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**THE PATIENT AND PHYSICIAN SAFETY AND PROTECTION ACT: CRUCIAL FEDERAL
LEGISLATION TO IMPROVE THE LIVES OF RESIDENTS AND PATIENTS**

Tracey B. Ehlers¹

* * *

Resident fatigue is a serious problem within the medical community that has not been addressed until relatively recently. Within the past decade, residents, legislators, the judicial system and the public have progressively begun to realize that resident-physicians work an excessive number of hours, ultimately harming the well being of residents and their patients. When residents are overworked and exhausted many opportunities for medical errors exist. In fact, the Institute of Medicine has found that up to as many as 98,000 deaths occur annually due to medical errors and has suggested that one necessary approach to reducing errors in hospitals is reducing the fatigue of residents.²

Historically, the medical community, including residents regarded long hours as a necessary element in physician training. Most physicians-in-training begin their residency program fully expecting to work an extraordinary number of hours, sometimes up to 130 hours per week and often thirty-six hours straight.³ The traditional mindset is that a resident must be present throughout a medical intervention in order to fully study the disease.⁴ Some educators and residents continue to regard these long hours as a necessity for a complete educational experience, suggesting that a reduced work schedule would produce “shift work mentality” that

¹ Juris Doctor, University at Buffalo Law School (2004); Master of Physician Assistant, Duquesne University 1999.

² See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1-25 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., Nat'l Acad. Press 2000).

³ Jay Greene, *Residencies Successful in Curbing Work-Hour Violations*, AM. MED. NEWS (July 30, 2001) available at <http://ama-assn.org/amednews/2001/07/30/prsc0730.htm> (last visited Dec. 6, 2004).

⁴ See David A. Asch & Ruth M. Parker, *The Libby Zion Case*, 318 NEW ENG. J. MED. 771, 774 (1988).

would negatively affect the continuity of patient care.⁵ Other residents, however, have become increasingly assertive in discussing their concerns about their experience in residency programs, while patients are concerned about the quality of care they are receiving at teaching hospitals.

The Patient and Physician Safety and Protection Act (“the Act”) is necessary to effectively remedy the problem of excessive work hours and sleep-deprivation among residents and interns in residency programs across the United States. The bill’s provisions include protections for residents and interns while also maintaining the safety and quality of patient care. Based on observations of the effectiveness of New York’s regulations, as well as similar proposals in other states, it is evident that legislation at the federal level can be extremely effective. Moreover, federal legislation will complete recent efforts by the Accreditation Council for Graduate Medical Education and collective bargaining organizations to improve residents’ working conditions. While support clearly exists for federal legislation, increased advocacy is essential for the bill to be successfully enacted into law.

I. The Act is Comprehensive and Enforceable

To show how the Act will meet the needs of the medical community and the public, it is necessary to see exactly what the Act would provide and how it would be enforceable. The Act’s provisions will be discussed in detail, including how it would be implemented and enforced. Similar legislation in New York, which has been in place for almost fifteen years, is discussed. Many lessons can be learned from the experience in New York. By studying the history of New York’s regulations it is evident that adequate enforcement measures and stiff penalties can make such legislation effective. Other bills proposed in various states within the

⁵ Joseph Conigliaro, William H. Frishman, Eliot Lazar & Lila Croen, *Internal medicine housestaff and attending physician perceptions of the impact of the New York State Section 405 regulations on working conditions and supervision of residents in two training programs*, 8 J. OF GEN. INTERNAL MED. 502, 507 (1993); See also American

past several years are also discussed to demonstrate the concern and desire for change on a national level.

A. The Act's Provisions

The Act's provisions are straightforward and inclusive, providing an effective means to impose work-hour limitations on residency programs. It offers strong enforcement provisions as well as measures providing for public accountability of residency programs and whistleblower protections for those who report violations. The Act's purpose, as stated by its sponsors, is to improve working conditions for residents and interns while also providing for patient safety. This legislation (S.952 and H.R.1228) was introduced by Representative John Conyers (D-MI) and Senator Jon Corzine (D-NJ) and is presently under consideration in the 108th Congress.⁶

The Act would require twenty-four hour maximum shifts for most residents,⁷ with twelve-hour maximum shifts for those working in emergency departments.⁸ The number of hours a resident would be allowed to work would be restricted to eighty hours per week.⁹

Additionally, the Act includes provisions requiring time off. The bill would require a minimum

Medical Association, *Reader feedback: 90 days of 80 hours* (Nov. 12, 2003), available at <http://www.ama-assn.org/ama/pub/category/11566.html>.

