

Vanderbilt Law Review

Volume 52

Issue 4 *Issue 4 - Symposium: Attorney Well-Being in Large Firms: Choices Facing Young Lawyers*

Article 11

5-1999

Working Without Rights: Recognizing Housestaff Unionization--An Argument for the Reversal of "Cedars-Sinai Medical Center and St. Clare's Hospital"

Jennifer A. Shorb

Follow this and additional works at: <https://scholarship.law.vanderbilt.edu/vlr>



Part of the [Labor and Employment Law Commons](#)

Recommended Citation

Jennifer A. Shorb, Working Without Rights: Recognizing Housestaff Unionization--An Argument for the Reversal of "Cedars-Sinai Medical Center and St. Clare's Hospital", 52 *Vanderbilt Law Review* 1051 (1999)
Available at: <https://scholarship.law.vanderbilt.edu/vlr/vol52/iss4/11>

This Note is brought to you for free and open access by Scholarship@Vanderbilt Law. It has been accepted for inclusion in Vanderbilt Law Review by an authorized editor of Scholarship@Vanderbilt Law. For more information, please contact mark.j.williams@vanderbilt.edu.

NOTES

Working Without Rights: Recognizing Housestaff Unionization—An Argument for the Reversal of *Cedars-Sinai Medical Center* and *St. Clare’s Hospital*

I.	INTRODUCTION	1052
II.	HISTORICAL AND LEGAL BACKGROUND	1056
A.	<i>Statutory Framework</i>	1056
B.	<i>History of the Housestaff Organization Movement</i>	1058
C.	<i>National Labor Relations Board Decisions</i>	1060
1.	<i>Cedars-Sinai Medical Center</i>	1060
2.	<i>St. Clare’s Hospital and Health Center</i>	1064
III.	HOUSESTAFF STATUS: ARGUMENTS IN FAVOR OF CLASSIFYING HOUSESTAFF AS “EMPLOYEES” UNDER THE NLRA	1066
A.	<i>The National Labor Relations Act: The Meaning of “Employee” Under Section 2(3) and “Professional Employee” Under Section 2(12)</i>	1067
1.	Statutory Construction	1067
2.	Supreme Court Decisions	1068
3.	Legislative History	1069
4.	Other NLRB Decisions Addressing Employee Status	1070
B.	<i>The Majority of Public Sector Jurisdictions Classify Housestaff as Employees</i>	1072
C.	<i>Other Federal Agencies Classify Housestaff as Employees</i>	1075
D.	<i>Additional Considerations Suggest That Housestaff Should Be Considered Employees Under the NLRA</i>	1077

1.	Indicia of Employment Status	1077
2.	Professional Associations and Guidelines	1081
3.	Physician Unionization	1083
IV.	IMPORTANT CONCERNS ABOUT HOUSESTAFF UNIONIZATION	1086
A.	<i>Effects on Academic Decision Making and Medical Training</i>	1086
B.	<i>Strikes</i>	1088
V.	CONCLUSION	1090

I. INTRODUCTION

Increased competition in today's health care industry has contributed to the industry's growing emphasis on cost-containment.¹ Concerns about this focus on the bottom line have motivated some caregivers to attempt to improve working conditions and the quality of patient care through unionization.² One such group, "housestaff" or "house officers," is comprised of hospital interns, residents, and fellows.³ These individuals are medical school graduates seeking

1. See Michael H. LeRoy et al., *The Law and Economics of Collective Bargaining for Hospitals: An Empirical Public Policy Analysis of Bargaining Unit Determinations*, 9 YALE J. ON REG. 1, 11 (1992). Cost pressures have forced hospitals to restructure. See generally J.D. Gammel, *Changing Consumer Practices: How Does Consumer Behavior Affect Medical Residents?*, HOSPITAL PHYSICIAN, Apr. 1997, at 50. Since the 1980s health care costs have been "escalating at a rate that employers could no longer afford." *Id.* at 50. In response, employers pressured hospitals and physicians to reduce expenses. *Id.* "This economic pressure forced a fundamental restructuring and consolidation of the health care industry." See *id.* This restructuring has translated into increased physician and hospital affiliation, independent physician organizations and physician-hospital organizations, and Health Maintenance Organizations ("HMOs"). See *id.* at 51; see also Jeremy Lutsky, *Is Your Physician Becoming a Teamster: The Rising Trend of Physicians Joining Labor Unions in the Late 1990's*, 2 DEPAUL J. HEALTH CARE L. 55 (1997) (stating that "[t]oday the health care industry is controlled not by the physicians, but by large insurance companies, health maintenance organizations (HMOs), physician practice management companies and for-profit corporations").

2. See Mary Chris Jaklevic, *Physicians Find Power in Unions: A Small but Growing Number of Docs are Using Organized Labor to Gain Economic Leverage*, MOD. HEALTHCARE, October 6, 1997, at 100 (stating that "physicians increasingly are using unions to gain economic leverage" but noting that "[u]nionized physicians are not a sweeping trend"); see also LeRoy et al., *supra* note 1, at 14-16.

3. Boston Med. Ctr. Corp., No.1-RC-20574, at 7 (Oct. 17, 1997) (Decision and Order) [hereinafter Decision and Order]. The house officers of Boston City Hospital, now Boston Medical Center, have engaged in collective bargaining since 1969 as a unit comprised of all interns, residents, and fellows. See *id.*; see also Cedars-Sinai Med. Ctr., 223 N.L.R.B. 251, 251 (1976), *motion for reconsideration denied*, 224 N.L.R.B. 626 (1976). The Board stated:

An intern is a medical school graduate serving his first period of graduate medical training in a hospital. . . . A resident is a physician who has completed an internship and serves a period of more advanced training, lasting from one to five years, in a

additional training for licensure and specialization.⁴ Housestaff are often overworked, underpaid, and forced to deal with working conditions that adversely affect patient care.⁵ Such conditions force many house officers to join union organizations and seek the right to bargain collectively.⁶ The housestaff unionization movement began in the 1930s when house officers sought to remedy poor working conditions and inadequate patient care.⁷ This movement is still alive today despite the National Labor Relation Board's ("NLRB") refusal to recognize housestaff collective bargaining rights.⁸

In 1976, the NLRB in *Cedars-Sinai Medical Center* considered whether house officers working in private nonprofit hospitals have the right to collectively bargain under the National Labor Relations Act

specialty. A clinical fellow is a physician who has completed an internship and a residency and is taking an educational postgraduate program to qualify for certification in an identifiable subspecialty of medicine.

Id. Currently, there are approximately 110,000 house officers in the United States. See Dolores Kong, *Resident Doctors Lose Round One; Plan Appeal of Labor Decision*, BOSTON GLOBE, Oct. 18, 1997, at B1 (discussing the Boston Medical Center housestaff's petition to the National Labor Relations Board ("NLRB") Regional Director for collective bargaining rights).

4. See Decision and Order, *supra* note 3, at 7; see also *Cedars-Sinai*, 223 N.L.R.B. at 251.

5. For example, an average Los Angeles hospital resident works between 80 and 90 hours per week and receives between \$26,900 and \$38,000 per year. Surgery residents may work up to 135 hours per week. See Jessica Drebon, *Doctor's Heal-in Called Off*, COPLEY NEWS SERV., Nov. 20, 1997, available in LEXIS, News Library, CURNEWS File. Housestaff often work in public hospitals which provide care for a large amount of Medicaid patients. In these hospitals there is typically a constant need for additional staff and equipment. See Steven R. Daugherty et al., *Learning, Satisfaction, and Mistreatment During Medical Internship: A National Survey of Working Conditions*, 279 J. AM. MED. ASS'N 1194, 1196 (1998) (reporting that a recent survey found that housestaff concerns included sleep deprivation, large patient loads, and too much "scut" work). Discrimination, sexual harassment, and unethical conduct also plague residency programs. See *id.* (stating that 93% of residents reported at least one instance of mistreatment during their internship year); see also Dolores Kong, *Medical Residency a Very Tough Experience, Survey Says*, TIMES UNION, April 21, 1998, at D4 (reporting that 63% of women reported "suffering at least one instance of sexual harassment or discrimination"); see generally Murray A. Gordon, *Hospital Housestaff Collective Bargaining*, 1 EMPLOYEE REL. L.J. 418 (1976) (discussing possible topics of housestaff collective bargaining and supplying an appendix addressing guidelines for housestaff contracts or agreements).

6. Some issues that have emerged in the area of housestaff collective bargaining include monetary compensation, fringe benefits, working conditions, tenure, medical governance participation, and impasse resolutions. For a discussion of these issues see Murray A. Gordon, *supra* note 5, at 418, 423-29. Over the past two years the Committee of Interns and Residents ("CIR"), a housestaff labor organization, has experienced a 50% increase in membership. See Jaklevic, *supra* note 2, at 100. While only 3% of practicing physicians are unionized, "most of them are interns, residents, or public employees." *Id.*

7. See Elizabeth Grace, *House-Staff Officers: Collective Bargaining in the Health Care System*, 2 J. LEGAL MED. 415, 415-23 (1981) (discussing the history of housestaff efforts to achieve recognition as employees for collective bargaining purposes).

8. The NLRB has refused to recognize housestaff collective bargaining rights in a series of cases, most notably *Cedars-Sinai*, 223 N.L.R.B. at 251, and *St. Clare's Hospital & Health Center*, 229 N.L.R.B. 1000, 1003-04 (1977).

("NLRA" or "the Act").⁹ The NLRB held that housestaff were "primarily students" rather than employees, and therefore not entitled to collective bargaining rights.¹⁰ The following year, in *St. Clare's Hospital and Health Center*, the NLRB clarified its holding in *Cedars-Sinai* and reaffirmed its denial of housestaff collective bargaining rights.¹¹ More than twenty years later dramatic changes have occurred in the health care industry, and the NLRB has decided to re-examine its determination that housestaff are not employees.¹² On February 13, 1997, the Committee of Interns and Residents ("CIR")¹³ filed a case petition seeking exclusive collective bargaining representation of the housestaff employed by Boston Medical Center.¹⁴ The Regional Director subsequently held a hearing on the issue¹⁵ and dismissed the case petition, citing *Cedars-Sinai* and *St. Clare's Hospital*.¹⁶ The NLRB has granted review of the Regional Director's decision in the Boston Medical Center case.¹⁷ In light of the dramatic changes that have occurred in the health care industry since the *Cedars-Sinai* and *St. Clare's Hospital* decisions, the Board should

9. *Cedars-Sinai*, 223 N.L.R.B. at 251.

10. *Id.* at 253; see also Judith L. Maute, Note, *Student-Workers or Working Students? A Fatal Question for Collective Bargaining of Hospital House Staff*, 38 U. PITT. L. REV. 762 (1977) (examining housestaff bargaining rights in Pennsylvania and arguing for limited bargaining rights for housestaff affiliated with a select group of hospitals).

11. *St. Clare's Hosp.*, 229 N.L.R.B. at 1000-04.

12. See Boston Med. Ctr. Corp., No.1-RC-20574 (Nov. 4, 1997) (Request for Review of Regional Director's Decision); Boston Med. Ctr. Corp., No.1-RC-20574 (Dec. 8, 1997) (Order Granting Request for Review of Regional Director's Decision).

13. The CIR is the largest and oldest housestaff union in the United States and currently represents approximately 8,000 interns, residents, and fellows. See *CIR Home Page* (visited Apr. 14, 1999) <<http://www.cirdocs.org>>. Two thousand of the housestaff represented by CIR are employed by private sector hospitals. See *id.*

14. See Boston Med. Ctr. Corp., No.1-RC-20574 (Feb. 13, 1997) (Petition for Recognition of Certification under the NLRA). The Petition was filed with Resemary Pye, NLRB Regional Director in the First Region.

15. See Boston Med. Ctr. Corp., No.1-RC-20574 (Nov. 5, 1997) (Employers' Request for Review).

16. See Decision and Order, *supra* note 3, at 5, 35. The Regional Director's Decision and Order first sets forth the decisions, then discusses the employee status of interns, residents, and fellows through a recitation of the facts, existing NLRB law, and the positions of the parties and the amici curiae. See *id.* at 1-31. The Decision and Order then addresses other issues raised by Boston Medical Center and discusses the status of chief residents. See *id.* at 32-50. While the Regional Director did make extensive findings of fact, see *id.* at 6-22 (summarizing the facts presented during the hearing and in the briefs), she stated that this issue "can only be resolved by the Board," *id.* at 35. (stating that Boston Medical Center'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*").

17. See Boston Med. Ctr. Corp., No.1-RC-20574 (Dec. 8, 1997) (Order Granting Request for Review of Regional Director's Decision).

classify housestaff as employees and allow them to bargain collectively.

The Board's decision in *Cedars-Sinai* was based on the notion that housestaff work primarily for educational purposes rather than as service providers.¹⁸ In addition to factors present at the time of the decision, recent legal and economic developments and changes in the health care industry support reversal of the *Cedars-Sinai* decision.¹⁹ In *Cedars-Sinai*, the NLRB ignored many strong indicia of employment, such as salary, benefits, hours worked, insurance coverage, and the value-adding services of the housestaff.²⁰ The Board also failed to recognize that statutory interpretation and legislative history supported classifying housestaff as employees.²¹ Recent Supreme Court interpretations of the term "employee" also suggest that housestaff fall within Section 2(3) of the NLRA.²² Since 1976, the majority of public sector jurisdictions considering this issue have determined that housestaff are employees for purposes of collective bargaining.²³ Numerous federal agencies and government bodies treat housestaff as employees for various purposes such as paying taxes, receiving worker's compensation, and stating a claim under Title VII.²⁴ In addition, the concerns underlying the physician unionization movement and the views of the American Medical Association ("AMA") demonstrate the importance of granting housestaff coverage under the NLRA.

This Note advocates the reversal of the NLRB's decisions in *Cedars-Sinai* and *St. Clare's Hospital*. Further, it recommends that the NLRB classify housestaff as employees under Section 2(3) of the

18. *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 260-262 (1976).

19. See Letter from Thomas M. Kennedy et al. to Rosemary Pye, Regional Director, NLRB, First Region (Feb. 13, 1997) (on file with author) [hereinafter Letter to the Regional Director]. The letter summarized the facts pertinent to the *Boston Medical Center* case petition, and the legal developments that necessitated reversing the *Cedars-Sinai* decision. See *id.* at 2-6, 7-12. The letter also explained that a hearing was necessary to develop a full record upon which the Board could base a decision. See *id.* at 12.

20. *Cedars-Sinai*, 223 N.L.R.B. at 255-57 (Member Fanning, dissenting).

21. See *id.* at 252-53 & n.4.

22. See *Sure-Tan, Inc. v. NLRB*, 467 U.S. 883, 891 (1984) (noting that "[t]he breadth of § 2(3)'s definition is striking").

23. See, e.g., *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192 (holding that housestaff are employees and allowing for collective bargaining); see also *infra* Part III.B.

24. See Post-Hearing Brief on Behalf of Petitioner Committee of Interns and Residents at 100, *Boston Med. Ctr. Corp.*, No. 1-RC-20574 (NLRB Region 1, Aug. 22, 1997) [hereinafter *Petitioner's Post-Hearing Brief*] (noting that federal agencies including the Internal Revenue Service, the Equal Employment Opportunity Commission, and the United States Department of Education view housestaff as employees for purposes of various federal statutes).

