THE NON-NEGOTIABLE EMPLOYMENT CONTRACT—DIAGNOSING THE EMPLOYMENT RIGHTS OF MEDICAL RESIDENTS

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“One goes through school, college, medical school and one’s internship learning little or nothing about goodness but a good deal about success.”*

INTRODUCTION

The recent debate concerning healthcare reform is wholly void concerning the ongoing employment plight of medical residents, who comprise a substantial percentage of the United States healthcare workforce. According to the National Resident Matching Program’s (“NRMP”) Results and Data Report, in 2009, there were approximately 25,185 medical residency positions for both first (PGY-1) and second (PGY-2) year medical residents within the United States.1 Additionally, the Accreditation Council for Graduate Medical Education (“ACGME”) reports that in 2009-2010, there were approximately 8,914 total United States medical residency programs and 111,386 total available United States medical resident positions.2 Despite the significant number of medical residents enrolled in thousands of

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Graduate Medical Education ("GME") programs, medical residents continue to be at a severe disadvantage with respect to employment rights and other corollary issues involving negotiation, due process, sexual harassment, discrimination, unlawful termination, and wage and hour matters. As Stephen L. Cohen, a physician and journalist observed,

[medical] residents typically work longer hours than any other professionals on the planet. In seven days, they are expected to cram in as much as 100 hours of work, and a single shift can last as long as the average mortal's entire workweek. . . . Potentially abusive practices occur in other specialties too. The JAMA [Journal of the American Medical Association] survey indicated that 93% of doctors-in-training experienced at least one incident of harassment or verbal abuse and more than half reported episodes of being belittled or humiliated by more senior physicians. Perhaps even more important, 70% of the residents reported seeing colleagues working in an impaired condition, most often due to a lack of sleep. In addition, the survey documented a pattern of mistreatment that closely paralleled similar reports of abuse by American medical students.3

During the past decade, medical residents' working conditions have not dramatically improved.4 A recent survey in 2009 by the Association of American Medical Colleges ("AAMC") highlighted the significant wage and economic inequities faced by medical residents. For example, since 1969-1970, the mean first-year resident stipend nationwide, after adjusting for inflation, has remained relatively unchanged (and arguably decreased).5 Additionally, for advanced

medical residents, salaries also remain stagnant, where in 2009 the weighted mean stipend for residents in seventh (PGY-7) and eighth (PGY-8) year post-MD programs was $60,166 and $61,776 a year respectively.6 This wage disparity for medical residents is significant given that tuition and fees for GME programs (typically four to six years depending on the type of program) is at an all time high, averaging annually $39,822 (non-resident) and $20,234 (resident) for public institutions and $39,755 (non-resident) and $39,233 (resident) for private institutions.7 Additionally, the median amount of medical school student loan debt for graduates in 2009 was $150,000 for public medical schools and $177,500 for private medical schools.8

The results of a 2009 GQ Medical School Graduation Questionnaire, published by the AAMC, similarly identified ongoing quality-of-life issues among medical students.9 For instance, in 2009, approximately 17% of all medical students surveyed reported that they had “personally been mistreated during medical school.”10 More specifically, approximately 48.9% of the medical students surveyed reported general mistreatment in the form of “occasionally” being “publicly belittled or humiliated.”11 Additionally, 8.2% experienced either being “threatened with physical harm or been physically punished (e.g. hit, slapped, kicked)” either “once” or “occasionally.”12 Furthermore, 9.5% reported being “subjected to unwanted sexual advances by school personnel” either “once” or “occasionally.”13 When asked whether a medical student had ever been “subjected to offensive sexist remarks/names directed at you personally,” approximately 12% of medical stu-

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6. Id. at 7.
10. ASSOCIATION OF AMERICAN MEDICAL COLLEGES, supra note 9, at 28.
11. Id. at 29.
12. Id.
13. Id.
dents surveyed indicated they had “occasionally” experienced such mistreatment. Other issues such as gender mistreatment,\textsuperscript{14} racial and ethnic mistreatment,\textsuperscript{15} and sexual orientation mistreatment,\textsuperscript{16} were also identified as areas of concern. Concerning the sources of such mistreatment, medical students overwhelmingly reported that such mistreatment was derived from clinical faculty (in hospital), residents/interns, and nurses.\textsuperscript{17}

There is strong evidence that such quality of life issues carry over into the medical residency. For instance, in a survey measuring the degree of stress among medical residents, approximately 23% of all medical residents surveyed expressed that “they had become less humanistic over the course of their residency training.”\textsuperscript{18} The same study also discussed that approximately 61% additionally reported “becoming more cynical.”\textsuperscript{19} Another study of internal and surgical medical residents revealed that increased levels of “stress were associated with increased levels of both job and patient-related burnout later in the residency year” and accordingly suggested that programs “designed to assess and address perceived stress, health, mood and level of burnout may be most effective in alleviating the professional and personal difficulties often associated with medical residency.”\textsuperscript{20} There are similar reports of abuse that continue into the medical residency.\textsuperscript{21} For instance, in 2006, it was reported that a group of medical residents in an anesthesiology GME program “felt intimidated and

\begin{itemize}
\item \textsuperscript{14} \textit{Id.} (stating that approximately 11.9% of medical residents surveyed reported being “denied opportunities for training or rewards because of your gender”).
\item \textsuperscript{15} \textit{Id.} at 30 (stating that approximately 8.2% of medical residents surveyed reported being “subjected to racially or ethnically offensive remark/names directed at you personally.”).
\item \textsuperscript{16} \textit{Id.} (stating that approximately 3.3% of medical students surveyed reported being “subjected to offensive remarks/names directed at you personally because of your sexual orientation.”).
\item \textsuperscript{17} \textit{Id.} at 31.
\item \textsuperscript{18} \textit{See Virginia U. Collier et al., Stress in Medical Residency: Status Quo After a Decade of Reform? 136 ANNALS OF INTERNAL MED. 384 (2002).}
\item \textsuperscript{19} \textit{Id.}
\item \textsuperscript{20} \textit{See J. J. Hillhouse, A Simple Model of Stress, Burnout and Symptomatology in Medical Residents: A Longitudinal Study, 5 PSYCHOLOGY, HEALTH & MED., 63 (2000); see also Angus McBryde, The Strange and Stressful Path to Residency, 97 SOUTHERN MED. J.1154 (2004); R. Sharpe, The Impact of Prolonged Continuous Wakefulness on Resident Clinical Performance in the Intensive Care Unit: a Patient Simulator Study, 38 CRIT. CARE MED. 766 (2010) (concluding that “during prolonged continuous wakefulness of medical residents, clinical performance in the management of a simulated critically ill patient deteriorates”).}
\item \textsuperscript{21} \textit{See, e.g., S. Nagata-Kobayashi, Universal Problems During Residency: Abuse and Harassment, 43 MED EDUC. 628 (2009) (reporting that 84.8% of Japanese medical residents surveyed reported mistreatment).}
\end{itemize}
scared to complain" about non-compliance issues occurring in the program.22

Although there is significant literature concerning excessive medical resident work hours,23 collective bargaining or unionization,24 tax

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22. See Lisa Greene, USF Ponders Strategy to Rebuild Program, St. PETERSBURG TIMES, Jun. 29, 2006; see also Paula Costa Mosca Macedo, Health-related Quality of Life Predictors During Medical Residency, in a Random, Stratified Samples of Residents, 31 REV. BRAS. PSIQIATRIA, 119 (2009) (discussing that “providing care to critically ill patients for more than 30 hours per week had a negative influence on the emotional aspects of the health-related quality of life ("HRQOL") factors for South American medical residents).


liability,\textsuperscript{25} and medical malpractice-liability issues among medical residents,\textsuperscript{26} no comprehensive legal literature discusses, assesses, or evaluates the employment rights of medical residents.\textsuperscript{27}

The purpose of this Article is to: 1) provide a brief historical overview of medical residents within the employment setting; 2) discuss the various employment issues faced by medical residents; 3) summarize the relevant legal case law governing medical resident employment related issues; and 4) present various legislative and policy reform proposals with respect to medical resident employment and the workplace. The goal of this Article is to provide medical residents, fellows, and medical students enrolled in GME programs, as well as legal practitioners representing the employment interests of medical residents, a comprehensive guide to legal issues arising in the context of the medical residency and hospital workplace.\textsuperscript{28}

I. HISTORICAL OVERVIEW OF MEDICAL RESIDENTS WITHIN THE EMPLOYMENT WORKPLACE

To fully understand the prevailing employment issues faced by medical residents within the workplace, it is important to understand the historical development of medical residents within the healthcare

\textsuperscript{25} See United States of America v. Mount Sinai Med. Ctr. of Fla., Inc., 353 F. Supp. 2d 1217 (S.D. Fla. 2005) (holding that for social security and tax purposes, medical residents not students qualified for exemption from FICA taxation); see also Patrick Timothy Rowe, The Impossible Student Exception to FICA Taxation and Its Applicability to Medical Residents, 66 Wash. & Lee L. Rev. 1369 (2009).

\textsuperscript{26} For a discussion of liability and standard of care issues among medical residents, see, for example, Merit Buckley, Imposing Liability in the United States Medical Residency Program: Exhaustion, Errors, and Economic Dependence, 12 DePaul J. Health Care L. 305 (2009); Joseph H. King, The Standard of Care For Residents and Other Medical School Graduates In Training, 55 Am. U. L. Rev. 683 (2006).

\textsuperscript{27} See Geiger, supra note 24 (providing a cursory review of the employment issues related to medical residents); M.H. Klaiman, Bonded Labor Characteristics of U.S. Postgraduate Medical Training, 39 J. Health L. 373 (2006); American Medical Association, GMED Companion: An Insider’s Guide to Selecting a Residency Program, (2006) (providing a comparison of GME program benefits, salary and other employment information).