⁶ S. 952 was referred to the Senate Committee on Finance in April 2003 and H.R. 1228 was referred to the House Ways and Means Committee, Subcommittee on Health in March 2003. See generally <http://thomas.loc.gov> (last visited Aug. 16, 2004). The PPSPA was first introduced by Representative Conyers in 2001 and Senator Corzine in 2002 (S. 2614, 107th Cong. (2002); H.R. 3236, 107th Cong. (2001)). The bills provided for similar limitations as the current bill. Specifically, it provided that post-graduate trainees (1) may work no more than a total of 80 hours per week and 24 hours per shift; (2) shall have at least 10 hours between scheduled shifts; (3) shall have at least 1 full day out of every 7 days off and one full weekend off per month; (4) who are assigned to patient care responsibilities in an emergency department shall work no more than 12 continuous hours in that department; and (5) shall not be scheduled to be on call in the hospital more often than every third night.

⁷ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

⁸ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

⁹ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

of ten hours off between shifts,¹⁰ one day off out of every seven,¹¹ and one full weekend off per month.¹² Further, on-call duty would be limited to no more than every third night.¹³

The Secretary of the Department of Health and Human Services would oversee implementation of the regulations as well as appoint an individual within the Department of Health and Human Services to handle all complaints and violations.¹⁴ Any resident would be allowed to file a complaint with the Department of Health and Human Services [“the Department”] anonymously.¹⁵ The Department would conduct annual anonymous resident surveys¹⁶ as well as on-site investigations to determine compliance.¹⁷ Further, the federal government would track violations and make annual reports to Congress on program compliance.¹⁸ The Department would distribute to the public a list of violative programs.¹⁹ Thus, teaching hospitals and residency programs would be accountable to the patients they treat and the public in general.

The Act provides strong enforcement provisions. Based on unannounced investigations and anonymous surveys, the government would have the ability to impose a significant penalty on non-compliant hospitals. Fines would be imposed up to \$100,000 in any six-month period for residency programs found in violation.²⁰ While the penalties are stiff, provisions for funding are included to help hospitals come into compliance. These funds may be used to hire support staff and/or to make sure programs are complying with regulations to ensure the continuity of patient

¹⁰ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

¹¹ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

¹² S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

¹³ S. 952, 108th Cong. § 3(a)(2) (2003); H.R. 1228, 108th Cong. § 3(a)(2) (2003).

¹⁴ S. 952 § 3(b)(1); H.R. 1228 § 3(b)(1).

¹⁵ S. 952 § 3(b)(2); H.R. 1228 § 3(b)(2).

¹⁶ S. 952 § 3(b)(4)(A); H.R. 1228 § 3(b)(4)(A).

¹⁷ S. 952 § 3(b)(4)(B); H.R. 1228 § 3(b)(4)(B).

¹⁸ S. 952 § 3(b)(4)(D); H.R. 1228 § 3(b)(4)(D).

¹⁹ S. 952 § 3(b)(4)(C); H.R. 1228 § 3(b)(4)(C).

²⁰ S. 952 § 3(b)(3)(A); H.R. 1228 § 3(b)(3).

care.²¹ Broad whistleblower protections are included as well to protect those reporting violations. Any individual, who, in good faith, reports a violation or merely discusses a supposed violation with co-workers, cannot be penalized, discriminated against, or retaliated against in any manner.²²

B. Enforcement Lessons from New York

Lessons can be learned from New York's experience with work-hour limitations over the last decade. Regulations in New York have proven that with adequate enforcement provisions and significant penalties, the Act can reach its goal of improving resident-physicians' working conditions while also providing for patient safety. Meaningful change did not take place overnight in New York. In fact, it took many years for the medical community to recognize the issue and for regulations to become effective. Recent amendments have made the original regulations more enforceable, considerably improving the residency experience in New York. Thus, while not perfect, the experience in New York shows what is needed to make federal legislation effective.