NLRA, thus entitling them to complete protection under federal labor laws. The NLRB's classification of housestaff as students failed to recognize that house officers are both students and employees, and deprived them of collective bargaining rights under the NLRA. Part II of this Note discusses the applicable sections of the NLRA, and the history of the housestaff unionization movement. It then analyzes the NLRB's holdings in *Cedars-Sinai* and *St. Clare's Hospital*. Part III presents arguments in favor of reversing the decisions in *Cedars-Sinai* and *St. Clare's Hospital*. A wide range of arguments and interpretations demonstrate why the NLRB should classify housestaff as students and grant them collective bargaining rights: these include interpretations of the term "employee" under the NLRA; relevant Supreme Court decisions; legislative history; public sector decisions involving housestaff status; other federal agency interpretations of housestaff as employees; and additional considerations such as indicia of employment, views of professional associations, and physician unionization. Part IV addresses and refutes the concerns of the NLRB and the medical community regarding the effect of collective bargaining on hospitals and medical education programs. Part V concludes by summarizing why the Board should reverse its decisions in *Cedars-Sinai* and *St. Clare's Hospital* in the pending Boston Medical Center case.

II. HISTORICAL AND LEGAL BACKGROUND

A. Statutory Framework

Originally enacted as the Wagner Act of 1935, the NLRA governs federal labor relations.²⁵ The Wagner Act gave health care employees the right to organize and collectively bargain.²⁶ The Act also established the NLRB as the administrative body designed to certify appropriate bargaining units and to prevent and remedy unfair labor practices in accordance with the NLRA.²⁷ In 1947, Congress amended the Wagner Act by passing the Taft-Hartley Act, which exempted the majority of hospital employees from coverage under the

25. 29 U.S.C. §§ 151-168 (1994).

26. See LeRoy et al., *supra* note 1, at 3-4 (explaining the history of collective bargaining rights and bargaining unit classifications for hospital employees).

27. 29 U.S.C. §§ 153-156, 160-162.

NLRA.²⁸ In the 1974 Health Care Amendments to the Act,²⁹ Congress deleted the Taft-Hartley Act's exemption for nonprofit private health care institutions, thereby bringing hospital employees back within the purview of the NLRA.³⁰ The removal of the exemption allowed health care workers at these hospitals to seek representation from national labor organizations and certification by the NLRB.³¹ The 1974 amendments also limited the rights of health care employees to organize and collectively bargain.³² Most of the relevant limitations seek to prevent proliferation of health care industry bargaining units in order to reduce the likelihood of strikes and other disputes.³³

Prior to 1974, housestaff bargaining rights were determined solely according to state labor regulations.³⁴ The subsequent removal of the hospital employee exemption through the 1974 Health Care Amendments created an opportunity for increased membership in housestaff unions. The inclusion of nonprofit private hospitals allowed several local housestaff associations and the Physicians National Housestaff Association to seek NLRB recognition to hold elections at private nonprofit hospitals.³⁵ In 1975, the house officers at Cedars-Sinai Medical Center petitioned for certification from the NLRB to gain recognition as an appropriate bargaining unit.³⁶ The

28. See LeRoy et al., *supra* note 1, at 3. The amended definition of "employer" under the Taft-Hartley Act excluded from coverage under the Act "any corporation or association operating a hospital, if no part of the net earnings inure to the benefit of any private shareholder or individual." Labor Management Relations Act, ch. 120, 61 Stat. 136, 137 (1947), codified at 29 U.S.C. § 152(2).

29. Pub. L. No. 93-360, 88 Stat. 395 (1974) (codified as amended in 29 U.S.C. §§ 158(d), 158(g), and 183 (1994)).

30. See 29 U.S.C. § 152(3) (1976).

31. See Jon D. Ehlinger, Comment, *Hospital House Staff—N.L.R.B. Did Not Exceed Its Statutory Authority in Holding That House Staff Are Not Employees Within the Meaning of the NLRA—Physicians National House Staff Association v. Fanning*, 56 NOTRE DAME L. REV. 314, 315 (1980). The NLRB is responsible for determining and certifying representatives for collective bargaining units. See 29 U.S.C. § 159(c) (1994). See generally Rebecca D. Graves, Note, *Appropriate Bargaining Units in Non-Profit Hospitals*, 37 WASH. & LEE L. REV. 1221 (1980) (discussing how the NLRB and the courts have determined appropriate bargaining units for hospital employees since the passage of the 1974 Health Care Amendments).

32. See Pub. L. No. 93-360, 88 Stat. 395, 396 (1974); see also LeRoy et al., *supra* note 1, at 4 n.5.

33. See 29 U.S.C. § 158(g) (1994); see also LeRoy et al., *supra* note 1, at 4 n.5 (giving as examples of limitations: parties must provide 90-day notice of termination of a collective bargaining agreement; parties must provide 60-day notice of contract termination; and labor organizations must provide 10-day notice of work stoppages).

34. See Martin H. Malin, *Student Employees and Collective Bargaining*, 69 KY. L.J. 1, 20 (1980) (discussing the union organizing activities of student employees).

35. See Ehlinger, *supra* note 31, at 315 (discussing the procedural history of 1970s attempts by housestaff associations to gain collective bargaining rights).

36. See *id.* (noting that the Board recognized the importance of this issue and selected *Cedars-Sinai* as a representative case for oral argument).

NLRB dismissed the house officers' petition in the Board's 1977 landmark decision *Cedars-Sinai Medical Center*.³⁷

B. History of the Housestaff Organization Movement

The organizing of hospital residents, interns, and fellows began in the early 1930s when hospital interns in New York who desired safer working conditions and higher salaries created the Interne Council of Greater New York.³⁸ A few years later a group of medical students founded another organization, the Association of Medical Students, which also advocated improved working conditions for hospital interns.³⁹ Both organizations developed national memberships and eventually combined to form the Association of Internes and Medical Students ("AIMS").⁴⁰ Charges of Communist Party affiliations and a lack of financial resources caused the organization to collapse approximately ten years after its inception.⁴¹

Despite these organizational efforts, housestaff continued to experience poor working conditions. In response, housestaff employed a variety of tactics. In 1957, several New York housestaff leaders established the CIR, which began a crusade for improved working conditions and a higher quality of patient care.⁴² During the late 1960s, some housestaff groups held "heal-ins" to protest low salaries

37. *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 253 (1976) (holding that the petitioner was not a labor organization because housestaff are not "employees" within the definition of "employee" under Section 2(3) of the Act).

38. See Grace, *supra* note 7, at 415. The group also published a newsletter, *The Interne*. The Interne Council of Greater New York later changed its name to the Interne Council of America. See *id.* The name change was facilitated by changes within the organization including a national membership and focus on reform in areas such as workers' compensation coverage, national health insurance, and binding contracts for house officers. See *id.* at 415-16.

39. See *id.* at 416.

40. See *id.* at 415-16 (noting that the organizations combined their efforts to "avoid duplication of effort and to achieve greater strength").

41. See Victor G. Devinatz, "Never Before Have M.D.'s Done So Much for Their Patients": *The 1975 Strike by the Cook County Hospital House Staff Association Against Cook County Hospital*, 25 J. COLLECTIVE NEGOT. 117, 119-131 (1996) (discussing the history of housestaff organizing and noting that "[b]y 1952, AIMS was dead" due to the left-wing nature of the organization); see also Grace, *supra* note 7, at 416-17 (noting that the AMA Convention authorized an investigation of AIMS alleging that AIMS "advocated the overthrow of the United States government by force and violence . . . [and] exhibited communist tendencies").

42. See Michael Myerson, *A Brief CIR History Housestaff Unions: Then and Now* (visited Apr. 14, 1999) <<http://www.cirdocs.org/history.htm>> (giving a comprehensive history of the CIR); see also Grace, *supra* note 7, at 417 (recognizing that the CIR quickly became involved in quality of patient care issues). The CIR began to negotiate contracts on behalf of housestaff while other similar organizations started to form on the west coast. See *id.* (noting that by 1966, the CIR had negotiated contracts with public hospitals).

by refusing to discharge patients.⁴³ A handful of heal-ins contributed to wage increases and better working conditions for the housestaff.⁴⁴

Other actions by housestaff groups included lawsuits, community activities, and the submission of grievances to the Joint Commission on Accreditation of Hospitals ("JCAHO").⁴⁵ Though rare, strikes were another option available to housestaff groups. For example, housestaff strikes occurred at San Francisco General Hospital⁴⁶ and at Freedman's Hospital in Washington, DC.⁴⁷ Later, on March 17, 1975, prompted by excessive hours and out-of-title work,⁴⁸ the CIR began a multi-hospital strike involving over 1,500 residents and interns.⁴⁹ The strike led to the creation of a two-year contract that set higher standards for patient care, lowered resident work hours, and established "for cause" removal requirements.⁵⁰ Finally, a few months later, in the largest single-hospital housestaff strike, concerns about patient care and working conditions at Cook County Hospital in Chicago motivated over 500 house officers to strike.⁵¹ This

43. See Grace, *supra* note 7, at 417. Heal-ins are protests in the form of various job actions such as refusing to discharge patients and ordering large quantities of costly laboratory tests. See *id.* at 417-18; see also Dreben, *supra* note 5.

44. See Grace, *supra* note 7, at 417-18. Heal-ins held at Los Angeles County General Hospital in 1965, Boston City Hospital in 1967, and Washington D.C. Veterans Administration Hospital in 1968 all resulted in pay increases for the housestaff. See *id.* Heal-ins have been considered as recently as 1997 when the housestaff at Harbor-UCLA Medical Center and other county hospitals threatened to hold a heal-in in response to an impasse in salary negotiations. The heal-in was called off at the last minute and a non-strike picket line was staged. See Dreben, *supra* note 5.

45. See Grace, *supra* note 7, at 418-19 (discussing the success of the housestaff at D.C. General, who won permission to submit patient care grievances to the Joint Commission on Accreditation of Hospitals).

46. See *id.* at 418. Interns went on a four day strike demanding improvements in patient services, pharmacy hours, and laboratory and X-ray coverage. Only after another four day strike did San Francisco General Hospital agree to some of the housestaff demands. See *id.*

47. See *id.* at 421 (noting that the Howard University housestaff's twelve day strike ended when Freedman's Hospital agreed to "upgrade laboratory services, to provide better nursing coverage, and to improve house-staff fringe benefits such as malpractice insurance coverage").

48. Out-of-title work is described by one commentator as "menial tasks commonly called 'scut' work." *Id.*

49. See *id.* at 421-22. Over 1,500 interns and residents participated. See *id.*; see also Myerson, *supra* note 42, at 2 (noting that during the multi-hospital strike many protesters used the slogan "[o]ur hours make you sick" and pointed out that the strike resulted in the abolition of every-other-night on-call for housestaff).

50. See Grace, *supra* note 7, at 422 (the contract specifically set forth a new salary schedule and provided that housestaff could not be required to be on call more than one night out of three or participate in out-of-title work).

51. See Devinatz, *supra* note 41, at 117-18, 120-31 (discussing in detail the Cook County Hospital housestaff and their 1975 strike and its aftermath, and concluding that the "primary motivation behind the Cook County Hospital House Staff Association's (HSA) 1975 strike" was "the interest[s] of their patients").

strike also demonstrated that housestaff efforts could achieve better standards of patient care.⁵²

By 1973, nine percent of American hospitals were parties to collectively-bargained contracts, and an additional ten percent had housestaff who requested collective bargaining recognition.⁵³ By deleting the statutory exemption of nonprofit private hospitals from the NLRA, the 1974 Health Care Amendments required the NLRB to integrate health care employees into the structure of federal labor law.⁵⁴ Professional medical organizations such as the AMA and the Physicians National Housestaff Association ("PNHA") expressed support for collective bargaining and employment contracts for housestaff. Hospitals and medical schools, however, were critical of the unionization movement.⁵⁵ Three years after the passage of the 1974 Health Care Amendments, in *Cedars-Sinai Medical Center*, the NLRB addressed housestaff status under the NLRA.⁵⁶

C. National Labor Relations Board Decisions

1. Cedars-Sinai Medical Center

Cedars-Sinai held that housestaff were not employees and thus were not entitled to collective bargaining rights.⁵⁷ Congress' repeal of the statutory exemption for nonprofit hospitals from the NLRA through the passage of the Health Care Amendments left open the question of whether collective bargaining rights were available to

52. See *id.* at 132. Housestaff unions can be agents for positive social change through the inclusion of patient-care as part of their collective bargaining agendas. Housestaff unions should also foster community support, build solidarity with other hospital employees, and talk to patients about their medical needs in order to improve bargaining strength and strike success. See *id.*

53. See Grace, *supra* note 7, at 419 (suggesting that the "house-staff union[ization] concept was spreading" and that housestaff unions were winning "attractive contracts with guaranteed improvements in patient care conditions, plus hefty hikes in salary and fringe benefits").

54. See *supra* Part II.A.

55. See Grace, *supra* note 7, at 420-22.

56. *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251 (1976). This case was later referred to as an "aberration in national labor policy." *St. Clare's Hosp.*, 229 N.L.R.B. 1000, 1000 (1974) (stating that although the Board did "not view Cedars-Sinai as a monumental decision . . . it is apparent that Cedars-Sinai has been viewed by many as an aberration in national labor policy").

57. *Cedars-Sinai*, 223 N.L.R.B. at 251. *Cedars-Sinai* set forth the proposition that housestaff were not employees under the NLRA. This proposition was later more clearly defined in *Kansas City General Hospital*, 225 N.L.R.B. 108 (1976), and *St. Clare's Hospital*, 229 N.L.R.B. at 1000. *Cedars-Sinai* was judicially upheld as not clearly erroneous and therefore unreviewable under the NLRA in *Physicians National House Staff Ass'n v. Fanning*, 642 F.2d 492 (D.C. Cir. 1980) (en banc), *cert denied*, 450 U.S. 917 (1981). For a discussion of *Physicians National House Staff Ass'n v. Fanning* see Ehlinger, *supra* note 31.

nonprofit hospital employees.⁵⁸ In response to this issue, residents, interns, and fellows of two Cedars-Sinai hospitals sought recognition as an appropriate bargaining unit from the NLRB.⁵⁹ The Board rejected their petition for recognition, thereby denying the house officers collective bargaining rights.⁶⁰ Applying a primary purpose test, the Board concluded that because the housestaff were primarily engaged in educational activity, they should be classified as students and not employees.⁶¹ The Board held that federal labor law required housestaff to be "employees" within the meaning of Section 2(3) of the NLRA.⁶²

The Board considered the house officers' subjective primary purpose for working as house officers and their subjective primary reason for performing health care services as the most important factors in its primary purpose analysis.⁶³ According to the majority of the Board, most house officers chose to accept a housestaff position to pursue a graduate medical education.⁶⁴ The Board found that the house officers worked in hospitals to further their medical education and gain specialized medical training regardless of the hours worked, wages earned, or benefits granted.⁶⁵ Despite the Board's recognition that housestaff possess many of the same characteristics as employees, it found that the educational nature and purpose underlying their work prevents them from being classified as employees and receiving federal labor law protection under the NLRA.⁶⁶

According to the Board, additional evidence that housestaff are primarily students includes that they are subject to: externally

58. See *Cedars-Sinai*, 223 N.L.R.B. at 251.

59. See *id.*; see also *supra* notes 29-31 and accompanying text.

60. See *Cedars-Sinai*, 223 N.L.R.B. at 253.

61. See *id.*

62. See *id.* at 251 (holding that "the interns, residents, and clinical fellows in the petitioned-for unit are not 'employees' within the meaning of Section 2(3) of the Act").

