UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

NEW YORK UNIVERSITY, Employer, and GSOC/UAW, Petitioner.	)	Case No. 2-RC-023481
POLYTECHNIC INSTITUTE OF NEW YORK UNIVERSITY, Employer, and INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), Petitioner.	)	Case No. 29-RC-012054

BRIEF OF AMICUS CURIAE
COMMITTEE OF INTERNS AND RESIDENTS/SEIU HEALTHCARE
IN SUPPORT OF PETITIONERS
GSOC/UAW AND INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA

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I. INTEREST OF THE AMICUS CURIAE

The Committee of Interns and Residents, SEIU Healthcare (CIR) is the largest organization of resident physicians in the country, representing more than 13,000 physicians-in-training. As physicians whose status as employees under the National Labor Relations Act (the Act) was at one time in question, CIR believes that those who perform services for pay while under the control of others, regardless of whether they derive an educational benefit from their employment, should be covered by the Act. In addition, CIR believes collective bargaining enhances – not harms - the education of student employees and that granting collective bargaining rights to such individuals is in furtherance of sound labor policy.

II. INTRODUCTION

The question before the Board in this case is whether graduate student assistants are employees protected by the Act. CIR urges the Board to overrule *Brown University*, 342 NLRB 483 (2004) and hold that graduate student assistants are employees protected by the Act.

III. ARGUMENT

When the NLRB ruled that resident physicians were statutory employees in *Boston Medical Center*, 330 NLRB 152 (1999), predictions of doom for the fate of graduate medical education were made. The dissent claimed that the decision placed "in jeopardy the finest system of medical education in the world." *Boston Med. Ctr.* at 170.

> The majority thus forces medical education into the uncharted waters of organizing campaigns, collective bargaining, and strikes…American graduate medical education will be irreparably harmed…By imposing the Act's alien processes on graduate medical education, the majority jeopardizes this delicate web of relationships on which the astounding success of American medical education depends.

Boston Med. Ctr, 330 NLRB at 182.

Similar expressions of alarm rang throughout the medical education industry. The president of the American Association of Medical Colleges lamented the "predictable intrusion of union activities into the domain of academic concerns and, with it, the inevitable degradation

of the learning environment." Jordan J. Cohen, M.D., *White Coats Should Not Have Union Labels*, 342 New Eng. J. Med. 431, 433 (2000). Unions, it was said, would destroy the mentor-mentee relationship between resident physicians and their teaching attendings.

Thirteen years later those predictions have been proven wrong. Those voices of dissent have been muted by the successful collective bargaining relationships that CIR has forged with hospitals since *Boston Medical Center*. Graduate medical education has not only continued to flourish since *Boston Medical Center,* but it has been enhanced by the collective bargaining process where CIR represents the resident physicians. And contrary to the concerns that unions would wedge themselves between residents and teaching attendings, unionization has led to *greater* collaboration between residents and their employer-hospitals in ways that have improved training and patient care.

Even the Accreditation Council for Graduate Medical Education (ACGME), the independent agency that oversees and accredits residency training programs that was vehemently opposed to the *Boston Medical Center* decision, has acknowledged the important role unions can play as an advocate for residents, a function the ACGME is unable to perform. While the ACGME sets minimum standards for accredited residency programs nationally, "there are local circumstances and concerns to be addressed…Resident unions or other bargaining entities, whose role is to optimize the position of a group of residents within an institution through discussion, negotiation, or bargaining, may or may not be the vehicle for that discussion." Thomas J. Nasca, M.D.[1] et al., *The ACGME: Public Advocacy Before Resident Advocacy*, 84 Academic Med. 293, 294 (2009). The ACGME, first and foremost, is an advocate for the public, and not residents, and therefore "the ACGME cannot and will not replace resident unions, associations, or other groups." *Id.* at 295.