\textsuperscript{28} The underlying purpose of this Article is to further trend toward the establishment of medical-legal partnerships (“MLPs”). See, e.g., Ellen Cohen et al., Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities, 25 J. Gen. Internal Med. S136 (2010). With respect to the employment rights of medical residents, this is significant where very few, if any, legal practitioners specialize in the representation of medical residents. There are some law-firms that maintain practices on behalf of GME programs and accreditation issues. See, e.g., Health Care: Graduate Medical Education & Residency Accreditation, Nixon Peabody, LLC http://www.nixonpeabody.com/services_overview.asp?SID=499 (last visited on December 10, 2010).
system. A resident physician, often referred to as a medical resident or in the United Kingdom as a "registrar" or "house-officer," is a "person who has received a medical degree (MD, DC, MBBS, MBchB)" and practices medicine under the supervision of fully licensed physicians, usually in a hospital or clinic setting. More precisely, a medical resident refers to:

any physician who has graduated from medical school, and is participating in a post-graduate, hospital-based training and education program . . . [including] both not-yet-licensed physicians (formerly referred to as 'interns') who are completing a shorter period of post-graduate training and licensed physicians who are continuing on in their graduate medical education . . . and training in order to become qualified (board certified) in their chosen medical specialty (and sometimes in a further subspecialty).

Historically, medical residency or accredited Graduate Medical Education ("GME") programs have been viewed "as an opportunity for advanced training in a medical or surgical specialty." By the end of the twentieth century in North America, "very few new doctors went directly from medical school into independent, unsupervised medical practice, and more state and provincial governments began requiring one or more years of postgraduate training for medical licensure." In fact, the medical internship was eventually introduced as an "optimal form of postgraduate medical education," offering students "a concentrated exposure to clinical medicine and [ ] hospitals [a] supply of relatively cheap labor.

Over time, given the increased demand and competition among hospitals for qualified medical interns and residents, labor unrest arose in the selection process as "hospitals began to try to hire interns earlier than their competitors, so medical students could only consider offers from one hospital at a time, without knowing their prospects at

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29. For a more comprehensive historical overview of medical residents within the employment workplace, see Alvin E. Roth, The Origins, History, and Design of the Resident Match, 289 JAMA 909 (2003).


32. See WIKIPEDIA, supra note 30.

33. See WIKIPEDIA, supra note 30.

34. See Roth, supra note 29.
other hospitals." 35 From 1945 to 1951, despite efforts to implement and enforce a uniform date for accepting offers, medical students were still faced with offers having very short deadlines, compelling them to accept or reject offers without knowing what other offers might be forthcoming. [Accordingly] hospitals often had to scramble for available students, since if an offer was rejected, it was often too late for them to reach their next preferred candidate. 36

As a result, a centralized clearing house was developed "as a way of alleviating this chaos and allowing a larger role to the preferences of both students and hospitals." 37 Presently known as the National Resident Matching Program ("NRMP"), the private, not-for-profit corporation provides a "uniform date of appointment to positions in graduate medical education (GME)." 38

Presently, hospitals derive a significant percentage of its labor force from medical residents enrolled in GME programs and therefore continue to compete for talent within this labor pool. 39 Neither the United States Department of Labor nor the United States Bureau of Labor Statistics maintains any formal statistics for the total number of medical residents employed at any given time. 40 Rather, such information is compiled by the National GME Census, an annual reporting of medical residents jointly conducted by the American Medical Association ("AMA") and the Association of American Medical Colleges ("AAMC"). 41 In 2004-2005, the National GME Census, "counted 101,291 physicians-in-training...the largest number ever recorded by this survey." 42 As of 2009, there have been continued efforts to

35. See Roth, supra note 29, at 909.
36. Id.
37. Id. For a more comprehensive history and discussion of the NRMP Match process, see, for example, Melinda Creasman, Resuscitating the National Resident Matching Program: Improving Medical Resident Placement Through Binding Dual Matching, 56 Vand. L. Rev. 1439 (2003); Gregory Dolin, Time to Enter a "Do Not Resuscitate" Order on the National Resident Matching Program's Chart, 8 Quinnipiac Health L.J. 59 (2004); Kristin Madison, The Residency Match, Competitive Restraints in an Imperfect World, 42 Hous. L. Rev. 759 (2005).
40. At the time of this Article, the Author was unable to locate any U.S. Department of Labor or U.S. Bureau of Labor Statistics related to medical residents.
accurately account for the number of medical residents within the United States, including seeking the wide-spread participation by medical residency programs in conducting the National GME Census.43

The net economic effect of medical residents upon the healthcare labor force has similarly been the subject of much scholarly literature, including research concerning the economic inelasticity of physician labor resulting from medical school admissions, physician licensure, and residency requirements.44 In fact, a recent study by the RAND Corporation estimated that the value of medical resident labor without maximum hour restrictions to the healthcare industry is approximately $1.6 billion dollars annually.45

The historical development of medical residents, including the economic factors directly affecting the labor supply of physicians, such as residency requirements and licensure, in turn, has significantly shaped work-place rules, standards, and working environments of a medical resident. As Sarah L. Geiger observed:

Patients of academic hospitals receive most of their direct care from medical interns, residents, and fellows who are one, two, three, or more years out of medical school. Although these doctors have graduated from medical school, their postgraduate training is essential for board certification. Most doctors cannot work in private practice until they have completed an accredited residency program. While residents are M.D.'s and D.O.'s, hospital faculty does not treat them as full-fledged doctors. The lack of status classification of medical residents has left a void in labor law protection for medical interns and residents.46

Unlike other professions, a medical resident's workplace has largely been shaped by various historical and institutional factors, dictating how medical residents are perceived, accepted, and categorized within the employment setting, specifically that medical residents are merely "in-training" and therefore, not traditional employees.47 Furthermore, as will be discussed later, even the Accreditation Council for

46. Geiger, supra note 24, at 523 (emphasis added).
47. Id.
Graduate Medical Education ("ACGME") refuses to afford medical residents the classification of "employees."\textsuperscript{48} In other words, the fact that medical residents are relegated and assumed to be second-class workers is a fundamental key to fully understanding their specific individual employment challenges, issues, and inequities.\textsuperscript{49} The issue of medical residents within the workplace is a very evolving issue and in fact, the United States Supreme Court has recently held that medical residents are in fact "employees" as opposed to students for tax related purposes, under the Federal Insurance Contribution Act (FICA).\textsuperscript{50} Overall, an understanding of the historical context of medical residents is a prerequisite to assessing current employment issues faced by them.

II. VARIOUS EMPLOYMENT ISSUES FACED BY MEDICAL RESIDENTS

A. UNEQUAL EMPLOYMENT BARGAINING POWER WITHIN THE NATIONAL RESIDENCY MATCH PROGRAM (NRMP)

Presumably unknown at the outset by the vast majority of medical residents and interns is that legitimate employment issues begin to arise well before a medical student actually commences a medical residency or graduate medical education ("GME") program. In fact, such employment issues originate during a medical resident's navigation through the National Residency Match Program ("NRMP") matching process.

As discussed herein, the NRMP was established in 1952, to "provide a uniform date of appointment to positions in graduate medical education (GME) in the United States."\textsuperscript{51} Generally occurring in March of each year, graduates from medical schools participate in a "matching process" whereby the NRMP serves as "an impartial venue for matching applicants' preferences for residency positions with program directors' preferences for applicants."\textsuperscript{52}
The NRMP purports to utilize a matching algorithm based upon “preferences expressed in the rank order lists submitted by applicants and programs to place individuals into positions.” According to the NRMP, the matching for such programs is highly competitive and involves “approximately 16,000 U.S. allopathic [M.D.] medical school seniors and 15,000 graduates of osteopathic [D.O.], Canadian or foreign medical schools compete for approximately 24,000 residency positions.” More recently, in 2009, the NRMP reported a total number of 29,890 medical school graduates participated in the matching process for approximately 25,185 positions.

If a medical student wishes to participate in the NRMP matching process and therefore obtain admission into an internship, residency or other GME program, the “NRMP requires that all parties agree in advance to accept its [NRMP] results without negotiating employment terms.” In other words, the mere registration of a medical student into the NRMP matching process inevitably invokes unequal bargaining and negotiating power with respect to the terms, conditions, and nature of the resident’s anticipated GME program and hospital employment.

More specifically, the Match Participation Agreement for Applicants and Programs for the 2011 Main Residency Match (“NRMP Agreement”) explicitly sets forth that “upon the NRMP’s acceptance of such party’s registration, these terms and conditions will be a binding agreement between such party and the NRMP, as well as between such party and any other party who executes this [Agreement] and whose registration is accepted by the NRMP.” Additionally, the NRMP Agreement provides that once an applicant matches, he or she “shall not discuss, interview for, or accept a concurrent year position in another program prior to the NRMP issuing its decision as to whether to

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56. Creasman, supra note 24, at 1446 (emphasis added).

57. See, e.g., Jung v. Assoc. of Am. Med. Colls., 300 F. Supp. 2d 119, 149 (D.D.C. 2004) (discussing Plaintiff’s argument that a “gross disparity in bargaining positions existed between the NRMP and the medical students, that plaintiffs had no meaningful choice when presented with the Student Match Contract”).

grant the requested waiver." Thus, unlike other employees, a medical resident is constructively prohibited from negotiating offers between prospective employers.

Additionally, a medical student has very little to no employment flexibility once a match occurs, where as set forth under the NRMP Agreement, "applicants and programs are not authorized to release each other from their binding match commitment . . . once a party has matched, a waiver of the binding match commitment may be obtained only from the NRMP." Once a medical student accepts a match, the student is contractually obligated to the terms of the program contract, including a start date.

59. Id. at § 2.5.

60. The NRMP attempts to address such issue by stating that programs must provide "complete, timely, and accurate information to interviewees, including a copy of the contract the applicant will be expected to sign if matched to the program and the institution’s policies on visa status and eligibility for appointment" and that such "information must be communicated to interviewees prior to the rank order list deadline, and a signed acknowledgment should be obtained from each interviewee." Frequently Asked Questions U.S. Seniors, NATIONAL RESIDENT MATCHING PROGRAM, http://www.nrmp.org/res_match/faq/us_seniors_faq.html (last visited Jan. 26, 2010).

The NRMP goes on to explain that since many "appointment contracts are lengthy and that others may not contain all of the institution’s relevant policies, an acceptable alternative is to post the contract and policies on the institution’s Web site and notify interviewees where the information may be found. The signed acknowledgment should include a statement that the interviewee was notified that the information is posted on the Web site." Id.

It is unclear whether or not the NRMP has any comprehensive means by which to insure that GME programs divulge and otherwise provide medical students notice of the terms of employment before a match actually takes places. Even assuming a medical student has the ability to review the employment contracts of prospective GME programs, the NRMP still prohibits a medical student from negotiating the terms of such agreements.