63. See *id.* at 253 (noting that housestaff chose their program based on the quality of education and opportunity for medical training); see also *Regents of the Univ. of Cal. v. Public Employment Relations*, 224 Cal. Rptr. 631, 637 (Cal. 1980) (noting that primary purpose usually turns on the subjective intent of the participating house officer).

64. See *Cedars-Sinai*, 223 N.L.R.B. at 253 (stating that housestaff are working in the hospitals "to pursue the graduate medical education that is a requirement for the practice of medicine"). The Board found that house officers participate in graduate medical education programs and perform direct patient care to gain knowledge and experience. See *id.*

65. See *id.* (recognizing that housestaff receive compensation and benefits, but dismissing these as a stipend, and recognizing long working hours but noting that direct patient care is part of the learning process).

66. See *id.* at 251 (stating that "although they possess certain employee characteristics, housestaff are primarily students").

imposed structures such as accrediting bodies and national selection; limits on housestaff involvement in patient care activity; and the educational aspects of graduate medical education programs, such as regular performance reviews and mandatory certification procedures.⁶⁷ The Board also noted that state requirements for internships, residencies, and fellowships demonstrate the educational nature of housestaff.⁶⁸ Most states require a one-year internship in order to qualify for the medical licensure examination, and "residency and fellowship programs are necessary to qualify for certification in specialties and subspecialties."⁶⁹ Although housestaff receive a yearly income and fringe benefits, the Board believed that the compensation and benefits were more like a stipend for living expenses than a salary.⁷⁰ Finally, the Board emphasized the temporary nature of housestaff employment by noting that few house officers remained employed at the teaching hospital after completion of training.⁷¹

In his dissent, Member Fanning noted many factors which indicate housestaff should be classified as employees. Fanning relied on the plain meaning of the term "employee," the overwhelming indicia of employment status, and the legislative history of the amendments.⁷² Fanning disagreed with the majority's use of the primary purpose test and instead advocated framing the issue as "whether the 'students' were also employees."⁷³ He contended that even under the majority's primary purpose test housestaff should be considered employees. Fanning emphasized that both the common law and NLRBA definition of employee appear to include housestaff, particularly noting that the NLRA's definition of employee includes "any employee" unless specifically excluded.⁷⁴ Under the NLRA,

67. *See id.* at 252-54 (discussing licensing, accreditation, the National Intern and Resident Matching Program, types of patient care performed by housestaff, and housestaff evaluations and certification).

68. *See id.*

69. *Id.* at 253.

70. *See id.* The Board noted that the house officers do not seem to attach any significance to the amount of the stipend and pointed out that housestaff do not receive all the benefits other hospital employees are eligible to receive. *See id.*

71. *See id.* at 252-53 (noting that the majority of housestaff go into private practice, group practice, or join an HMO).

72. *See id.* at 259 (Member Fanning, dissenting). Member Fanning pointed out Congress' acknowledgment that the exemption of nonprofit hospitals from the Act resulted in recognition strikes and picketing and argued for coverage of housestaff under the NLRA as a means for resolving "organizational and recognition disputes." *Id.*

73. *Id.* at 254.

74. *See id.* The NLRA defines employee as follows:

[T]he term "employee" shall include any employee, and shall not be limited to the employees of a particular employer, unless this subchapter explicitly states otherwise, and shall include any individual whose work has ceased as a consequence of, or in

students are not listed among the groups excluded from the definition of employee, and nothing in the statute suggests that the two terms are mutually exclusive.⁷⁵

Fanning also examined indicia of employment status, specifically focusing on the duties of house officers. For example, housestaff spend the majority of their time performing health care services and making important medical decisions about patient care without supervision.⁷⁶ Hospitals charge for services performed by housestaff, compensate them, and provide benefits.⁷⁷ Fanning disagreed with the majority's finding that housestaff were not "professional employees" within Section 2(12) of the Act, arguing that the House Conference Report to the Taft-Hartley Act demonstrated that the definition was designed to embrace "such persons as legal, engineering, scientific and medical personnel *together with their junior professional*

connection with, any current labor dispute or because of any unfair labor practice, and who has not obtained any other regular and substantially equivalent employment, 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 parents or spouse, or any individual having the status of an independent contractor, or any individual employed as a supervisor, or an individual employed by an employer subject to the Railway Labor Act, as amended from time to time, or by any other person who is not an employer herein defined.

29 U.S.C. § 152(3) (1994); *see also infra* Part III.A.

75. *See Cedars-Sinai*, 223 N.L.R.B. at 254 (Member Fanning, dissenting). Member Fanning then explained that the common law definition of employee is an outgrowth of the term "servant," defined as "a person employed to perform services in the affairs of another who with respect to the physical conduct in the performance of the services is subject to the other's control or right of control" *Id.* (quoting RESTATEMENT (SECOND) OF AGENCY § 200 (1957)). Therefore, housestaff are employees because they perform services for a hospital, are subject to its control, and are compensated (which is an additional modern standard consideration for employee classification). Thus, other cases involving students are distinguishable because they do not perform a service for the employer, but instead are working for their personal benefit. *See id.* at 254-55. Despite the majority's use of a primary purpose test and insistence on distinguishing between students and employees, the majority claimed that it did not regard students and employees as mutually exclusive categories. *See id.* at 253.

76. *See id.* at 255 (arguing that housestaff act without supervision and perform a variety of significant health care services). Fanning stated that "individuals would hardly take comfort in the notion that the individual in whose hands their life itself may repose is not primarily interested in performing that service for the hospital and patient but, rather, is primarily a student of that matter." *Id.* at 256. The housestaff role in the hospital is one of extreme involvement and dedication. They work long hours and spend approximately 80% of their time providing patient care with very little supervision. *See id.* at 256. Member Fanning cited a study conducted by the Association of American Medical Colleges ("AAMC") which determined that "approximately 80 percent of a housestaff officer's time is spent in direct patient care activities." *Id.*

77. *See id.* at 255. Fanning also cited to several provisions in the Essentials, which describe the standards for graduate medical education, and an accompanying memorandum from the AMA. These documents continually referred to the employment status of the house officer, her compensation and benefits, and other conditions of her employment. *See id.* at 256.

assistants."⁷⁸ In Fanning's view, the lack of evidence that Congress intended to exclude housestaff was also significant.⁷⁹

2. *St. Clare's Hospital and Health Center*

Shortly after its decision in *Cedars-Sinai*, the NLRB decided *St. Clare's Hospital & Health Center*.⁸⁰ The CIR challenged the Board's decision in *Cedars-Sinai*, in an attempt to have the NLRB recognize the housestaff at St. Clare's Hospital as employees.⁸¹ The Board used *St. Clare's Hospital* to clarify its reasoning in the *Cedars-Sinai* decision.⁸² Similar to its decision in *Cedars-Sinai*, the Board in *St. Clare's Hospital* relied on distinctions between students and employees. The Board explained that NLRB precedent classified students into four categories.⁸³ Housestaff were placed in the fourth category: students employed in a capacity directly related to their course of study.⁸⁴ By including housestaff in this category, the Board barred them from participating in labor organizations and collective bargaining.⁸⁵ The Board determined that the housestaff were employed as a part of their medical training.⁸⁶ According to the Board, this finding supported the primary purpose test, and again the

78. *Id.* at 258 (quotation omitted).

79. *See id.* at 258 (stating that "any reasonably diligent reading of the legislative history surrounding the amendments would make it clear that coverage of housestaff, in some context, was an assumption on the part of Congress").

80. *St. Clare's Hosp. & Health Ctr.*, 229 N.L.R.B. 1000 (1977).

81. *See id.* at 1000 (explaining, in its opinion denying the housestaff's motion for reconsideration, that the NLRB dismissed the St. Clare's Hospital housestaff's representation petition on the grounds that they were not a labor organization within the meaning of the Act because the housestaff are not "employees" as determined by *Cedars-Sinai*).

82. *See id.* The Board began its opinion in *St. Clare's Hospital* by stating that its opinion in *Cedars-Sinai* "may not have been as precise as [it] might have been in articulating [its] views." *Id.*

83. *See id.* at 1000-02. The Board set forth four categories of prior cases relating to students: (1) students employed by a commercial employer in a capacity unrelated to the students' course of study; (2) students employed by their own educational institutions in a capacity unrelated to their course of study; (3) students employed by a commercial employer in a capacity which is related to the students' course of study; (4) students performing services at their educational institutions which are directly related to their educational program. *See id.*

84. *See id.* at 1002 (noting that the student-teacher relationship is not at all analogous to the employee-employer relationship).

85. *See id.* In discussing the category of students performing services at their educational institutions which are directly related to their education the Board stated that "[i]n such cases, the Board has universally excluded students from units which include nonstudent employees, and in addition has denied them the right to be represented separately." *Id.* Yet, the Board only cited two such cases: *The Leland Stanford Junior University*, 214 N.L.R.B. 621 (1974), and *Adelphi University*, 195 N.L.R.B. 639 (1972).

86. *See St. Clare's Hosp.*, 229 N.L.R.B. at 1002 (stating that because housestaff's interests were "predominantly academic" they were not "readily adaptable to the collective bargaining process").

Board concluded that an individual's interest is "more academic than economic" when he or she provides services "at the educational institution itself as part and parcel of his or her educational development."⁸⁷ Furthermore, the Board expressed concern that collective bargaining by housestaff would impair medical training and academic decision making.⁸⁸

As in *Cedars-Sinai*, Member Fanning again dissented, arguing that housestaff should be granted collective bargaining rights.⁸⁹ Fanning observed that although the majority opinion in *St. Clare's Hospital* addressed the issue of "whether state regulation of housestaff activity is, in light of *Cedars-Sinai*, precluded by virtue of the preemption doctrine," the *Cedars-Sinai* holding determined whether house officers are covered under the NLRA.⁹⁰ Fanning rejected the majority's claim that a "long standing policy" exists that "denied representation rights to 'students' who are also 'employees'."⁹¹

After carefully examining each of the four categories discussed by the majority, Fanning concluded that the majority misinterpreted Board precedent.⁹² According to Fanning, Board policy required an examination of three factors: "whether the student fits the definition of employee"; whether he or she is a temporary or regular employee; and whether a commonality of working interests exists among the employees.⁹³

87. *Id.* at 1003. The Board concluded that "[s]ince the individuals are rendering services which are directly related to—and indeed constitute an integral part of—their educational program, they are serving primarily as students and not primarily as employees." *Id.* at 1002.

88. *See id.* at 1002-03. The Board stated that "the nature of collective bargaining is such that it is not particularly well suited to academic decisionmaking." *Id.* at 1002. The Board expressed concern that hospitals' emphasis would change from educational quality to economic concerns. *See id.* Housestaff participate in a hands-on training experience and the Board noted that issues such as the notoriously long hours might be necessary to the educational experience. *See id.* Although these long hours might increase the housestaff learning curve in the beginning, recent literature reveals that these long hours can also be detrimental to patient care. *See infra* note 250.

89. *See id.* at 1009 n.58 (Member Fanning, dissenting) (stating that if housestaff are "students who also happen to be employees, there is no policy of denying them coverage").

90. *Id.* at 1005 (Member Fanning, dissenting). The preemption doctrine is a doctrine adopted by the Supreme Court holding that "certain matters are of such a national, as opposed to local, character that federal laws preempt or take precedence over state laws. As such, a state may not pass a law inconsistent with the federal law." BLACK'S LAW DICTIONARY 1177 (6th ed. 1990).

91. *St. Clare's Hosp.*, 229 N.L.R.B. at 1007 (Member Fanning, dissenting).

92. *See id.* at 1007-08.

93. *Id.* at 1007-09.

III. HOUSESTAFF STATUS: ARGUMENTS IN FAVOR OF CLASSIFYING HOUSESTAFF AS "EMPLOYEES" UNDER THE NLRA

The NLRB should reverse its holdings in *Cedars-Sinai* and *St. Clare's Hospital* and hold that house officers are employees entitled to engage in collective bargaining under the NLRA. For over twenty years, housestaff have been unjustifiably deprived of the advantages of collective bargaining.⁹⁴ The primary purpose test requires a determination that individuals are either students or employees, but in practice housestaff are both students and employees. As employees, housestaff are entitled to collective bargaining rights.

The *Cedars-Sinai* decision failed to acknowledge that both academic and economic purposes may motivate housestaff. By using the primary purpose test, which considers only the house officers' subjective intent, the Board failed to recognize the reality of the relationship between hospital and housestaff. Teaching hospitals serve as both teacher and employer; the house officer acts as both student and employee.

The primary purpose test interprets "employee" narrowly, contrary to the NLRA's broad definition. The NLRA defines "employee" under Section 2(3) as "any employee." Significantly, students do not come within any of the statutory exceptions.⁹⁵ Since the *Cedars-Sinai* decision, the Supreme Court has analyzed the term "employee" under the Act and construed the term broadly, noting that it should only be limited by specific exceptions.⁹⁶ The legislative history also supports a broad interpretation and defines "employees" protected under the Act as broadly as "every man on a payroll."⁹⁷

Several public sector jurisdictions have also considered housestaff status. The overwhelming majority of these jurisdictions have found that housestaff are employees entitled to collective bargaining rights.⁹⁸ Federal agencies have also invariably treated housestaff as employees for a variety of purposes, ranging from tax

94. See Richard B. Gallagher, *Hospital House Staff Physicians as "Employees" Under Section 2(3) of the National Labor Relations Act (29 U.S.C. § 152(3)), and Therefore Subject to Provisions of the Act, as Amended*, 57 ALR FED. 608, 613 (1982) (listing cases after *Cedars-Sinai* in which the NLRB held that housestaff are not employees under the Act); see also Hilary Jewett, *Professionals in the Health Care Industry: A Reconsideration of NLRA Coverage of Housestaff*, 19 CARDOZO L. REV. 1125, 1145 (1997) (arguing for "a labor policy granting health care professionals," specifically housestaff, "the right to organize and bargain collectively" but not calling for a reversal of *Cedars-Sinai* and *St. Clare's Hospital*).

95. See *infra* Part III.A.1.

96. See *infra* Part III.A.2.

97. See *infra* note 116 & Part III.A.3.

98. See *infra* Part III.B.

status to employment discrimination.⁹⁹ An examination of the relationship between the hospital and the house officer reveals clear indicia of employment status, such as house officers receiving compensation and fringe benefits.¹⁰⁰ Finally, other considerations, such as AMA policy and the factors motivating increased physician unionization, argue in favor of granting collective bargaining rights to housestaff.¹⁰¹ All of these factors recommend a reversal of the *Cedars-Sinai* decision and a finding that housestaff are employees under Section 2(3) of the NLRA.