The medical community in New York did not address resident-physician work hours until the late 1980's, when a young woman named Libby Zion died at New York Hospital.²³ Her death was apparently due to overworked residents who made a fatal mistake. The grand jury investigating the incident did not find fault with the physicians, but did find numerous faults with the resident-physicians' working conditions. At that time, resident-physicians at New York Hospital were working more than one hundred hours per week, while some were providing continuous patient care for up to forty hours.²⁴

²¹ S. 952 § 4; H.R. 1228 § 4.

²² S. 952 § 3(c)(1); H.R. 1228_§ 3(c)(1).

²³ Asch, *supra* note 4, at 771.

²⁴ Conigliaro, *supra* note 5, at 503, 506.

In response to the Libby Zion case, the New York State legislature amended the Health Code in 1989 to provide for resident-physicians work restrictions.²⁵ These restrictions were termed the “Bell” regulations after Dr. Bert Bell, a professor at the Albert Einstein College of Medicine in New York City.²⁶ These restrictions were similar to those currently proposed in the federal legislation. The Bell regulations limited a resident’s scheduled work-week to eighty hours, averaged over a four-week period.²⁷ Further, the regulations called for at least one scheduled twenty-four hour period of non-working time per week²⁸ and a twenty-four hour limitation on work shifts.²⁹

Subsequent studies, however, demonstrated that the 1989 amendments did not have a significant positive impact on the quality of patient care. Although there were some benefits, the amendments to the Health Code were not achieving the goal of improving patient care.³⁰ Further, the Bell regulations were not adequately enforced because, as originally drafted, residency programs were only supposed to “voluntarily comply” with the regulations.³¹

Since 1989, Dr. Bell has continued to advocate for practical enforcement of New York’s regulations and even for meaningful national legislation.³² In 2001, New York gave “teeth” to the Bell regulations.³³ Rather than relying on voluntary compliance, the state contracted with an independent peer review agency to conduct unannounced inspections. The amendment also increased the penalties significantly.

²⁵ N.Y. COMP. CODES R. & REGS tit. 10, § 405.4 (2004).

²⁶ *A Personal History of Work Hours Reform – An Interview with Dr. Bert Bell*, Hours Watch, (Nov. 6, 2003) at <http://www.hourswatch.org/48breakingnewsstory.html>.

²⁷ N.Y. COMP. CODES R. & REGS tit. 10, § 405.4(b)(6)(ii)(a).

²⁸ N.Y. COMP. CODES R. & REGS. tit. 10, § 405.4(b)(6)(iv).

²⁹ N.Y. COMP. CODES R. & REGS. tit. 10, § 405.4(b)(6)(ii)(b).

³⁰ Conigliaro, *supra* note 5, at 506.

³¹ *Making Regulations Work – the New York State Experience*, Hours Watch, (Nov. 6, 2003) available at <http://www.hourswatch.org/51breakingnewsstory.html>.

³² *Supra* note 26, *A Personal History of Work Hours Reform – An Interview with Dr. Bert Bell*.

Hours Watch, a resident advocacy group, reported that these additions have improved the residency experience in New York, suggesting that firm penalties, unannounced and independent inspections, and anonymous reporting of violations can successfully reduce resident-physicians' work hours.³⁴ It reported that sixty percent of hospitals inspected in 2002 had at least one non-compliant program, but that most of these hospitals reformed their programs to become compliant, possibly due to the threat of stiffer fines. According to New York residents, "many programs in specialties notorious for excess hours such as surgery and OB-GYN have successfully implemented night- and day-float schedules and have added additional support staff to reduce resident hours."³⁵ Further, the independent peer review agency conducting inspections in New York has shown a commitment to protecting residents who speak out about their experiences.³⁶

C. Support for this Approach on a National Level

Several other states have introduced similar legislation, suggesting that there is ample concern regarding over-worked residents and a willingness to accept legislation limiting work-hours. State legislatures have realized that meaningful change will only occur when work-hours are regulated on a broad level along with the imposition of significant monetary penalties. From the following examples, it is evident that concern is intensifying amongst state legislatures and the public that something concrete and enforceable must be established.