61. The NRMP actually provides Case Summaries, wherein the NRMP has granted waivers to medical residents, namely identifying situations where the "match would cause serious and extreme hardship." Such situations include where: 1) a medical resident’s spouse is diagnosed with a serious illness after the match; and 2) a medical resident’s fails to timely obtain a Visa or other immigration documents. Waiver Reviews and Violation Investigations, NATIONAL RESIDENT MATCHING PROGRAM, http://www.nrmp.org/res_match/policies/case.html (last visited Feb. 1, 2010).

Conversely, the NRMP has explicitly identified situations where match waivers will not be granted, including where: 1) a medical resident after a match decides to change a program specialty and failed to timely request such match change; and 2) a GME program wants to withdraw a match to a medical student after not feeling “comfortable” offering such position, although there was no evidence of prior misconduct in the medical resident’s record. Id.


63. Id. NRMP Agreement “establishes a binding commitment to offer or to accept an appointment if a match results and to begin training on the date specified in the appointment contract.” Id.
Thus, a medical student faces substantial uncertainty and risk when disputing a match wherein "the NRMP's decision to grant or deny the waiver is at the sole discretion of the NRMP and is not subject to arbitration."\(^6\) In fact, the NRMP Agreement sets forth that "failure to honor this commitment by either party participating in a match will be a breach of this Agreement and may result in penalties to the breaching program or applicant."\(^6\) Such penalties or findings of violation\(^6\) of the NRMP Agreement may include the report of such violation to the applicant's medical school and state medical boards.\(^6\)

Despite various substantive legal challenges to the NRMP including claims pursuant to the Sherman Antitrust Act,\(^6\) the NRMP

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\(^6\) Id. See also Frequently Asked Questions U.S. Seniors, supra note 60 (stating "under certain limited circumstances, the NRMP may grant to an applicant or program a waiver of the match commitment if honoring the Match outcome would result in serious and extreme hardship. Waivers must be requested from, and can be granted only by, the NRMP").

The NRMP process by which a medical resident may seek a waiver includes: 1) a Formal Request for Waiver; 2) Written Statement in Support of Waiver; 3) Examination by the NRMP; 4) NRMP Assessment and Examination; and 5) Reconsideration of NRMP Decision. Policies and Procedures for Waiver Requests, NATIONAL RESIDENT MATCHING PROGRAM, http://www.nrmp.org/res_match/policies/waivers.html (last visited Jan. 26, 2010).

Since the NRMP does not maintain any waiver specific statistics, it is unknown how many matched applicants per a year seek such waiver and accordingly, the percentage, if any that are granted waivers by the NRMP. The consequences of being denied a waiver are significant though, resulting in the applicant being "expected to honor the match commitment" or being "barred from accepting a position in any program sponsored by an institution." Id.

\(^6\) Id. See also Frequently Asked Questions U.S. Seniors, supra note 60 (stating "A decision not to honor that commitment is a breach of the Agreement and will be investigated by the NRMP in accordance with the Policies and Procedures for the Reporting, Investigation, and Disposition of Violations of NRMP Agreements. Penalties may be levied if a violation is confirmed").

\(^6\) The NRMP has identified Case Summaries where it has imposed penalties or made findings of violations of the NRMP Agreement, including: 1) a medical resident misrepresented application information, including probation of licensure on the match application; 2) a GME program solicits information from a prospective medical resident as to the programs he or she was interested in or had interviewed with; 3) a medical resident fails to honor a match commitment by accepting a position from another GME program; and 4) a GME program attempts to contact an unmatched student prior to match week. Waiver Reviews and Violation Investigations, NATIONAL RESIDENT MATCHING PROGRAM, http://www.nrmp.org/res_match/policies/case.html (last visited Feb. 1, 2010). Other circumstances in which a medical resident or GME program may be cited for a violation is discussed in detail by the NRMP's The Integrity of the NRMP Match, NATIONAL RESIDENT MATCHING PROGRAM http://www.nrmp.org/res_match/about_res/ensuring.html (last visited Feb. 1, 2010).


\(^6\) 15 U.S.C. §§ 1-7 (2006). See, e.g., Jung, 339 F. Supp. 2d at 119 (dismissing Plaintiffs' class action claims where Congress passed 15 U.S.C. § 37b (Section 207) and providing an antitrust exemption to NRMP residency matching program). For a more comprehensive discussion of Jung, see Geiger, supra note 24, at 533-37. See also vari-
Agreement continues to govern the placement of medical students into GME programs, fostering the continued inequitable relationship between medical residents and their hospital employers. In assessing such challenges faced by medical students with respect to the NRMP, Gregory Dolin described that:

the Match system run by the NRMP started out as an attempt to bring order to medical students' frustrating experience of attempting to secure residency positions. Over the years, however, the Match has become so restrictive as to limit students' choice and ability to obtain the best deal for the hard work they provide . . . the time has come to abandon the Match and to allow students to engage in true negotiations with the potential employers . . . the time has come to recognize that the market for medical residencies should be treated like any other employment market.69

Despite the widespread criticism and challenges to the NRMP process, medical students continue to have no viable alternative but to participate in such NRMP process, including acceptance of any and all subsequent employment terms, conditions, and agreements that are derivative of such matching process.

B. THE NON-NEGOTIABLE RESIDENT OR APPOINTMENT CONTRACT—SIMILARITIES AND DIFFERENCES IN FORM AND STRUCTURE

Another employment issue medical residents face is processing and understanding the actual terms and conditions of employment, especially where the National Resident Matching Program ("NRMP") Agreement requires a complete acceptance of all employment terms and conditions of the matching Graduate Medical Education ("GME") program or hospital, including start date, training provisions, salary, vacation, and benefits.70 Accordingly, absent any exigent circumstances whereby a medical resident could argue force majeure, the appointment contract is for all intent and purpose, a non-negotiable contract.71

69. Dolin, supra note 37, at 88 (emphasis added).
70. See supra Part II(A).
71. An interesting query outside the scope of this Article is whether medical resident or appointment contracts are essentially contracts of adhesion, akin to the boilerplate and seemingly unconscionable contract language used in the context of insurance contracts. See, e.g., Brokers Title Co. v. St. Paul Fire & Marine Ins. Co., 610 F.2d 1174, 1179 (defining an adhesion contract as "one which is dictated by a predominant party to cover transactions with many people rather than with an individual, and which resembles an ultimatum or law rather than a mutually negotiated contract").
Complicating the situation is the fact that medical resident appointment contracts are not uniform (nor are they required to be), but rather are drafted in a variety of different ways, varying in form, structure, and substance.\(^7\) Despite this, medical residents, in reviewing and executing such contracts, should be aware of a few general similarities.\(^7\) First, such contracts typically discuss, reference, or include a duty hour provision or statement concerning a medical resident's hours worked.\(^7\) The purpose of such provision is to provide medical students with notice concerning the GME program's expectations regarding work hours, and often, referencing that duty hours must be limited to eighty hours per week, averaged over a four-week period. Increasingly, independent GME standing policies governing resident duty hours are also supplementing such duty hour contractual provisions.\(^7\) Incorporating such resident duty hour provisions into the appointment contract largely resulted from the Accreditation Council for Graduate Medical Education ("ACGME") recently promulgating uniform standards with respect to maximum hours for residents.\(^7\)

Second, such contracts, generally, but not always, contain a "due process" clause. The "due process" clause identifies, in pertinent part, that a medical resident has an inherent claim of due process and that in the event of an employment dispute involving suspension, termination, or any other decision, the resident has a right to assert an appeal

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\(^7\) The Author in evaluating the common contractual provisions of medical resident appointment contracts reviewed approximately thirty (30) different program and institutional PGY-1 through PGY-4, Fellowship, and Graduate Medical Education (GME) related contracts. It is important to note that the Author was focused solely on the contractual provisions of 1) duty hours, 2) due process; 3) grievance procedures, 4) sexual harassment, 5) termination, 6) non-discrimination, 7) evaluation, and 8) certificate of completion provisions that were explicitly set forth. Thus, the Authors assessment did not include where the above provisions may have been implied or incorporated by reference to ACGME or other applicable guidelines or standards.

\(^7\) It is important to note that there are no guidelines, by the ACGME or otherwise, that require GME programs have uniform appointment contracts.

\(^7\) Id.


before a committee composed of faculty members and, in certain circumstances, fellow medical residents.77

Similarly, the resident contracts contain or reference grievance procedures whereby a medical resident, if aggrieved as a result of termination, suspension, or other reason, may file a formal complaint or appeal.78 Often, such grievance procedures are incorporated into a due process provision or may actually be considered a mutually exclusive and independently recognized contractual right or procedure.79

Third, the standard resident contract often includes an explicit sexual harassment statement or policy. This statement or policy sets forth, in pertinent part, the hospital, program, or institution's goal in maintaining a harassment free environment and that sexual harassment, under no circumstances will be tolerated.80

Fourth, resident contracts typically contain a termination provision, which sets forth the circumstances, procedures, and process by which a medical resident's employment may be terminated.81 The basis for termination of a medical resident is often referenced very broadly to include any failure to comply with hospital or program by-laws, rules, regulations, and standards.82 Some contracts are more favorable to the medical resident where it is specifically delineated in the contract that unsatisfactory resident evaluations or deficient performance and progress in medical knowledge and skills are circum-


79. Id.


82. See, e.g., Resident Contract, Paragraph 5, Promotion and Termination, MONMOUTH MEDICAL CENTER, http://www.saintbarnabas.com/education/mmced/Acrobat/RESIDENT_CONTRACT_FORM1.pdf (last visited Feb. 14, 2011) (discussing that the "Medical center may terminate, may not renew, or not promote at any time for cause.").
stances whereby the hospital or GME program may effectuate termination. 83 Interestingly, the resident contracts that have a termination clause rarely reference that a medical student’s employment is “at will” and therefore subject to termination for any reason whatsoever. 84 Rather, the termination clauses will generally state that the program may terminate a medical resident for “cause.” 85

Fifth, similar to a sexual harassment provision, resident contracts will often contain a non-discrimination clause or a statement of non-discrimination that incorporates an expression of equal employment opportunity consistent with Title VII of the Civil Rights Act of 1964, 86 Title IX of the Education Amendments of 1972, 87 and the Americans with Disabilities Act of 1990. 88 89 Such contracts may include a specific process by which a medical resident may file an inquiry, complaint, or claim with a civil rights department or discrimination officer. 90 Based upon a sample of medical resident appointment contracts, this seems to be more the exception than the rule.