In denying graduate student employees the right to collectively bargain, the Board in *Brown* opined that "collective bargaining would have a deleterious impact on overall educational decisions" and would "be detrimental to the educational process." *Brown Univ.*, 342 NLRB at 490, 493. The *Brown University* majority criticized the dissent's confidence in the collective

[1] Dr. Nasca is the ACGME's Chief Executive Officer.

bargaining process as speculative. Yet, CIR's experience after *Boston Medical Center* makes clear that those who favor extending collective bargaining rights to graduate students are correct and that concerns about the harm they could cause to the educational process are based upon false speculation.

Although there are clear differences between resident physicians and graduate student employees – residents, for example, have already obtained their professional degree and are not responsible for tuition – those differences have nothing to do with whether collective bargaining and graduate education are compatible. Instead, evidence of the positive impact that collective bargaining has had on resident training is entirely relevant to the question of how collective bargaining would impact the education of graduate student employees.

The alarmists who predicted the end of graduate medical education as we know it when *Boston Medical Center* was decided were wrong as are those who are now making similar claims about graduate student employees and graduate education. The Board should therefore overrule *Brown University* with complete confidence that graduate education at private universities will continue to thrive, and, in fact, likely will be enhanced, if collective bargaining rights are extended to graduate student employees.

A. Collective Bargaining Has Enhanced Graduate Medical Education at Hospitals Where Residents Are Represented by CIR.

Since *Boston Medical Center* was decided, CIR has successfully negotiated dozens of collective bargaining agreements on behalf of resident physicians in both the private and public sectors. In addition to improving their wages, benefits and working conditions, the resident members of CIR have used negotiations to enhance their training by winning paid time off to attend medical conferences, and funding for journals, textbooks and other items. They have also bargained for funding to purchase equipment to aid in the care of patients, and have won contract language to create quality improvement programs designed to improve patient care and save their hospitals money.

Collective bargaining has also created opportunities for CIR and its individual resident members to partner with their hospital-employers to develop programs to promote quality

medical education and patient care. For example, CIR has co-sponsored presentations on patient safety and patient communication with certain hospitals and is collaborating with Boston Medical Center on a joint patient safety project. CIR has also created an initiative to promote public health in some of the poorest neighborhoods where its members work and certain hospitals have eagerly sought to participate with CIR.

The result has been that, whether through collective bargaining or via partnerships formed outside of the collective bargaining process, the unionization of resident physicians has led to improvements in medical education and patient care, and a strengthened relationship between resident physicians and their employers.

1. Resident Physicians Have Used Collective Bargaining to Seek Improvements in Their Medical Training and Education.

a. CIR Routinely Bargains for Educational Allowances and Medical Conference Leave Time for Residents.

While the negotiation of wages and benefits has been a priority for residents in collective bargaining, they have placed the improvement of their training and medical education benefits on an equal footing. Many of CIR's collective bargaining agreements guarantee minimum levels of access to the hospital's medical library and electronic database of journals, textbooks and other resources that are needed for both medical education and patient care. CIR-negotiated agreements also provide for leave time to attend educational conferences and Board reviews, and allow resident physicians to seek reimbursement for textbooks, journals and electronic devices that aid residents in their patient care duties and are also used as learning tools.

For example, CIR negotiated to have residents participate in a portable electronic medical device program at New York Methodist Hospital, a private, voluntary hospital in Brooklyn, New York. These devices not only enable residents to access medical books and journals, but also the hospital's own electronic medical records. *See* Collective Bargaining Agreement Between New York Methodist Hospital and the Committee of Interns and Residents, November 1, 2010 – October 31, 2013, pp. 19, 38-40 (hereinafter "Methodist Agreement"). http://www.cirseiu.org/files/2012/02/NY-Methodist-2010-2013.pdf. This same agreement also

provides a $3,500 Library Fund for the purchase of books and journals by residents for the medical library, and grants access to the library during hours that it is otherwise closed. *Id*. at 20. Thus, the Methodist residents have contractual rights that will help, not hinder, their training.