Delaware introduced a bill similar to the federal legislation in June 2003.³⁷ This legislation, termed the "Hospital Patient Protection Act," allows anonymous complaints³⁸ and,

³³ *Supra* note 31, *Making Regulations Work – the New York State Experience*. Further information available at <http://www.hourswatch.org/51breakingnewsstory.html> (last visited July 1, 2004).

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ S. 133, 142d Gen. Assemb. (Del. 2003).

³⁸ S. 133, 142d Gen. Assemb. § 10206(b) (Del. 2003).

unlike the Accreditation Council for Graduate Medical Education regulations, provides protections for whistleblowers.³⁹ Further, residency programs that violate the regulations are subject to civil penalties of up to \$100,000⁴⁰ and a yearly report to Delaware's General Assembly would publicly identify programs and hospitals found in violation.⁴¹

Pennsylvania has also introduced similar legislation.⁴² The legislation, also known as the "Medical Resident and Patient Safety Act," provides for anonymous complaints,⁴³ whistleblower protections,⁴⁴ and public disclosure.⁴⁵ Violating programs may be fined \$5,000 for the first offense and \$10,000 for each additional violation.⁴⁶

The New Jersey Assembly has already voted to pass a bill restricting resident work-hours to an average of eighty hours per week over a four-week period and limiting shifts to twelve hours for emergency department work and twenty-four hours for all other areas.⁴⁷

II. The Act Completes what the Medical Establishment and Collective Bargaining have Begun

A. The Act Covers All Resident-Physicians in the U.S.

The Act is presently the only means that can effectively enforce work restrictions across all residency programs. The Act would cover every resident-physician in the United States, not merely those in a few states or a few residency programs, because it provides for federal oversight and implementation. Every resident in the U.S. therefore, would reap the benefits of work-hour limitations, leading to increased worker and patient safety.

³⁹ S. 133, 142d Gen. Assemb. § 10207 (Del. 2003).

⁴⁰ S. 133, 142d Gen. Assemb. § 10206(c) (Del. 2003).

⁴¹ S. 133, 142d Gen. Assemb. § 10206(d)(8) (Del. 2003).

⁴² S.B. 775, Gen. Assemb., (Pa. 2003).

⁴³ S.B. 775, Gen. Assemb., § 5(a) (Pa. 2003).

⁴⁴ S.B. 775, Gen. Assemb., § 4 (Pa. 2003).

⁴⁵ S.B. 775, Gen. Assemb., § 5(c) (Pa. 2003).

⁴⁶ S.B. 775, Gen. Assemb., § 20 (Pa. 2003).

Federal legislation regulating the training of all resident-physicians is necessary to produce significant change. The federal government already enforces work hour limitations in other industries where employees and the public are at risk. For instance, it regulates the transportation industry. Truckers are only permitted to drive sixty hours per week and airline pilots are only permitted to fly thirty-four hours per week.⁴⁸ Since promoting patient safety is a necessary function of the federal government, regulating resident work-hours based on this foundation is a logical step.

In addition to its interest in maintaining patient and resident safety, the federal government also has a fiscal interest in enacting such legislation. The federal government, through the Medicare program, pays approximately \$8 billion per year solely to train resident-physicians in the United States.⁴⁹ Further, the federal government provides necessary Medicare funding to hospitals. The Act requires hospitals to comply with federal restrictions as a condition to Medicare participation.⁵⁰ By tying the Act to Medicare funding, this legislation reaches all teaching hospitals, ensuring successful enforcement while assuring the safety of patients treated by residents and the well-being of residents.

B. The Act Provides for Independent Regulation

While the medical community has argued that the Accreditation Council for Graduate Medical Education (Accreditation Council)⁵¹ is the best organization to restrict and monitor resident work hours because it is critical for physicians to regulate themselves,⁵² independent

⁴⁷ A. 1852, 210th Leg. (N.J. 2002); S. 1712, 210th Leg. (N.J. 2002).