*A. The National Labor Relations Act:
The Meaning of "Employee" Under Section 2(3)
and "Professional Employee" Under Section 2(12)*

1. Statutory Construction

The NLRA permits employees to collectively bargain with their employer relating to the terms and conditions of employment.¹⁰² For the NLRA to apply, housestaff must be considered employees under Section 2(3) of the Act.¹⁰³ That Section broadly defines the term "employee" as "any employee, and shall not be limited to the employees of a particular employer, unless this subchapter explicitly states otherwise."¹⁰⁴ An examination of the plain meaning of a statutory provision is often the first step in statutory interpretation.¹⁰⁵ If the plain meaning is unambiguous, the court's only function is to enforce the statute on its face.¹⁰⁶ Section 2(3) defines "employee" as "any employee."¹⁰⁷ No statutory exception for students exists; therefore, a natural reading of the Act requires that the NLRB consider employed students as "employees" under Section 2(3).

99. See *infra* Part III.C.

100. See *infra* Part III.D.1.

101. See *infra* Part III.D.2-3.

102. See 29 U.S.C. §§ 158(a)(5), 159(a) (1994).

103. See generally John Robert Shelton, Note, *N.L.R.B. Guidelines for Determining Health Care Industry Bargaining Units: Judicial Acceptance or Back to the Drawing Board*, 78 KY. L.J. 143 (1989-90). Shelton argues that the Supreme Court should "grant certiorari and confirm the validity of the Rules in relation to the NLRA" which would allow the Board to "establish a consistent standard for the determination of appropriate bargaining units in the health care industry." *Id.* at 180.

104. 29 U.S.C. § 152(3) (1994).

105. See *Caminetti v. United States*, 242 U.S. 470, 485 (1916).

106. See *id.*

107. 29 U.S.C. § 152(3).

The definition of "professional employee" set forth in Section 2(12) also includes housestaff. This Section defines professional employee as "any employee, who (i) has completed the courses of specialized intellectual instruction and study . . . 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)."¹⁰⁸ In *Cedars-Sinai*, the dissent stated that the NLRA's legislative history indicates that "Section 2(12) was, in part, designed to cover housestaff *specifically*."¹⁰⁹ The majority in *Cedars-Sinai* rejected this argument, reasoning as a threshold matter that the first part of the definition required that the individual must be considered "an employee."¹¹⁰ Despite the majority's claim, both Section 2(3) and Section 2(12) demonstrate that Congress intended to include housestaff within the coverage of the Act.

2. Supreme Court Decisions

Since 1976 and the NLRB's ruling in *Cedars-Sinai*, Supreme Court decisions "have undercut the Board's reasoning in that case by interpreting Section 2(3) in an expansive manner."¹¹¹ The Supreme Court has determined that the Act's purpose of encouraging collective bargaining supports using the dictionary definition of the term "employee."¹¹²

In *Sure-Tan, Inc. v. NLRB*, the Court determined that the construction of the Act required inclusion of any group not specifically

108. 29 U.S.C. § 152(12)(b). The term "professional employee" is defined as follows:

(a) any employee engaged in work (i) predominantly intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work; (ii) involving the consistent exercise of discretion and judgment in its performance; (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (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, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental manual or physical processes.

29 U.S.C. § 152(12)(a).

109. *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 257 (1976) (discussing Section 2(12) of the NLRA and arguing that the language of 2(12) was intended to cover housestaff in part by citing to the house conference report accompanying the Taft-Hartley Act, which stated that medical personnel and their junior professional assistants came within the definition of professional employee).

110. *Id.*

111. See Decision and Order, *supra* note 3, at 25 (discussing the CIR's position).

112. See, e.g., *NLRB v. Town & Country Elec., Inc.*, 516 US 85, 90 (1995); *Sure-Tan, Inc. v. NLRB*, 467 U.S. 883, 891 (1984); see also Decision and Order, *supra* note 3, at 25 (discussing the position of the Petitioner, CIR, on the Supreme Court's interpretation of the term "employee" in Section 2(3) of the NLRA).

excluded from the term “employee.”¹¹³ The Court stated that the “breadth of Section 2(3)’s definition is striking: the Act squarely applies to ‘any employee.’”¹¹⁴ Similarly, in *NLRB v. Town & Country Electric, Inc.*, the Court stated that “[t]he phrasing of the Act seems to reiterate the breadth of the ordinary dictionary definition, for it says ‘the term “employee” shall include *any* employee.’”¹¹⁵

3. Legislative History

The legislative history of the Wagner Act also supports a broad reading of Section 2(3) as it characterizes “employees” covered by the act as “every man on a payroll.”¹¹⁶ Similarly, the legislative history of the Taft-Hartley Act indicates that Congress supported a broad interpretation of “employee.” A House Report defined “employee” under Section 2(3) “according to the law as the courts have stated” as “someone who works for another for hire.”¹¹⁷

The legislative history of the Health Care Amendments also challenges the reasoning underlying the *Cedars-Sinai* decision.¹¹⁸ The senator sponsoring the legislation stated that the purpose of the amendments was to remedy the “notoriously underpaid average salary for all health care workers—including doctors.”¹¹⁹ A House and Senate Conference Committee examined the status of housestaff under the NLRA and determined that residents, interns, and fellows were not supervisors under Section 2(11) of the Act and it was

113. See *Sure-Tan*, 467 U.S. at 892 (holding that “[s]ince undocumented aliens are not among the few groups of workers expressly exempted by Congress, they plainly come within the broad statutory definition of ‘employee’”).

114. *Id.* at 891. The only limitations are specific exemptions for agricultural workers, domestic workers, individuals employed by their spouses or parents, individuals employed as independent contractors or supervisors, and individuals employed by a person who is not an employer under the NLRA. See 29 U.S.C. § 152(3) (1994).

115. *Town & Country Elec.*, 516 U.S. at 90 (quoting 29 U.S.C. § 152(3) (emphasis in original)).

116. 79 CONG. REC. 9686 (June 19, 1935) (discussion between Reps. Taylor and Connery); see also *Town & Country Elec.*, 516 U.S. at 91 (explaining the legislative history of the Wagner Act); Petitioner’s Post-Hearing Brief, *supra* note 24, at 93.

117. H.R. REP. NO. 245 ON H.R. 3020, at 18 (1947), reprinted in 1 Legislative History of the Taft-Hartley Act 309; see also Petitioner’s Post-Hearing Brief, *supra* note 24, at 94.

118. See *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 254 (1976) (Memher Fanning, dissenting).

119. 120 CONG. REC. 12937 (May 2, 1974). The senator proceeded to point out that “the average intern, resident, or fellow—works 70 to 100 hours per week, and earns about \$10,000 per year.” *Id.*; see also Petitioner’s Post-Hearing Brief, *supra* note 24, at 96-97.

unnecessary to explicitly exclude housestaff, thereby implicitly recognizing that Congress considered them to be employees.¹²⁰

4. Other NLRB Decisions Addressing Employee Status

Despite the use of the primary purpose test in *Cedars-Sinai* and *St. Clare's Hospital*, the NLRB has not uniformly adopted this test in all cases involving the definition of employee.¹²¹ The Board has recognized that dual roles do not preclude coverage under the Act.¹²² In *Chinatown Planning Council*, the NLRB determined that participants in a job-training program were employees despite testimony that the purpose of participation in the program was for individuals to gain skills, graduate, and obtain outside employment.¹²³

120. See S. REP. NO. 93-766, at 6 (1974); H.R. REP. NO. 93-1051, at 7 (1974); Petitioner's Post-Hearing Brief, *supra* note 24, at 97. Congress, however, has not responded to the NLRB's holdings in *Cedars-Sinai* and *St. Clare's Hospital*. Following the *Cedars-Sinai* decision, Representative Frank Thompson introduced legislation (which Congress did not pass) to include residents and interns in the definition of employee. See H.R. 2222, 95th Cong., 1st Sess. (1977) (proposed amendment to 29 U.S.C. § 152(12)) (originally introduced as H.R. 15842, 94th Cong., 2d Sess. (1976)). The bill proposed to amend the NLRA to include the following provision:

(b) any employee, including any intern, resident or fellow, or other such trainee in a professional training program who is receiving a stipend or compensation for work performed in connection with such program or for performing related work described in clause (ii) of this paragraph, who has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a) and (ii) and is performing related work under the supervision of a professional person to qualify himself to become a professional person or a professional employee as defined in paragraph (a).

Id. Congress held hearings on the matter and heard testimony from interested groups ranging from the CIR and the AMA to the AAMC and the American College of Physicians. See *Hospital Housestaff as Professional Employees: Hearings before the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor*, 95th Congress (1977), 125 CONG. REC. 933, 943 (1979).

121. See Malin, *supra* note 34, at 1 (providing an excellent discussion of the NLRB's treatment of students under the NLRA); see also Daniel W. Srsic, Comment, *Collective Bargaining by Physicians in the United States and Canada*, 15 COMP. LAB. L.J. 89, 104-08 (1993) (discussing physicians as employees and specifically housestaff as employees).

122. The Board has recently held that control over employees is not determinative of their status. See *Management Training Corp.*, 317 N.L.R.B. 1355 (1995). Regional Director Pye cited the Board's holding in *Management Training Corp.*, in which the Board found that "it would not refuse to exercise jurisdiction over an employer because of concerns that collective bargaining could encompass some areas over which the employee did not have meaningful discretion." Decision and Order, *supra* note 3, at 25 & n.85. The NLRB previously used a "patient care" test in determining whether nurses were supervisors under the Act. The test examined whether nurses acted in the interest of their employer or their patients. The Supreme Court rejected this test in its 1994 decision *NLRB v. Health Care & Retirement Corp.*, 511 U.S. 571 (1994). The Court held that the patient care test created a "false dichotomy" and nurses could not be excluded because they had an interest in patient care apart from that of their employer. Jewett, *supra* note 94, at 1135 (citing *Health Care & Retirement Corp.*, 511 U.S. at 576).

123. *Chinatown Planning Council*, 290 N.L.R.B. 1091, 1094 (1988). The Board stated that the goal of the program was to train the workers so "they could graduate from the program and, with the skills learned, seek employment elsewhere." *Id.* The Board specifically stated that the workers were apprentices and not students. See *id.* at 1095.

The NLRB has generally considered both apprentices and on-the-job trainees as employees under the Act.¹²⁴ Arguably, apprentices are distinguishable from students, but medicine also requires extensive workplace training. Housestaff more closely resemble on-the-job trainees or apprentices than students.¹²⁵ Of the four types of student employees described in *St. Clare's Hospital*, students employed by their University are the only group not considered "employees" under the NLRA.

The Board's decision in *St. Clare's Hospital* analogized housestaff to graduate or teaching assistants.¹²⁶ The NLRB denied these groups collective bargaining rights in *Adelphi University* and *Leland Stanford Junior University*.¹²⁷ These cases are distinguishable, however: in *Adelphi University*, the teaching assistant position required that the instructors be graduate students; and in *Leland Stanford*, the research by the assistants was a required part of course instruction.¹²⁸ Housestaff are not degree candidates, and are therefore unlike the students in *Adelphi University* and *Leland Stanford*.

Cedars-Sinai is also inconsistent with prior Board decisions that have granted collective bargaining rights to full-time employees who are also part-time students. Member Fanning referred to *Macke II* as an example of a decision in which the Board gave collective bargaining rights to a group of student employees.¹²⁹

124. See Kathleen Drake, Comment, *Labor Problems of Interns and Residents: The Aftermath of Cedars-Sinai*, 11 U.S.F. L. REV. 694, 705 (1977) (citing *United Aircraft Corp. v. NLRB*, 333 F.2d 819 (2d Cir. 1964); *General Motors, Inc.*, 133 N.L.R.B. 1063 (1961)).

125. See *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 258 (1976) (Member Fanning, dissenting).

126. *St. Clare's Hosp. & Health Ctr.*, 229 N.L.R.B. 1000, 1002 & nn.19-20 (1977).

127. *The Leland Stanford Junior Univ.*, 214 N.L.R.B. 621, 623 (1974) (finding that research assistants are like graduate teaching and research assistants and therefore are primarily students and not employees within the meaning of Section 2(3) of the Act); *Adelphi Univ.*, 195 N.L.R.B. 639, 640 (1972) (finding that graduate teaching and research assistants are primarily students and therefore should be excluded from the bargaining unit). For an argument that graduate teaching assistants should be recognized as employees and that student interns are entitled to greater protection see David L. Gregory, *The Problematic Employment Dynamics of Student Internships*, 12 NOTRE DAME J.L. ETHICS & PUB. POL'Y 227 (1998).

128. See *Leland Stanford*, 214 N.L.R.B. at 621 (noting that all graduate students enrolled in the program are required to participate in research as part of the course instruction); *Adelphi Univ.*, 195 N.L.R.B. at 640 (stating that graduate assistants' employment is dependant on their degree status); see also *St. Clare's Hosp.*, 229 N.L.R.B. at 1008 (discussing the *Leland Stanford* case and its applicability to housestaff status); Drake, *supra* note 124, at 704 (discussing NLRB precedent on the exclusion of students from bargaining units).

129. See *Cedars-Sinai*, 223 N.L.R.B. at 254 (Member Fanning, dissenting) (citing *The Macke Co (II)*, No. 2-RC-16725 (1974)); see also *St. Clare's Hosp.*, 229 N.L.R.B. at 1006 (Member Fanning, dissenting).

According to Fanning, the majority decision in *St. Clare's Hospital* increases confusion as to the exact status of housestaff because the Board re-characterized housestaff status as "student-employees" instead of as "students rather than employees."¹³⁰ The majority's recognition of the dual roles of housestaff in *St. Clare's Hospital* makes it even more apparent that housestaff fall within the definition of "employee" in Section 2(3) of the NLRA.

*B. The Majority of Public Sector Jurisdictions
Classify Housestaff as Employees*

Since 1974, the NLRA has not applied to public nonprofit hospital employees. Consequently, a separate body of state court and board decisions addresses housestaff status for private nonprofit hospital employees prior to 1974 and for public employees. The majority of the public sector jurisdictions considering housestaff status have analyzed the issue differently than the Board in *Cedars-Sinai*, holding that housestaff are employees for the purpose of collective bargaining and unionization.¹³¹ Only one jurisdiction has followed *Cedars-Sinai's* holding that interns and residents are students and not employees; notably, this court still recognized that housestaff possess numerous "employee attributes."¹³²

These decisions have offered various rationales in declining to follow the reasoning used in *Cedars-Sinai*. The majority of these cases have held that the combination of the overwhelming indicia of employment, the lack of a statutory exclusion, and the purpose behind

130. *St. Clare's Hosp.*, 229 N.L.R.B. at 1006 (Member Fanning, dissenting).

