law began to fall by the wayside. Increased attention was paid to the establishment of tortious liability for the master for the acts committed by the servant.[91] This, of course, was the result of the doctrine of respondeat superior and plays a critical role in current malpractice cases today. Fanning made the point that the majority ignored this very significant part of the hospital house staff relationship, that of vicarious liability, and that there exists a certain level of liability for the hospital with regard to the actions of the house staff that is relative to medical malpractice.[92] On this count, the majority failed to explore the full range of liability and was too quick in concluding that the master-servant doctrine need not be discussed.[93]

The dissent referred specifically to the number of hours that the house staff worked each week. He discussed the around-the-clock, seven-days-a-week work period that is peculiar to house staff status. Particularly disturbing was the requirement of working over one hundred hours a week, in shifts often exceeding fifty consecutive hours.[94] It was not uncommon to see an emergency room with only house staff at times when supervising physicians were not even in the facility. The majority failed to correctly consider these critical facts. Of equal concern was the fact that after having been awake for over forty hours, these individuals, with no supervision, might have to perform a serious procedure on a small child, administer potentially lethal medications, and do so in a manner that would pass muster under the rules of malpractice negligence.[95]

In return for this medical supervision by trained experts, the house staff received a stipend that barely covered their living expenses and from which federal taxes, state taxes, and social security taxes were

89. *Id.*
90. *Id.* at 255.
91. *Id.*
92. *Id.*
93. *Id.*
94. *Id.*
95. *Id.*

withheld.[96] Should the house staff member perform in a negligent fashion, the hospital and any supervisory personnel also stood to be potentially liable.[97] The disparity regarding the level of evidence presented as to whether any type of evaluation was made of house staff would surely have been one point of contention in any litigation. Consequently, this argument by the majority lacked substantial basis. As to the argument that the individuals are primarily students, the Association of American Medical Colleges (AAMC) pointed out that about eighty percent of the house staff time is spent "in direct patient care activities."[98] However, just because someone is learning while performing a particular service to an individual patient, does not mean that he or she cannot also be classified as an employee for purposes of the Wagner Act. The majority was not persuaded by this particular fact and paid little attention to the variety of factors, which the NLRB relied upon in previous cases, when determining whether or not an individual was an employee.

Member Fanning paid special attention to "Essentials,"[99] publications in which the majority relied in reaching its conclusion that the house staff are students.[100] It might be said that the "Essentials" constitute at least guidelines, if not contracts, relative to the manner in which hospitals are to treat these incoming medical school graduates. Even though "Essentials" emphasizes that the hospitals are supposed to look at the primary purpose as educational, this has no bearing on whether the house staff is ultimately entitled to compensation for a service which they perform, or whether the house staff are also entitled to be viewed as employees pursuant to the master-servant relationship.[101] These guidelines acknowledge that the relationship between hospitals and house staff are the mandate of "employment agreements," which should specify at a minimum, salary, vacation, and duty hours.[102] The majority conveniently overlooked this point, since it is clear that the "Essentials" publications view the learning process during the residency phase of instruction as deserving of a variety of compensation forms.[103]

Even more important was that on January 13, 1975, the American Medical Association (AMA) sent out a memorandum to all AMA

96. *Id.*
97. *Id.* at 256.
98. *Id.*
99. Essentials," as they are referred to by Member Fanning, include both "Essentials of an Approved Internship" and "Essentials of Approved Residencies." *Id.* at 252. Prepared by the Council on Medical Education and approved by the American Medical Association, "Essentials" provide a set of guidelines for interns and residents to follow while they complete their internships and residencies. *Id.*
100. *Id.* at 256.
101. *Id.*
102. *Id.*
103. *Id.*

approved teaching hospitals, noting that it had adopted "guidelines for house staff contracts or agreements and that this had been done by the house of delegates."[104] This was very instructive, in that the AMA used the word contract or agreement when talking about any form of compensation that residents or house staff should receive. Again, the majority overlooked this particular fact. These guidelines provided three things. First, the agreement should be fair and equitable, relative to conditions of employment. Second, the institution must be aware of the need to accept the house staff's input relative to establishing in-house procedures. Third and finally, the institution should recognize that the house staff have a right to put forth the means by which they should be organized, relative to receiving their training, and house staff contracts should be freely negotiated.[105] This latter point included the comment that the contract with the institution may be negotiated either individually or collectively and that any terms regarding training should not be denied or infringed.[106] It also stated, "No contract should require or proscribe that members of the housestaff shall or shall not be members of an association or union."[107] At this point the AMA memorandum discussed a variety of very important employment related subjects. These included: shift hours, off duty activities, vacation, leave, insurance liability, and grievance procedures.[108] Member Fanning was stunned that the majority reached its opinion without at least some discussion of these compelling factors that are contained within the guidelines.[109]

Fanning believed the evidence clearly showed that the house staff's primary concern was to improve patient care and, thereby, enhance the quality of the institution.[110] Fanning stated that no one benefits when overworked and exhausted house staff members are providing services without the supervision of a trained physician and when the host hospital is exposed to a wide range of medical malpractice claims. Further, he was incredulous that the majority found no argument to support the conclusion that under section 2(11) and (12) of the Wagner Act, these individuals are employees.[111] The majority again merely footnoted its response to these significant considerations and overlooked case law, statutory language, and legislative history.