⁴⁸ Congressman John Conyers, Jr., *The Patient and Physician Safety and Protection Act of 2001*, available at www.house.gov/conyers/news_patientsafetyprtectionact.htm (last visited Feb. 21, 2004).

⁴⁹ S. 952, 108th Cong. § 2(1) (2003); H.R. 1228, 108th Cong. § 2(1) (2003).

⁵⁰ S. 952 at § 3(a); H.R. 1228 at § 3(a).

⁵¹ The Accreditation Council for Graduate Medical Education oversees all residency programs in the United States. See <http://www.acgme.org>.

⁵² Myrle Croasdale, *Resident work-hour bill lives on in Senate*, AM. MED. NEWS, (May 19, 2003) available at <http://www.ama-assn.org/amednews/2003/05/19/gvse0519.html>.

oversight is essential because self-regulation has limitations. The medical community is ill equipped to enforce work-hour rules and cannot provide independent oversight of compliance with such rules. In fact, guidelines set forth by the medical community through the Accreditation Council, contain certain ambiguities that allow residency programs to get around work-hour limitations. Federal legislation, however, would provide for the necessary means to carry out successful monitoring of residency programs. As an independent regulator, the federal government is in a better position to effectively enforce work-hour regulations, including closing up loopholes the Accreditation Council crafted into its guidelines.

The Accreditation Council announced its new standards in February 2003, which became effective July 1, 2003.⁵³ These standards include a work-hour limitation of eighty hours per week, as well as provisions for rest periods and days off.⁵⁴ If these standards are not met, a program risks losing its accreditation.⁵⁵ The compliance plan consists of interviewing residents and program directors, internet surveys of residents, and reviews of work-hour documentation.⁵⁶

At first glance, the guidelines seem similar to the proposed federal legislation. The guidelines, however, have been created with built-in loopholes. For instance, residency programs are allowed to “average” hours. According to the guidelines, residents can average eighty hours of work over a *four week period*.⁵⁷ As a result, many residents can theoretically continue to work as much as 100 hours per week. Further, programs can apply for exemptions from the averaged maximum eighty-hour week if they can show “sound educational rationale”--

⁵³ Myrle Croasdale, *ACGME gives final nod to 80-hour workweek*, AM. MED. NEWS, (Mar. 10, 2003) available at www.ama-assn.org/amednews/2003/03/10/prsb0310.html.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., 2003 COMMON PROGRAM REQUIREMENTS § VI(B)(2), available at www.acgme.org/dutyhours/dutyhourscommonpr.pdf (last visited July 1, 2004).

a vague and amorphous standard.⁵⁸ This exemption allows programs an increase of ten percent in weekly hours reported,⁵⁹ which could result in a total of eighty-eight maximum hours per week, averaged over four weeks.

Programs can get around the Accreditation Council's thirty-hour on-call maximum as well. The guidelines state residents "should" have ten hours off between shifts.⁶⁰ By using permissive language instead of strict language, such as using the word "must," the Council gives it's reviewing committees leeway in determining program compliance. Because of these loopholes, the same problems that prompted regulation in the first instance – overworked, sleep-deprived residents – will seemingly continue under self-regulation.

Nonetheless, the medical community argues that self-regulation is critical for physicians and that loss of accreditation is an effective enforcement measure. Without Council accreditation, teaching hospitals cannot get government funding.⁶¹ When faced with loss of accreditation, supporters of self-regulation argue that programs will try to fix the problem, at least in part, because of the financial incentives associated with Medicare reimbursement. Some argue that these consequences are considerable compared to a monetary fine as proposed by federal legislation.⁶²

However, loss of accreditation, the Accreditation Council's only enforcement measure, will ultimately harm residents – the very people whom the Accreditation Council is supposed to protect. If a residency program loses accreditation and residents do not complete an accredited residency program, it may threaten residents' future careers. This, in turn, inhibits residents from reporting program violations.

⁵⁸ *Id.* at § VI(F).

⁵⁹ *Id.*

⁶⁰ *Id.* at § VI(B)(4).

⁶¹ See ACGME Federal Government Report available at <http://www.acgme.org>; Croasdale, *supra* note 53.