131. Jurisdictions that have considered the issue include California, the District of Columbia, Florida, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New York, Ohio and Pennsylvania. See *Regents of the Univ. of Cal. v. Public Employee Relations Bd.*, 715 P.2d 590 (Cal. 1986) (en banc); *In re on Mental Health Serv. Dep't of Human Serv., D.C. Gov't & Committee of Interns & Residents*, 38 DCR 1628, Op. No. 269, PERB Case No. 90-R-04 (1991); *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192; *In Re Physician's Nat'l Housestaff Ass'n*, No. 77-PG-R-29 (Prince George's County PERB, March 30, 1978); *Worcester City Hosp.*, 3 MLC 1290 (Mass. Labor Rel. Comm'n 1976); *Regents of Univ. of Mich. v. Mich. Employee Relations Comm'n*, 204 N.W.2d 218 (Mich. 1973); *House Officers Ass'n v. Univ. of Neb. Med. Ctr.*, 255 N.W.2d 258 (Neb. 1977); *Veterans Admin. Med. Ctr., East Orange N.J.*, 20 FLRA 900 (1985); see also *Williams v. Bresnahan*, 536 N.E.2d 365, 366 (Mass. App. Ct. 1989); *University of Med. & Dentistry of N.J., Sch. of Osteopathic Med.*, Case No. CO-H-92-20, PERC No. 94-60, 20 NJPER P25, 014, 6; *University Hosp., Univ. of Cincinnati College of Med. v. State Employment Relations Bd.*, 587 N.E.2d 835 (Ohio 1992). But see *Philadelphia Ass'n of Interns & Residents v. Albert Einstein Med. Ctr.*, 369 A.2d 711 (Pa. 1976).

132. *Philadelphia Ass'n of Interns & Residents*, 369 A.2d at 711. In a four to three decision, the court chose to adopt the primary purpose test instead of relying on the abundant indicia of employee status. See *id.* at 714.

a grant of collective bargaining rights require a finding that housestaff are employees entitled to the right to collectively bargain.¹³³ Several jurisdictions have noted that if the legislatures intended to exclude housestaff from the definition of "employee" they could have specifically excepted this group.¹³⁴ Some cases have rejected the mutually exclusive student/employee dichotomy,¹³⁵ reasoning that although educational activities and direct patient care are both part of housestaff responsibilities, "educational objectives are subordinate to the services . . . performed [by housestaff]."¹³⁶

In the most recent of these public sector cases, the Florida Public Employee Relations Commission granted a petition for an employee organization at the Public Health Trust of Metropolitan Dade County.¹³⁷ For the first time, the Commission addressed the employment status of interns and residents.¹³⁸ After discussing the current body of law, the Commission decided to "join the host of other public sector jurisdictions" and held that "[re]sidents are public employees entitled to engage in collective bargaining."¹³⁹ In reaching this conclusion, the Commission employed the common-law test to determine if an employer/employee relationship existed.¹⁴⁰ This test required an examination of "whether [the] public employer ha[d] sufficient control over the employees' terms and conditions of employment to engage in meaningful collective bargaining."¹⁴¹ The Commission rejected the primary purpose test used in *Cedars-Sinai*,¹⁴² holding that "an individual's subjective motivation for seeking employment should not determine [his or her] status as an

133. See *supra* note 131.

134. See *Regents of the Univ. of Mich.*, 204 N.W.2d at 225 (stating that "[n]o exception is made for people who have a dual status of students and employees").

135. See *id.* at 218 (holding that housestaff are both students and employees).

136. *Regents of the Univ. of Cal.*, 715 P.2d at 598.

137. See *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192.

138. See *id.* (noting that although the Commission had considered the employment status of residents, it had "never been presented with an employee organization's petition seeking to represent Residents for the purposes of collective bargaining").

139. *Id.* at *4. The Commission viewed residents as analogous to graduate assistants who were previously found to be public employees under Florida law. See *id.* at *5 (finding the Florida appellate court opinion that graduate students were public employees supportive).

140. This test requires a determination that a "public employer has sufficient control over the employees' terms and conditions of employment to engage in meaningful collective bargaining." *Id.* at *10. The Commission, however, also analyzed the residents' status under the student-employee dichotomy used in other jurisdictions. See *id.*

141. *Id.*

142. See *id.* (noting that the hearing officer considered the case according to a control test, but the Commission also considered the case within the "student-public employee dichotomy").

employee."¹⁴³ Instead, the Commission found that indicia of employment and the noticeable lack of a statutory prohibition established the residents' right to collectively bargain.¹⁴⁴

Even Pennsylvania, the one state that has followed the *Cedars-Sinai* approach, may be moving away from its decision. In *Simmonds v. State Employees' Retirement System*, the Commonwealth Court of Pennsylvania found that a state hospital medical resident qualified as a state employee for the purpose of creditable state service under the State Employees' Retirement system.¹⁴⁵ The *Simmonds* court distinguished its decision from the Pennsylvania Supreme Court's holding in *Philadelphia Ass'n of Interns & Residents v. Albert Einstein Medical Center*¹⁴⁶ based on the plaintiff's continued employment with the State after she completed her residency.¹⁴⁷ Arguably, because the interests of the Public Employee Relations Act and the State Employees' Retirement System are different, employee status may be granted for one and not the other.¹⁴⁸ The court's rejection of the primary purpose test and its examination of factors such as the amount of time housestaff spend delivering patient care, hospitals compensating housestaff for services, and hospitals billing for residents' services may indicate movement away from considering residents as primarily students.¹⁴⁹

The sharp division between state public sector law and federal law arises in part because collective bargaining rights under federal law are not based upon a constitutional guarantee, as they are in many of the states that classify residents as employees.¹⁵⁰ In addition,

143. *Id.* at *14 (adopting the view of Justice Eagen, a dissenter in *Einstein Medical Center*, that "individuals having the indicia of employee status are nonetheless employees even though their primary purpose may be to advance their educational experience to either enlarge their knowledge or fulfill qualifications necessary for progression in their professional career[s]").

144. *See id.* at *15 (noting that indicia of employment were established and there was no statutory prohibition in the definition of public employee set forth in section 447.203(3) of the Florida Statutes).

145. *Simmonds v. State Employees' Retirement Sys.*, 663 A.2d 304 (Pa. Commw. Ct. 1995). For a discussion of the *Simmonds* case and its possible relationship to residents' employee status in collective bargaining see Susan Hensel, *Annual Survey of Pennsylvania Administrative Law: Simmonds v. State Employees' Retirement System: The Commonwealth Court Broadens the Definition of State Employment to Include Transitory Worker*, 6 WIDNER J. PUB. L. 811 (1997).

146. *Philadelphia Ass'n of Interns & Residents v. Albert Einstein Med. Ctr.*, 369 A.2d 711 (Pa. 1976). *Einstein Medical Center* is discussed in more detail in Maute, *supra* note 10.

147. *Simmonds*, 663 A.2d at 306; *see also* Hensel, *supra* note 145, at 815.

148. *See* Hensel, *supra* note 145, at 819.

149. *See id.* at 816-17.

150. *See* *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192 at *12 (discussing the possible reasons for the differing outcomes in public sector cases).

the statutes granting public employees bargaining rights are often phrased differently than in the NLRA.¹⁵¹ Many public sector jurisdictions have not employed the primary purpose test and instead concentrated on the indicia of employment and statutory exclusion.¹⁵² Despite these distinctions, the analysis underlying these cases supports a NLRB finding that housestaff are employees.

C. Other Federal Agencies Classify Housestaff as Employees

Federal agency treatment of housestaff as employees further supports reversal of the NLRB's finding to the contrary. The Internal Revenue Service ("IRS") considers payments to medical residents as compensation for services rendered, and thus prohibits residents from declaring their salaries as tax-exempt.¹⁵³ The IRS has rejected the position that residents' salaries are stipends or monies granted for purposes of study.¹⁵⁴ Factors the IRS has viewed as indicative of an employment relationship include written agreements between the residents and the hospitals referring to the resident as an employee; payment of compensation to the resident as payment for services rendered; and a finding that residents perform work that would otherwise be performed by other employees.¹⁵⁵ Several courts have reviewed the IRS's interpretation of housestaff stipends and

151. See *Regents of the Univ. of Cal. v. Public Employee Relations Bd.*, 715 P.2d 590, 597 (Cal. 1986) (en banc). The court emphasized that, unlike the NLRA, the Higher Education Employer-Employee Relations Act ("HEERA") "expressly permits PERB to find students in both categories entitled to collective bargaining rights in appropriate circumstances." *Id.* The court held that housestaff were employees and granted them collective bargaining rights. See *id.* at 605.

152. See Bettina E. Brownstein, *Medical Housestaff: Scholars or Working Stiffs? The Pending PERB Decision*, 12 PAC. L.J. 1127, 1137 (1981) (discussing the possibility of housestaff bargaining rights under California's HEERA).

153. See Letter to the Regional Director, *supra* note 19, at 11 (citing *Meek v. United States*, 608 F.2d 368 (9th Cir. 1979); *Christman v. Commissioner*, 57 T.C.M. (CCH) 538 (1989)).

154. See *infra* note 156 and accompanying text; see also Jerri M. Blaney, *Residents' Stipends: To Exclude or Not to Exclude*, 1 B.U. J. TAX LAW 167 (1983) (discussing whether and how the stipend exclusion applies to housestaff); Stephen L. Sepinuck, *Hospital Residents and Interns: Inconsistent Treatment Under Federal Law*, 29 ST. LOUIS U. L.J. 665 (1985) (arguing that the *Cedars-Sinai* decision was correctly decided and the tax courts should exclude housestaff from application of Section 117). The IRS considers housestaff to be no different than other "on-the-job" trainees. See Comment, *Medical Residents and Section 117—Time for a Closer Examination*, 25 ST. LOUIS U. L.J. 117, 120 (1981) (examining the possibilities for exclusions for medical housestaff under Section 117 and suggesting legislative modification of the Section).

155. See Comment, *supra* note 154, at 133-36 (discussing factors considered by courts in determining whether a resident is an employee for the purpose of determining if his or her income (compensation) can qualify for exclusion under Section 117).

determined that housestaff are "employees" who are not entitled to a federal income tax exclusion.¹⁵⁶

The Equal Employment Opportunity Commission ("EEOC") classifies housestaff as employees within the scope of Title VII of the Civil Rights Act.¹⁵⁷ In one sexual discrimination case, the EEOC conceded that residents and interns received educational benefits but found sufficient indicia of employee status to classify them as "employee(s) with rights under the law."¹⁵⁸ In deciding the case, the EEOC relied on the standards set forth by dissenting Member Fanning in the NLRB's *Cedars-Sinai* decision.¹⁵⁹ According to the EEOC, the existence of an employment contract, monetary compensation, worker's benefits, paid leave, and malpractice coverage demonstrated that housestaff were employees.¹⁶⁰ The EEOC found Member Fanning's dissent in *Cedars-Sinai* "more persuasive" than the majority opinion and held that the intern was "also an employee with rights under the law."¹⁶¹ The EEOC's decision to classify residents and interns as employees provides them protection from all forms of employment discrimination and includes coverage under the Age Discrimination in Employment Act of 1967 and the Equal Pay Act of 1963.¹⁶² Therefore, hospitals with medical residencies and internship programs are required to treat the residents as employees in regard to employment decisions such as hiring, advancement, and termination.¹⁶³

The Department of Education does not consider a hospital's records regarding interns and residents to be educational records under the Family Educational Rights and Privacy Act because residents and interns are not students.¹⁶⁴ Because housestaff are

156. See, e.g., *Cooney v. United States*, 630 F.2d 438, 442 (6th Cir. 1980) (holding that housestaff are not degree candidates, but are "employees" and therefore not entitled to the exclusion of their income from the hospital); *Rockswold v. United States*, 620 F.2d 166, 169 (8th Cir. 1980); *Meeh*, 608 F.2d at 372-73 (holding that the primary purpose of the payment was to compensate the resident and the resident was not entitled to the exclusion).

157. See *Empl. Prac. Guide (CCH)* ¶ 6870, at 7114 (reprinting U.S. EEOC Decision No. 88-1, June 27, 1988); see also *Selected Recent Court Decisions*, 15 AM. J.L. & MED. 129, 134-36 (1989) (discussing the EEOC's holding that medical interns and residents are "employees" and fall within the scope of Title VII and the Civil Rights Act).

158. *Empl. Prac. Guide (CCH)* ¶ 6870, at 7119.

159. See *id.* at 7115-19.

160. See *id.* at 7118-19.

161. *Id.* at 7119.

162. See *Selected Recent Court Decisions*, *supra* note 157, at 136 (discussing the implications of the EEOC's decision to classify residents and interns as employees for Title VII purposes).

163. See *id.*

164. See *id.* (citing 20 U.S.C. § 1232g(a)(4) (1994 & Supp. 1996)).

considered employees, they may receive COBRA employee benefits under ERISA and Family Medical Leave Act benefits.¹⁶⁵ The Department of Labor also classifies housestaff as employees. Hospitals with foreign house officers must submit a labor condition application to the department, in which the hospital must describe itself as “the employer of a non-immigrant worker” attesting to the fact that the employment of the non-immigrant will not have negative effects on the working conditions of similar workers.¹⁶⁶

D. Additional Considerations Suggest That Housestaff Should Be Considered Employees Under the NLRA

1. Indicia of Employment Status

When evaluating housestaff status, it is necessary to first understand the post-graduate training process. Medical school graduates enter an internship or a residency to specialize and obtain the licensure required to practice medicine.¹⁶⁷ Every state requires one year of graduate medical education in order to receive a medical license.¹⁶⁸ Upon completing a one-year internship and passing a licensing exam, usually no further requirements for becoming a licensed physician exist.¹⁶⁹ These limited requirements suggest that during the additional years that medical residents spend as housestaff, they serve primarily as employees. Residency programs and clinical fellows programs can continue for more than six years.¹⁷⁰ Most individuals who participate in additional years of residency programs or become fellows are seeking increased experience or certification in a specialty.¹⁷¹ Many physicians are required to renew

165. See Petitioner's Post-Hearing Brief, *supra* note 24, at 100 (citing 29 U.S.C. § 1163 (1994); 29 U.S.C. § 1002(4) (1994); 29 U.S.C. § 2611(2)(A) (1994)).

166. Decision and Order, *supra* note 3, at 14 (quoting Petitioner's Exhibit 13).

167. See Michael J. Frank, *Safeguarding the Consciences of Hospitals and Health Care Personnel: How the Graduate Medical Education Guidelines Demonstrate a Continued Need for Protective Jurisprudence and Legislation*, 41 ST. LOUIS U. L.J. 311, 315-16 (1996) (citing AMERICAN MEDICAL ASSOCIATION, U.S. MEDICAL LICENSURE STATISTICS AND CURRENT LICENSURE REQUIREMENTS 35 (1995) and discussing the range of moral issues housestaff confront).

168. See *id.* at 316.

169. See Decision and Order, *supra* note 3, at 7 n.28 (stating that “state boards require that in order for medical school graduates to practice as fully licensed physicians, they must successfully complete the one-year internship” and pass a licensing exam); see also Petitioner's Post-Hearing Brief, *supra* note 24, at 84.