Sixth, resident contracts reference an evaluation process, providing medical residents notice as to the process, period, and form to which such evaluations will occur. Such provisions set forth the various circumstances and method by which the program will notify the resident concerning deficits in performance and the possibility of non-renewal in the upcoming program year. 91

86. 42 U.S.C.A. § 2000e et seq.
91. See, e.g., Resident/Fellow Contract, University of Chicago Medical Center, Section 13, http://www.uchospitals.edu/pdf/uch_008666.pdf (last visited Jan. 26, 2010) (setting forth that “reappointment is at the discretion of UCMC and is contingent upon several factors, including but not limited to, the following: satisfactory completion of all training components, the availability of a position, satisfactory performance evalua-
Additionally, the resident contract will occasionally set forth whether a medical resident is entitled to copies of such evaluations and the process by which a medical resident may request such information.\(^2\) Similarly, some resident contracts may contain a separate provision governing what, if any, documentation the hospital or program institution is required to give to the medical resident upon completing the program requirements.\(^3\) Often referred to as a certificate of completion or letters of verification, such provisions govern the process by which such certificates are issued.\(^4\)

In terms of common contractual elements, the majority of resident contracts reviewed did contain provisions summarized in Table I.

| Table I. Common Contractual Elements Medical Resident Appointment Contract |
|-----------------------------|-----------------------------|
| Duty Hours                  | Due Process                 |
| Grievance Procedure         | Sexual Harassment/Non-Discriminatıon |
| Termination                 | Non-Discrimination          |
| Evaluation/Certificates of Completion |

Just as relevant to an understanding of the common elements within GME program appointment contracts, is recognizing the various contractual differences.\(^5\) First, the formatting, including page length for the reviewed resident contracts, differs dramatically by hospitals, full compliance with the terms of this Agreement, the continuation by ACGME of institutional and program accreditation, and UCMC's financial ability\(^5\).

\(^2\) See, e.g., Resident Contract, University of Missouri-Columbia School of Medicine, http://som.missouri.edu/dermatology/residency/ResContract%202010-11.doc (last visited Jan. 26, 2010) (discussing “performance will be evaluated at regular intervals by my residency program director and supervising physicians, and that my reappointment and/or promotion to the next level is subject to my receiving satisfactory evaluations”).


\(^4\) Id.

\(^5\) In fact, the Author did not assess the other possible differences between appointment contracts, including with respect to a resident's responsibilities, duration of appointment, financial support, conditions for reappointment, academic or disciplinary action, professional liability insurance, health and disability insurance, leaves of absence, and moon-lighting. Presumably, incorporating these other elements would bolster that there are substantial differences among GME programs with respect to appointment contracts.
hospital or program institution. The average page length for the resident contracts reviewed was generally six to eight pages, with the longest reviewed resident contract approximately eleven pages and the shortest just a single page.66 Second, a few resident contracts may include a contractual provision or a disclaimer in the event that the hospital or program institution reduced or closed its residency program.67 Third, with respect to due process or grievance process, a few resident contracts have established very elaborate dispute and appeal procedures, including provisions for notice, composition of hearing committees, the calling of witnesses, and the decision process.68 Table II is a summary of the type of differences found within a sampling of various GME program agreements. In short, along with common similarities, there are also striking differences between various GME appointment contracts.

Table II.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tr>
<td>DH</td>
<td>Duty Hours</td>
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<td>DP</td>
<td>Due Process</td>
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<tr>
<td>GP</td>
<td>Grievance Procedure</td>
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<td>SH</td>
<td>Sexual Harassment</td>
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<td>TM</td>
<td>Termination</td>
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<td>ND</td>
<td>Non-Discrimination</td>
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<td>EV</td>
<td>Evaluation</td>
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<tr>
<td>CC</td>
<td>Certificate of Completion</td>
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</table>

67. See, e.g., *Sample Pediatric Resident Contract*, Akron Children’s Hospital, https://www.akronchildrens.org/cms/tipsActions/169c7374306f28ae/pl_1_sample_contract_for_web.pdf (last visited Jan. 2, 2010) (setting forth that “if . . . the hospital . . . intends to reduce the size of the Residency Program or close the Residency Program, the Program Director will inform the resident as soon as possible. In the event of such a reduction or closure, every effort will be made to allow a resident in the program to complete his/her education. If a resident is displaced by a closure or a reduction in the number of residents, every effort will be made to assist the resident in identifying a program at the same level in which he/she can complete training”).
C. ACGME Standards and Guidelines—A Means to Supplement GME Program Appointment Contracts

In addition to weaving through the intricacies of a Graduate Medical Education (“GME”) program appointment contract, medical residents may in the course of their employment need to reference or otherwise invoke specific Accreditation Council for Graduate Medical Education (“ACGME”) standards and guidelines. The purpose of this Section is to provide a brief overview as to the means by which a medical resident may refer to such standards for assistance.

At the outset, it is important to note that generally, most resident and appointment contracts recite, reference, or incorporate specific ACGME standards and guidelines.99 In the event a particular provi-

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sion within a GME program appointment contract is in any way ambiguous, reference to ACGME standards, guidelines, and program requirements can constructively serve to clarify, supplement, and where necessary, enhance the employment terms and agreement.100 Below are some ways in which this is accomplished.

First, the ACGME Institutional Requirements, ("ACGME Requirements") effective July 1, 2007, provide a clear directive as to what medical residents should reasonably be provided notice of with respect to their employment.101 For instance, Section II of such ACGME Requirements provide that GME programs "must assure that residents are provided with a written agreement of appointment [or] contract outlining the terms and conditions of their appointment to a program."102 More specifically, the ACGME Requirements establish that such agreements or contracts must contain or provide reference to residents' responsibilities; duration of appointment; financial support; grievance procedure and due process; academic or other disciplinary action; adjudication of resident complaints; professional liability insurance; health and disability insurance; leaves of absence; duty hours; moonlighting; counseling services; physician impairment; harassment; and accommodation for disabilities.103 Although not required to be put in the appointment agreement or contract, the ACGME Requirements also set forth that GME programs have a written policy with respect to closures and reductions;104 resident participation in educational and professional activities;105 and resident educational and work environment.106

With respect to the process of measuring medical resident performance, the ACGME Requirements explicitly set forth that "the faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document

100. Although the actual appointment agreement is the explicit instrument memorializing the employment terms, the ACGME standards and guidelines may be effectively referenced in circumstances where the appointment agreement may not clearly define such terms, especially where there may be issues of non-reappointment or non-promotion.
102. Id. at § II.
103. Id. at § II.D.4(a)-(n). Despite the ACGME Requirements pertaining to what contractual elements must be contained within GME Program Appointment Contract, as discussed in supra Part II(B), there is still a significant variation among such contracts.
104. ACGME, supra note 101, at § II.D.5.
105. Id. at § II.E.
106. Id. at § II.F.
More specifically, ACGME program requirements set forth that:

The program must: (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice; (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (3) document progressive resident performance improvement appropriate to educational level; and (4) provide each resident with documented semiannual evaluation of performance with feedback.108

Furthermore, the ACGME Requirements are clear that “the evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.”109

The ACGME Requirements also explicitly outline the types of assessments, evaluations, and other methods by which a GME program should employ to measure a medical resident’s competency, including:
direct observation, videotaped/recorded assessment, global assessment, simulations/models, record/chart review, standardized patient examination, multisource assessment, project assessment, patient survey, in-house written examination, in-training examination, oral exam, objective structured clinical examination, structured case discussion, anatomic or animal models, role-play or simulations, formal oral exam, practice/billing audit, review of case or procedure log, review of patient outcomes, review of drug prescribing, resident experience narrative and any other applicable assessment method.110

Furthermore, ACGME Requirements specifically identify the types of appropriate program individuals for conducting such medical resident evaluations, including:

program director, nurse, faculty supervisor, medical student, faculty member, attending preceptor, allied health professional, chief resident, junior resident, resident supervisor, patient, family, peers, technicians, clerical staff, evaluation committee, consultants.111

It is important to note that ACGME Requirements make it mandatory that GME hospital and program institutions advise medi-

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108. Id.
109. Id.
110. Id.
111. Id.
The non-negotiable employment contract

residents of the "performance criteria" upon which they will be assessed. Overall, with respect to conducting evaluations, and irrespective of what contractual language is put into the employment contract, ACGME guidelines place the burden upon the hospital or program institution to demonstrate a process that "assures the timely completion of evaluations" and "involves the program director or a designee who meets with the resident semi-annually to provide some continuity in guiding the resident through the assessment process."

Second, with respect to certificates of completion, verification letters, and summative evaluations issued to a medical resident upon completing the hospital or program institution requirements, ACGME guidelines provide that:

the program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must: (a) document the resident's performance during the final period of education, and (b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

Third, medical residents pursuant to ACGME Requirements, and exclusive of contractual provisions governing due process or grievance procedure, if any, have the right to submit confidential assessments and evaluations of the hospital or institution program. Specifically, ACGME guidelines set forth that, "residents . . . must have the opportunity to evaluate the program confidentially and in writing at least annually . . . " Such ACGME Requirements are relevant where a medical resident may be unduly exposed to retribution or other retaliatory action for submitting possibly negative assessments, evaluations, feedback, or criticism about the hospital or program institution.