The agreement between CIR and the University of New Mexico Medical Center (UNM) provides $450 annually to each resident for educational purposes such as educational or professional software, board review programs, conference registration and travel, and work-related medical equipment, among other educational items. *See* Collective Bargaining Agreement Between the University of New Mexico and the Committee of Interns and Residents, August 1, 2011 – August 31, 2013, p. 35. http://www.cirseiu.org/files/2012/02/UnivNewMexico-2011-2013.pdf. Prior to the UNM residents unionizing in 2007, only some departments provided an educational reimbursement. Through collective bargaining, CIR was able to ensure that all residents received this educational benefit. CIR also negotiated tuition reimbursement for UNM residents who wished to further their "medical academic education" with courses that "add[s] to the knowledge base of any of the ACGME Clinical Core Competencies (Patient Care, Medical Knowledge, Professionalism, Interpersonal Communication Skills, System Based Practice and Practice Based Learning and Improvement)." *Id.* at 34. There was no tuition reimbursement prior to the negotiation of the first collective bargaining agreement between CIR and UNM.

At Kingsbrook Jewish Hospital Center, in addition to negotiating an annual $700 educational material allowance, the resident physicians bargained for the creation of an Education Enhancement Committee. *See* Collective Bargaining Agreement Between Kingsbrook Jewish Hospital Center and the Committee of Interns and Residents, January 1, 2011 – December 31, 2013, p. 31. http://www.cirseiu.org/files/2012/01/Kingsbrook-Jewish-2011-2013.pdf. The Committee, which is comprised of two residents and two hospital representatives chosen by the hospital administration, is charged with reviewing the educational needs of the hospital and residents, and makes written proposals on educational matters for consideration by the Kingsbrook administration and Board of Directors. Here, collective bargaining has enabled residents to not only negotiate for funding for additional educational resources, but it has also

established a mechanism to allow those most impacted by the quality of the training program to offer suggestions that could improve the program.

In addition to the aforementioned educational and tuition reimbursement benefits that the residents at UNM negotiated, the CIR resident physician leaders at UNM recently launched a Quality Improvement and Ethics Journal in conjunction with the hospital's Graduate Medical Education department. With a goal of coordinating collaboration among residents interested in quality improvement, the journal provides an overview of resident quality improvement projects. http://www.cirseiu.org/files/2012/07/CIR-UNM-QI-Journal-6.9.12.pdf.

Finally, perhaps the greatest success story among CIR's many achievements in enhancing resident training and job performance has been the Patient Care Trust Fund (PCTF) for New York City Health and Hospitals Corporation (HHC) medical facilities. Resident physicians employed by HHC[2] collectively bargained to have a percentage of their payroll placed in the PCTF to purchase medical equipment and fund educational projects at HHC hospitals. *See* Collective Bargaining Agreement Between The City of New York, Health and Hospitals Corporation and the Committee of Interns and Residents, October 26, 2008 – October 25, 2010, p. 11, http://www.cirseiu.org/files/2012/02/HHC-2008-2010.pdf. The Fund is governed by a Board of Trustees comprised of HHC resident physicians. It is also HHC residents who develop proposals and apply for funding through the PCTF. In addition to items such as stretchers, exam tables, microscopes and other medical equipment, the resident physician Trustees have allocated funds to support hospital-wide educational events as well as the attendance of residents at patient safety conferences. http://www.cirseiu.org/pctf/.

For example, in February 2012 the CIR PCTF co-sponsored the first ever Resident Research Day at Metropolitan Hospital Center in conjunction with New York Medical College and Metropolitan. *See* "Patient Care Trust Funds at Work," http://www.cirseiu.org/pctf/. PCTF funds were also used to support two CIR resident physicians' attendance at the Telluride Patient

[2] HHC medical facilities that employ residents include Bellevue Hospital Center, Harlem Hospital Center, Metropolitan Hospital, Jacobi Medical Center, Lincoln Medical and Mental Health Center, Coney Island Hospital, Kings County Hospital Center and Woodhull Medical and Mental Health Center.

Safety Camp in Telluride, Colorado. As Paul Levy, a former hospital CEO and current health care blogger who attended the Telluride camp, noted:

> In addition to traditional collective bargaining issues, CIR has a major focus on creating a better patient quality and safety environment in the hospitals in which its members work. Also, it supports education and training to improve the quality of care the members are able to provide to patients.