170. See Frank, *supra* note 167, at 316 (using neurological surgery as an example).

171. See *supra* note 3 and accompanying text.

their certification every ten years by retaking exams and earning continuing medical education credits throughout their careers.¹⁷² These requirements make it increasingly difficult to discern between active residents and certified specialists who are performing services for continued medical education within their career.¹⁷³

Residency programs are governed by the "Essentials of Accredited Residencies" ("Essentials") promulgated by the ACGME.¹⁷⁴ The Essentials guide hospitals in developing residency programs and require hospitals to integrate housestaff as colleagues.¹⁷⁵ Current requirements refer to "Resident Support, Benefits, and Conditions of Employment" and mandate that applicants be informed "in writing of the terms and conditions of employment and benefits."¹⁷⁶

Although a residency provides an opportunity for additional training and education, the primary priority of both residents and interns is patient care.¹⁷⁷ Eighty to ninety percent of residents' time is

172. See Decision and Order *supra* note 3, at 12-13 (noting that upon expiration of certification, physicians may take a recertification exam and recognizing that "Massachusetts requires physicians to have 100 hours of continuing medical education over a two-year period in order to maintain their state licensure"); see also *Cedars-Sinai*, 223 N.L.R.B. at 257 (Member Fanning, dissenting). Fanning stated in dissent that it is "common knowledge that physicians engaged in private practice for many years take up residencies both within their certified specialty (to keep abreast of new developments) and outside their certified specialty (to expand their skills)." *Id.* Although certification in various specialties used to be permanent, it now usually remains valid for a ten year period. See Decision and Order, *supra* note 3, at 12 (noting that "23 or 24 of the 40 or more medical specialty boards have adopted time-limited certifications that are valid for periods ranging from seven to ten years"); Petitioner's Post-Hearing Brief, *supra* note 24, at 84 (discussing how a number of specialties no longer have permanent certification but now have ten year limits on certification which require physicians to retake certification exams).

173. See Petitioner's Post-Hearing Brief, *supra* note 24, at 85 (arguing that "[i]t is therefore impossible now to draw a credible distinction between Residents who are performing services while learning and certified post-residency specialists").

174. See Decision and Order, *supra* note 3, at 15-16.

175. See *Regents of the Univ. of Cal. v. Public Employee Relations Bd.*, 715 P.2d 590, 603 (Cal. 1986) (en banc) ("The intern and resident must be integrated into the medical staff as true colleagues in order that effective programs of medical education and patient care be carried out." (quoting the Essentials)).

176. Petitioner's Post-Hearing Brief, *supra* note 24, at 83 (citation and emphasis omitted).

177. See *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192, at *9 (discussing housestaff's primary role in the hospital setting as providing patient care). Residents participate in and attend lectures, conferences, and other educational activities. See Decision and Order, *supra* note 3, at 10-11. The Regional Director's findings of fact stated that interns often miss educational lectures because they are beeped or are on "night float[s]." *Id.* at 11. Various witnesses testified as to the amount of time interns and residents spend in educational conferences during a week. See *id.* The numbers ranged from fifty percent of total time for interns in oral and maxillofacial surgery program to two to four hours for orthopedic residents. See *id.*

dedicated to direct patient care.¹⁷⁸ Long hours spent providing patient care make residents a source of profit for their hospital employers.¹⁷⁹ Unlike students, housestaff add economic value to a hospital's operation. Studies show that residents provide invaluable services by supplying a constant source of on-call physicians and allowing other physicians to treat more patients.¹⁸⁰ Because housestaff receive less compensation than other physicians but share a strong commitment to patient care, hospitals benefit economically from housestaff. One study revealed that the elimination of a graduate medical education program would cost one hospital and its community several million dollars, in part because of the cost of finding staff replacements for the housestaff.¹⁸¹

Because housestaff services add economic value to the hospital while furthering their medical training, housestaff are arguably similar to other professions that implement a hands-on training period. Early in their careers, associates in law firms, consultants, and other business professionals experience intense training immediately after graduation from professional school.¹⁸² The Board has classified groups such as accountants as professional employees.¹⁸³ These professionals learn their skills through direct work experience, work long hours, and are often paid salaries based on their years of experience, not by the number of hours worked. The salaries and benefits paid to interns, residents, and fellows closely resemble those of other professionals in training, such as architects and

178. See *Committee of Interns and Residents*, 1996 FPER (LRP) LEXIS 192, at *9 (noting that "patient care occupies eighty to ninety percent of the Resident's time").

179. Currently, the federal government subsidizes teaching hospitals an average of \$70,000 per resident. See Fitzugh Mullan, *Graduate Medical Education and Water in the Soup*, 334 NEW ENG. J. MED. 916, 916 (1996); see also *Decision and Order*, *supra* note 3, at 17 & n.58 (noting that a 1994 budget committee recommendation at Boston City Hospital stated that "under the current reimbursement system, the cost of housestaff and attending physicians is virtually free. The cost of providing services without a teaching program would be significantly higher.").

180. See Maute, *supra* note 10, at 777 (quoting A. CARROLL, PROGRAM COST ESTIMATING IN A TEACHING HOSPITAL, A PILOT STUDY 78, 87 (1969)).

181. See *id.* at 778 (citing Ernst & Ernst Management Consultants, *Hartford Hospital: Study of the Cost of Education Programs, Year Ended September 30, 1971* (1972) (unpublished document, on file with Hartford Hospital)).

182. See *House Officers Ass'n for the Univ. of Neb. Med. Ctr. & Affiliated Hosp. v. University of Neb. Med. Ctr.*, 255 N.W.2d 258, 262 (Neb. 1977) (stating that learning new skills does not preclude housestaff from being classified as employees because "[m]embers of all professions continue their learning throughout their careers. For example, fledgling 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" (quoting *Regents of Univ. of Mich. v. Employment Relations Comm'n*, 204 N.W.2d 218 (Mich. 1973))).

183. See *Petitioner's Post-Hearing Brief*, *supra* note 24, at 39 n.20.

accountants.¹⁸⁴ Typical of professions requiring advanced education, housestaff are salaried, rather than paid hourly. Housestaff are employees of the hospital because they receive compensation and perform necessary services such as starting an I.V. or drawing blood.¹⁸⁵ Once a skill is acquired, it no longer offers educational value¹⁸⁶ for housestaff, but as employees, they continue to perform these services.¹⁸⁷

The structure of residency programs exhibits many elements of an employment relationship.¹⁸⁸ First, hospitals pay housestaff a salary for services rendered with monthly payroll checks and also withhold taxes.¹⁸⁹ Housestaff receive annual and step salary increases and complete personnel forms required of all employees.¹⁹⁰ They also typically receive fringe benefits, such as paid vacation, sick leave, health insurance, life insurance, dental insurance, and malpractice insurance.¹⁹¹ Also notable is the apparent lack of indicia of student status. Specifically, housestaff do not pay tuition or complete registration forms,¹⁹² nor do they take exams or receive grades.¹⁹³ In sum, housestaff perform the same duties as employees and are treated as employees within the hospital.

Residents also often fall under the definition of "employee" found in state workers' compensation statutes.¹⁹⁴ Although definitions

184. See *id.* at 3 (arguing that housestaff are similar to other employees that learn through their course of employment).

185. See Decision and Order, *supra* note 3, at 9 (noting the responsibilities of housestaff).

186. See *Regents of the Univ. of Cal. v. Public Employment Relations Bd.*, 715 P.2d 590, 603 (Cal. 1986) (en banc) (stating that "[m]any services housestaff perform become routine and do not have a continuing educational value").

187. See *id.* (noting that housestaff continue to perform routine activities in part because "their day-to-day routine, like that of regular physicians, is dictated almost entirely by the exigencies of injury and disease").

188. See *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192, at *15-*16 (referring to numerous indicia of employment including being paid monetary compensation and benefits in exchange for providing patient care, being subject to income and social security tax, and being subject to performance evaluations and disciplinary procedures).

189. See *Regents of the Univ. of Cal.*, 715 P.2d at 602 (discussing the indicia of employment status).

190. See *id.* (stating that "[h]ousestaff receive annual step and cost of living increases. They complete personnel forms, signing as 'employees'").

191. See Decision and Order, *supra* note 3, at 13-14 (listing the benefits received by the housestaff at Boston Medical Center); see also *Regents of the Univ. of Cal.*, 715 P.2d at 602 (noting that housestaff "receive several fringe benefits including paid vacations and medical coverage").

192. See *Regents of the Univ. of Cal.*, 715 P.2d at 603 (discussing the lack of indicia of student status).

193. See *id.*

194. See Stewart R. Reuter, *Professional Liability in Postgraduate Medical Education: Who is Liable for Resident Negligence?*, 15 J. LEGAL MED. 485, 493-95 (1994) (discussing that

of "employee" vary from state to state, most state statutes define "employee" broadly. For example, California's definition of employee includes "every person in the service of an employer under any appointment or contract of hire or apprenticeship, expressed or implied, oral or written, whether lawfully or unlawfully employed."¹⁹⁵ This definition likely encompasses any house officer with an employment contract. Several courts have considered the issue and ruled that housestaff are employees under state workers' compensation statutes.¹⁹⁶ As discussed above, many federal agencies classify housestaff as employees. As hospitals are bound to comply with these federal and state statutes and interpretations, they implicitly recognize the employee status of housestaff.

2. Professional Associations and Guidelines

Numerous medical associations have taken a stand on the issue of housestaff collective bargaining rights. Because these groups have first-hand knowledge of the relationship between housestaff and their teaching hospital, the support of some of these groups in the recent effort to reverse *Cedars-Sinai* and *St. Clare's Hospital* is significant.

Nine groups filed amicus briefs in support of the residents' right to collectively bargain, including the American Medical Women's Association, the American Public Health Association, and the California Medical Association.¹⁹⁷ The amicus brief submitted by the AFL-CIO and the American Nurses Association argued that housestaff are both students and employees and that dual status should not preclude them from receiving protection under the

residents are classified as employees in a variety of contexts including employment contracts, workers compensation, federal taxation, and professional liability). According to Reuter, "[t]he N.L.R.B. should change its position to reflect the realities of house staff employment as some states have done." *Id.* at 493. Reuter argues that agency principles should apply in determining housestaff negligence and hospital liability. *See id.* at 531.

195. CAL. LAB. CODE § 3351 (West 1989).

196. *See Reuter, supra* note 194, at 492-94 (citing N.Y. WORK. COMP. LAW § 3 (McKinney 1992); *Ross v. University of Minn.*, 439 N.W.2d 28, 31 (Minn. Ct. App. 1989)).

197. *See Dolores Kong, Resident Doctors' Union Bid Supported But Some Groups Side with Hospital*, BOSTON GLOBE, Feb. 1, 1998, at E8 (discussing the various groups submitting amicus briefs in the Boston Medical Center case); *see also* Michelle Amber, *Health Care Employees: Parties Respond to N.L.R.B. Request for Briefs on Employment Status of Interns, Residents*, 31 Daily Lab. Rep. (BNA) C1 (Feb. 17, 1998) (stating that "[n]early a dozen parties" submitted amicus briefs in the *Boston Medical Center* case and they were "nearly unanimous" in their opinion that housestaff are employees); Mark Moran, *Medical Groups Weigh in on Boston Resident Union Case*, AM. MED. NEWS, Feb. 23, 1998, at 9 (discussing the various positions of some of the parties that submitted briefs).

NLRA.¹⁹⁸ The Association of American Medical Colleges ("AAMC") filed a brief in support of the Boston Medical Center on behalf of five organizations, but was "only one of two" such briefs that supported the Boston Medical Center's request that the Board continue to classify housestaff as students.¹⁹⁹

The AMA initially considered supporting the Boston Medical Center's Residents' attempts to challenge the *Cedars-Sinai* decision.²⁰⁰ Instead, the AMA presented its position in a letter to the Regional Director stating that the AMA believed that house officers are both students and employees and should have the right to organize in any manner they choose.²⁰¹ After the case was appealed to the NLRB, the AMA again decided against taking sides and filed an amicus brief jointly with the Massachusetts Medical Society stating the AMA's existing policy "that physicians, including residents, have the right to collective negotiation without fear of retaliation, but without the ability to strike."²⁰²

The AMA had previously recognized the rights of housestaff to engage in collective bargaining.²⁰³ In an earlier resolution, the AMA addressed guidelines for housestaff contracts and mandated that hospitals recognize that housestaff have a right to contract collectively and negotiate freely with the institution "for terms and conditions of

198. See Amber, *supra* note 197, at C1. In addition, housestaff who lost bargaining rights when the public hospitals in which they worked became private argued that denying bargaining rights may encourage public hospitals to privatize in order to prevent housestaff unionization. See *id.*

199. *Id.*

200. See Mark Bloom, *AMA's Support for Residents' Union Doesn't Materialize*, 14 PHYSICIAN'S WKLY., (visited Apr. 14, 1999) <http://www.physweekly.com/archive/97/09_22_97/itn1.html> (stating that the AMA intended to endorse the CIR). It was further reported that the AMA retracted its endorsement after it received pressure from the AAMC. See *id.* Although the AMA can suggest policies on the standards for housestaff bargaining, it can not act as a negotiator on behalf of physicians. See MANAGEMENT SCIENCE ASSOCS., INC., THE MSA REPORT ON PHYSICIAN UNIONIZATION 9 [hereinafter MSA REPORT ON PHYSICIAN UNIONIZATION] (citing the Doctors Council Fact Sheet on Physicians Unions); see also Dolores Kong, *Hospital Residents Seek Right to Unionize Boston Medical Center Case Watched Closely*, THE BOSTON GLOBE, Aug. 24, 1997, at A1 (reporting that the AMA initially notified the NLRB regional director that it intended to file a brief in support of the housestaff at Boston Medical Center, and later decided not to proceed). At the December 1997 AMA Delegates Meeting, the delegates voted to support resident physicians' efforts to collectively bargain with their hospital employers. See Mary Chris Jaklevic, *Pot Yes, Tobacco No: AMA Delegates Take Stands on Range of Issues*, MOD. HEALTHCARE, Dec. 15, 1997, at 14. The delegates also voted against filing an amicus brief in support of the residents in the Boston Medical Center case. See *id.*

201. See Decision and Order, *supra* note 3, at 31 (citing letter from the AMA dated August 28, 1997).

202. Moran, *supra* note 197, at 9.

203. See Petitioner's Post-Hearing Brief, *supra* note 24, at 92 (discussing AMA House of Delegates Policy 310.999, Guidelines for Housestaff Contracts or Agreements, and arguing that the AMA guidelines support housestaff unionization and collective bargaining rights).

employment and training.’”²⁰⁴ In 1997, the AMA House of Delegates adopted several resolutions requesting that the AMA remove restrictions on physician collective bargaining and amend ACGME guidelines to require teaching hospitals to provide housestaff organizations with adequate power to address and resolve patient care and working condition concerns.²⁰⁵

Currently, the AMA supports house officers’ right to bargain collectively, but opposes giving them the right to strike.²⁰⁶ The AMA advocates that housestaff bargain through self-governing, voluntary organizations of house officers which would operate “within the context” of the ACGME guidelines rather than union organizations.²⁰⁷ The AMA’s first housestaff organizations manual discusses how to establish independent housestaff organizations and ways to encourage collaboration between hospitals and housestaff.²⁰⁸

3. Physician Unionization

The housestaff unionization movement reflects a larger movement among physicians in the United States.²⁰⁹ Physicians are increasingly concerned with decreasing salaries and interference with medical decision making.²¹⁰ Currently, collective bargaining is only

204. *Id.* (quoting the AMA House of Delegates Policy 310.999, Guidelines for Housestaff Contracts or Agreements).