112. Id.
114. Id.
115. Id.
116. See, e.g., Procedures for Addressing Complaints Against Residency Programs and Sponsoring Institutions, Accreditation Council for Graduate Medical Education, http://www.acgme.org/acWebsite/resInfo/ri_complaint.asp (last visited Mar. 30, 2010) (discussing that "the ACGME requires that sponsoring institutions and programs provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation").
Fourth, with respect to quality of the workplace, including excessive hours, the ACGME Requirements are similarly insightful. For instance, the ACGME recognize four specific principals governing resident duty hours, including:

1) the program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment;
2) the learning objectives of the program must not be compromised by excessive reliance on the residents to fulfill service obligations;
3) Didactic and clinical education must have priority in the allotment of residents’ time and energy;
4) Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.\textsuperscript{117}

The GME program is also required to “ensure a healthy and safe work environment” that provides for food services,\textsuperscript{118} call rooms or sleeping quarters,\textsuperscript{119} and safe work-place facilities and grounds.\textsuperscript{120}

Fifth, the ACGME Requirements provide additional guidance as to other important standards that should govern the workplace. With respect to fostering professionalism within the workplace, ACGME highlights that residents “must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principals” [including]:

1) compassion, integrity, and respect for others;
2) responsiveness to patient needs that supersedes self-interest;
3) respect for patient privacy and autonomy;
4) accountability to patients, society and the profession; and
5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.\textsuperscript{121}

\textsuperscript{118.} ACGME Institutional Requirements, Accreditation Council for Graduate Medical Education, § II.F.3(a), http://www.acgme.org/acWebsite/irc/irc IRCr07012007.pdf (last visited Feb. 6, 2011).
\textsuperscript{119.} Id. at § II.F.3(b).
\textsuperscript{120.} Id. at § II.F.3(c).
The ACGME Requirements mandate that a GME program "must have written policies covering sexual and other forms of harass-ment"\textsuperscript{122} and "a written policy regarding accommodation, which would apply to residents with disabilities."\textsuperscript{123} Interestingly, the ACGME Requirements also mandate that a GME program facilitate a medical resident's access to counseling services and incorporate policies for physician impairment as a result of substance abuse.\textsuperscript{124}

Furthermore, ACGME Requirements set forth that activity relating to professionalism and ethics, "should be structured [and] demonstrate active faculty involvement (not just passive role modeling) and timely feedback to residents."\textsuperscript{125} Medical residents should also be allowed to submit information, concerns, questions, or resolution via survey concerning the above standards of professionalism "without fear of intimidation or retaliation."\textsuperscript{126}

\section*{D. Termination and Transition Employment Disputes}

Some of the more significant employment issues medical residents face are termination or non-promotion to the next level of training by a Graduate Medical Education ("GME") program, or an employment transition from one GME program to another, especially if the medical resident has completed only part of the GME program.\textsuperscript{127} In such employment circumstances, a medical resident may often have employment concerns as to the basis for termination; whether the resident will obtain credit for the work completed to date; whether the GME program will provide a letter of recommendation; and whether the GME program will provide the medical resident support in transitioning or transferring to another program.

The Accreditation Council for Graduate Medical Education ("ACGME") Requirements provide some guidance concerning these termination and transition employment issues. For instance, the ACGME Requirements mandate that a GME program must provide a medical resident sufficient notice of "non-renewal of appointment or

\begin{footnotes}
\item[122.] \textit{Id.} at § II.D.4m.
\item[123.] \textit{Id.} at § II.D.4n.
\item[124.] \textit{Id.} at § II.D.4k-4l.
\item[125.] \textit{Id.}
\item[126.] \textit{Id.}
\item[127.] Frequently, such employment termination and transition disputes may not arise until a medical resident is within their second (PGY-2) or third (PGY-3) year of the GME program. Therefore, from a medical resident's perspective, the risk of non-renewal or non-promotion are significantly greater in terms of cost, expense, time, and sources expended.
\end{footnotes}
non-promotion.” Specifically, “in instances where a resident’s agreement will not be renewed, or when a resident will not be promoted to the next level of training, the [GME program] must ensure that its programs provide the resident(s) with a written notice of intent no later than four months prior to the end of the resident’s current agreement.” In situations, where the “primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the [GME program] must ensure that its programs provide the resident(s) with as much written notice of the intent not to review or not to promote as circumstances will reasonably allow, prior to the end of the agreement.”

Additionally, the ACGME Requirements set forth that “residents must be allowed to implement the [GME programs'] grievance procedures if they receive a written notice either of intent not to renew their agreement(s) or of intent to renew their agreement(s) but not to promote them to the next level of training.” If a medical resident chooses to utilize a GME program's grievance procedures, the GME program “must provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process.” Furthermore, the ACGME Requirements set forth that a GME program's grievance procedures must “minimize conflict of interest” by adjudicating “academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident’s agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident's intended career development” and other “complaints and grievances related to the work environment or issues related to the program or faculty.”

Although the ACGME Requirements mandate that GME programs provide medical residents sufficient notice of non-renewal of appointment or non-promotion, the ACGME has very little involvement in a GME program’s final decision regarding such employment issues. For instance, the ACGME procedures for addressing complaints against GME programs are limited only “regarding compliance with

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129. Id.
130. Id.
131. Id. at § II.D.4 (d)(2).
132. Id. at § II.D.4 (e).
133. Id. at § II.D.4 (e)(1).
134. Id.
According to the ACGME, it will only "investigate potential noncompliance with accreditation standards, that relate to program quality and does not, adjudicate disputes between individual persons and residency programs or sponsoring institutions regarding matters of admission, appointment, credit, promotion, or dismissal of faculty, residents or fellows." Thus, although the ACGME purports to provide certain guidelines governing non-renewal of appointment or non-promotion to a higher training level, there is nothing that ACGME can do to assess, evaluate, or review a specific case relating to a medical resident's discipline, termination, or dismissal.

In summary, where medical residents may face certain employment related issues that may or may not be addressed in the GME program's appointment contract, medical residents to some extent may utilize ACGME standards, rules, and protocols as a means to advocate their employment interests.

III. SUMMARY OF LEGAL CASELAW GOVERNING MEDICAL RESIDENT EMPLOYMENT ISSUES

Although the established legal jurisprudence governing medical resident employment issues is very negligible, this Part will attempt to provide a brief overview of the applicable relevant employment-related caselaw affecting a medical resident's workplace. In doing so, it is important to note that in the majority of these cases, courts have not necessarily furthered or enhanced the employment rights of medical residents, rather courts have adversely affected, limited, and potentially hindered such rights.

A. JUDICIAL VALIDATION OF THE NRMP MATCHING PROCESS

As discussed herein, despite various legal challenges to the National Resident Matching Program ("NRMP") matching process, the NRMP continues to govern the employment placement of medical residents into Graduate Medical Education ("GME") programs. In determining that the NRMP matching process does not violate federal anti-trust laws, including the Sherman Antitrust Act, the United States Court of Appeals for the District of Columbia unequivocally held that the NRMP matching process "falls squarely within both the

136. Id. (emphasis added).
exemption and bar of Section 207" of the Pension Funding Equity Act of 2004138 ("PFEA Act"). Signed into law by President Bush on April 10, 2004, Section 207 of the PFEA Act, entitled "Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs" provides that "[i]t shall not be unlawful under the antitrust laws to sponsor, conduct, or participate in a graduate medical education residency matching program, or to agree to sponsor, conduct, or participate in such a program."140 The exemption of GME programs from federal antitrust laws has been the subject of much criticism, especially where such exemption was granted with very little Congressional debate or discussion.141

As one Senator expressed after the passage of such an exemption, this provision grants a retroactive antitrust exemption to the graduate medical education matching program, a subject that is entirely unrelated to the bill and never received a full consideration by normal processes of this body. . . . I do not think that exemptions from this nation's antitrust laws should be lightly given. Second, I think the process by which this exemption was given—without any opportunity for hearing before the appropriate committees or full and real consideration by this body—was improper.142

In short, the Court's validation of the NRMP matching process, namely that such process is exempt from antitrust regulation, has and will continue to profoundly adversely impact the employment rights of medical residents for years to come. This is especially true where the NRMP and GME programs have now been given the unfettered ability to continue implementing, governing, mandating, and overseeing the NRMP matching process.

B. DISCRIMINATION CASES

Other significant judicial decisions have similarly been unfavorable to medical residents with respect to employment claims involving

142. Turner, supra note 141, at 5.
discrimination, wherein courts have emphasized the heavy burden upon the medical resident to demonstrate direct evidence of such discrimination.\textsuperscript{143} For example, in Sreeram \textit{v.} Louisiana State University Medical Center-Shreveport,\textsuperscript{144} the United States Court of Appeals for the Fifth Circuit, in dismissing the plaintiff’s discrimination claims, held that the evidence on the record was insufficient to support either “direct evidence” or even an “inference” of discrimination.\textsuperscript{145} In that case, Suhu Sreeram, M.D. (“Dr. Sreeram”), a woman of Indian national origin, after graduating from the Emory University School of Medicine and completing a two-year non-clinical surgical residency, applied for and was accepted into Louisiana State University Medical Center-Shreveport’s (“LSUMC-S”) surgical residency along with five other residents.\textsuperscript{146} At the time of Dr. Sreeram’s admission, she was the only female resident, although there was another resident of Indian nation origin.\textsuperscript{147} Under the terms of Dr. Sreeram’s employment, surgical residents worked as “house officers” under one-year contracts whereupon a Residency Review Committee (“Committee”) composed of faculty assessed performance quarterly and made recommendations to a Department Chair as to whether a particular resident should continue in the program and receive renewal of contract.\textsuperscript{148} Furthermore, “Dr. Sreeram entered into three successive one-year contracts, the last commencing on July 1, 1994, and ending on June 30, 1995.”\textsuperscript{149}

After commencing the residency on July 1, 1992, “the Committee expressed concerns about Dr. Sreeram’s performance in the program as early as late 1992.”\textsuperscript{150} In March of 1994, close to the end of Dr. Sreeram's second year as a surgical resident (PGY-2), the Committee eventually voted to expel Dr. Sreeram.\textsuperscript{151} Upon approval by the Department Chair, Dr. Sreeram was able to continue in the program for an additional year.\textsuperscript{152} The Committee again recommended Dr. Sreeram’s expulsion, and on January 9, 1995, Dr. Sreeram was in-

\textsuperscript{143} See, e.g., Sreeram \textit{v.} Louisiana State Univ. Med. Ctr.-Shreveport, 188 F.3d. 314, 318 (5th Cir. 1999) (holding that “a Title VII plaintiff bears the initial burden of proving a prima facie case of discrimination by a preponderance of the evidence.”) (citing McDonnell Douglas Corp. \textit{v.} Green, 411 U.S. 792, 801-03 (1973)); but see Medical \textit{Student with Stutter Wins ADA Ruling}, LEGAL INTELLIGENCER, Mar. 26, 2010.

\textsuperscript{144} 188 F.3d 314 (5th Cir. 1999).