Paul Levy, *Jumping for joy in Telluride*, Not Running A Hospital, June 12, 2012, http://runningahospital.blogspot.com/2012/06/jumping-for-joy-in-telluride.html. The Telluride Camp brings health care leaders together with resident physicians to discuss practices and policies that will lead to enhanced patient safety and quality health care. http://www.telluridescience.org/reg/workshop_details.php?wid=353. Those resident physicians then bring this knowledge back to their health care facilities and ultimately, it is hoped, become leaders on patient safety issues. To effectuate this, residents who attended, including those sponsored by CIR, were required to "implement, lead and successfully complete a safety or quality improvement project" at their hospital during the subsequent 12-month period. Paul Levy, *Reaching greater heights at Telluride*, Not Running A Hospital, June 14, 2012, http://runningahospital.blogspot.com/2012/06/reaching-greater-heights-at-telluride.html. For these residents, none of this would have been possible without collective bargaining.[3]

b. Resident Physicians Have Used Collective Bargaining to Improve Patient Care.

Because resident physicians are front-line health care providers – much like the graduate student employees are front-line teachers and researchers at private universities – quality improvement of patient care has been an important component of CIR's focus in collective bargaining. Whether advocating for the creation of a patient care fund to pay for much needed medical equipment and other patient care-centered items or bargaining for a quality improvement program to enhance patient care and save the hospital money, unionized resident physicians have made both medical education and patient care a priority. They have been able to do so because

[3] It is important to note that none of the collective bargaining achievements cited involved bargaining over the educational content of the programs. In addition, while CIR has bargained for additional funding for equipment and materials that help resident physicians do their work better and also enhance their medical training, oftentimes the actual equipment or material sought by the residents must still be approved by a hospital program director or administrator.

the union has given them a voice at the workplace that has enabled them to share their experiences as health care providers with their employers in a serious forum that otherwise would not be available to them.

Resident physicians and CIR have done so because they understand that they have a personal and professional stake in the future of medicine and collective bargaining is an opportunity to affect their chosen profession in a positive manner. Graduate student employees, as future academics, have a similar motivation and collective bargaining would give them an opportunity to effect similar positive change in a way that would benefit them, their universities and the professional education industry in general.

A vivid illustration of how the unionization of resident physicians had such an impact on patient care can be found at UNM. Despite initial reservations, academic physicians found that unionization had a positive impact on the residents at UNM. In an article published in Academic Medicine and jointly written by the Associate Dean for Graduate Medical Education and the program directors for Internal Medicine and Pediatrics, it was noted that the union was a "responsible partner with the ability to mobilize residents" and that it had "contributed to organizational culture change, resulting in the empowerment of the organized residents" in a way that had enhanced resident professionalism. David Sklar, M.D. et al., *Experience With Resident Unions at One Institution and Implications for the Future of Practicing Physicians*, 86 Academic Med. 552, 553 (2011). Most compelling, these attending physicians noted, was that the presence of CIR gave the residents a stronger voice to advocate for a patient care fund that improved the quality of patient care, whereas prior to the arrival of the union, both resident and attending physicians had been frustrated in similar attempts.

> [O]ur residents sought to allocate money to a patient care fund, which they control, for unmet patient care needs. This fund has been used for medical equipment, for discharge medications for patients who cannot afford them, and for transportation assistance. The assumption behind this fund is that residents have a unique perspective about the priority of patient care needs that is not represented within the current budgetary system. Before the unionization, residents and other physicians could participate in the hospital budget committee that assesses and prioritizes all requests for funding. Because of the scheduling of the meeting and the long, complex budget review process, physicians often

> felt that their requests did not fare well in the final budgetary decisions. Faculty physicians and residents perceived the physicians' voices to be weak compared with those of the nurses or the administrators. *With the presence of the union, the influence of the residents' voices regarding a portion of the budget was greatly enhanced. Because the patient care fund improved the quality of patient care, this aspect of unionization did not seem to erode professionalism…but may have actually enhanced it.*

Id. at 553.[4] (emphasis added).