205. See MSA REPORT ON PHYSICIAN UNIONIZATION, *supra* note 200, at 7 (quoting AMA Res. 239 (1997)); Amber, *supra* note 197, at C1.

206. See Bloom, *supra* note 200; see also Decision and Order, *supra* note 3, at 31 (noting that the AMA, in a letter, stated its policy was that “house staff should be able to organize in any manner they choose for the purpose of negotiating . . . [but] that house officers should not have the right to strike”).

207. Amber, *supra* note 197, at C1 (noting that the AMA believes that the ACGME guidelines provide the necessary standards and procedures for resolving housestaff concerns).

208. The manual is entitled *Independent Housestaff Organizations: A Win/Win Opportunity* and reportedly provides guidelines for organizing housestaff and working with hospitals on issues such as standards of patient care. See Charles Rainey, AMA-RPS Offers Resources for New Housestaff Organizations, 280 J. AM. MED. ASS’N 1714h (1998). The manual specifically provides that housestaff should not challenge the academic content of their medical training and should not jeopardize patient care through actions such as strikes. See *id.*

209. “The future of physician unions depends in large measure on whether the nation’s more than 96,000 interns and residents win the right to form collective-bargaining units.” Robert L. Lowes, *Strength in Numbers: Could Doctor Unions Really Be the Answer?*, 75 MED. ECON. 114 (1998); see also Jewett, *supra* note 94, at 1134-37 (discussing NLRB recognition of professional bargaining units in the health care area specifically nurses, doctors, and housestaff).

210. For in-depth discussions of physician unionization see Lutsky, *supra* note 1; K. Bruce Stickler & Mark D. Nelson, *Doctors and Unions: Is Collective Bargaining the Cure for Physicians’ Labor Pains?*, 13 EMPLOYEE REL. L.J. 4, 6 (1988); Francis J. Serbaroli, *When Physicians Try to Unionize Against HMOs*, 220 N.Y.L.J. 3 (1998).

available to physicians who are employees of hospitals or health care plans.²¹¹ As evidenced by the recent membership increases in some of the nation's largest physician unions, physicians view unionization as a means to address their concerns.²¹² Factors that motivate physicians to unionize include quality of patient care, compensation, benefits, grievance procedures, job security, professional autonomy over practices such as patient load, and limitations on available tests and specialists.²¹³ Housestaff concerns extend even farther to include long work hours, availability of malpractice and disability insurance, and regulation of outside employment.²¹⁴

One reason for the growth in physician unionization is the increasing number of physicians who practice medicine as employees of hospitals, HMOs, group practices, or the government.²¹⁵ According to an AMA survey, the percentage of salaried doctors grew more than twenty percent over a ten-year period.²¹⁶ Another study found that housestaff consider salaried positions more attractive than an income guarantee.²¹⁷ These findings suggest that it is more likely that a resi-

211. See Lutsky, *supra* note 1, at 68; see also Lowes, *supra* note 209.

212. There are currently at least seven unions mounting efforts to organize physicians. See Lowes, *supra* note 209. The CIR, the group bringing the claim in the *Boston Medical Center* case, saw a 40% increase in membership during an 18-month period in 1996 and 1997. See MSA REPORT ON PHYSICIAN UNIONIZATION, *supra* note 200, at 3. Similar growth trends have occurred in other physician union organizations. See *id.* The Union of American Physicians and Dentists is averaging 15% annual growth and the National Union of Hospital and Health Care employees authorized a 60% increase in funds directed toward physician organization. See *id.*

213. See MSA REPORT ON PHYSICIAN UNIONIZATION, *supra* note 200, at 4-7, 12 (discussing reasons that physicians decide to unionize).

214. See *id.* at 6-7 (discussing housestaff unionization as a model for physician unionization). These issues contributed to the housestaff vote (497-120) at Jackson Memorial Hospital in Florida to join the CIR in 1996. See *id.* at 7. This election was the largest election ever held by physicians in the United States. See *id.*

215. See David Kushlan Wanger, *Unionization by the Salaried Physicians and the Managerial-Employee Exclusion: The Need for a Modified Approach by the National Labor Relations Board*, 15 LAW, MED. & HEALTH CARE 144, 144 (1987) (attributing the increasing unionization among doctors to the tension created by the fiscal goals of hospital administrators and the traditional goals of physicians). Health care institutions have undergone fundamental changes in recent years including increased concern with cost-containment and cost-efficient delivery of services. See *id.* The rising costs of health care are causing an increased number of physicians to become employees. Wanger argues that as the number of salaried physicians increase the need for physician unions also increases. See *id.*; see also Jewett, *supra* note 94, at 1136, 1144 (discussing HMOs' affect on health care and physician unionization, and citing BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS* 235-36 (1991)).

216. See MSA REPORT ON PHYSICIAN UNIONIZATION, *supra* note 200, at 6. The number of salaried physicians has increased from 25% in 1985 to 45.4% in 1995. See *id.* Self-employed doctors make an average of 50% more than employed physicians. See *id.*

217. See Terese Hudson, *Show Them The Money*, HOSPS. & HEALTH NETWORKS, May 5, 1997, at 40, 40 (reporting that a recent survey of 300 residents revealed that 86% would prefer a salaried position as opposed to 55% two years earlier).

dent or fellow will continue to work for the hospital where she did her residency.²¹⁸

Managed care organizations ("MCOs") offer many of these salaried positions. Managed care has significantly impacted the health care industry, implementing numerous cost-containment measures by reducing inpatient care and instead serving patients through outpatient ambulatory care centers.²¹⁹ Many physicians who work within MCOs complain of usurpation of control.²²⁰ HMOs are affecting residency programs, in part because the growth of HMOs decreases the amount of inpatient hospital care and reduces hospitals' ability to care for the uninsured.²²¹ These pressures are forcing some teaching hospitals to increase housestaff workloads and reduce salaries.²²² Overall, because managed care is creating a new set of problems for physicians including housestaff, they are increasingly turning to unionization.²²³ The unknown future of the health care industry and housestaff's role within the health care system underscores the need for housestaff to have a method to protect both their rights and their patients' rights.

218. See Petitioner's Post-Hearing Brief, *supra* note 24, at 87 (noting that "residents constitute one of the more stable work forces in American industry"). This growth in employed physicians is evidenced in the *Boston Medical Center* case, in which testimony revealed that between 20% and 30% of the residents at Bosten Medical Center will remain there after completing their program. See *id.* at 86-87.

219. See Mark Moran, *Easing the 'Cold War' Between Managed Care, Academic Med*, AM. MED. NEWS, Dec. 8, 1997, at 3, 3 (discussing the effects of managed care on teaching hospitals and how those hospitals are adapting to the future of managed care); see also Lutsky, *supra* note 1, at 58 (discussing how "under managed care, physicians are being stripped of their medical autonomy since they are often required to gain approval prior to providing certain services").

220. See Larry Tye, *MDs Examine Benefits of Unionizing*, BOSTON GLOBE, Nov. 14, 1997, at A1 (reporting that the increase in MCOs and individual participants in managed care plans threatens physicians); see also Gammel, *supra* note 1, at 50, 56 (noting that with all the changes in the health care industry physicians can not be assured of the high compensation and job security that they received in past decades). Because managed care reduces the number of individuals receiving inpatient care there will be fewer hospital patients and more ambulatory care. This means that in the short-term, hospital physicians and housestaff will experience uncertainty and dislocation. See *Graduate Medical Education and Healthcare Delivery in the Age of Managed Care* (visited Apr. 14, 1999) <<http://www.cirdocs.org/gmemancare.htm>> [hereinafter *Age of Managed Care*] ("For physicians, and particularly housestaff, the short-term future will be one of dislocation and uncertainty.")

221. See *Age of Managed Care*, *supra* note 220 (discussing the effects of managed care on hospitals and graduate medical education and offering opinions about the future of residency programs).

222. See Sean Martin, *AMA Treads Middle Ground on Residents' Unions*, AM. MED. NEWS, Sept. 8, 1997, at 3, 35 (discussing the effects of managed care on staff).

223. See *id.*

IV. IMPORTANT CONCERNS ABOUT HOUSESTAFF UNIONIZATION

The NLRB's reluctance to reverse its decisions in *Cedars-Sinai* and *St. Clare's Hospital* and to grant housestaff collective bargaining rights may stem from concerns over the scope of bargaining and the possibility of an increase in housestaff strikes. Some members of the Board and teaching hospital management fear that collective bargaining will adversely affect academic decision making and medical training.²²⁴ Many in the medical community also fear that collective bargaining rights increase the amount of strike activity.²²⁵

A. *Effects on Academic Decision Making and Medical Training*

Section 8(d) of the NLRA requires that the scope of bargaining subjects include wages, hours, and other terms or conditions of employment.²²⁶ Because of this broad range of issues, many in the medical community believe that collective bargaining may "interfere substantially with the educational objectives of graduate medical education programs."²²⁷ The NLRB expressed similar apprehension in *Cedars-Sinai* and *St. Clare's Hospital*. In *St. Clare's Hospital*, the Board stated that academic concerns are unrelated to employment issues such as hours and compensation, and therefore concluded that "subjecting academic decisionmaking to collective bargaining is at best of dubious value."²²⁸

At least one medical association, the AAMC, opposes housestaff collective bargaining rights because it believes these rights will interfere with academic decision making.²²⁹ The AAMC

224. See *St. Clare's Hosp. & Health Ctr.*, 229 N.L.R.B. 1000, 1002-03 (1977) (explaining that collective bargaining is an economic process and is not well-suited to academic decision making).

225. See *infra* notes 240-42 and accompanying text.

226. See 29 U.S.C. §§ 158(a)(5), 158(d), 159(a) (1994).

227. Jordan J. Cohen, *President's Memorandum on Houseofficer Unionization: The Boston Medical Center Case* (last modified July 25, 1997) <<http://gopher.aamc.org/hlthcare/union.htm>> (discussing the AAMC's position that housestaff are primarily students and should not be granted collective bargaining rights under the NLRA). Dr. Cohen expressed concern about the "impact [that] would result from the need to submit to arbitration issues that are traditionally and fundamentally educational in nature." *Id.*

228. *St. Clare's Hosp.*, 229 N.L.R.B. at 1002.

229. See Brief of the Association of American Medical Colleges Amicus Curiae at 4-19, *Boston Med. Ctr. Corp.*, No. 1-RC-20574 (NLRB Region 1, Aug. 28, 1997) [hereinafter AAMC Brief] (arguing that the Board in *Cedars-Sinai* and *St. Clare's Hospital* sought to avoid involvement in academic decision making and that this remains a compelling rationale); see also Jordan J. Cohen, *Point/Counterpoint: Should Residents Be Allowed to Unionize in Private Hospitals?*, 14 PHYSICIAN'S WKLY. (visited Apr. 14, 1999) <http://physweekly.com/archive/97/10_20_97/pc.html> (providing a debate between Dr. Cohen, President, AAMC and Dr.

submitted an *amicus curiae* brief in support of Boston Medical Center arguing that graduate medical education programs are governed by national standards that provide uniformity and continuity to teaching programs.²³⁰ According to the AAMC, collective bargaining will undermine these standards.²³¹ Furthermore, because collective bargaining will limit educators' control over teaching programs, it will adversely affect graduate medical education.²³² The AAMC, however, does not refute that housestaff are employees of the teaching hospitals who have economic and patient care issues that must be addressed.

Public sector decisions and the CIR have responded to these concerns. Several public sector decisions have found that housestaff collective bargaining rights do not interfere with academic decision making. In *Regents of University of California v. PERB*, the California Supreme Court determined that collective bargaining would not undermine the educational aspects of housestaff programs and that such concerns were "exaggerated."²³³ In *Public Health Trust of Dade County*, the Commission stated that "an employer need not accept bargaining proposals inconsistent with quality education."²³⁴

The CIR has stated that it intends to avoid bargaining over academic matters, and, therefore, these issues "would not be the

Angela Moore, President, CIR). Dr. Cohen stated that "[c]ollective bargaining as designed and structured under the National Labor Relations Act would drive a fatal stake into the heart of the teacher-student relationship." *Id.* Cohen argues that residents' rights should be addressed "through established mechanisms that exist within the profession." *Id.*

230. See AAMC Brief, *supra* note 229, at 4-5 (discussing the Essentials as the formulation of standards for graduate medical education). The AAMC also argues that the educational nature of the hospital-house officer relationship is intensely personal and would not conform well to collective bargaining. See *id.* at 8. Instead, the AAMC suggests that the Essentials protect housestaff interests and insure educational integrity. See *id.* at 17-18 (arguing that the accreditation and review processes are sufficient measures to protect housestaff rights).

231. See *id.* at 15-19 & n.56 (arguing that a national labor policy is necessary to enforce national graduate medical education standards and collective bargaining would place these standards within the control of the Board, which is "ill-equipped" to handle that responsibility).

232. See *id.* at 9 (arguing that collective bargaining would harm graduate medical education because decisions regarding academic matters could become subject to arbitration); see also *All Things Considered*, *Boston Residents Union* (National Public Radio, Inc., radio broadcast, Sept. 4, 1997) (transcript on file with author) [hereinafter *Boston Residents Union*].

233. *Regents of the Univ. of Cal. v. Public Employment Relations Bd.*, 715 P.2d 590, 604-05 (Cal. 1986) (en banc) (pointing out that the University had engaged in collective negotiation sessions with housestaff organizations prior to California's passage of HEERA).

234. *Committee of Interns & Residents v. Public Health Trust*, 22 FPER P27, 230 (Fla. PERC Sept. 4, 1996), available in 1996 FPER (LRP) LEXIS 192, at *17. The commission also suggested that the "scope of bargaining issues may be considered and balanced at the negotiating table." *Id.*

subject of negotiations.²³⁵ The CIR points to its forty-year history of collective bargaining efforts²³⁶ and suggests that the success of current collective bargaining agreements is evidence that "collective bargaining is fully compatible with the achievement of educational objectives."²³⁷ In the *Boston Medical Center* case, the CIR emphasizes the effective use of collective bargaining between Boston Hospital and the Boston Hospital Housestaff.²³⁸ The CIR also contends that hospitals oppose housestaff collective bargaining rights primarily because of concerns about higher costs resulting from collective bargaining.²³⁹ The CIR's long history of successful collective bargaining demonstrates that fears of interference with academic decision making and medical training are largely unfounded.

B. Strikes

Strikes remain a major concern surrounding housestaff collective bargaining rights. Critics of housestaff collective bargaining rights argue that the CIR and hospitals have reached agreements with relative ease because housestaff do not have the right to strike.²⁴⁰ Although some housestaff groups claim that strikes run counter to their philosophy as physicians, other groups view strikes as powerful

235. *Boston Residents Union*, *supra* note 232. Harry Franklin, General Counsel for the CIR, claimed that the AAMC was "just fearmongering" and that opposition is economically motivated. *Id.*

236. See Petitioner's Post-Hearing Brief, *supra* note 24, at 89 (arguing that the willingness of housestaff to engage in organized activity without the protection of the NLRA evidences their deep concern about employment issues).