\textsuperscript{145} Sreeram \textit{v.} Louisiana State Univ. Med. Ctr.-Shreveport, 188 F.3d. 314, 318 (5th Cir. 1999).

\textsuperscript{146} Sreeram, 188 F.3d at 316.

\textsuperscript{147} Id. at 316-17.

\textsuperscript{148} Id. at 317.

\textsuperscript{149} Id.

\textsuperscript{150} Id.

\textsuperscript{151} Id.

\textsuperscript{152} Id.

In denying Dr. Sreeram’s discrimination claims, the Court determined that she had “failed to establish a prima facie case of sex and/or national origin discrimination, because she did not demonstrate that she was qualified for the position in question at all relevant times.” Such a finding was made despite the fact that Dr. Sreeram had been permitted to continue to work, as a medical resident, years after the program had found deficiencies in her performance.

In essence, the Court relied upon facts within the record that “everyone who reviewed Dr. Sreeram’s performance determined that it was not commensurate with what is expected of a third-year surgical resident.” Additionally, the Court cited to minutes from quarterly meetings of the Committee from January 15, 1992, to January 20, 1995, that discussed Dr. Sreeram’s “deficiencies as a surgical resident.” The record is not clear as to whether Dr. Sreeram was provided formal notice of such deficiencies or the basis as to why Dr. Sreeram was allowed to continue working as a medical resident.

With respect to medical residents, this case is significant for a number of reasons. First, aside from the Court’s finding that Dr. Sreeram had failed to substantiate any evidence of discrimination, the Court insisted that she substantiate her qualification as a surgical resident “at all relevant times.” In doing so, the Court failed to acknowledge that despite Dr. Sreeram’s alleged deficient behavior, the Graduate Medical Education (“GME”) program had explicitly allowed her to continue, without limitation, in her capacity as a surgical resi-

153. Id.
154. Id.
155. Id.
156. Id. at 318 (emphasis added).
157. There is no evidence in the record that between late 1992 through June 30, 1995, that Dr. Sreeram’s surgical, hospital, and patient privileges were in any way suspended or otherwise limited.
158. Sreeram, 188 F.3d at 318.
159. Id.
160. As discussed herein, ACGME guidelines would have likely mandated that LSUMC-S provide Dr. Sreeram notice of such performance deficiencies.
dent for a period of three years, including presumably unfettered participation in patient care.\footnote{161}{Additionally, such prompt and timely notice of non-renewal or appointment or non-promotion would have been consistent with ACGME guidelines.}

In other words, assuming arguendo that there were in fact concerns about Dr. Sreeram's performance early on, it would have been reasonable for LSUMC-S to have provided prompt notice of non-renewal of appointment or non-promotion, rather than wait two years into the program. It would have similarly been appropriate for LSUMC-S to have put Dr. Sreeram on probation or disciplined or suspended her from surgical and hospital privileges, none of which occurred in this case. The failure of a GME program to do so, in light of patient safety, alludes to the fact that staff limitations, economics, and other issues may be taking precedent over the interests of the medical resident.

Second, the case highlights the importance that medical residents independently and actively conduct self-monitoring, recording, documenting, and memorializing their own resident performance, especially where issues relating to non-renewal of appointment or non-promotion may arise. Third, the case demonstrates the employment risks involved wherein a GME program may not provide formal notice of non-performance or non-promotion until a medical resident's third (PGY-3) or fourth year (PGY-4).

In another case, \textit{Brown v. Hamot Medical Center},\footnote{162}{No. 05-32E, 2008 WL 55999, at *1 (W.D. Pa. Jan. 3, 2008).} the Plaintiff medical resident, Lisa Brown, M.D. ("Dr. Brown") filed claims against Hamot Medical Center ("Hamot"), alleging gender discrimination.\footnote{163}{\textit{Brown} v. Hamot Medical Center, No. 05-32E, 2008 WL 55999, at *6 (W.D. Pa. Jan. 3, 2008).} Hamot employed Dr. Brown as a first-year orthopaedic resident (PGY-1).\footnote{164}{Id. at *2.} "Hamot's orthopaedic residency program comprised five years."\footnote{165}{Id. at *3.} During her first-year, Dr. Brown performed poorly on the Orthopaedic In-Training Examination ("OITE") and received mediocre evaluations by program officials.\footnote{166}{Id. at *4.} After an alleged failure to follow her supervisor's instructions during an Emergency Room procedure, Dr. Brown was "placed on academic and clinical probation."\footnote{167}{Id. at *4.} At the beginning of Dr. Brown's third year of residency (PGY-3) and after improvement in academic performance, she was removed from probation.\footnote{168}{Id.} But, as a result of another poor performance on an OITE...
exam, the hospital later informed Dr. Brown that the contract “would not be renewed beyond that current academic year.”

In support of her discrimination claims against Hamot, Dr. Brown relied upon evidence that at the time, “only 2.6% of Orthopaedic residents nationally were women,” despite the fact that nearly “half of medical school graduates [were] women.” Furthermore, Dr. Brown referenced that prior to her commencement of employment, there was only one other female Orthopaedic resident in the program. Thus, Dr. Brown asserted both sex and gender discrimination claims pursuant to Title VII of the Civil Rights Act of 1964, and the Pennsylvania Human Relations Act.

The District Court for the Western District of Pennsylvania, in dismissing Dr. Brown’s discrimination claims, determined that she had failed to meet a prima facie case for gender discrimination and that the defendant GME program had sufficiently articulated “a legitimate, non-discriminatory reason for its employment action against the Plaintiff.” According to the court, such legitimate non-discriminatory reason was based upon Dr. Brown’s poor performance as a medical resident.

Both Sreeram and Brown highlight the immense obstacles medical residents face in asserting claims of discrimination. These cases highlight these obstacles especially where the particular GME program, whether by evaluations, assessments, or test results, regardless of whether such were provided to the medical resident, may serve as a legitimate non-discriminatory basis for either non-renewal of appointment or non-promotion.

C. DUE PROCESS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES CASES

The courts have similarly addressed, albeit not favorable to medical residents, cases involving issues pertaining to due process and the exhaustion of administrative remedies. One of the earliest cases, Ong v. Tovey, involved the issue of whether the Graduate Medical Education (“GME”) program had afforded William T. Ong, M.D. (“Dr.

Id. at *4-5.

Id. at *6.

Id.


43 PA. CONS. STAT. ANN. §§ 951-63 (West [2009]).


Id. (citing to In re Carnegie Assoc., 129 F.3d 290, 294-95 (3d Cir. 1997)); see also McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973).

Id. at *10.

552 F.2d 305 (9th Cir. 1977).
sufficient constitutional due process, including a right to a hearing with respect to his termination as a medical resident.\textsuperscript{178} Dr. Ong commenced employment under a four-year residency program specializing in general surgery.\textsuperscript{179} At the beginning of Dr. Ong’s fourth year of residency (PGY-4), the department faculty “began to question his competence for the job” and subsequently “relieved [Dr.] Ong of his duties as a senior surgical resident and recommended that he resign from the residency program.”\textsuperscript{180} After various meetings with the department faculty, which included a question-answer period by Dr. Ong and his counsel of the faculty, Dr. Ong formally requested a “hearing on the loss of [his] operating procedures.”\textsuperscript{181}

In dismissing the due process claims, the United States Court of Appeals for the Ninth Circuit noted that Dr. Ong was given sufficient notice of his employment deficiencies, including an opportunity to discuss the matter with department faculty, and therefore, the GME program “satisfied the basic requirements of constitutional due process.”\textsuperscript{182} The Ong case is significant in that although the grievance process utilized by the GME program with respect to Dr. Ong was seemingly informal, the Court still determined that such satisfied the minimal constitutional due process requirements.

Other courts of various jurisdictions have followed the same due process analysis as articulated in Ong. For example in Davis v. Mann,\textsuperscript{183} Isaac E. Davis. D.D.S. (“Dr. Davis”) entered a general practice residency program.\textsuperscript{184} The employment contract signed by Dr. Davis set forth that termination could result from “malfeasance, inefficiency, or contumacious conduct.”\textsuperscript{185} In dismissing Dr. Davis’s due process claims against the GME program, the Court relied upon and referenced the sufficiency of “frequent and detailed notice of his academic problems and potential dismissal.”\textsuperscript{186}

As another example, in Allahverdi v. Regents of the University of New Mexico,\textsuperscript{187} the United States District Court for the District of New Mexico assessed the sufficiency of due process with respect to the

\textsuperscript{178} Ong v. Tovey, 552 F.2d 305, 307 (9th Cir. 1977).
\textsuperscript{179} Ong, 552 F.2d at 306.
\textsuperscript{180} Id.
\textsuperscript{181} Id.
\textsuperscript{182} Id. at 306; see also Stone v. Univ. of Md. Med. Sys. Corp., 855 F.2d 167 (4th Cir. 1988) (holding that plaintiff was not deprived of a property interest in continued employment or denied due process as required by the Fourteenth Amendment).
\textsuperscript{183} 882 F.2d 967 (5th Cir. 1989).
\textsuperscript{184} Davis v. Mann, 882 F.2d 967, 968 (5th Cir. 1989).
\textsuperscript{185} Davis, 882 F.2d at 968-69.
\textsuperscript{186} Id. at 975.
\textsuperscript{187} No. Civ. 05-2777 JB/DJS, 2006 WL 1313807, at *1 (D.N.M. April 25, 2006).
termination of a medical resident by a GME program. In this case, Dr. Houman Allahverdi ("Dr. Allahverdi") began working as a House Officer in the Family Practice Residency Program on June 21, 2002. At the time of his employment, the GME program had various policies in place including a Code of Professional Conduct and sexual harassment policy. Four months after the commencement of Dr. Allahverdi's employment as a medical resident, he was placed on administrative leave because he allegedly made "inappropriate and threatening comments while on duty, engaged in inappropriate communications with co-workers, and was untruthful." After a series of Committee hearings, on April 15, 2003, the University dismissed Dr. Allahverdi. In response, Dr. Allahverdi filed subsequent grievance appeals without success and eventually filed a formal lawsuit on January 18, 2005, alleging that the University breached his employment contract by terminating him without just cause and failing to afford him a hearing in a timely manner.