The Accreditation Council guidelines are inadequate in other ways as well. They do not provide for public disclosure of violations. The public is denied access to compliance information, including identification of non-compliant programs and hospitals, as well as the frequency and nature of violations. Thus, there is no public accountability to patients. Additionally, protections are not included for residents who report violations. Because of this, many residents may be unwilling to come forward with evidence of non-compliance. They may fear being singled out by their colleagues or superiors.

Since the Accreditation Council guidelines were put into effect in July 2003, it has reviewed 500 to 600 programs and has issued seventy-nine citations related to work-hour violations.⁶³ Johns Hopkins' internal medicine program was the first to be threatened with loss of accreditation in August 2003,⁶⁴ suggesting that the Accreditation Council will diligently police even the most prestigious programs. While citations have been issued, loopholes remain that residents and residency programs can utilize to get around the rules. There are many anecdotal reports of programs allowing residents to lie about their hours. For instance, one surgical resident explained that it was not uncommon for him to spend greater than 100 hours on duty in one week.⁶⁵ However, he logs only twelve hours per day on his monthly time sheets instead of fifteen hours per day – a common practice among residents. Despite the new regulations, he stated that the program director and attending physicians are willing to look the

⁶² Croasdale, *supra* note 52.

⁶³ Myrle Croasdale, *Beat the clock: The new challenges to residents. Residency programs now must adhere to an 80-hour workweek. How do residents do it and still learn all that they need?*, AM. MED. NEWS (Mar. 8, 2004) available at <http://www.ama-assn.org/amednews/2004/03/08/prsa0308.htm>.

⁶⁴ Myrle Croasdale, *Johns Hopkins penalized for resident hour violations. Internal medicine residency is threatened with loss of accreditation.*, AM. MED. NEWS (Sept. 15, 2003) available at <http://www.ama-assn.org/amednews/2003/09/15/prsc0915.htm>.

⁶⁵ Myrle Croasdale, *Resident work-hour limits still a struggle one year into restrictions. General compliance appears to be the norm, but residents see flaws in the system.* AM. MED. NEWS (July 19, 2004) available at <http://www.ama-assn.org/amednews/2004/07/19/prl10719.htm>.

other way when it comes to reporting hours as long as patients are cared for and work is completed.⁶⁶

It is evident that the Accreditation Council standards have not significantly impacted the problem of resident fatigue. Nonetheless, the Council is seemingly weakening its rules for some residency programs. It has recently been reported that the Council is considering modifying its standards.⁶⁷ Modifications include raising the eighty-hour *average* for chief residents in surgical programs to eighty-eight hours.⁶⁸ The ten-hour rest period following in-hospital call duty is also under review.⁶⁹

These changes are being considered based, at least in part, on statements that many residency programs have had a difficult time complying with work-hour rules. Residents have complained that a significant amount of time has been spent doing non-physician tasks, such as paperwork – valuable time taken away from monitoring patients.⁷⁰ Since July 2003 however, many residency programs have successfully re-designed their daily routines in order to conform to work-hour limits, creating a more efficient system.⁷¹ For example, Boston Medical Center has successfully made the transition to an eighty-hour workweek by implementing changes to make the workday proceed more efficiently. Nurses have been hired to do non-physician tasks, attending physicians have taken more shifts for extra pay, physician assistants have been hired, and technological changes have been implemented in order to decrease the amount of paperwork residents need to complete.⁷² These programs have been successful at reducing resident work-

⁶⁶ *Id.*

⁶⁷ Myrtle Croasdale, *Some resident work hour limits could change: The ACGME considers raising 80-hour averages for a few specialties*, AM. MED. NEWS (Apr. 12, 2004) available at <http://www.ama-assn.org/amednews/2004/04/12/prse0412.html>.

⁶⁸ *Id.* (emphasis added).

⁶⁹ *Id.*

⁷⁰ Croasdale, *supra* note 63.

⁷¹ Croasdale, *supra* note 63.

⁷² Croasdale, *supra* note 63.

hours because they have “embraced a culture of change.”⁷³ If the Accreditation Council elects to modify its rules only one year since they were first implemented, resident and patient safety will continue to be at risk. This will create even greater urgency for federal legislation.