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104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.* at 257.
109. *Id.*
110. *Id.*
111. *Id.* at 258.

Just one year after *Cedars-Sinai*, the case of *St. Clare's Hospital & Health Center*[112] came before the NLRB and gave the administrative agency another opportunity to address the same question. In *St. Clare's Hospital*, the agency went a step further and noted that the distinction between employee and student was one of national labor policy. Furthermore, there was a grave danger that if collective bargaining were permitted among house officers, it would go far beyond the strictures of the Wagner Act.[113] In fact, house staff work could be evaluated with regard to academic freedom, and any type of collective bargaining could limit the individual's right to challenge program content or instructional method.[114] In other words, the NLRB was saying that these issues had no place at the bargaining table. It seems fair to speculate that dissenter Fanning's likely response would be that the house staff would not dispute that the internship residency process plays an important role in their educational process and that matters regarding program content remained the province of the host institution. However, when the focus is switched to work shifts that exceed forty and fifty hours, along with receiving minimum wage salaries, Fanning would argue that these are issues that ought to be on the collective bargaining table. This should be the case even if some sort of prearranged agreement is reached regarding the limited reach of any collective bargaining process.

If given this opportunity, the house staff would readily agree to some sort of restriction on the number and range of topics that would be available for collective bargaining discussion and that none of the topics would have anything to do with diminishing the quality of patient care. If anything, it might mean that the doctors on staff with the hospital might have to work more hours or that the hospital might have to hire more staff physicians, since house staff would likely focus primarily on pay and working conditions. These are also the issues that the management team least wants thrust upon it in a collective bargaining setting. But this is the hospital's problem since the primary contention is that the apprenticeship served by a resident is part of the educational process, and this is inextricably bound to the argument that house staff members are grossly underpaid and overworked. They provide the inexpensive, skilled labor that allow hospitals to garner profits that are disproportionate to the actual cost of services. Hospitals ought not be permitted to profit at the expense of house staff by placing the patient population in a less than safe environment. Medical academics disagree with this

112. 229 N.L.R.B. 1000 (1977).
113. *Id.*
114. *Id.*

assessment, arguing that neither is an issue in the student versus employee debate regarding house staff training.[115]

III. *BOSTON MEDICAL*—THE EMPLOYEE DEFINITION CHANGE

On November 26, 1999, the NLRB issued its opinion in *Boston Medical Corp.*,[116] upsetting the years of case law precedent since *Cedars-Sinai* and sending shock waves through many teaching hospitals regarding the manner in which contract negotiations with house staff would be handled. In October 1997, the NLRB regional director for the Boston region dismissed the petition filed by the interns and residents of the Boston Medical Center Corporation (BMC) seeking certification as a unit for collective bargaining as employees pursuant to the appropriate sections of the Wagner Act.[117] The house staff officers who filed the petition were aware of the precedent set forth in *Cedars-Sinai Medical*, as clarified in the *St. Clare's Hospital* case, but believed that it was appropriate for the Board to look to the strong dissent filed in *Cedars-Sinai* and rule that the individuals were not only students, but employees as well.[118] The NLRB concluded in *Boston Medical* that after twenty plus years of *Cedars-Sinai*, it was time to treat house staff personnel as both students and employees pursuant to the Wagner Act.[119]

BMC funds a 432-bed, non-profit, teaching hospital in Boston, Massachusetts that focuses on acute care cases.[120] Not only does it provide in-patient services, but it also provides outpatient services on a twenty-four hour emergency basis.[121] It also serves as the primary teaching facility for Boston University School of Medicine.[122] As a result, BMC sponsors thirty-seven different residency programs varying from three to five years, with a few that last a little longer.[123] At any given time there are about 430 house officers in the unit, all of which were present on July 1, 1996.[124] This is the date that the Boston City Hospital and the Boston University Medical Center Hospital were consolidated since the two hospitals were located a block apart, with the Boston University School of Medicine in between.[125] It seemed appropriate that BMC should affiliate with the University School of Medicine and that some of

115. *See, e.g.*, Magnan, *supra* note 28.
116. 162 L.R.R.M. (BNA) 1329 (1999).
117. *Id.* at 1332.
118. *Id.*
119. *Id.*
120. *Id.*
121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.* at 1333.
125. *Id.*

the residency programs should be integrated prior to the merger of the two hospitals.