The district court undertook a thorough assessment of the level of due process afforded to medical residents, including distinguishing between due process as a result of academic and disciplinary dismissals. In doing so, the court discussed that judicial intervention was more appropriate where "a dismissal is disciplinary because it does not involve substantive evaluations of a student's performance like an academic dismissal does." Furthermore, in assessing Dr. Allahverdi's claims, the court took into consideration prior legal precedent that medical residents are not employees protected by the due process clause. As a result, the court dismissed Dr. Allahverdi's claims, finding that Dr. Allahverdi was afforded an appropriate level of due process based upon what was reasonably expected to be given to a medical student subject to an academic dismissal.

Similar to the due process cases, courts have also refused to allow aggrieved medical residents to assert employment claims before the judiciary, without first exhausting their administrative remedies.

188. See Allahverdi v. Regents of the Univ. of New Mexico, No. 05-2777 JB/DJS, 2006 WL 1313807 (D.N.M. April 25, 2006).
190. Id.
191. Id.
192. Id. at *4.
193. Id. at *8.
194. Id. at *11-14.
195. Id. at *14.
196. Id. at 14-15 (citing Davis, 882 F.2d 967; Shaboon v. Duncan, 252 F.3d 722 (5th Cir. 2001); Ezekwo v. New York City Health & Hosps. Corp., 940 F. 2d 775 (2d Cir. 1991); and Fenje v. Feld, 398 F.3d 620 (7th Cir. 2005)).
197. Id. at *24.
before the GME program.\textsuperscript{198} For example, in \textit{O’Neill v. St. Luke’s Medical Center},\textsuperscript{199} the Plaintiff, Brendan O’Neill, M.D. (“Dr. O’Neill”) began an ophthalmology residency, beginning on July 1, 1993.\textsuperscript{200} At the time of commencing his residency, Dr. O’Neill entered into a series of one-year residency employment agreements, setting forth that “failure to meet any of the terms and conditions set forth may result in disciplinary action up to and including termination.”\textsuperscript{201} The employment agreement set forth that “in the event of disciplinary action the House Officer [the resident] shall be entitled to a hearing in accordance with the Grievance and Fair Hearing Procedure applicable to House Officers.”\textsuperscript{202} Such procedure essentially involves an “administrative review by a three-person panel consisting of two residency program directors and the current house staff president to hear the resident’s grievances.”\textsuperscript{203}

According to the facts of the case, by the end of Dr. O’Neill’s second year of residency (PGY-2), the ophthalmology staff concluded “that his clinical performance was ‘significantly below that expected of a resident beginning the third year of ophthalmology training’ and his interpersonal skills were lacking.”\textsuperscript{204} As a result, on June 29, 1995, the GME program put Dr. O’Neill on probation and on an oversight plan to “improve and monitor his clinical and interpersonal skills.”\textsuperscript{205} Upon determining that Dr. O’Neill’s performance was still “deficient,” on August 11, 1995 the GME program terminated Dr. O’Neill’s employment, providing him with notice of a right to a hearing and a copy of the Fair Hearing Procedure.\textsuperscript{206} Rather than filing a grievance pursuant to such procedure, Dr. O’Neill first filed a lawsuit on August 21, 1995, for claims of breach of contract.\textsuperscript{207}

Although Dr. O’Neill argued that he never consented by signing the GME’s Fair Hearing Procedure, the Court of Appeals of Ohio for the Eighth District, Cuyahoga County, in dismissing Dr. O’Neill’s claims, found that he was duly provided notice of such and therefore could not “disclaim his knowledge or acquiescence in the process referenced in his employment contract.”\textsuperscript{208} Furthermore, the court simi-

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\textsuperscript{198} Often such inquiry presupposes that all GME programs in fact have some comprehensive grievance and/or dispute resolution process.
\textsuperscript{201} \textit{O’Neill}, No. 70372, 1996 WL 684343, at *1.
\textsuperscript{202} Id.
\textsuperscript{203} Id.
\textsuperscript{204} Id. at *4.
\textsuperscript{205} Id.
\textsuperscript{206} Id. at *1-2.
\textsuperscript{207} Id. at *2.
\textsuperscript{208} Id. at *4.
\end{flushleft}
larly dismissed Dr. O'Neill's argument that the Fair Hearing Procedure violated his due process rights, holding that "Dr. O'Neill was not entitled to due process because no state action affected his constitutionally protected rights [where] St. Luke's is a private hospital, not a state agent."209

As shown above, the judicial precedent set by courts with respect to due process and the exhaustion of administrative remedies significantly favors the GME program.

D. **EMPLOYMENT SEPARATION CASES: NON-RENEWAL AND NON-PROMOTION**

Similar to the cases discussed herein, courts have also rendered decisions in cases where the Graduate Medical Education ("GME") program has rendered a decision pertaining to non-renewal or non-promotion. Other cases involve situations where a medical resident's employment is discontinued prematurely as a result of the GME program losing accreditation or otherwise cancelling its medical resident program.

For example, in *Chu v. United States*,210 a number of medical residents employed also as civil service employees of the Public Health Service ("PHS") sought breach of contract claims against the GME program after a loss of funding had discontinued the residency program.211 At the time, the medical residents were receiving board certified training in various medical specialties.212 At the commencement of the residency program, the employment terms included the following:

It is to be understood that this appointment is for the minimum specified number of years required by the appropriate American Specialty Board for certification or for the period for which the specific program is approved. However, each year of subsequent training will be contingent upon your performance during the preceding year.213

In other words, the medical residents argued that the GME program had contractually agreed to provide the medical residents training, sufficient for them to obtain board certification.214 Despite the

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209. *Id.* at *1-6.
210. 773 F.2d 1226 (Fed. Cir. 1985).
211. *See Chu v. United States*, 773 F.2d 1226, 1227 (Fed. Cir. 1985); *see also* Hardison v. Cohen, 375 F.3d 1262 (11th Cir. 2004) (dismissing plaintiff resident's back pay and due process claims where there was no constitutional employment claim pursuant to civil service regulations).
212. *Chu*, 773 F.2d at 1227.
213. *Id.*
214. *Id.* at 1228.
terms of the employment agreement and medical resident's claims for breach of contract, the United States Court of Appeals for the Federal Circuit held that the "United States was not contractually obligated to provide medical residency training to the [residents] after their government employment was lawfully terminated." More specifically, the court determined that since the medical resident's training was only authorized for and available to federal employees and "the resident's status as a trainee was clearly secondary to and dependent upon his or her status as an employee [once] employment was properly terminated, their right to receive training was concomitantly terminated." 

Although the medical residents were per se federal employees, the Chu case highlights a potential employment dilemma among medical residents, where the GME related program is discontinued, is canceled, or, for circumstances beyond the medical resident's control, ceases operation. The fact that such situation may arise well into a medical resident's third (PGY-3) or fourth year (PGY-4), as with any employment issues, increases the risk of economic harm to the resident, especially if the GME program does not maintain comprehension guidelines for assisting a medical resident with a transition to a new program. The National Resident Matching Program ("NRMP"), to some extent, attempts to prevent such situations through its comprehensive accreditation and auditing process, and by requiring that GME programs provide the NRMP notice of withdrawal of positions before the "quota change deadline" (usually January 31). But accreditation audits by the NRMP may still not adequately protect a medical resident from harm as a result of a GME program that is discontinued, cancelled, or no longer accredited.

In another case, Zafar v. Roger Williams General Hospital, Syed Zafar ("Dr. Zafar") entered into an employment agreement with a GME program to "serve as a rotating intern for one year." The agreement set forth that the parties could be released from their employment responsibilities if the resident as a result of illness or good cause could not continue or if the "Resident Physician, following

215. Id. at 1229.
216. Id. at 1228.
217. From an economic cost perspective, calculating the time, labor, and cost related to undergraduate education, medical education, and then residency, the potential costs and opportunity costs could be in the hundreds of thousands.
timely notice and opportunity to be heard, had failed to perform and discharge his/her responsibilities in acceptable manner."\(^{221}\)

The contract also provided that the GME program would provide "a suitable environment for medical education experience, a training program accredited by the [Accreditation Council for Graduate Medical Education] ACGME; and a mechanism, with appropriate due process safeguards, whereby actions which impact upon the Resident's status and/or career development may be addressed."\(^{222}\)

According to the facts of the case, months after starting his residency, Dr. Zafar's supervisor became aware of "highly critical evaluations of Dr. Zafar's work" and recommended to the assistant director of the residency program that Dr. Zafar be taken off of medical service.\(^{223}\) Although Dr. Zafar denied being provided any notice of such, the GME program informed Dr. Zafar that he had received an unsatisfactory evaluation and provided him "the option of either seeking an appointment to another hospital or moving into the department of surgery."\(^{224}\)

Despite Dr. Zafar's deficient performance, in July of 1984 the GME program sent a certificate confirming "that Dr. Zafar had successfully completed a one-year mixed internship approved by the [American Medical Association] AMA" to the New Jersey medical licensing authority.\(^{225}\) In 1989, Dr. Zafar later discovered that the "AMA records did not show him as having completed an approved GME program."\(^{226}\) Thus, Dr. Zafar sued claiming breach of contract due to the GME program's failure to certify his completion of an ACGME-approved internship.\(^{227}\) In dismissing Dr. Zafar's breach of contract claims, the United States Court of Appeals for the First Circuit upheld the factual findings that Dr. Zahar "has orally received actual notice . . . of his situation [and] had an opportunity for discussion and for hearing to contest those allegations if he wanted to pursue that matter, and he chose not to pursue that avenue."\(^{228}\)

E. Unemployment Compensation

In a number of cases before unemployment compensation hearing boards throughout the county, medical residents have been deemed to qualify for unemployment compensation. In Bureau of Worker's & Un-

\(^{221}\) Zafar, No. 93-1390, 1994 WL 9857 at *1.
\(^{222}\) Id.
\(^{223}\) Id. at *2.
\(^{224}\) Id.
\(^{225}\) Id.
\(^{226}\) Id.
\(^{227}\) Id.
\(^{228}\) Id. at *5.
employment Compensation v. Detroit Medical Center, the Michigan Court of Appeals held that a medical resident’s service to the hospital was considered employment pursuant to the Michigan Employment Security Act ("MESA"), and therefore, medical residents were qualified for unemployment compensation benefits. In contrast, the Supreme Court of New York, Appellate Division for the Third Department took a different view in the Claim of Siu finding that pursuant to New York Labor Law section 511(15), "services rendered to an educational institution by a person who was enrolled in and regularly attended said institution did not constitute employment" and therefore, claimant was not entitled to unemployment compensation. Other courts have specifically examined whether or not a party was serving as a medical "intern" or a medical "resident" when deciding to grant unemployment compensation.