C. The Act Maintains the Educational Relationship

The Act allows maintenance of the educational relationship between residents and attending physicians while averting any negative outcomes of collective bargaining, such as strikes. Further, as compared with collective bargaining, the Act would allow all residents to obtain the benefits of work-hour limitations in a more substantial and timely manner. All residents are included under the Act, not merely a few resident groups who can effectively come together to petition the National Labor Relations Board for recognition.

Overruling more than twenty years of precedent, the National Labor Relations Board held, in *Boston Medical Center Corporation and House Officers’ Association/Committee of Interns and Residents*, that medical interns, residents, and fellows at private hospitals are employees, rather than students, granting them the same rights as other employees, including the right to collectively bargain.⁷⁴ The Board previously held that residents were not employees, but students, under the National Labor Relations Act, thus, unionization was not allowed.⁷⁵ However, in 1997 residents and interns at Boston Medical Center petitioned the Board for recognition as employees when the hospital refused such recognition. The residents and interns were concerned about the terms and conditions of their employment and contended that unionization would help to alleviate these problems. House staff, including residents and interns,

⁷³ Croasdale, *supra* note 63.

⁷⁴ 330 N.L.R.B. 152 (1999).

⁷⁵ See *Cedars-Sinai Medical Center*, 223 N.L.R.B. 251 (1978); *St. Clare’s Hospital and Health Center*, 229 N.L.R.B. 1000 (1977).

are involved in direct patient care and make independent treatment decisions.⁷⁶ Moreover, as a residency program progresses, residents become increasingly autonomous.⁷⁷ Hence, residents and interns argued that they should be regarded as employees to promote “effective graduate medical training programs.”⁷⁸

On the other hand, the hospital took the position that interns and residents are primarily students. It argued that graduate medical education is different from employer-employee relationship considered by the National Labor Relations Act. The purpose of residency programs is primarily academic, whereas an employer-employee relationship is one where each desires equal bargaining power.⁷⁹ This is not the case in a student-teacher relationship. Thus, the hospital argued that unionization of residents would undermine the academic relationship and the educational process as a whole.⁸⁰

The Board held that residents at Boston Medical Center were indeed students, but also employees and therefore were allowed to collectively bargain. The Board looked to the definition of an “employee” under the National Labor Relations Act and concluded that “nothing in the statute suggest[ed] that persons who are students but also employees should be exempted from the coverage and protection of the Act.”⁸¹

The Board determined that the “essential elements” of the residents’ relationship with the hospital defined an employer-employee relationship.⁸² Residents and interns work for an “employer” within the meaning of the National Labor Relations Act, are compensated for their

⁷⁶ *Boston Medical Center*, 330 N.L.R.B. at 153-55.

⁷⁷ *Id.* at 154.

⁷⁸ *Id.* at 156.

⁷⁹ *Id.* at 157.

⁸⁰ *Id.*

⁸¹ *Id.* at 160.

⁸² *Id.*

services, and provide essential patient care for hospitals.⁸³ The hospital receives a great amount of medical services from its residents and therefore, residents' status as students is not "mutually exclusive of a finding that they are employees."⁸⁴

Despite the residents' supposed achievement in gaining recognition at Boston Medical Center, there was much disagreement over this decision. Many argued that such individuals should not be considered employees for the purposes of collective bargaining, arguing that the relationship between residents and attending physicians is that of student-teacher, not employee-employer.

Medical educators and attending physicians argued that a student-teacher relationship does not encompass the notions of a traditional employee-employer relationship where each side ideally desires equal bargaining power.⁸⁵ Unionization of residents would undermine the academic relationship and the educational process as a whole.⁸⁶ According to dissenters, "[e]ducational interests 'are completely foreign to the normal employment relationship and ... are not readily adaptable to the collective bargaining process.'⁸⁷ Collective bargaining affords residents the right to bargain over-all terms and conditions of employment, and possibly even curriculum and other educational matters.⁸⁸ Such acts are not consistent within the traditional notion of medical education.

Two members of the Board dissented in *Boston Medical Center*, including Members Brame and Hurtgen. The crux of their argument is that medical education will suffer because of collective bargaining. Member Brame argued that costs and uncertainty of union elections will

⁸³ *Id.*

⁸⁴ *Id.* at 161.