The patient care fund at UNM, for which $40,000 annually is set aside for the purchase of "medical equipment, patient materials, or educational supplies and programs to improve patient care at UNM," is no anomaly.[5] In fact, it is a staple in both public and private CIR collective bargaining agreements, including many negotiated since *Boston Medical Center* was decided. For example, the CIR bargaining unit at Brooklyn Hospital, which was certified in 2001, negotiated a $10,000 annual contribution to its patient care fund for the "purchase of needed medical equipment, patient materials, or educational materials that would facilitate the GME program's ability to provide quality patient care." *See* Collective Bargaining Agreement Between Brooklyn Hospital Center and the Committee of Interns and Residents, February 1, 2011 – December 31, 2013, p. 32. http://www.cirseiu.org/files/2012/01/Brooklyn-2011-2013.pdf. The collective bargaining agreement at Boston Medical Center provides $35,000 annually for the "purchase of equipment, supplies, educational materials and other items deemed to be of benefit to patients." *See* Collective Bargaining Agreement Between Boston Medical Center and the Committee of Interns and Residents, October 1, 2011 – September 30, 2013, pp. 34-35. http://www.cirseiu.org/files/2012/07/BMC-2011-2013-Contract-For-Web.pdf. While the residents' recommendations for expenditures must be approved by the hospital's Director of Medical Affairs, the fund is administered by the resident physician members of CIR. Residents at Boston Medical Center have used patient care funds to provide taxi vouchers for pregnant women with limited means and for a prosthetic electronic speech device loan program for

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[4] In an attempt to devalue the experience of public sector resident physician and graduate student employee unions, those opposed to granting them collective bargaining rights under the Act have argued that those experiences are irrelevant because some states have limited bargaining subjects for public academic employees. *Brown Univ.* at 492. However, this is not true in New Mexico nor New York, where collective bargaining for resident physicians has flourished in both the public and private sector.

[5] *See* "UNM Agreement," p. 12. http://www.cirseiu.org/files/2012/02/UnivNewMexico-2011-2013.pdf.

patients who have had their voice boxes removed due to cancer. http://www.cirvitals.org/tag/patient-care-funds/.

Resident physicians have also used collective bargaining as a vehicle to jointly develop a ground-breaking quality improvement program at Maimonides Medical Center that includes an incentive bonus program for residents should the hospital reach certain efficiency and patient care goals. Specifically, the collective bargaining agreement states:

> The parties recognize that they have shared interests in ensuring effectiveness and efficiency in the delivery of patient care and in improving clinical outcomes and patient satisfaction. The parties also recognize the important role that residents play in many of the processes that contribute to these shared interests.

See Collective Bargaining Agreement Between Maimonides Medical Center and the Committee of Interns and Residents, November 1, 2010 – October 31, 2013, p. 3. http://www.cirseiu.org/files/2012/01/Maimonides-2010-2013.pdf. The contract calls for an incentive bonus program to be designed by a committee of faculty, residents, a CIR staff person and the hospital's Executive Vice President of Clinical and Academic Development. In the same agreement, CIR also bargained for the creation of a new quality improvement fellowship position – the Maimonides/CIR Fellow for Quality and Work Redesign -- to help the hospital achieve improvements in patient care on a system-wide basis. *Id*. Maimonides CEO Pamela Brier recognized the value that collective bargaining with the residents brought to the hospital.

> "The [Quality Improvement] program that we developed together will reward house staff when they directly contribute to better health outcomes and costs savings," says Pam Brier, the Brooklyn hospital's chief executive. "It's a 'win-win' strategy to improve patient care, bend the cost curve and position Maimonides for health reform."

Barbara Benson and Gale Scott, *Maimonides residents negotiate efficiency bonuses*, crain's health pulse, Nov. 9, 2010.