IV. INSTITUTIONAL POLICY AND LEGISLATIVE PROPOSALS—ACGME, NRMP, AND GME PROGRAMS

Although the Accreditation Council for Graduate Medical Education ("ACGME"), National Resident Matching Program ("NRMP"), and various other Graduate Medical Education ("GME") related programs and organizations have implemented guidelines, measures, and other processes, to advance the employment rights of medical residents, it is clear that substantial reform, including addressing the continued workplace inequities faced by medical residents, is still needed. The purpose of this Section is to provide an overview of various legislative and policy proposals in support of medical resident labor and employment reform.

A. AFFIRMATION BY ACGME CLASSIFYING MEDICAL RESIDENTS AS "EMPLOYEES"

As discussed herein, the perception that medical residents lack an employment status is shaped by well-established historical and traditional views of a residency program, whereby medical residents are and continue to be understood as "physicians in-training."

234. See, e.g., Hughes v. Variety Children's Hosp., 710 So.2d 683 (Fla. Dist. Ct. App. 1998) (holding that a physician with 16 years experience was neither a medical resident or intern, and therefore was not excluded unemployment compensation benefits under Fla. Stat. § 443.036(19)(n)(12) (1995)).
235. See supra Part I.
though the purpose of a Graduate Medical Education ("GME") program is to provide physicians with additional training sufficient for licensure, the professional medical care services and economic benefit rendered by medical residents should not be understated.\textsuperscript{236} Accordingly, for medical residents to ever have equal standing with other professions, it is important that they be designated, classified, and afforded the status of employees.\textsuperscript{237} As of date, neither the Accreditation Council for Graduate Medical Education ("ACGME"), National Resident Matching Program ("NRMP"), or any other organization governing medical residents, has been willing to draft a formal directive, guideline, or declaration, clarifying that medical residents are in fact employees and therefore, should be afforded the same employment rights, privileges, and claims as other employees. In fact, to the contrary, the ACGME has recently taken the position that medical residents are primarily students "rather than employees."\textsuperscript{238} Thus, until medical residents are definitively clarified as "employees," they will continue to be subjected to inequitable employment standards, rights, and protections.

B. \textbf{IMPROVED TRANSPARENCY AND UNIFORMITY OF GME APPOINTMENT CONTRACTS}

Before or during the time a medical student applies for a Graduate Medical Education ("GME") program or resident match, he or she should reasonably be afforded sufficient notice concerning the terms and conditions of employment. As discussed, although the National Resident Matching Program ("NRMP") purports to require that GME programs provide applicants an advance copy of the appointment con-

\textsuperscript{236} \textit{See supra} note 39 and accompanying text.

\textsuperscript{237} From a tax perspective, the issue of whether or not medical residents are "employee" rather than "students" and therefore not exempt pursuant to the Student FICA Tax Exemption, is an issue that has been adjudicated by the Internal Revenue Service (IRS). In fact, the Court in \textit{Center for Family Medicine v. United States}, Civ. 05-4049-KES, 2008 U.S. Dist. LEXIS 59816 at *19-20 (D. S.D. Aug. 6, 2008), the Court determined that "residency programs are the employers of medical residents." Furthermore, the Court recognized that the "analogy between a medical residency and an apprenticeship or an entry-level job is accurate." \textit{Ctr. for Family Med.}, Civ. 05-4049-KES, 2008 U.S. Dist. LEXIS 59816 at *31-32. Despite this, the Court held that ultimately, "medical residents obtained and performed there residencies for the purpose of furthering their educations" and therefore exempt.

\textsuperscript{238} \textit{See Statement of ACGME Relating to November 26, 1999 Decision of Labor Relations Board Holding Resident Physicians to be "Employees" under the National Labor Relations Act, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, http://www.acgme.org/acWebsite/reviewComment/rev_residentEmployee.asp} (last visited Mar. 26, 2010). At the time of this article, it remains unclear as to what if any formal action the ACGME will do with respect to the U.S. Supreme Court's determination that medical residents are "employees" for tax purposes.
tract,\textsuperscript{239} there is no assurance by the NRMP that the appointment contract is made available, accessible, or contains accurate information. In fact, the NRMP states that it "is not responsible for ensuring the accuracy of information exchanged between applicants and programs."\textsuperscript{240}

It is seemingly in the interest of both the medical resident and GME program that the terms, conditions, and expectations regarding employment are completely and accurately divulged at the outset, prior to or at the commencement of the matching process. The NRMP could easily accomplish this through a centralized accessible clearinghouse, whereby the GME programs would be required, as part of their participation in the matching process, to provide the NRMP an updated copy of the appointment agreement, available to applicants.\textsuperscript{241}

Despite the Accreditation Council for Graduate Medical Education ("ACGME") Requirements mandating that GME programs specifically include residents' responsibilities, duration of appointment, financial support, and specific conditions for reappointment,\textsuperscript{242} significant differences and variations among GME appointment contracts still exist.\textsuperscript{243} In fact, as demonstrated herein, the content, structure, language, and provisions of medical resident appointment contracts widely differ across GME programs.\textsuperscript{244}

The ACGME has the policy framework and ability to effectuate uniformity in GME program appointment contracts in the following ways. First, given that through its own Institutional Requirements the ACGME has established a framework for uniformity of appointment contracts,\textsuperscript{245} it should seek to not only mandate uniformity but also enforce as a part of its accreditation and compliance standards that appointment contracts must contain certain provisions, including any conditions for reappointment.\textsuperscript{246} If a GME program failed to adhere to a uniform appointment contract or include certain ascertainable contractual provisions, the ACGME, as part of its institutional oversight role and internal review process, could initiate its accredita-

\textsuperscript{239} See Match Participation Agreement for Applicants and Programs, NRMP, http://www.nrmp.org/res_match/policies/map_main.html (last accessed Jan 3, 2011) (Section 4.3 stating "a copy of the contract the applicant will be expected to sign if matched to the program if such contract is available, or a copy of the contract currently in use").
\textsuperscript{240} Id.
\textsuperscript{241} As of date, the NRMP does not have a centralized clearinghouse by which applicants can easily access, locate, and view GME appointment contracts.
\textsuperscript{242} See supra Part II(C).
\textsuperscript{243} See supra Part II(B).
\textsuperscript{244} Id.
\textsuperscript{245} See supra Section II(C).
\textsuperscript{246} As discussed herein, the vast majority of GME contracts may not contain, discuss, or even reference the conditions by which medical residents may seek or otherwise be qualified for reappointment.
tion policies and procedures, including probation or withdrawal of accreditation.\textsuperscript{247}

C. ACGME Mandate Favoring Uniform Grievance Policy and Procedures

The Accreditation Council for Graduate Medical Education ("ACGME") is equally situated to more effectively develop, implement, and enforce uniform grievance policies and procedures for Graduate Medical Education ("GME") programs. This includes explicitly authorizing the ACGME to not only review "potential noncompliance with accreditation standards that relate to program quality" but also affirmatively "adjudicate disputes between individual persons and residency programs or sponsoring institutions regarding matters of admission, appointment, credit, promotion, or dismissal of faculty, residents or fellows."\textsuperscript{248}

Although the ACGME purports to mandate that GME programs implement "non-renewal of appointment or non-promotion" related guidelines, including providing medical residents notice of such policies and procedures, the ACGME does seemingly very little to enforce, audit, or otherwise assess the integrity of such process.\textsuperscript{249} Rather, the ACGME has and continues to refuse to consider, review, or assess any decision by a GME program with respect to a medical resident's termination, discipline, dismissal, suspension, and/or termination.\textsuperscript{250}

Accordingly, a medical resident faced with a non-renewal of appointment or non-promotion is subjected to the GME's own internal policies and procedures that may or may not be consistent with ACGME guidelines and, in many situations, may not provide any recourse for appeal.\textsuperscript{251} Furthermore, nothing in ACGME's compliance policies provides that the GME must report to the ACGME annual data concerning the number of medical residents that utilized such

\textsuperscript{247} Such additional responsibility would be consistent with the ACGME's administrative goals and mission.

\textsuperscript{248} As discussed, this will require the ACGME to abandon its current policy that it "does not adjudicate disputes between individual persons and residency programs or sponsoring institutions regarding matters of admission, appointment, credit, promotion, or dismissal of faculty, residents or fellows." Procedures for Addressing Complaints Against Residency Programs and Sponsoring Institutions, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, http://www.acgme.org/acWebsite/resInfo/ri_complaint.asp (last accessed Mar. 30, 2010).

\textsuperscript{249} The ACGME does maintain an Accreditation Data System (ADS) which includes information about accreditation decisions and withdrawn GME programs, but there is no self-reporting data by GME programs concerning non-renewal of appointment or non-promotion, or information concerning the number of medical residents invoked GME program's grievance policies.

\textsuperscript{250} See supra note 150 and accompanying text.

\textsuperscript{251} See supra Part II(D).
grievance procedures and the outcome. The net result is that medical residents with respect to potential employment issues relating to non-renewal of appointment or non-promotion continue to be at a severe disadvantage, especially often in the absence of a neutral arbitrator or third party decision maker. The ACGME is in the best position to fill such void and provide medical residents much needed employment related protection.

CONCLUSION

Medical residents continue to lack the fundamental employment rights and protections commonly afforded other professions. Such deficiency is the by-product of long-standing institutional perceptions concerning a medical resident’s employment classification or lack thereof. The survey research, which was compiled by medical residents themselves, highlights that as an employment group, medical residents feel arguably demoralized, abused, disadvantaged and marginalized. Given that the United States healthcare system is inexplicitly dependant upon this identifiable sub-set of the healthcare labor force, it is of the utmost importance that the Accreditation Council for Graduate Medical Education (“ACGME”), National Resident Marching Program (“NRMP”), Graduate Medical Education (“GME”) programs, and other state medical regulatory and licensing boards, consider legislative and policy measures to enhance the overall working conditions and rights of medical residents.

252. See supra note 150 and accompanying text.
253. Id.