⁸⁵ *Id.* at 157.

⁸⁶ *Id.*

⁸⁷ *Id.* at 177 (citing *St. Clare's Hospital and Health Center*, 229 N.L.R.B. at 1002).

⁸⁸ *Id.* at 179.

force private hospitals to eliminate residency programs.⁸⁹ Attending physicians or faculty will be reticent to develop curriculum pertinent to the specific program since decisions will be subject to collective bargaining.⁹⁰ While some argue that residents can voluntarily avoid bargaining on such topics, Member Brame argued that these are inherent rights under the National Labor Relations Act and that recognized employees do not have to refrain from taking advantage of them.⁹¹

Since 1999, only a few resident groups at various private hospitals have sought to exercise their collective bargaining rights pursuant to *Boston Medical Center*. A group of residents from Lutheran General, a hospital near Chicago, were the first to petition the National Labor Relations Board for recognition.⁹² It took them over three years to successfully enforce their rights under *Boston Medical Center*. They first petitioned the Board in August 2000, and were vehemently opposed by the hospital. After several appeals, residents were able to conduct a vote in September 2003 – over three years later. Petitions were also filed at two New York hospitals, one in April 2001 and the other in October 2002.⁹³ Notably, resident-physicians at New York’s St. Luke’s-Roosevelt Hospital voted overwhelmingly to join the union.⁹⁴

Although collective bargaining provides residents with a voice of their own allowing them to band together to effect change, relying solely on unionization to improve working conditions and the delivery of care could lead to a breakdown in the educational process. Collective bargaining, while improving residents’ working conditions, may shift control of

⁸⁹ *Id.* at 182.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² See Press Release, Physicians for Responsible Negotiation, PRN Offers Representation to Chicago-Area Resident Group, (Aug. 16, 2000) available at <http://www.4prn.org/pr20000816.html>.

⁹³ Tanya Albert, *New York interns, residents get NLRB nod to join union*, AM. MED. NEWS, Apr. 16, 2001 at www.ama-assn.org/sci-pubs/amnews/pick_01/prsc0416.html; *Mandate at Maimonides. Montefiore Housestaff Campaign – CIR/SEIU*, Dec. 16, 2002 at <http://www.joincirseiu.org/29breakingnews.html> (last visited Mar. 3, 2003).

⁹⁴ Albert, *supra* note 93.

residency programs from faculty to organized labor. Moreover, as evident by the Lutheran General experience, the process of gaining recognition is long and arduous. It takes considerable energy on the part of residents themselves to come together and petition the National Labor Relations Board -- precious time they may not have.

It is questionable whether collective bargaining will ultimately advance the quality of resident well-being. If a hospital opposes unionization of its residents, which would be the most likely response, tension between the hospital administration, attending physicians and residents will ensue -- an unconstructive result on all levels. Federal legislation, on the other hand, will not hinder the educational experience of residency or impede the educational relationship of faculty and residents. By not having to petition for change themselves, residents will avoid animosity between themselves and the medical establishment. This is a crucial factor since residents rely on their superiors to provide them with recommendations and positive reviews.

III. The Act's Current Plight

While many people have continued to advocate for federal legislation, including the American Medical Student Association and a handful of public interest groups, the bill is currently not receiving the support it should in order to produce change. Broad support for state bills seems promising, but support for the federal bill has waned since it was introduced in the 108th Congress. In fact, the House bill had seventy-one co-sponsors in 2001, but has only four co-sponsors in the current Congress. It appears once again that the current House and Senate bills will not make it out of committee.

Change is necessary to improve resident-physicians' working conditions. So far, attempts at improving the daily lives of residents have resulted in inadequate rules, resistance by the medical community, or criticism from all involved parties. It is evident that reform at the

federal level through the Patient and Physician Safety and Protection Act, can produce considerable and meaningful change. In particular, the Act can offer numerous elements that neither the Accreditation Council nor collective bargaining organizations can provide alone. The only element missing is complete and well-deserving support from legislators, the public, and more resident-physicians to enact this piece of legislation into law.