Boston City Hospital (BCH) was a public sector institution and, therefore, was subject to the state public employee collective bargaining law under which all house staff had a right to organize in union fashion according to federal and state law.[126] The petitioner in this case represented a unit of house staff at BCH since 1969 and negotiated about ten collective bargaining agreements with BCH since 1970.[127] One condition of the 1996 merger between BCH and University Hospital was that the Boston City Council required that BMC recognize the petitioner as a collective bargaining representative of the existing 280 former house staff personnel from the public sector hospital.[128] BMC signed this recognition agreement, agreeing to allow similar representation among all house officers at the merged entity.[129] On August 29, 1996, the issue flared as to whether or not the parties wanted the NLRB to supervise an election that would ultimately determine unionization and collective bargaining rights.[130]

It is important to understand the unique conditions of BMC's residency programs in relation to those at other hospitals. The programs at BMC were funded at least in part through direct or indirect medical education payments coming from medicare payments from the federal government.[131] These payments were based on historical costs of the medical center that used a formula that incorporated the total number of house staff that enroll in a particular medical residency program at BMC.[132] Like all institutions that sponsor medical residency programs, BMC starts its academic year on July 1 of each year, and the students who are half-way through their fourth year of medical school decide the area of medicine that they wish to pursue and apply to appropriate medical programs for matching at that time.[133] BMC receives hundreds or even thousands of applications from which only a small percentage of applicants are chosen to interview for individual residency programs.[134] The match list is initially set up in March so that by summer it is well in place, and individuals know where they are going.[135] Finally, no

126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.*

matching process exists with fellowships; they are handled on a case-by-case basis with the teaching hospital involved.[136]

The interns, residents, and fellows work for physicians, known as "attendings," and these physicians are also faculty of the Boston University School of Medicine.[137] The attendings are technically employees of the Faculty Practice Plan Foundation, Inc., an umbrella corporation for a variety of subsidiary practice plans that are in place for all departments within the hospital.[138] The attendings receive their paychecks from the School of Medicine, which hires them just like the house staff personnel.[139] As Senator Cranston, a co-sponsor of the 1974 amendments noted, the legislation was intended to affect the notorious reputation of the meager salaries given to these individuals.[140] The majority also looked at nearly every aspect of the *Cedars-Sinai* case and sided with the position taken by Member Fanning in the dissent.[141]

IV. CONCLUSION

The *Boston Medical Corp.* case also included an important dissent written by Member Hurtgen, which began:

> 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. 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.[142]

The limited scope of this rationale leaves much to be desired from an analytical perspective. First, the essence of the common law is that change makes the law real and in accordance with contemporary moral, ethical, and legal values. Just because residents and interns have been mistreated for twenty years pursuant to Board precedent provides insufficient reasons to ignore the basic legal, if not humane, need to change the law. Member Hurtgen would have us follow outdated case law just on precedent alone. This argument is not supported by a wide variety of case decisions that affect a number of societal rights and values.

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136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.* at 1342.
141. *See generally id.*
142. *Id.* at 1348.

Criminal procedure and a woman's right to choose birth or abortion are merely two examples. In the last thirty years these two areas have seen tremendous case law change, all sanctioned within the context that the common law is a living law that does not just allow for such change, but rather demands it at the appropriate time in history.

Second, Member Hurtgen revealed only a portion of the facts when he stated that Congress endorsed the holding in *Cedars-Sinai* and the cases that followed. The fact is that Congress took significant action in the 1974 amendments to the NLRA in an attempt to address some of the inequities faced by house staff.[143] Senator Cranston's comment is testament to that fact and directly contradicts the Hurtgen dissent. Simply stated, it was time for change, and the *Boston Medical* case made a positive, decent change in the case law, which was backed by statutory precedent as well as by common ethical standards.[144] For Member Hurtgen to overlook this crucial point in his dissent is highly unusual given the need to support his strong conclusion with a balanced rationale.

Regardless, the Board reached the correct result in this case, and it is sure to have a significant impact on the quality of life for house staff personnel around the country for years to come.

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143. *See supra* text accompanying notes 36, 38, 148.

144. Two commentators foresee other implications of the *Boston Medical* case that go beyond the limited scope of the opinion.

> This decision will likely result in attempts to unionize house staffs throughout the country. . . . The threat of strikes, although disapproved by groups such as the AMA, potentially provides residents with a powerful tool to negotiate improvements. However, only time will tell what type of disruption strikes may cause to this country's system of inpatient care and medical education.
>
> This decision could have other far reaching implications, such as on negotiations with managed care organizations. There are still two roadblocks inhibiting physicians from organizing: labor laws and antitrust laws. The NLRA only offers protection to bargaining units of employees who are neither managers nor supervisors. A physician may be considered an "employee" if the "employer" exercises control over the manner and means of performance, not just the end result. In regard to antitrust, physician competitors cannot organize or bargain collectively unless they have achieved a high degree of financial or clinical integration.
>
> . . . .
>
> It is clear that this change in the law has the potential of creating a revolution in medical education. What remains to be seen is whether that revolution will merely strengthen the entire profession's ability to bargain with insurance companies and managed care organizations, or whether unionization will cause a realignment of professional values and priorities.
>
> Strong arguments can be made for both positions that such changes are needed to maintain the availability of high quality care. Unless physicians can resist and overcome third-party payors' efforts to limit the expense of and access to healthcare, it is likely that public trust in the profession, as well as the physicians' incomes, are likely to erode. Of course, if organized physicians ever strike, as they have in other countries, it may erode public trust as well . . . .

Bloch & Sanborn, *supra* note 42, at 3, 9.