Similar programs achieved through collective bargaining with Bronx Lebanon Hospital Center and New York Methodist Hospital have benefitted both hospitals as well as the residents. At Bronx Lebanon, residents earned bonuses from a collectively bargained performance

incentive program after they helped achieve improvements in lengths of stay at the hospital. Methodist Hospital residents also received bonuses after patient satisfaction scores jumped. Joe Carlson, *Rewards and their risks*, Modern Healthcare, April 30, 2012 at p. 29.[6] The existence of these programs not only is evidence of the value of collective bargaining with employees who carry certain indicia of student status, but it also underscores the important role that residents play in the provision of patient care and the success of the hospital.

The resident physicians in CIR have not only negotiated for quality improvement programs at individual hospitals but they have also used collective bargaining to affect positive change in patient care and medical education in a more broad-based manner. Specifically, CIR formed the CIR Joint Quality Improvement Association (JQIA), a multi-employer, not-for-profit organization created for the purpose of developing safety and quality health care best practices and methodologies to be shared with other CIR members and the participating hospitals.

Funded with employer contributions that CIR negotiated for in its collective bargaining agreements with Methodist Hospital, Interfaith Medical Center, Bronx Lebanon Hospital Center, Brookdale Hospital, Flushing Hospital and Jamaica Hospital Medical Center, JQIA acts as a joint labor-management committee whose focus is to improve patient care and training at participating hospitals through collaborative projects with CIR.[7] It is important to note that at these hospitals, funding for the JQIA program has been negotiated as an addition to the

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[6] The Bronx Lebanon collective bargaining agreement provides incentive bonuses for reductions in lab expenses, patient lengths of stay, increases in patient satisfaction and reductions in denials of service by managed care organizations. *See* Collective Bargaining Agreement Between Bronx Lebanon Hospital Center and the Committee of Interns and Residents, November 1, 2010 – December 31, 2013, http://www.cirseiu.org/cir-member-hospitals/bronx-leb/. The Methodist agreement established a joint committee of residents, CIR staff, faculty and hospital administrators to develop areas of concentration that included patient satisfaction. *See* Methodist Agreement at p. 35. Like the Maimonides agreement, the Methodist contract also provides funding for a quality improvement fellow who would be selected from among the existing resident physicians at Methodist. *Id*.

[7] An example of the JQIA contract language can be found on pages 35-36 of the Methodist Hospital collective bargaining agreement. http://www.cirseiu.org/files/2012/02/NY-Methodist-2010-2013.pdf.

aforementioned individual medical education and conference reimbursements as well as the quality improvement incentive bonus programs.[8]

2. CIR Has Partnered With Employers Outside of the Collective Bargaining Process to Collaborate on Projects That Have Improved Resident Training and Public Health.

The relationships that have been developed through collective bargaining have directly led to CIR teaming up with certain hospitals on other projects. While these collaborative efforts have occurred outside of the collective bargaining process, they would not have been possible without collective bargaining. Collective bargaining has given CIR and its resident physician members an opportunity to explore shared interests in resident training and patient care with their hospital-employers and, to their credit, these employers have recognized the value of working with their resident physicians in a manner that benefits both parties.

One such example is the Healthy Bronx Initiative (HBI). CIR developed HBI in response to concerns expressed by its members employed by hospitals in the Bronx, who repeatedly were dealing with patients suffering from obesity and asthma. By working closely with community groups and becoming active in surrounding neighborhoods, HBI seeks to address the root causes of these medical conditions rather than wait to treat them when patients present at the hospital. http://healthybronx.org/what-we-do/. Rather than stubbornly sit on the sidelines and pretend that because resident physicians are doctors-in-training they are unable develop good ideas related to medical education and patient care, CIR hospitals in the Bronx such as St. Barnabas Hospital, Bronx Lebanon Hospital Center and others embraced HBI by co-sponsoring public health projects such as a presentation to the Albanian community, http://healthybronx.org/2011/10/31/albanian-health-event/, and by sending resident physicians and social workers to meet with tenants in dilapidated housing to treat illnesses related to their poor living conditions. Alec Hamilton, *Stopping Apartments From Making Tenants Sick*, Gotham Gazette, January 2012, http://old.gothamgazette.com/article/housing/20120130/10/3676.