237. Letter to the Regional Director, *supra* note 19, at 6 (arguing that collective bargaining concerning the terms and conditions of housestaff employment does not interfere with graduate medical education). The amici's brief in the *Boston Medical Center* case filed by the University of Michigan House Officers Association discussed its 25 year successful bargaining history and stated that "collective bargaining has produced stable labor relations without detriment to the exceptional educational and professional standards at the University of Michigan." Amber, *supra* note 197, at C1. Currently, CIR is a party to 20 collective bargaining agreements covering 7500 house officers at 30 private and public sector hospitals. See Decision and Order, *supra* note 3, at 18. Coverage under these agreements includes wages, vacation, health insurance, and working hours. See *id.*

238. See Letter to the Regional Director, *supra* note 19, at 3 ("This long-standing history of successful collective bargaining strongly supports CIR's contention that it is time to reexamine the Board's *Cedars-Sinai* doctrine."). This bargaining arrangement was voluntary and worked well for both parties for over 30 years as they negotiated 10 successive agreements. See *id.*

239. See Petitioner's Post-Hearing Brief, *supra* note 24, at 86 (arguing that residents and hospitals met necessary staffing needs and noting that in literature addressing the issue there was "unanimous agreement . . . that there would be a substantial cost associated with replacing residents" because they "perform critical productive work and generate significant revenues").

240. See Brief of Boston Med. Ctr. at 84-86, *Boston Med. Ctr. Corp.*, No. 1-RC-20574 (NLRB Region 1, Aug. 27, 1997); Decision and Order, *supra* note 3, at 30.

tools for achieving their demands.²⁴¹ Most housestaff strikes are recognition strikes, protesting the hospital's refusal to recognize the housestaff association or union.²⁴² For example, in 1996, the housestaff at Howard University Hospital in Washington D.C. threatened to strike if the hospital continued to refuse to recognize their union.²⁴³ Numerous other recognition strikes have occurred since 1975.²⁴⁴ The legislative history of the 1974 Health Care Amendments states that Congress hoped to prevent future recognition strikes by health care employees. The Senate Report recognized that the inclusion of nonprofit hospitals under the Act would provide procedures for resolving organizational and recognition disputes, thereby eliminating the need for "recognition strikes and picketing."²⁴⁵

241. See Dolores Kong, *Hospital Residents Seek Right to Unionize Boston Medical Center Case Watched Closely*, THE BOSTON GLOBE, Aug. 24, 1997, at A1 (noting the countervailing views on the ability to strike). The housestaff at Boston Medical Center aspire to protect patient care, but believe that while unions can strike "that would go counter to their principle of do no harm." *Id.*; see also Richard L. Kravitz & Lawrence Linn, *Conditions that Justify Strikes as Perceived by Housestaff at a Public Hospital*, 67 ACADEMIC MED. 342, 343 (1992) (recognizing that most housestaff considered it justifiable to strike when threats to future patients were high and risks to current patients were low). For an argument that to calm fears raised about strike ability and gain support for collective bargaining rights for housestaff the United States should emulate Canadian guidelines in which physicians agree to maintain emergency care during strikes, see Lutsky, *supra* note 1, at 61.

242. See Cohen, *supra* note 229 (stating that it is "misleading to assume that collective bargaining experiences under state public employee labor laws, or voluntary arrangements in some private institutions, none of which provide for the right to strike, are indicative of what will follow under federal law").

243. See *News at Deadline*, MOD. HEALTHCARE, Apr. 8, 1996, at 4. Howard University Hospital refused to recognize the housestaff union, claiming that the housestaff are "students not employees and therefore have no right to unionize." *Id.* The housestaff held a three hour sit-in demanding recognition. See *id.* at 3; see also Ronald Sullivan, *Eight Hospitals in City Struck by Doctors*, N.Y. TIMES, Mar. 18, 1981, at A1 (reporting on housestaff and physicians strike in New York).

244. Some such recognition strikes include a nine day housestaff strike at Bronx Lebanon Hospital in 1990 and an eleven day housestaff strike at Interfaith Hospital in 1985. See Decision and Order, *supra* note 3, at 21 (discussing the CIR's involvement in several housestaff recognition strikes); see also John Hurst & George Ramos, *Doctors Walk out as County Nurses Return*, L.A. TIMES, Jan. 30, 1988, at 1 (reporting that a three day housestaff strike ended when a court ordered the housestaff back to work); Ken Yamada, *Doctors End Strike at Bronx Hospital*, NEWSDAY, May 13, 1990, at 19 (reporting that the housestaff strike was a success resulting in a pay raise, a bonus, more sleeping rooms, and an eighty hour maximum work week). Recognition strikes are not a recent phenomenon as shown by the housestaff strike by the residents at Jackson Memorial Hospital in 1981, and a strike by approximately 2000 housestaff in eight New York hospitals also in 1981. See MSA REPORT ON PHYSICIAN UNIONIZATION, *supra* note 200, at 8-10 (discussing tactics employed by union organizers and the possible results.)

245. S. REP. NO. 93-766, at 3 (1974), reprinted in 1974 U.S.C.C.A.N. 3946, 3948. The California Supreme Court agreed that collective bargaining helps to deter strikes. In *Regents of the Univ. of Cal.*, the court stated that "it is widely recognized that collective bargaining is an alternative dispute resolution mechanism which diminishes the probability that vital services

The NLRA's alternative mechanisms for handling conflict between health care employees and hospitals can prevent strikes in the majority of situations. Specifically, the 1974 Health Care Amendments enacted special notice provisions for strikes and picketing to maintain patient care.²⁴⁶ The NLRB's failure to allow federal labor law coverage of housestaff has resulted in the exact problem that the Health Care Amendments intended to avoid. Collective bargaining rights for nonprofit health care institutions provide alternatives to strikes rather than encouraging their use.

V. CONCLUSION

The policy established in *Cedars-Sinai* not only deprives thousands of residents, interns, and fellows employed in nonprofit private hospitals of collective bargaining rights, but also threatens the provision of quality patient care and stability in these hospitals. Collective bargaining rights provide both a mechanism for achieving better working conditions for housestaff and, perhaps more importantly, better patient care.²⁴⁷ By failing to provide housestaff with an adequate mechanism to assert their needs and voice dissatisfaction, the NLRB's decisions leave housestaff with virtually no alternative but to take extreme action such as strikes and work stoppages.²⁴⁸

Unfortunately, the question of housestaff bargaining rights has largely been one of "statutory interpretation and semantics" rather than a realistic evaluation of the housestaff's role as "*both* students

will be interrupted." *Regents of the Univ. of Cal. v. Public Employment Relations Bd.*, 715 P.2d 590, 605 (Cal. 1986) (en banc).

246. See 29 U.S.C. §§ 158(d), (g) (1994); see also S. REP. NO. 93-766, at 3-5 (1974), reprinted in 1974 U.S.C.C.A.N. 3946, 3948-50 (stating that the Health Care Amendments recognized the needs of patients and provided special notice provisions including 10 day advance notice of any anticipated strike or picketing and 90 day notice before terminating a collective bargaining agreement).

247. See Petitioner's Post-Hearing Brief, *supra* note 24, at 90 (noting that the CIR currently is a party to "20 different collective bargaining agreements covering 30 separate hospitals"); see also Devinatz, *supra* note 41, at 118, 130 (noting that as a result of a housestaff strike, "[t]he union achieved important patient-care demands"). The House Staff Association proposals addressed many patient care issues and ultimately the contract contained many of their demands, including "enough Spanish translators to aid physicians on patient intake, quicker processing of both X-rays and blood tests in emergency cases, additional nursing staff . . . , [and] a reduction in the work week from 100 to eighty hours." *Id.* at 130. The President of the House Staff Association at the time of the strike was quoted as stating: "Never before have M.D.'s done so much for their patients." *Id.* at 130 (quoting Dr. John Raba).

248. Housestaff at Howard University Hospital in Washington staged a three hour sit-in and voted to strike unless the hospital recognized their union. See *Late News*, MOD. HEALTHCARE, April 8, 1996, at 4. The hospital took the position that the housestaff were students, not employees, and refused to recognize their right to unionize. See *id.*

and employees.²⁴⁹ Today's housestaff confront many of the same problems they did in years past. Extended work hours, sometimes up to one hundred hours per week, are a primary housestaff concern.²⁵⁰

The reversal of the *Cedars-Sinai* and *St. Clare's Hospital* decisions would appropriately give bargaining rights to housestaff.²⁵¹ *Boston Medical Center* presents an opportunity to grant housestaff these rights. The Boston Medical Center housestaff are a typical example of the housestaff working in private nonprofit hospitals across the nation today. The arguments expressed in this Note indicate that

249. *Regents of the Univ. of Cal.*, 715 P.2d at 606-07 (Lucas, J., dissenting).

250. See Decision and Order, *supra* note 3, at 8 (noting the "very long hours" worked by housestaff). Hospitals have been accused of overworking interns and have even been held liable for interns' negligence. For a discussion of overworked interns and possible hospital liability see Susan Gardner Huffman, *A Proposal for Expansion of Hospital Liability to Patients Injured By Overworked Interns*, 7 J. CONTEMP. L. 135 (1982). The author argues that hospitals should be held legally liable for patient injuries resulting from actions of sleep-deprived interns through an expansion of the doctrine of corporate negligence. See *id.* at 152. New York has passed legislation limiting the amount of hours that housestaff can work, but housestaff still work dangerously long shifts in other states. See Frank, *supra* note 167, at 317 n.47 (citing N.Y. COMP. CODES R. & REGS. Tit. 10, § 405.4(b)(6)(ii) (1992)); see also *NBC News at Sunrise* (NBC television broadcast, Mar. 12, 1998) (reporting that 49 states are without limits on resident work hours). See generally Dorothy J. McNoble, *Expanded Liability of Hospitals for the Negligence of Fatigued Residents*, 11 J. LEG. MED. 427, 427-28, 432-33 (1990) (discussing the ACGME guidelines, which suggest regulation of hours in some specialties, and other efforts to reduce resident hours). The article noted the significant economic impact that a reduction in work hours could have on many hospitals. See *id.* at 437.

251. Former NLRB Chair William Gould's term expired in August, 1998, and at the time of this Note, the future composition of the Board was undecided. Due to the incomplete nature of the Board, it is possible that the *Cedars-Sinai* decision could be reaffirmed. Although this decision would negatively impact the housestaff unionization movement, it would not be its death knell. Since *Cedars-Sinai*, public sector jurisdictions have ruled that housestaff are employees and are thus entitled to collective bargaining rights. Housestaff could continue to pursue collective bargaining rights under public sector law. Although this alternative does not achieve rights for all housestaff, it does benefit a substantial number. Housestaff could also form physician organizations that operate like a union. See Mark A. Kadzielski et al., *The Hospital Medical Staff: What Is Its Future?*, 16 WHITTIER L. REV. 987, 1000-01 (1995) (discussing the role of physician associations in achieving workplace changes for physicians). These organizations would not receive the support of the NLRA, but if properly organized, they could attempt to bargain collectively and achieve necessary changes.

Another possibility is that a district court would agree to hear the *Boston Medical Center* case and rule in favor of housestaff bargaining rights. Although unlikely, the growth in physician unionization might motivate a court to reconsider this issue. Board orders regarding representation proceedings are typically unreviewable unless they become the subject of unfair labor practice orders. The Supreme Court has allowed a plaintiff to challenge a Board violation of an identified provision of the NLRA which is clear and mandating. See *Leedom v. Kyne*, 358 U.S. 184 (1958). An amendment to the NLRA remains a viable alternative; however, it is unlikely that even if proposed, such an amendment would be successful. Although there are an array of possibilities for housestaff rights, the reversal of the *Cedars-Sinai* and *St. Clare's Hospital* decisions would provide the most effective and full-ranging grant of collective bargaining rights. The Board's decision in the *Boston Medical Center* case is expected sometime in 1999. See *No News is No News* (visited April 14, 1999) <<http://www.cirdocs.org/history.htm>> (reporting on the status of the *Boston Medical Center* case).

housestaff serve dual roles as both students and employees. Their status as employees justifies a grant of collective bargaining rights and a reversal of the *Cedars-Sinai* and *St. Clare's Hospital* decisions.

A full range of arguments supports the reversal of the *Cedars-Sinai* and *St. Clare's Hospital* decisions. The plain language of Section 2(3), the Supreme Court's broad interpretations of the term "employee," the inconsistent NLRB decisions, and the legislative history of the NLRA all support a finding that housestaff are employees. In the context of public sector law, the majority of jurisdictions to consider the issue have determined that housestaff are employees. Similarly, all federal agencies addressing this issue have classified housestaff as employees. Housestaff pay taxes on their earnings and are covered under employment laws such as discrimination laws and worker's compensation. Most importantly, they deliver direct patient care. Housestaff provide a valuable service and learn from the work they perform.

The *Cedars-Sinai* decision suggests that there is nothing inconsistent about being a student and an employee. The primary purpose test, however, examines only the subjective intent of an individual participating in the program, and does not consider the services that an individual performs or the employment relationship between the house officer and the hospital. Many hospitals and the majority of past Boards insist that housestaff are primarily interested in their academic pursuit and the educational aspects of the graduate medical education programs. If the house officers are primarily interested in achieving specialty certification and unconcerned with salary, fringe benefits, and employment conditions, it then seems illogical that they would pursue collective bargaining rights.²⁵²

As health care costs continue to rise and hospital management attempts to contain costs, all physicians, especially housestaff, will need a mechanism to protect their patients and themselves. Unionization and collective bargaining create a forum for voicing con-

252. See Post-Hearing Reply Brief on Behalf of the Petitioner Committee of Interns and Residents at 13, Boston Med. Ctr. Corp., No. 1-RC-20574 (NLRB Region 1, Sept. 9, 1997) ("If interns and residents are as utterly focused on board certification, and as unconcerned with wages, benefits, and other terms and conditions of their employment . . . they will not be interested in or willing to engage in . . . collective bargaining."); see also Mark Moran, *Medical Educators Voice Concerns over Resident Unions*, AM. MED. NEWS, Nov. 24, 1997, at 4. Dr. David C. Leach, executive director of the ACGME, says that the majority of residents do not want to unionize. Dr. Steve Smith, associate dean for medical education at Brown University, however, states that "if only unhappy residents are [prone to unionize], then every program in the United States should be ready for unionization." *Id.*

cerns and assure that health care services will not be disrupted.²⁵³ Therefore, upon considering the case of *Boston Medical Center*, the NLRB should reverse its holdings in the 1976 and 1977 cases, *Cedars-Sinai Medical Center* and *St. Clare's Hospital*.

*Jennifer A. Shorb**

253. See *Regents of the Univ. of Cal.*, 715 P.2d at 605 (rejecting the argument that collective bargaining for housestaff could lead to more strikes and noting that "it is widely recognized that collective bargaining is an alternative dispute resolution mechanism which diminishes the probability that vital services will be interrupted") (citing *San Diego Teachers Ass'n v. Superior Court*, 593 P.2d 838 (Cal. 1979) (en banc)).

* I would like to thank Harry Franklin for his assistance and Brian Baker, Brant Brown, Christin Camp, and Amanda Vaughn for their helpful edits. I would also like to thank my mother for suggesting this topic and for being a true best friend. Most of all thanks to my parents and my brother for their endless love and support.