[8] JQIA also sponsored two residents, one from Bronx Lebanon Hospital Center and one from New York Methodist Hospital, to attend the 2012 Telluride Patient Safety Camp, described earlier on page 10.

CIR created another initiative whose objective is to improve patient safety, the quality of patient care and medical education. Funded by CIR, individual donations and private grants, the CIR Policy and Education Initiative (PEI) sponsors workshops, trainings and conferences to achieve these objectives. http://www.cirpei.org/our-mission/. Most notable among those collaborating with PEI have been the eight New York City Health and Hospitals Corporation hospitals that employ residents. Each year since 2008, PEI and HHC have jointly hosted a conference designed to build patient safety skills for both resident and attending physicians. http://www.cirpei.org/patient-safety/. A 2011 CIR PEI-HHC joint project on improving medication safety through teamwork and communication was deemed worthy of a $39,000 grant from the Federal Mediation and Conciliation Service. http://www.fmcs.gov/assets/files/Grants/2011kit/FY2011FundingSummary.pdf. The project, comprised of a one-day conference followed by the development of educational material and a series of events at individual HHC hospitals, educated physicians and other front line health care providers about medication safety. *Id.*

One final example of CIR partnering with an employer occurred recently when CIR and Boston Medical Center's Division of Geriatrics were awarded a $22,000 grant for a patient safety project aimed at the hospital's residents. The goal of the project is to survey residents about why they do not report adverse patient care events and to implement interventions to increase reporting based on the results of the survey.

While these joint projects are noteworthy, CIR, through its sponsorship of CIR PEI, has also undertaken educational projects on its own. In November 2011, CIR PEI, with financial help from a private foundation, hosted a Physician-Patient Communication Conference at the New York Academy of Medicine. With approximately 150 resident physicians, medical students and faculty in attendance, academic physicians from the Yale School of Medicine and Montefiore Medical Center, as well as from residency programs at CIR hospitals such as St. Luke's Roosevelt Hospital, Maimonides Medical Center and Methodist Hospital, among others, provided cutting edge training in patient interviewing techniques, skills covered in residency training only cursorily. Video clips of the presentations were also created so that other

physicians could benefit. "NYC Residents Learn the Art of Patient-Centered Interviewing," CIR PEI website, http://www.cirpei.org/bulletin/2012/3/7/nyc-residents-learn-the-art-of-patient-centered-interviewing.html. Health care blogger Paul Levy thought the CIR PEI videos were impressive enough to post them on his blog while reporting from the Telluride Patient Safety Camp. Paul Levy, *Effective Communication Videos From CIR*, Not Running A Hospital, June 13, 2012. http://runningahospital.blogspot.com/2012/06/effective-communication-videos-from-cir.html.

IV. CONCLUSION

CIR's membership is comprised of highly motivated, highly educated resident physicians which, because of the nature of resident employment, is constantly changing as residents complete their training programs and are replaced by new medical school graduates. As a result, resident physician bargaining units are dynamic groups that constantly bring new ideas and enthusiasm for enhancing their medical education and patient care.

The same could be said about graduate student employee bargaining units, which are comprised of an ever-changing group of highly educated individuals. One could expect then that the success and achievements enjoyed by the resident physicians who have collective bargaining rights under the Act will be matched should graduate student employees be granted those same rights. The inevitable conclusion thus is that allowing private sector graduate student employees to organize is not only correct as a matter of law, but is also in furtherance of sound labor policy.

For the above-stated reasons, the Board should reverse the decisions of the Regional Directors and hold that graduate student assistants are employees covered by the Act.

Respectfully submitted,

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CERTIFICATE OF SERVICE

Ralph DeRosa, an attorney, certifies that he caused a copy of the foregoing Brief of Amicus Curiae in Support of Petitioners GSOC/UAW and International Union, United Automobile, Aerospace, and Agricultural Implement Workers of America to be served upon counsel named below and the Regional Director, by email, this 23rd day of July, 2012.

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